

Inequities in Health and Health Care in Black and Latinx/Hispanic Communities: 23 Charts

Jesse C. Baumgartner
Gabriella N. Abouafia
Yaphet Getachew
David C. Radley
Sara R. Collins
Laurie Zephyrin

INTRODUCTION

COVID-19 has devastated Black and Latinx/Hispanic communities in the United States during the past year, erasing recent life expectancy gains and reinforcing racism as a potent, structural driver of health and human inequity.¹

The health disparities contributing to this burden are long-standing. They reach well beyond the pandemic and have left many communities of color with historically worse outcomes. This chartbook details inequities between white, Black, and Latinx/Hispanic communities across a range of health indicators in four main areas:

- insurance coverage and access to care
- receipt of health services
- health status
- mortality.

To say that these communities are at higher risk of poor health means recognizing the reasons why. During the pandemic, socioeconomic factors — where people live and work, how much they are paid, and what kind of access they have to healthy living environments and high-quality health care — have all influenced who is exposed to COVID-19 and, ultimately, who has died.² Across almost all U.S. age groups, that has disproportionately been Black and Latinx/Hispanic people.³

These associations should invoke moral outrage, but they should not surprise us. They stem from a history of structural racism that is entrenched in U.S. policies.⁴ It is a legacy where, in some U.S. cities, people born a few miles apart might have a 20-year difference in life expectancy.⁵

It is therefore important to assess the performance of U.S. health care through a racial equity lens. And, in our efforts to reform that system, we must acknowledge that health inequities cannot be separated from “the policies and institutions that undergird the U.S. racial hierarchy.”⁶

For example, we cannot talk about health without understanding the impact of racial segregation.⁷ By refusing to underwrite mortgages in neighborhoods of color, intercede against racial housing covenants and discriminatory zoning, and, later in the 20th century, regulate predatory lending, the federal government cut Black and other nonwhite Americans out of government-subsidized wealth-building programs and helped create separate and unequal living conditions.⁸

The health effects of these policies are vast⁹:

- In many areas, residents of heavily Black neighborhoods have less access to primary care providers than those living in neighborhoods with fewer Black residents.¹⁰
- Air pollution emissions are higher where people of color live, temperatures are hotter, and green spaces scarcer.¹¹
- In historically redlined neighborhoods, poor health outcomes such as elevated preterm birth risk, asthma-related emergency visits, later cancer-stage diagnoses, and a wide range of chronic health conditions remain prevalent decades later.¹²

Past policies like these also have helped create wide economic inequities, which can influence who is more likely to be covered

by health insurance and have timely access to care, who has the financial assets to recover from medical financial shocks, whose insurance plans pay providers more, and which health facilities accept someone as a patient.¹³

At the same time, the effects of structural and interpersonal racism also manifest within health systems:

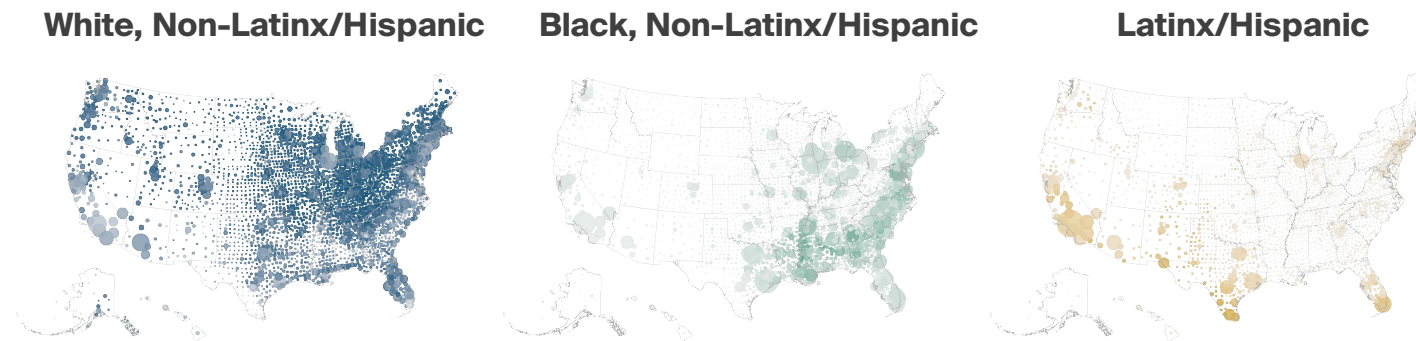
- Many Black and Latinx/Hispanic patients receive inadequate care once they are in the doctor’s office, following on generations of unequal treatment and medical racism.¹⁴ Commonly they are mistreated and disregarded by providers, encounter significant language and cultural communication barriers, are prescribed lower-value or suboptimal care, or suffer the effects of racial bias within hospital treatment algorithms.¹⁵
- Even within the same hospitals, Black and Latinx/Hispanic patients are more likely than white patients to experience severe complications related to birth, regardless of insurance status.¹⁶

Achieving antiracism in the health care delivery system will require policies that account for, and confront, the underlying structures that have brought us to this point. In the following charts, we depict current inequities in the way that Black and Latinx/Hispanic people experience health and health care in the U.S.¹⁷ and highlight policies associated with improvement. And, along the way, we reference national and state-level barriers standing in the way of further progress.¹⁸

SOCIOECONOMIC INEQUITIES

Where communities are located can have large health implications.

U.S. racial and ethnic demographics map



White people make up a significant but slowly declining majority of the U.S. population (60% vs. 12% African American and 19% Latinx/Hispanic).¹⁹ There are large differences in where racial and ethnic communities are concentrated. For example, nearly 60 percent of Black people live in southern states, which have among the poorest health outcomes, lowest access to health care, and weakest social safety nets in the country.²⁰ The Latinx/Hispanic population, which is more spread out regionally, also comprises many distinct communities and nationalities that include a wide range of socioeconomic levels.

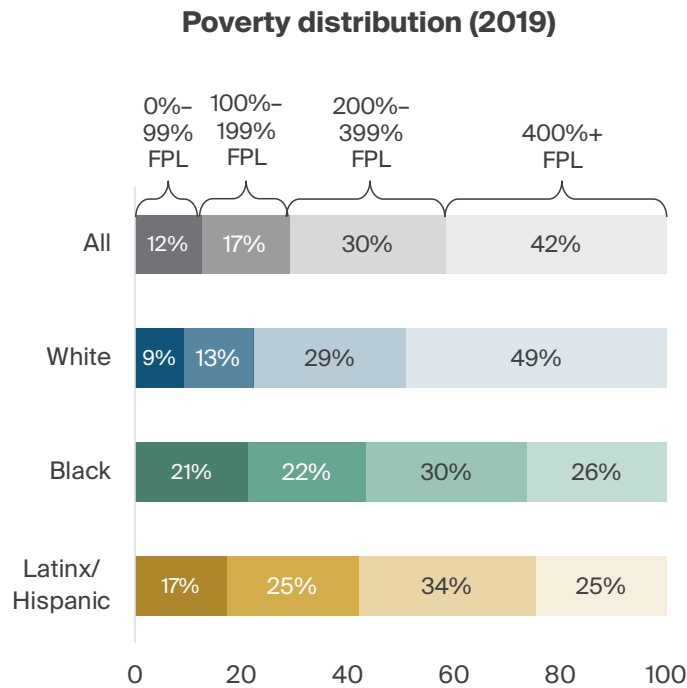
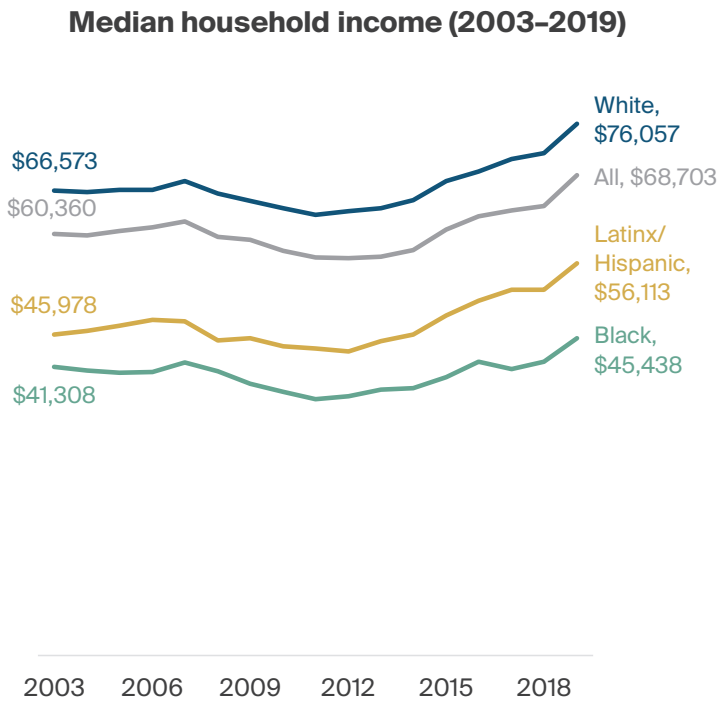
Significant variation in state policies and the way states implement federally funded programs, such as the Affordable Care Act (ACA), can disproportionately affect communities of color.²¹

Note: Bubbles are sized relative to the county population count for each race/ethnicity group; color density is based on the share of the county population in each race/ethnicity group.

Data: National Center for Health Statistics. Vintage 2019 postcensal estimates of the resident population of the United States (April 1, 2010, July 1, 2010–July 1, 2019), by year, county, single-year of age (0, 1, 2, . . . 85 years and older), bridged race, Latinx/Hispanic origin, and sex. Prepared under a collaborative arrangement with the U.S. Census Bureau. Available from: https://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm as of July 9, 2020, following release by the U.S. Census Bureau of the unbridged Vintage 2019 postcensal estimates by five-year age group on June 25, 2020.

SOCIOECONOMIC INEQUITIES

Income inequities, which impact health and access to care, persisted over the past 15 years. Black and Latinx/Hispanic households live below the poverty level at around twice the rate of white households.



The United States has a long history of government-aided residential segregation, unequal access to education, discriminatory financial institutions and assistance programs, disproportionate incarceration, disparate employment hiring practices and pay, and discrimination within the workplace.²² These policies and practices, marked by entrenched structural racism, have contributed to significant gaps within education, economic opportunity, and income, factors that are themselves associated with health access and outcomes.²³ Income disparities have persisted in the U.S. during the past 15 years as wealth inequality has increased.

