Unrealized Health Potential:

A Snapshot of Minnesota

UNREALIZED HEALTH POTENTIAL AMONG CHILDREN

Based on two important indicators of health, infant mortality and children's general health status, children in Minnesota are not as healthy as they could be. The levels of health for most Minnesota children fall short of levels for children in the most-advantaged subgroups in the state and across the country. This snapshot describes these gaps as well as the social factors that are linked with these differences in health.

INFANT MORTALITY

Minnesota ranks 6th among states based on the size of the gap in infant mortality by mother's education, when comparing the current overall state rate of 5.1 deaths per 1,000 live births with the lower rate—3.7 deaths per 1,000 live births—seen among infants born to the state's most-educated mothers. If Minnesota achieved this lower rate overall, infant mortality in the state would be close to the *national benchmark* of 3.2 deaths per 1,000 live births—the lowest infant mortality rate seen in any state among babies born to mothers with 16 or more years of schooling. Despite the relatively low infant mortality rate seen for babies born to the most-educated mothers in Minnesota, rates for other maternal education and racial or ethnic groups in the state did not meet the national benchmark.

CHILDREN'S GENERAL HEALTH STATUS

Minnesota ranks 4th among states based on the size of the gap in children's general health status by family income, when comparing the current overall rate of 9.6 percent of children in less than optimal health with the lower rate—5.8 percent—seen among children in higher-income families. Even if Minnesota achieved this lower rate overall, the state's rate would still exceed the *national benchmark* for children's general health status of 3.5 percent—the lowest rate of less than optimal health seen in any state among children in families that both were higher income and practiced healthy behaviors. In Minnesota, the general health status of children in every income, education and racial or ethnic group did not meet the national benchmark.

SOCIAL FACTORS AFFECTING CHILDREN'S HEALTH

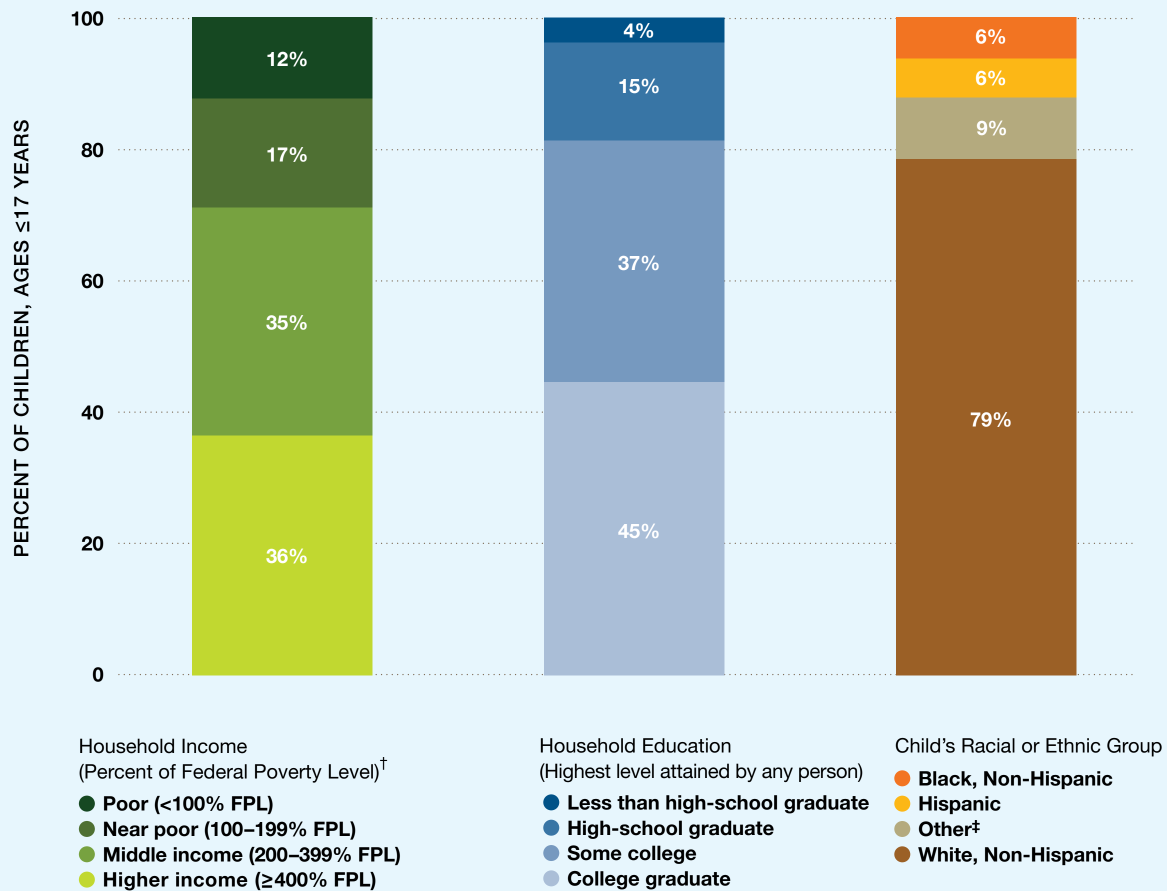
Social factors such as income, education and racial or ethnic group can greatly affect a child's health. This snapshot describes these factors and how they are linked with infant mortality and children's general health status in the state.

MINNESOTA:

Social Factors Affecting Children's Health

Health during childhood is powerfully linked with social factors such as the income and education levels of a child's family and his or her racial or ethnic group. This snapshot of children ages 17 years or younger in Minnesota shows that:

- Nearly one third of Minnesota's children live in poor or near-poor households, approximately one third live in middle-income households and one third live in higher-income households.
- One fifth of children in Minnesota live in households where no one has education beyond high school, approximately one third live with at least one person who has attended but not completed college and nearly one half live with at least one college graduate.
- Four fifths of Minnesota's children are non-Hispanic white, 6 percent are non-Hispanic black and 6 percent are Hispanic.