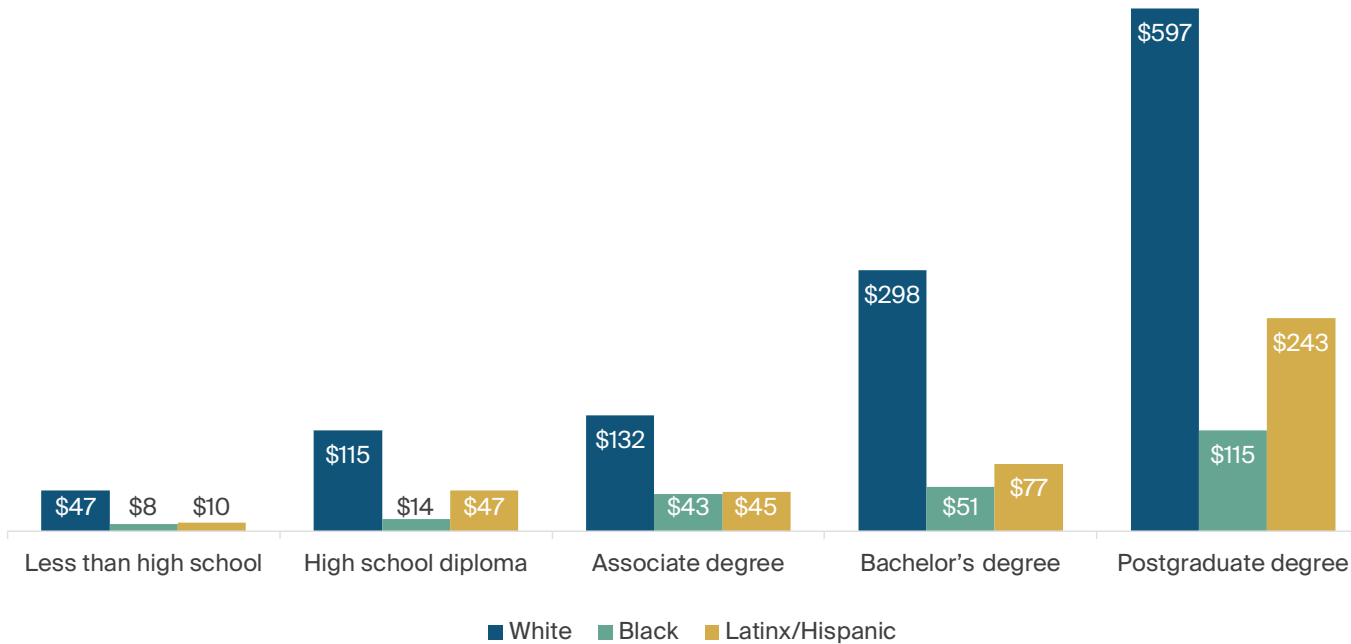
Note: 100% of the federal poverty level (FPL) in 2019 was \$12,490 for an individual and \$25,750 for a family of four.

Data: Median household income – [Current Population Survey](#), 2003–2019 Annual Social and Economic Supplements (2019 dollars); Poverty distribution – [American Community Survey](#), Public Use Microdata Sample (ACS PUMS), 2019.

SOCIOECONOMIC INEQUITIES

Reflecting the impact of racism on social and economic policies, Black and Latinx/Hispanic household wealth is significantly lower than white household wealth across all education levels.

Median household wealth (in \$ thousands), 2019



Inequities often persist regardless of education or income. This is particularly true of household wealth, defined as the net value of a family’s assets — such as bank accounts, stock holding, and home equity — against debt. Wealth has now become a frequent prerequisite for accessing care as health costs have grown, and patients pay more out of their own pocket.

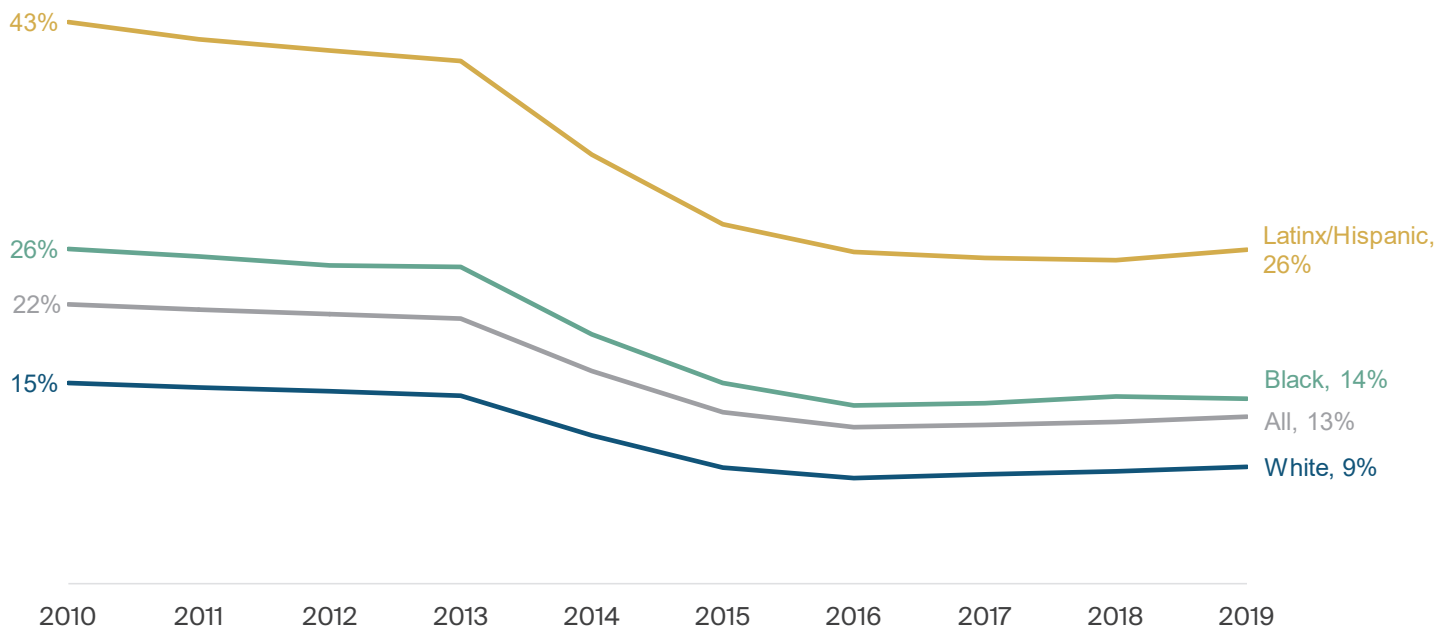
White wealth is substantially higher than Black and Latinx/Hispanic wealth. Research shows that to be true at every income and education level, and that white people with a high school degree have the same median household wealth as Black people with a postgraduate degree. The disparities reflect the impact of discriminatory policies like federal home-lending programs that excluded nonwhite Americans from participating in the wide expansion of home ownership during the 20th century.²⁴

Data: Federal Reserve Board’s 2019 Survey of Consumer Finances; Chart reproduced from Ana Hernández Kent and Lowell R. Ricketts, “Wealth Gaps Between White, Black and Hispanic Families in 2019,” Federal Reserve Bank of St. Louis, Jan. 5, 2021.

INSURANCE COVERAGE AND ACCESS TO CARE

Coverage inequities significantly declined after key ACA provisions went into effect, but gains have stalled and disparities persist.

Percent of adults ages 19–64 who are uninsured, 2010–2019



Data: American Community Survey, Public Use Microdata Sample (ACS PUMS), 2010–2019.

Insurance coverage disparities are long-standing and are associated with lower health care access and poorer health.²⁵ These gaps have become even more perilous during the COVID-19 pandemic.²⁶

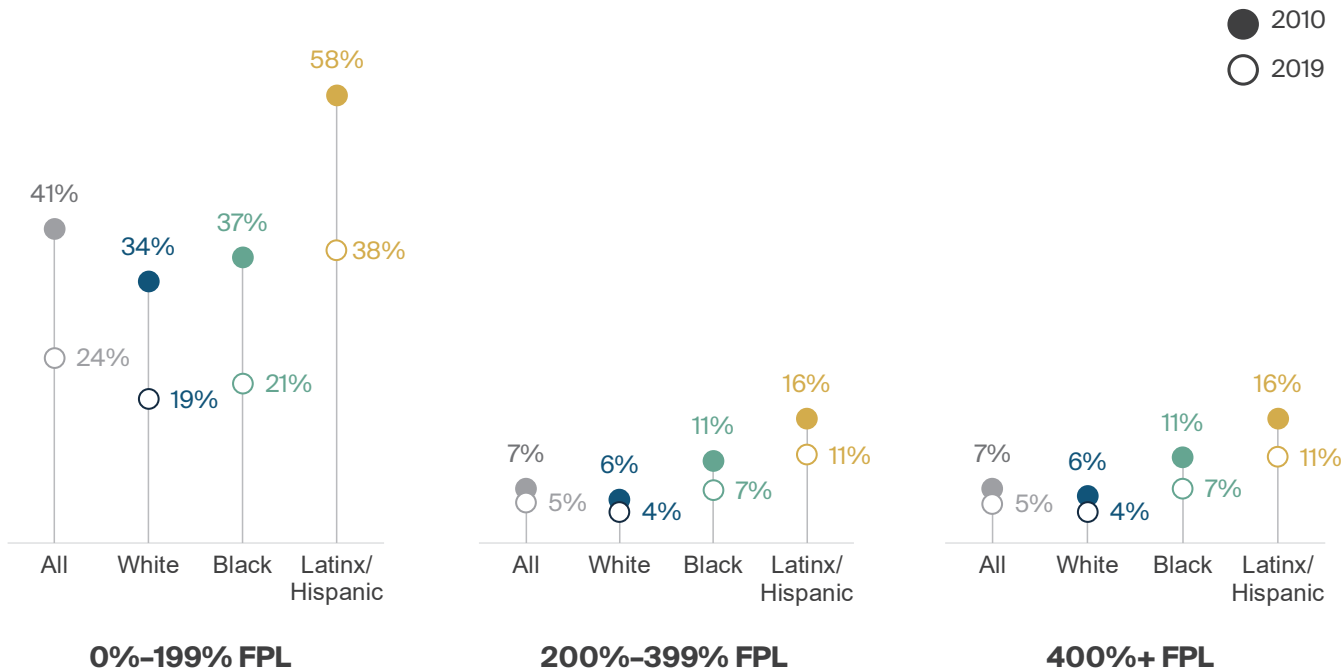
Insurance for U.S. adults has historically been tied to employment, which reflects racial and ethnic economic inequality. Black and Latinx/Hispanic adults are much less likely to receive coverage through their employer.²⁷ The ACA aimed to address these inequities through the expansion of Medicaid and the availability of subsidized individual plans. Thus far, the law has increased coverage and significantly reduced racial and ethnic differences.²⁸

But disparities persist, particularly for Latinx/Hispanic communities, and national progress has stalled since 2016. The uninsured are also more likely to have medical debt, which can lead to long-term financial problems.²⁹

INSURANCE COVERAGE AND ACCESS TO CARE

Black and Latinx/Hispanic nonelderly adults are still uninsured at higher rates than white adults across all income levels, underscoring the need for additional reforms.

Percent of adults ages 19–64 who are uninsured, by income, 2010–2019



The ACA increased coverage the most for lower-income adults, who are disproportionately Black and Latinx/Hispanic. By providing virtually no-cost insurance through Medicaid expansion and significantly limiting costs for low-income families through the marketplaces, it has reduced financial burden and preserved wealth and income for many households.⁵⁰

Though racial and ethnic coverage differences across all income groups have decreased since 2010, Black and Latinx/Hispanic adults within each category are still more likely than whites to be uninsured. Those remaining disparities could be addressed through additional targeted reforms like filling the Medicaid expansion gap and enhancing marketplace subsidies (as the American Rescue Plan does temporarily for the next two years).

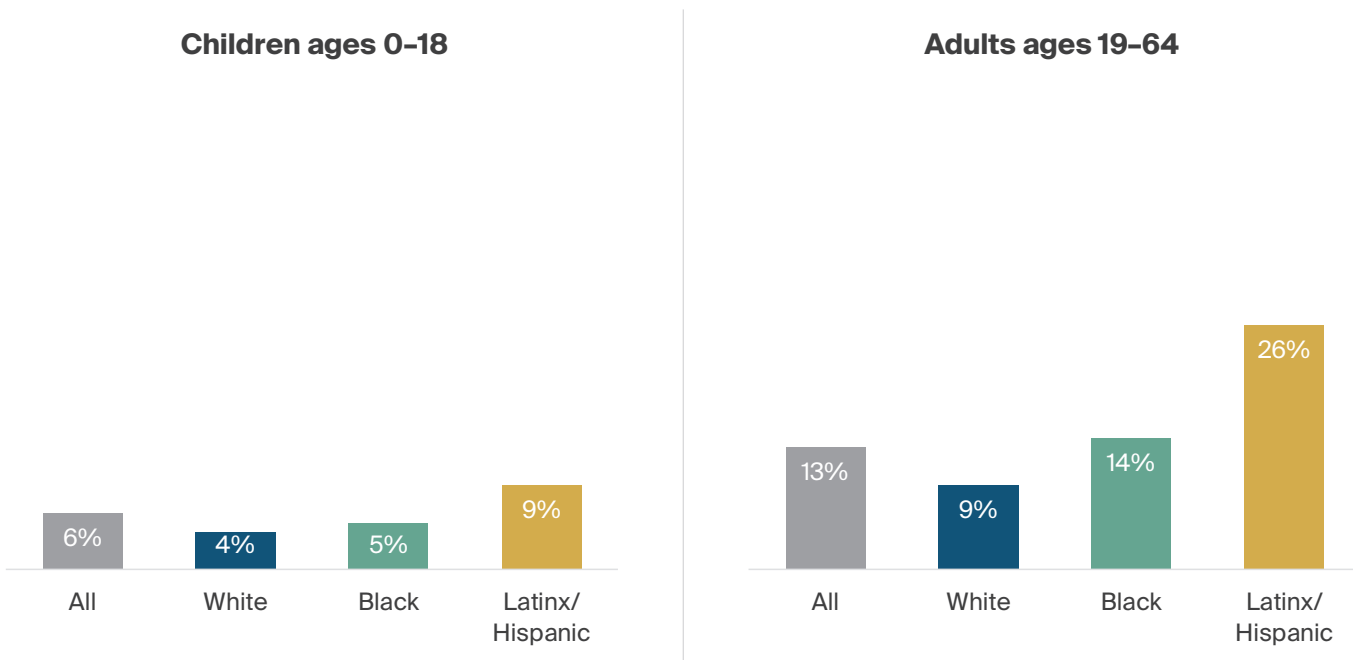
Note: FPL = federal poverty level.

Data: American Community Survey, Public Use Microdata Sample (ACS PUMS), 2010–2019.

INSURANCE COVERAGE AND ACCESS TO CARE

Reflecting federal and state policies, children across all groups are more likely to be insured than adults, but Latinx/Hispanic children are still uninsured at twice the rate of white and Black children.

Percent of children and nonelderly adults who are uninsured, 2019



Uninsured rates and disparities among children are significantly lower than among adults. This is linked to the implementation of the Children’s Health Insurance Program (CHIP) in 1997 and federal and state Medicaid expansions for children.³¹ However, some 4.4 million children still lack insurance, and the number has increased by at least 200,000 each year since 2016.³²

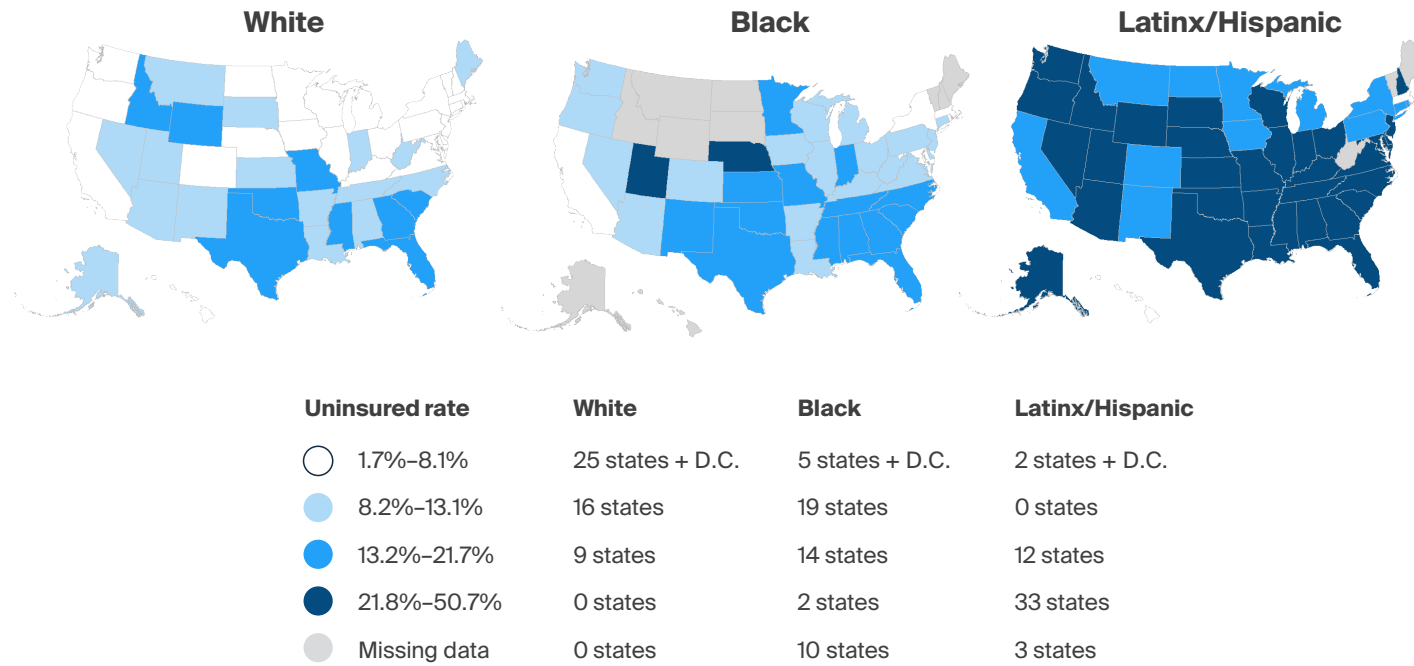
The uninsured rate for Latinx/Hispanic children is higher, largely because undocumented children are typically ineligible for Medicaid or CHIP. The Trump administration’s immigration policies also may have deterred eligible families.³³ While the Biden administration is seeking to end many of these, longer-term impacts are uncertain.³⁴ Some states also enforce more frequent Medicaid and CHIP eligibility checks, which can disproportionately affect Black and Latinx/Hispanic children.³⁵

Data: American Community Survey, Public Use Microdata Sample (ACS PUMS), 2019.

INSURANCE COVERAGE AND ACCESS TO CARE

State-level coverage rates by race and ethnicity exhibit significant regional variation that is often tied to state policy decisions.

Percent of adults ages 19–64 who are uninsured, by state, 2019



Coverage rates and disparities exhibit significant regional variation, in part because of the 2012 Supreme Court decision that allowed states to choose whether they expanded Medicaid to all adults with low income.

Research indicates that expansion is associated with large increases in coverage equity.⁵⁶ Eight of the 14 remaining nonexpansion states are in the South, and Black adults are significantly concentrated in these states.

Because undocumented immigrants are ineligible for coverage through the marketplaces and Medicaid, Latinx/Hispanic people still have the highest uninsured rate in almost every state. They are also more likely to live in certain nonexpansion states, like Texas and Florida.

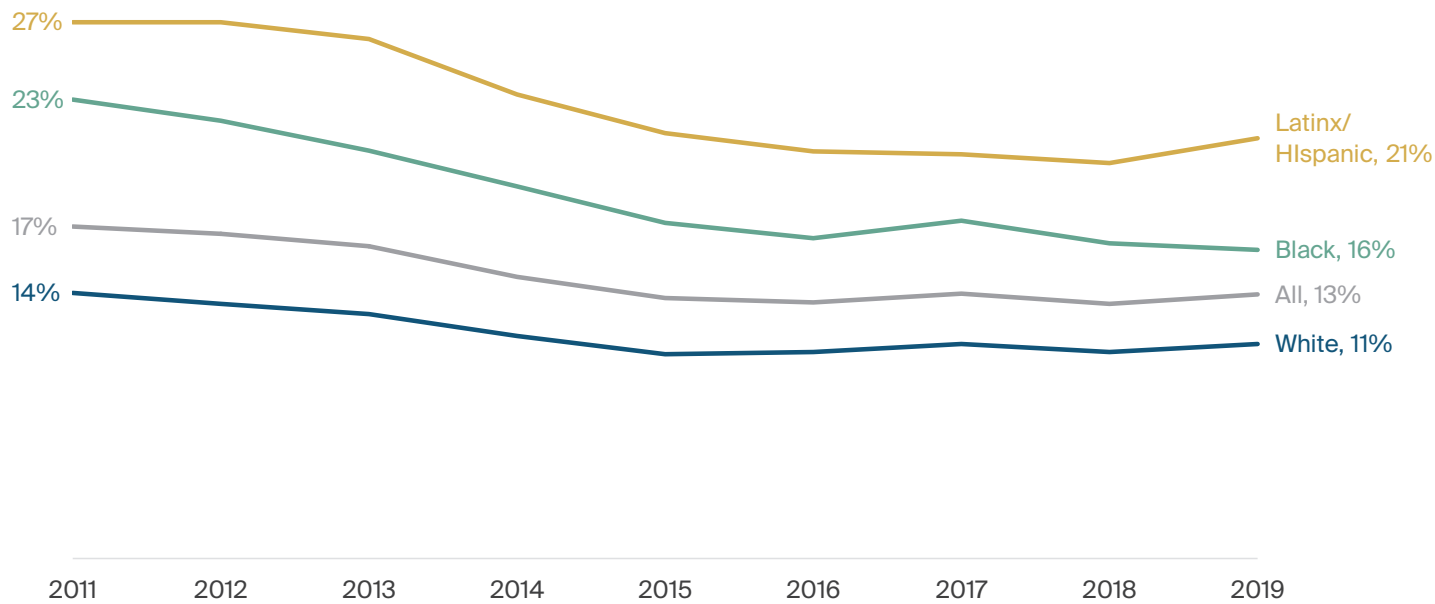
Note: Map groupings are calculated by taking the 25th, 50th, and 75th percentiles across the full distribution of state uninsured rates for all three racial/ethnic groups.

Data: American Community Survey, Public Use Microdata Sample (ACS PUMS), 2019.

INSURANCE COVERAGE AND ACCESS TO CARE

All groups experienced fewer financial barriers after the ACA coverage expansions, but Black and especially Latinx/Hispanic adults are still more likely than white adults to forgo needed care because of cost.

Percent of adults age 18 and older who went without care because of cost in the past year, 2011–2019



Insurance coverage is the most important determinant of access to care, and people with no coverage or inadequate insurance are more likely to avoid care because of cost.³⁷ The ACA's coverage expansions made large improvements in both areas, but Black and Latinx/Hispanic adults still report cost-related barriers at higher rates.

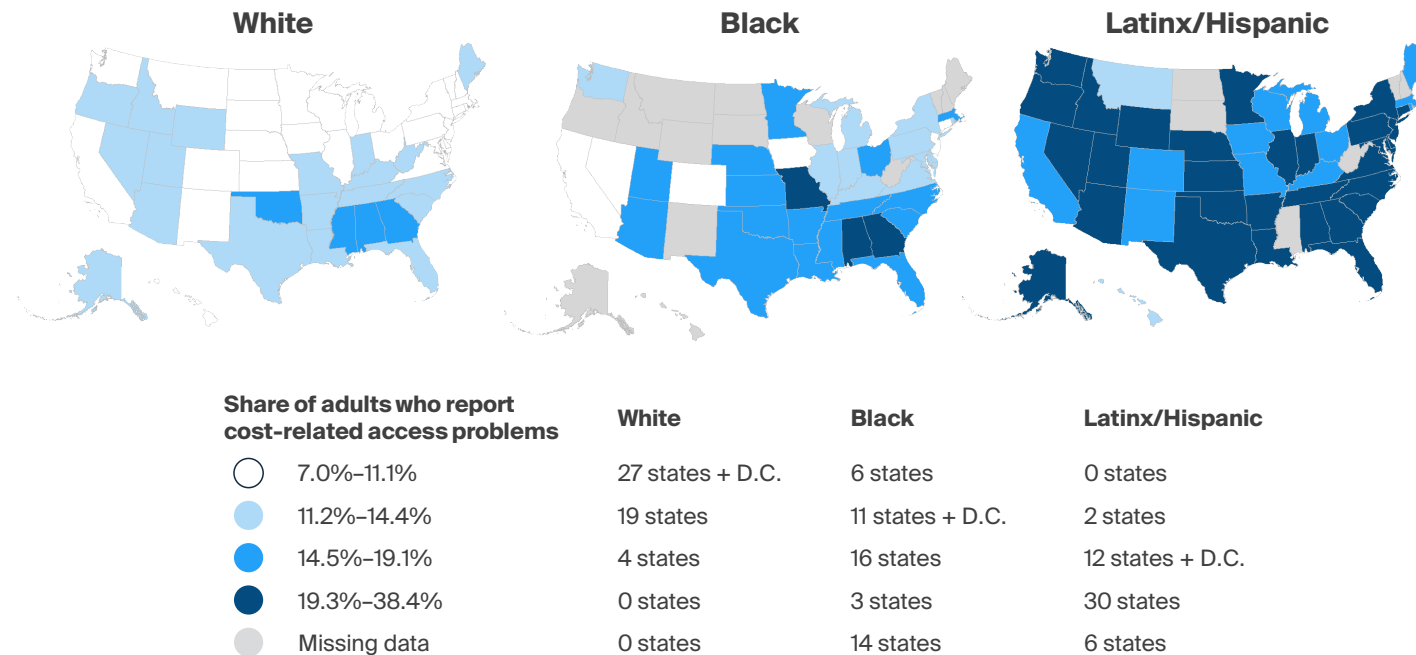
Disparities in cost-related barriers reflect differences in uninsured rates and “underinsurance” or high cost-sharing responsibilities in private plans.³⁸ Data show that Black and Latinx/Hispanic people in employer-coverage households are more likely to have high out-of-pocket costs relative to income.³⁹

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2011–2019.

INSURANCE COVERAGE AND ACCESS TO CARE

Financial barriers to health care vary widely across states but are particularly high for Black and Latinx/Hispanic adults in states that have not expanded Medicaid.

Percent of adults age 18 and older who went without care because of cost in the past year, by state, 2019



Cost-related access problems across the U.S. follow a similar pattern to the geographic variation that exists within insurance coverage.

Cost barriers are higher in states that have not expanded Medicaid, particularly for Black and Latinx/Hispanic adults. Research indicates that expansion is associated with larger declines in cost-related access problems and increased equity.⁴⁰ However, cost-related access problems exist for lower- and middle-income people who are privately insured, too.⁴¹

Latinx/Hispanic adults also face larger cost-related access problems in most states, likely reflecting insurance barriers related to current immigration policies.

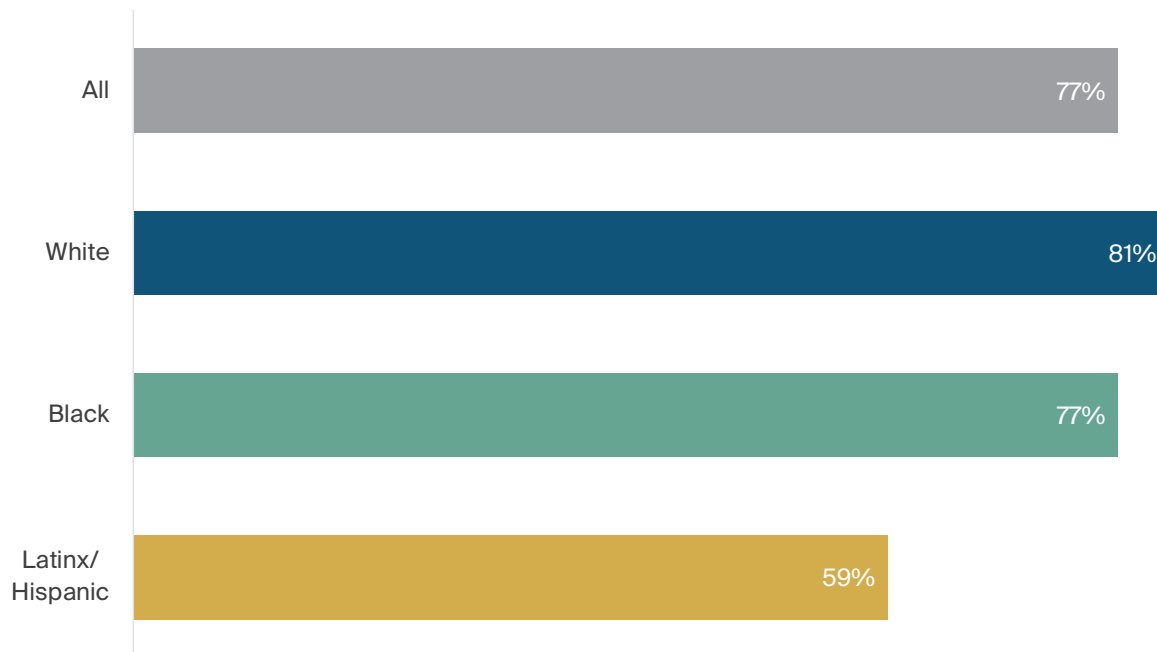
Note: Map groupings are calculated by taking the 25th, 50th, and 75th percentiles across the full distribution of state rates for all three racial/ethnic groups.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019.

INSURANCE COVERAGE AND ACCESS TO CARE

Black and Latinx/Hispanic adults are less likely to have a usual care provider, driven in part by coverage disparities and structural access barriers.

Percent of adults age 18 and older with a usual source of care, 2019



Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019.

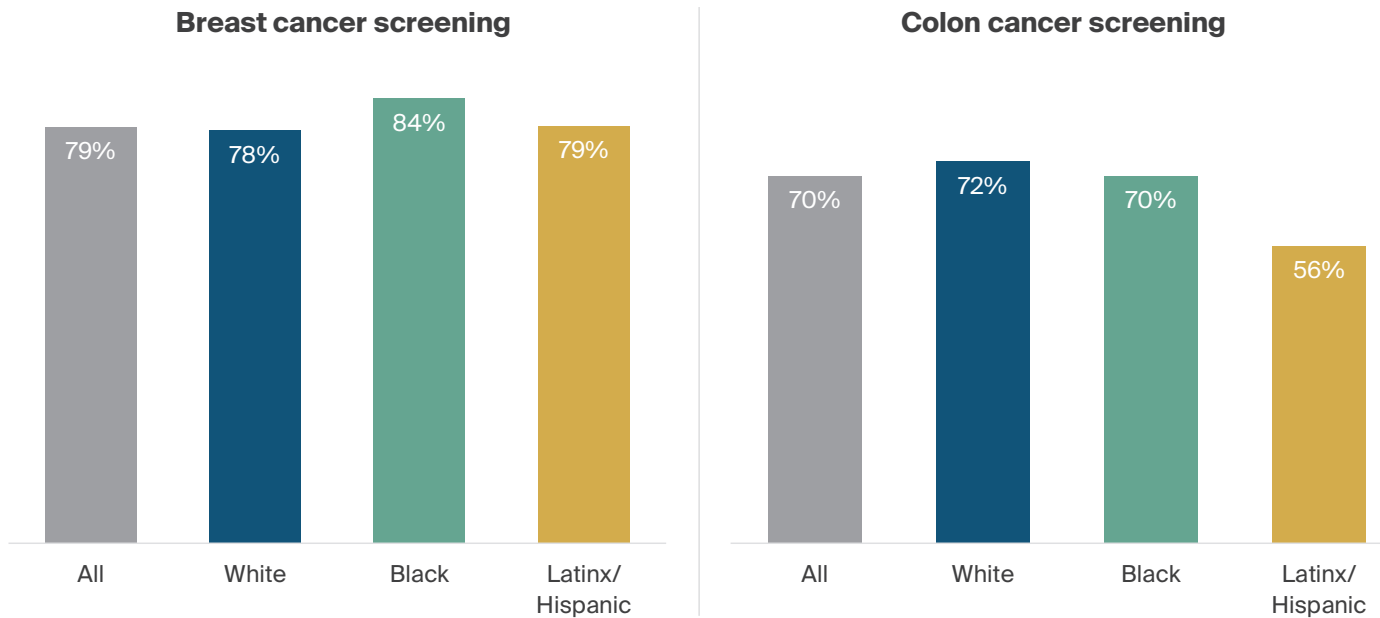
Studies have pointed to coverage as a key component of disparities in usual source of care, finding that those without insurance are more likely to report not having a regular provider and skipping preventive services.⁴²

An additional barrier is the distance to and supply of providers in an area, which often reflects historical racial segregation.⁴³ Researchers have found that, in some cities, neighborhoods with more Black and Latinx/Hispanic adults have access to fewer primary care providers in close proximity.⁴⁴ Other studies have shown racial inequities within facility admissions,⁴⁵ as well as insurance-type segregation⁴⁶ that can limit choices. In addition, Black and Latinx/Hispanic communities may have difficulty finding providers that can deliver care with cultural humility.⁴⁷

RECEIPT OF HEALTH SERVICES

Breast cancer screening rates are high for all groups, but Black and Latinx/Hispanic adults are often diagnosed at more advanced stages.

Percent of adults age 18 and older with up-to-date cancer screenings, 2018



Age-appropriate screening can identify cancers early and improve treatment success rates. Access to screening is mediated by insurance coverage,⁴⁸ as well as cost-sharing barriers⁴⁹ and access to a usual care provider.⁵⁰ The ACA narrowed coverage disparities and required all insurers and employers to cover recommended preventive care without cost sharing.⁵¹

While screening rates have increased, and the current variation within breast cancer exams is modest, Latinx/Hispanic adults have much lower rates of colon cancer screening. Research also indicates that breast cancer screening rates may be overestimated for Black and Latinx/Hispanic women.⁵²

Black adults continue to die from cancer at higher rates than white adults and are often diagnosed at later stages,⁵³ a trend that also occurs among Latinx/Hispanic adults for breast cancer.⁵⁴ (See page 23 for breast and colon cancer mortality data.) This could relate to remaining disparities in care quality, timing differences for screening exams, and broader health system access barriers to high-quality care.

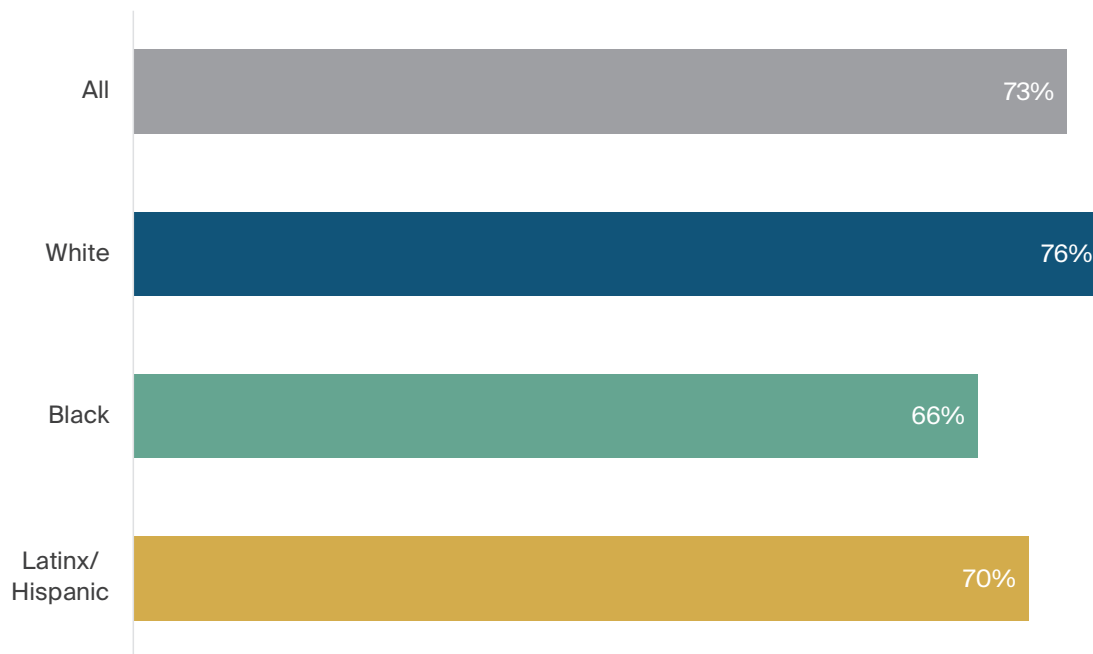
Note: Breast cancer screening is women ages 50 to 75 who received a mammogram in the past two years; colon cancer screening is adults ages 50 to 75 with a recent colon cancer screening test.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2018.

RECEIPT OF HEALTH SERVICES

Higher child vaccination rates reflect public policy, though rates are still lower for both Black and Latinx/Hispanic children.

Percent of children ages 19–35 months who received all recommended doses of seven key vaccines, 2019



Note: Recommended vaccines are the 4:3:1:3:3:1:4 series, which includes ≥ 4 doses of DTaP/DT/DTP, ≥ 3 doses of poliovirus vaccine, ≥ 1 doses of measles-containing vaccine, full series of Hib (3 or 4 doses, depending on product type), ≥ 3 doses of HepB, ≥ 1 dose of varicella vaccine, and ≥ 4 doses of PCV.

Data: National Immunization Survey, 2019.

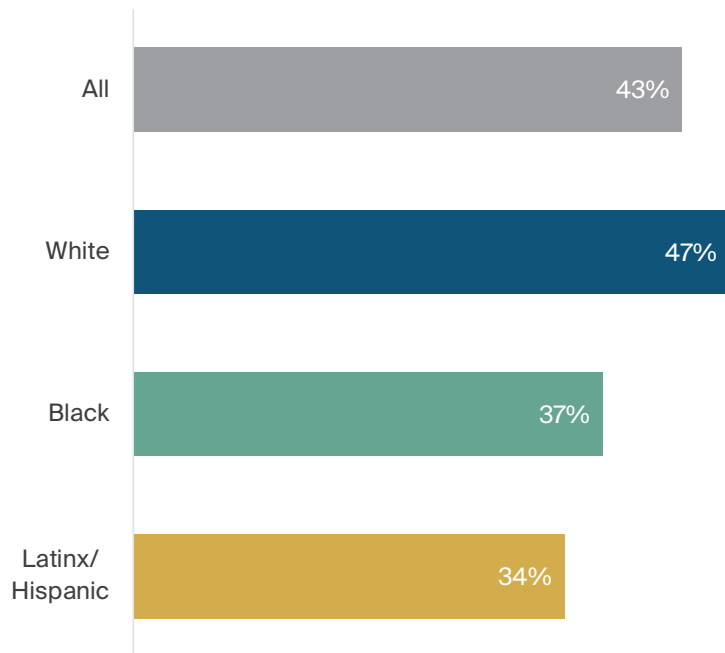
Higher child vaccination rates for all groups can be explained in large part by direct federal and state policies implemented during the past 30 years. These include the Vaccines for Children (VFC) program⁵⁵ run by the CDC, as well as the Children's Health Insurance Program (CHIP) and Medicaid expansions for children.

By greatly decreasing the number of uninsured children and providing free or low-cost vaccines to lower-income families, those policies have removed financial barriers and helped decrease vaccination disparities between the different communities.⁵⁶ Still, notable differences remain between white and Black and Latinx/Hispanic children. These programs will be particularly critical during the next several years, as COVID-19 vaccines are distributed to the general population.

RECEIPT OF HEALTH SERVICES

Adult flu vaccination rates are below the target for all groups, but especially among Black and Latinx/Hispanic adults who face more access barriers.

Percent of adults age 18 and older with a seasonal flu shot in the past year, 2019



Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019.

Adult flu vaccination rates for all groups are well under the national goal of 70 percent,⁵⁷ and rates for Black and Latinx/Hispanic adults are much lower than for whites.

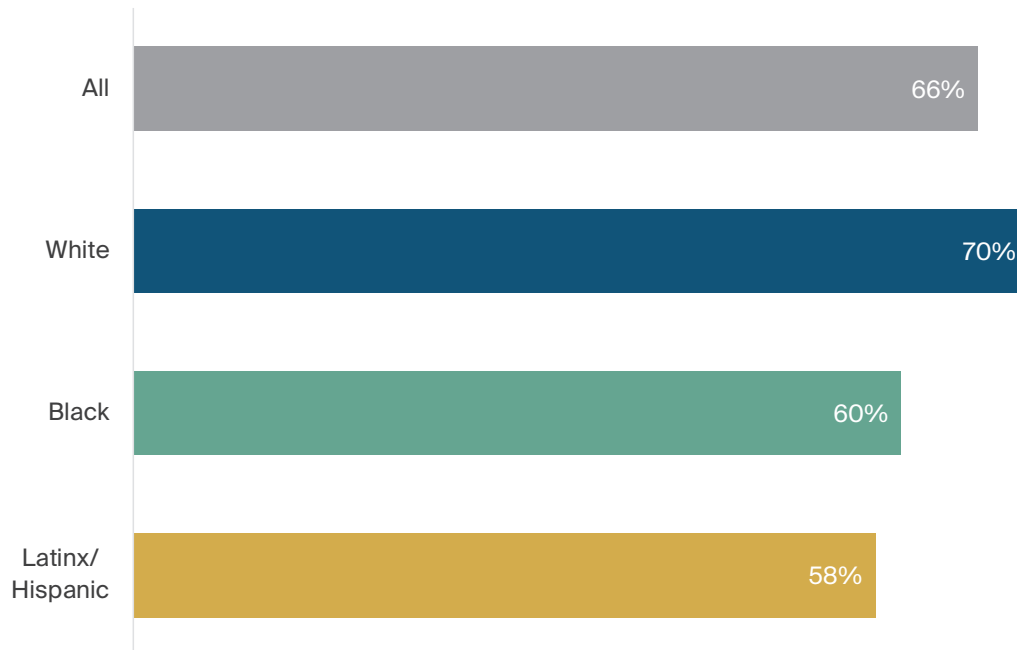
This inequity is particularly troubling in the context of COVID-19. Black and Latinx/Hispanic communities have been disproportionately burdened by the pandemic but have lower access to COVID-19 vaccines,⁵⁸ a racial vaccination disparity also appeared during the H1N1 pandemic in 2009–2010.⁵⁹

Vaccination is strongly linked to access measures including insurance coverage and having a usual care provider.⁶⁰ Data presented earlier show that those access disparities remain significant for Black and Latinx/Hispanic adults but are much lower for children.

RECEIPT OF HEALTH SERVICES

Black and Latinx/Hispanic adults are less likely to receive dental care services, which insurance plans often do not cover.

Percent of adults age 18 and older with a dental visit in the past year, 2018



Data: Behavioral Risk Factor Surveillance System (BRFSS), 2018.

Differences in dental care access reflect both economic inequity and insurance coverage inadequacies.

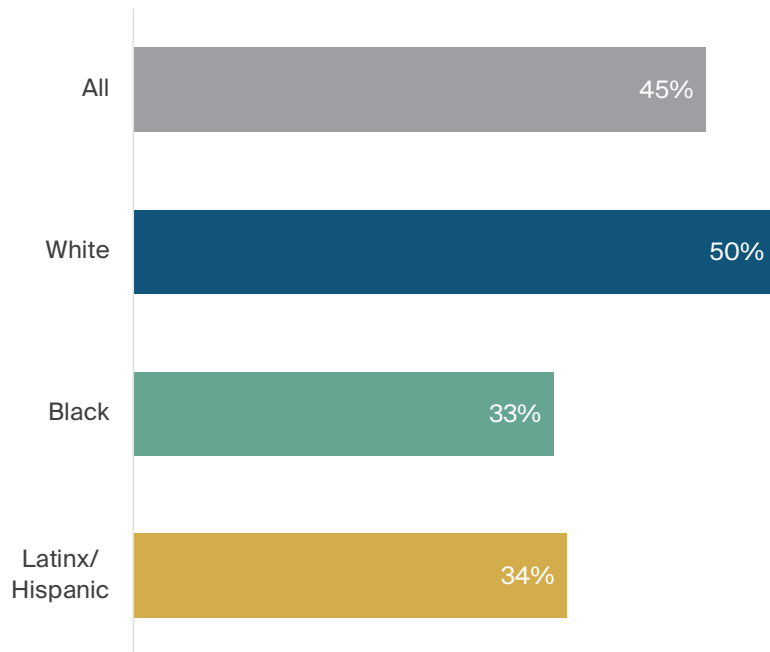
Black and Latinx/Hispanic families are more likely to be uninsured or insured by public health insurance programs. Traditional Medicare does not cover most dental services and state Medicaid programs have discretion over whether to offer it. Only 18 states and the District of Columbia provide comprehensive Medicaid coverage for dental care; the majority of states provide restricted or emergency-only coverage.⁶¹ In addition, many dentists still do not accept Medicaid.⁶²

Private insurance plan coverage of adult dental services is also limited, although less so. Dental benefits are not included in the ACA's essential benefit package for marketplace plans, and only 60 percent of employers who provide health benefits offer dental coverage.⁶³

RECEIPT OF HEALTH SERVICES

Black and Latinx/Hispanic adults with a mental health illness are less likely to receive mental health care.

Percent of adults age 18 and older with any mental illness who received mental health services in the past year, 2019



While recent federal legislation has improved access to mental health services overall,⁶⁴ Black and Latinx/Hispanic adults are less likely than white adults to receive needed mental health services. The pandemic has likely exacerbated this, as Black and Latinx/Hispanic adults have been more likely to experience mental health concerns related to COVID-19.⁶⁵

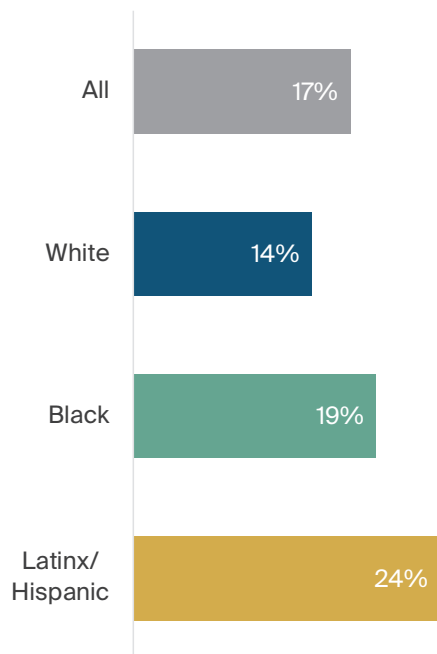
These differences partly reflect disparities in coverage and access. Language and cultural factors also can influence utilization, and experiences with racism have eroded trust in medical providers and institutions.⁶⁶ In addition, the criminal justice system, which targets Black and Latinx/Hispanic people disproportionately, fails to provide adequate support for individuals with mental health issues.⁶⁷

Data: Chart reproduced from National Institute of Mental Health, "Mental Illness," NIMH, last updated Jan. 2021. See "Figure 2. Mental Health Services Received in Past Year Among U.S. Adults with Any Mental Illness (2019)." Data from SAMHSA, National Survey on Drug Use and Health (NSDUH), 2019.

HEALTH STATUS

Latinx/Hispanic and Black working-age adults are more likely to report being in fair or poor health.

Percent of adults ages 18–64 who report being in fair or poor health, 2019



Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019.

Poor health outcomes are often a manifestation of racism's cumulative impact, through long-term discrimination, socioeconomic inequity, unequal access to health care, and differential treatment within care delivery systems.⁶⁸

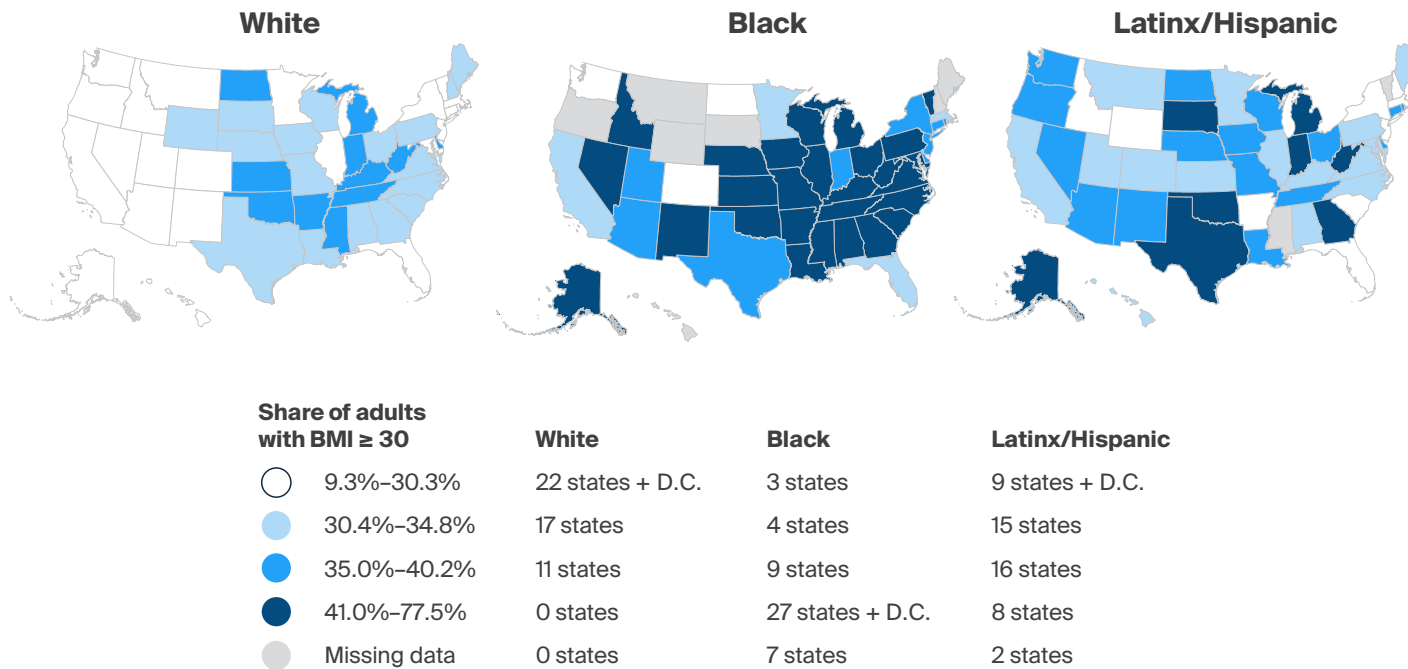
Federal surveys have consistently tracked self-reported health to assess the population's quality of life and the potential burden of chronic health conditions. Though health status can be interpreted differently, past research has linked poor self-reported health with elevated mortality risk.⁶⁹

Over the past 10 years, there have been consistent and significant differences between white, Black, and Latinx/Hispanic adults with respect to self-reported health.

HEALTH STATUS

All groups report elevated obesity. Black and Latinx/Hispanic adults, whose living environments can be impacted by policies like residential segregation, report higher rates in most states.

Percent of adults ages 18–64 who are obese, by state, 2019



The U.S. has a much higher rate of obesity than other wealthy countries.⁷⁰ Working-age adults in all three racial and ethnic groups currently report rates above 30 percent.⁷¹ However, in most states, rates for Black and Latinx/Hispanic adults are higher than they are for white adults. Obesity rates are particularly high in southern states, where Black, Latinx/Hispanic, and white residents all tend to have poorer health outcomes and access to health care.

Researchers find a connection between obesity and both residential segregation (stemming from structural racism) and the socioeconomic environment of different communities. These barriers can affect access to resources associated with healthy lives, such as green spaces and healthy food.⁷²

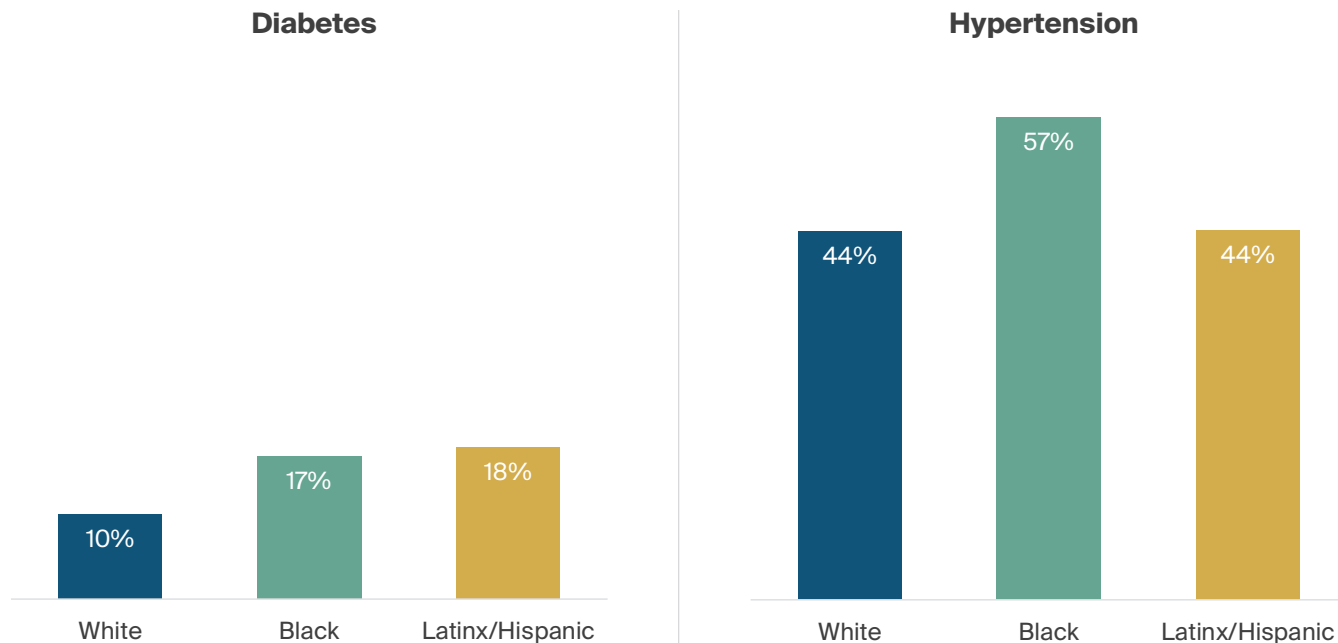
Notes: Obesity is measured by adults with BMI ≥ 30. Map groupings are calculated by taking the 25th, 50th, and 75th percentiles across the full distribution of state rates for all three racial/ethnic groups.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019.

HEALTH STATUS

Obesity is associated with additional health risks. Black and Latinx/Hispanic adults experience higher rates of diabetes than whites, and Black adults also report higher hypertension rates.

Age-adjusted prevalence of hypertension and diabetes among adults age 18 and older



Obesity can lead to significant chronic health conditions such as diabetes and hypertension, which disproportionately burden Black adults and can lead to additional health complications — including those resulting from COVID-19.

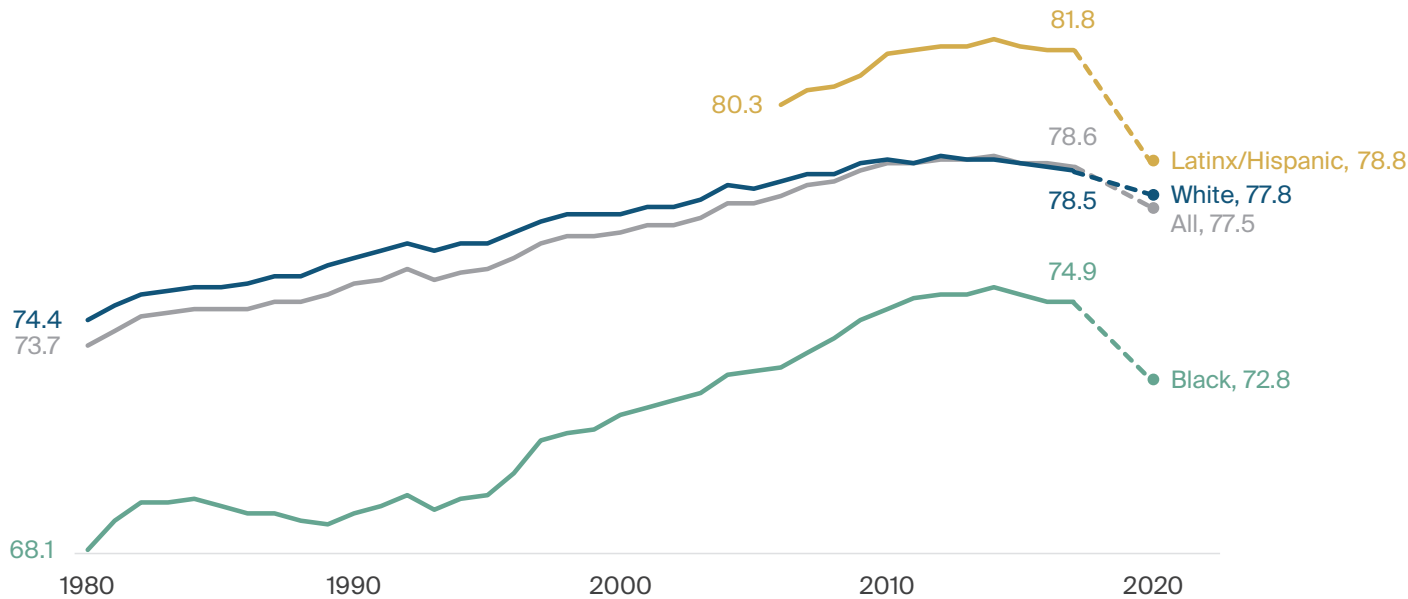
Many chronic conditions are associated with an array of upstream inequities beyond health care, but Black and Latinx/Hispanic communities also deal with an unequal health system in trying to manage their illness. For example, people with diabetes who are uninsured and have lower income are much more likely to encounter problems paying for their medications.⁷³ Diabetes treatment rates are also lower for Black and Latinx/Hispanic people, and research has shown that even with insurance, Black Americans with the condition are less likely than others to receive newer medications.⁷⁴ Diabetes-related amputation rates are also much higher among Black Medicare beneficiaries compared to white beneficiaries, who are more likely to be offered limb-saving procedures or to receive early-intervention services.⁷⁵

Data: Diabetes — 2013–16 National Health and Nutrition Examination Survey (NHANES), as reported in *2020 National Diabetes Statistics Report* (Centers for Disease Control and Prevention, Aug. 2020); Hypertension — 2017–18 NHANES, reproduced from Yechiam Ostchega et al., *Hypertension Prevalence Among Adults Aged 18 and Over: United States, 2017–2018* (NCHS, Apr. 2020).

MORTALITY

The gap in average life expectancy between Black and white adults has existed for generations, and COVID-19 erased recent progress.

Average life expectancy at birth (years), 1980–2020



Notes: 1980–2017 data come from: [United States Life Tables](#), *National Vital Statistics Reports* 68, no. 7 (June 24, 2019). Black and white data points before 2006 include Latinx/Hispanic people; starting in 2006, they represent non-Latinx/Hispanic Black and non-Latinx/Hispanic white. 2020 projections (dashed lines) appear in Andrasfay and Goldman (see below), reflecting the Institute for Health Metrics and Evaluation (IHME) current/medium projection (Oct. 2020).

Chart reproduced from: Theresa Andrasfay and Noreen Goldman, “Reductions in 2020 U.S. Life Expectancy Due to COVID-19 and the Disproportionate Impact on the Black and Latino Populations,” *PNAS* 118, no. 5 (Feb. 2021): e2014746118.

One of the most powerful health indicators is the number of years one expects to live. Mirroring other racial inequities, this number has always been markedly different for Black and white people in the U.S.

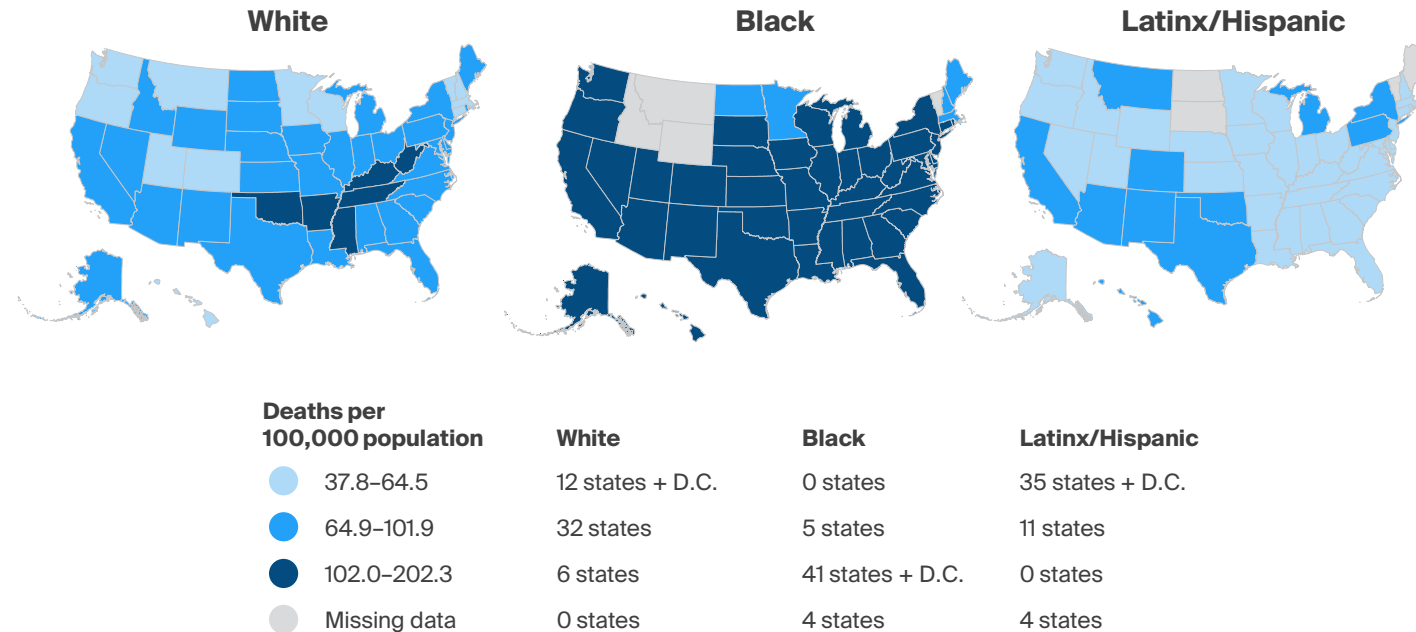
Latinx/Hispanic people, who comprise a range of nationalities, have historically lived longer — a paradox of sorts when considering the broad socioeconomic disadvantages many of these communities have faced.⁷⁶

White, Black, and Latinx/Hispanic adults were experiencing modest declines in life expectancy by 2014. But COVID-19, through its disproportionate impact on communities and neighborhoods shaped by structural racism, has dramatically changed those trajectories.⁷⁷ Early data indicate that Latinx/Hispanic and Black communities, who have been much more likely to die at younger ages during the pandemic, have lost between two and three years of life expectancy; whites have lost less than one year.⁷⁸

MORTALITY

Black adults across the U.S. die from treatable conditions at significantly higher rates than white and Latinx/Hispanic adults.

Mortality amenable to health care (deaths per 100,000 population), 2016 and 2017



The Commonwealth Fund tracks deaths before age 75 from medical conditions that, with proper health care, are usually manageable and treatable. Nationally, Black people die from these causes (such as diabetes) at a rate of 154.9 deaths per 100,000, double the rate for whites.⁷⁹ Disparities exist across all states, and Black adults are concentrated within regions that do worse overall.

Differences within this health care measure reflect an unequal health system as well as underlying structural racism that produces different living environments. Rates of premature death are linked to factors such as poverty, insurance status, and hospital quality.⁸⁰ Premature deaths also lead to loss of economic productivity in racially and ethnically diverse communities.⁸¹

Mortality rates are much lower among Latinx/Hispanic adults, with researchers pointing to potential immigration-related factors and health behaviors like smoking as reasons.⁸² But Latinx/Hispanic obesity and diabetes rates are on the rise, and pre-COVID mortality data showed increasing Latinx/Hispanic midlife mortality from several related causes.⁸³

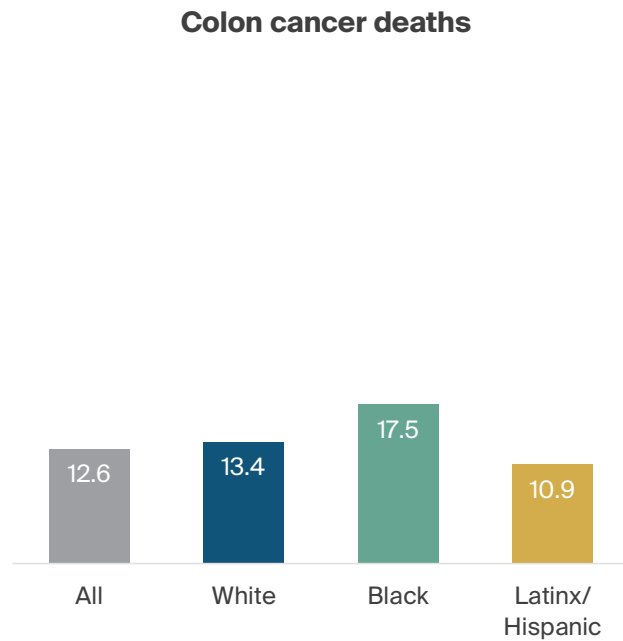
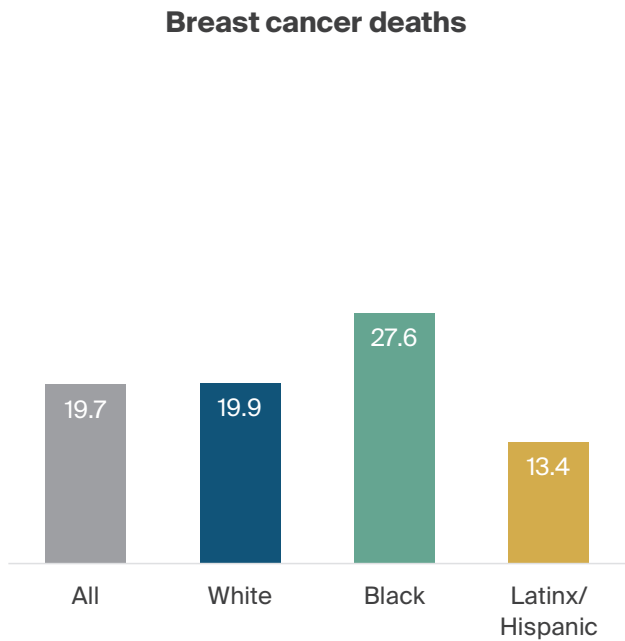
Note: Measure includes deaths before age 75 from one of 33 preventable or treatable health conditions. Map groupings are calculated by taking the 33rd and 66th percentiles across the full distribution of state rates for all three racial/ethnic groups.

Data: National Vital Statistics System (NVSS) Mortality All-County Micro Data Files, 2016 and 2017.

MORTALITY

Black individuals are more likely to die from breast and colon cancer, reflecting both later-stage diagnoses and differential treatment.

Age-adjusted breast and colorectal cancer deaths per 100,000 population, 2018



Black individuals are more likely than white people to be diagnosed later and die of both breast and colon cancer. Disparities in mortality persist even when controlling for factors such as age and stage of cancer.

It appears that hospital attributes, such as quality, have significant effects on these outcomes.⁸⁴ Even when a diagnosis is made, Black breast cancer patients are more likely to experience subpar treatment that departs from standard clinical guidelines. Such treatment disparities are seen with other types of cancer as well.⁸⁵

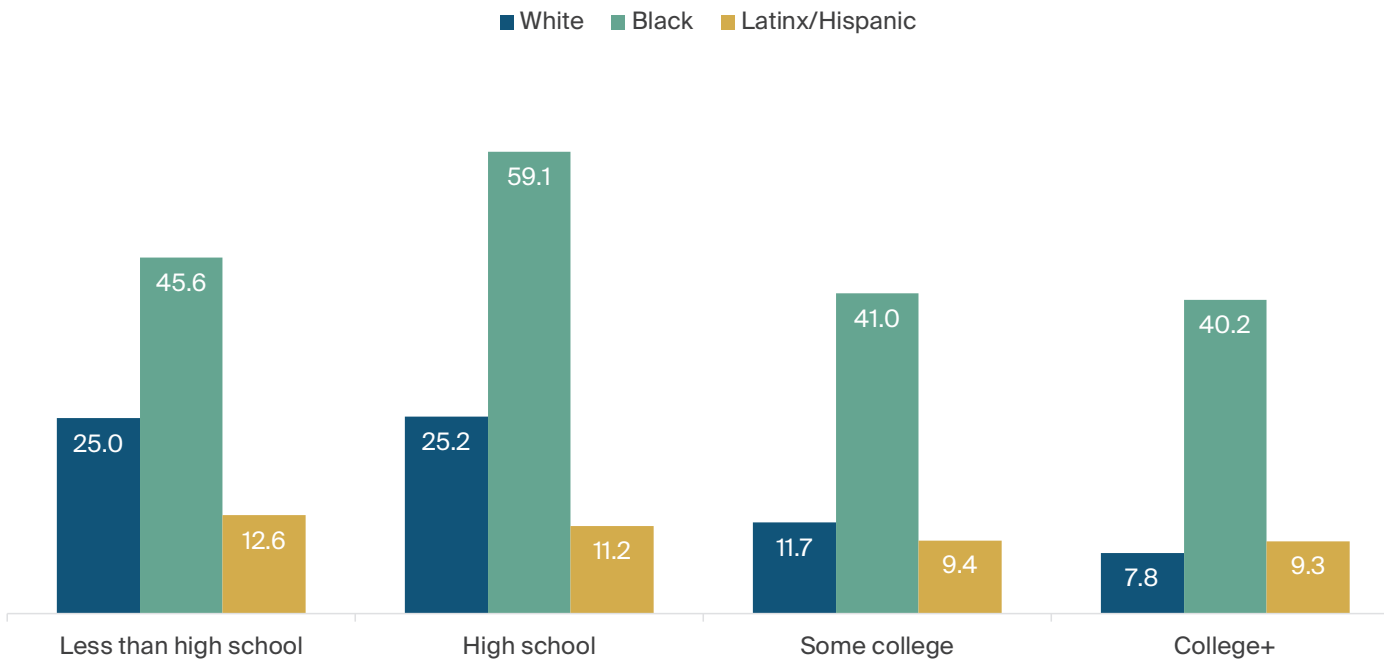
Latinx/Hispanic individuals are less likely to die from cancer overall, though risk is higher for certain cancers related to infection. Averages also mask significant differences for certain Latinx/Hispanic communities, such as rates for prostate cancer among Puerto Ricans.⁸⁶

Note: Breast cancer deaths are among female population; colon cancer deaths are among full population.
Data: National Vital Statistics System (NVSS) Mortality Data Files, 2018.

MORTALITY

Across all education levels, Black people suffer pregnancy-related deaths at two to four times the rate of white and Latinx/Hispanic people.

Pregnancy-related deaths per 100,000 live births in the U.S., by education level, 2007–2016



Black and Latinx/Hispanic people are more likely than white people to experience severe complications related to birth, irrespective of insurance status.⁸⁷

Disparities in pregnancy-related deaths between Black and white populations are long-standing and persist regardless of economic status or education.⁸⁸ These inequities have been documented between different hospitals and even within the same hospital.⁸⁹ Latinx/Hispanic maternal mortality rates are lower than white rates, despite the well-documented disadvantages many members of Latinx/Hispanic communities face.⁹⁰

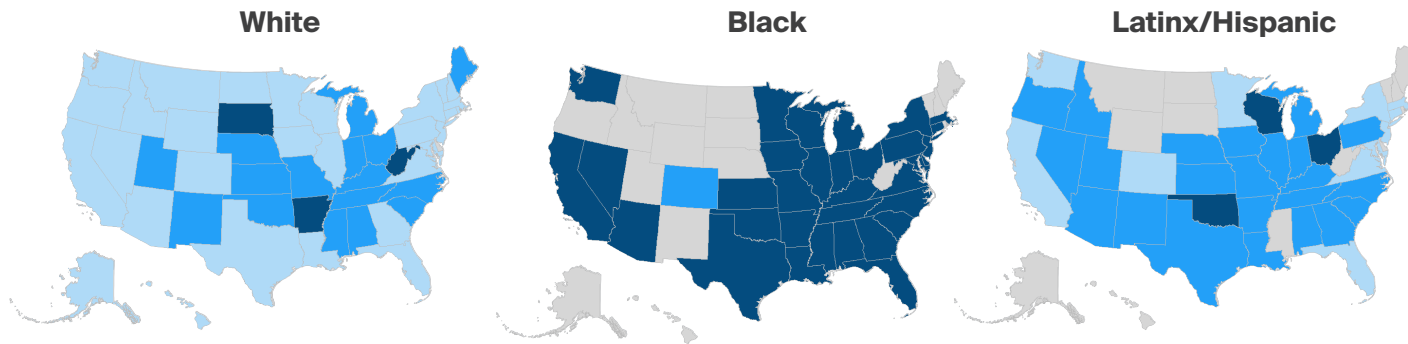
Where people give birth in the U.S. is important: three-fourths of Black babies are delivered in one-fourth of hospitals, which tend to be of lower quality and perform worse on delivery-related indicators than hospitals where white babies are delivered.⁹¹ Providers are also more likely to disregard Black people’s pregnancy requests.⁹²

Data: Emily E. Petersen et al., “Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007–2016,” *Morbidity and Mortality Weekly Report (MMWR)* 68, no. 35 (Sept. 6, 2019): 762–65.

MORTALITY

Infant mortality disparities exist in nearly every state; rates are particularly high in Black communities.

Deaths in the first year of life per 1,000 live births, by state, 2017



Deaths in the first year of life per 1,000 live births	White	Black	Latinx/Hispanic
2.7–4.9	30 states	0 states	11 states
5.0–6.8	16 states	1 state	23 states
6.9–15.9	3 states	33 states + D.C.	3 states
Missing data	1 state + D.C.	16 states	13 states + D.C.

The national Black infant mortality rate is more than two times that for whites,⁹⁵ with inequities in every state. While there is not a large national difference between Latinx/Hispanic and white infant mortality rates, the maps show disparities in many individual states.⁹⁴ Certain Latinx/Hispanic communities, including Puerto Ricans, experience larger disparities.⁹⁵

Socioeconomic factors such as employment and education are closely tied to structurally racist policies and are associated with infant mortality;⁹⁶ yet they cannot fully explain the differences.⁹⁷ Hospital quality and differential treatment, as well as doctors’ race, play a significant role in deaths.⁹⁸

Insurance coverage also matters. Infant mortality rates have declined since the ACA became law, with Black mortality dropping the most. Rates also decreased by greater amounts in states that have expanded Medicaid eligibility.⁹⁹

Note: Map groupings are calculated by taking the 33rd and 66th percentiles across the full distribution of state rates for all three racial/ethnic groups.

Data: National Vital Statistics System (NVSS) Linked Birth and Infant Death Data, 2017.

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ABOUT THE AUTHORS

Jesse C. Baumgartner, M.P.H., joined the Commonwealth Fund in 2019 as a research associate in the Health Care Coverage and Access program and the Tracking Health System Performance initiative. Before joining the Fund, he worked as a technology development/licensing manager at Memorial Sloan Kettering Cancer Center (2016–2018), a life sciences consultant at Stern Investor Relations (2012–2016), and earlier in his career as a reporter for the *Lewiston Tribune* in Idaho. Baumgartner earned his B.A. in journalism and history from the University of North Carolina at Chapel Hill, where he was elected *Phi Beta Kappa*, and his M.P.H. in Health Policy and Management at the CUNY Graduate School of Public Health and Health Policy. He is also a CFA® charterholder.

Gabriella N. Aboulafia is a program assistant in the Health Care Coverage and Access program at the Commonwealth Fund. She provides daily support for the program, with responsibilities ranging from administration and grants management to tracking health reform policy developments and working on research projects. Ms. Aboulafia graduated with distinction with a B.S. in public health from the University of North Carolina, Gillings School of Global Public Health in May 2019, and previously has held health policy-related positions and internships at the Cecil G. Sheps Center for Health Services Research, the North Carolina Department of Health and Human Services, the Marwood Group, and MSOC Health.

Yaphet Getachew is the former program associate in the Advancing Health Equity program. He was responsible for providing support for the Vulnerable Populations portfolio and performed a variety of duties including grants management, administrative functions, writing, editing, and research and analysis. Mr. Getachew received his B.A. in global affairs from Yale University in May 2016 and a certificate in global health studies. He spent the summer of 2014 as an intern with Deloitte in Ethiopia and in 2015 as an early childhood health and development intern at the Yale Global Health Leadership Institute, with field work in Brazil. Also in 2015 he worked on a project advising the Clinton Health Access Initiative on their health workforce management program in Liberia. In 2017–2019 he helped launch assisted living centers in the Twin Cities metro area in Minnesota.

David C. Radley, Ph.D., M.P.H., is a senior scientist for the Commonwealth Fund's Tracking Health System Performance initiative. Dr. Radley and his team develop national, state, and substate regional analyses on health care system performance and related insurance and care system market structure analyses. He is also a senior study director at Westat, a research firm that supports the Scorecard project. Dr. Radley joined the Fund in July 2010 from Abt Associates where he was associate in Domestic Health Policy. His methodological expertise is in small-area analysis and in the design, implementation, and interpretation of observational studies that take advantage of large administrative and survey-based datasets. Dr. Radley received his Ph.D. in Health Policy from the Dartmouth Institute for Health Policy and Clinical Practice. He holds a B.A. from Syracuse University and an M.P.H. from Yale University.

Sara R. Collins, Ph.D., is vice president for Health Care Coverage and Access at the Commonwealth Fund. An economist, Dr. Collins directs the Health Care Coverage and Access program as well as the Fund's research initiative on Tracking Health System Performance. Since joining the Fund in 2002, Dr. Collins has led several multiyear national surveys on health insurance and authored numerous reports, issue briefs, and journal articles on health insurance coverage, health reform, and the Affordable Care Act. She has provided invited testimony before several Congressional committees and subcommittees. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine, Division of Health and Science Policy. Earlier in her career, she was an associate editor at *U.S. News & World Report*, a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. She holds an A.B. in economics from Washington University and a Ph.D. in economics from George Washington University.

Laurie Zephyrin, M.D., M.P.H., M.B.A., is vice president for Advancing Health Equity at the Commonwealth Fund. Dr. Zephyrin has extensive experience leading the vision, design, and delivery of innovative health care models across national health systems. From 2009–2018, she was the first national director of the Reproductive Health Program at the Department of Veterans Affairs.

In 2016–2017, she served as acting assistant deputy under secretary for Health for Community Care, and later in 2017, as acting deputy under secretary for Health for Community Care. As part of the Community Care leadership team, she represented the VA before Congress and other internal and external stakeholders. Dr. Zephyrin is a board-certified clinician. She is a clinical assistant professor of Obstetrics and Gynecology at NYU Langone School of Medicine (2013–present) and was previously an assistant professor at Columbia University, College of Physicians and Surgeons (2007–2012). She earned her M.D. from the New York University School of Medicine, M.B.A. and M.P.H. from Johns Hopkins University, and B.S. in Biomedical Sciences from the City College of New York. She completed her residency training at Harvard’s Integrated Residency Program at Brigham and Women’s Hospital and Massachusetts General Hospital.

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For more information about this brief, please contact:

Jesse C. Baumgartner
Research Associate
Health Care Coverage and Access &
Tracking Health System Performance
The Commonwealth Fund
jb@cmwf.org



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