Household Income
(Percent of Federal Poverty Level)†

- Poor (<100% FPL)
- Near poor (100–199% FPL)
- Middle income (200–399% FPL)
- Higher income (≥400% FPL)

Household Education
(Highest level attained by any person)

- Less than high-school graduate
- High-school graduate
- Some college
- College graduate

Child's Racial or Ethnic Group

- Black, Non-Hispanic
- Hispanic
- Other‡
- White, Non-Hispanic

Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.
Source: 2006 American Community Survey (for data on income and racial or ethnic group); 2005-2007 Current Population Survey (for education data).

† Guidelines set by the U.S. government for the amount of income providing a bare minimum of food, clothing, transportation, shelter and other necessities. In 2006, the U.S. FPL was $16,079 for a family of three and $20,614 for a family of four.

‡ "Other" includes children in any other racial or ethnic group or in more than one group.

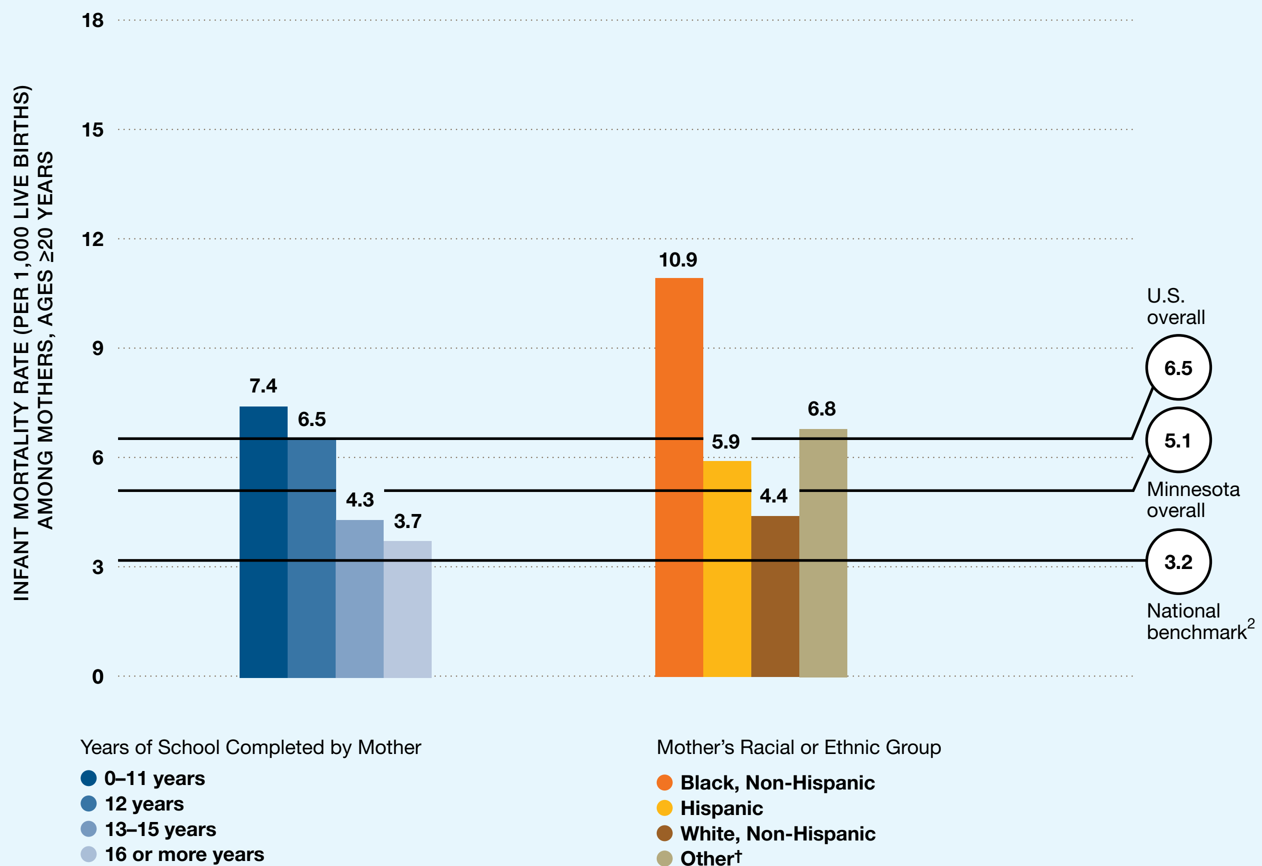
MINNESOTA:

Gaps in Infant Mortality

Infant mortality rates[1]—a key indicator of overall health—vary by mother's education and racial or ethnic group in Minnesota.

- Compared with babies born to the most-educated mothers, babies born to mothers with less education appear more likely to die before reaching their first birthdays. The infant mortality rate among babies born to mothers with less than 12 years of education is twice the rate seen among babies born to mothers with 16 or more years of schooling.
- The infant mortality rate among babies born to non-Hispanic black mothers is 2.5 times the rate seen among babies of non-Hispanic white mothers and nearly twice the rate among babies born to Hispanic mothers.

Comparing Minnesota's experience against the national benchmark[2] for infant mortality reveals unrealized health potential among Minnesota babies in almost every maternal education and racial or ethnic group. Infants in most groups could do better.



Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.
Source: 2000-2002 Period Linked Birth/Infant Death Data Set.

1 The number of deaths in the first year of life per 1,000 live births.

2 The national benchmark for infant mortality represents the level of mortality that should be attainable for all infants in every state. The benchmark used here—3.2 deaths per 1,000 live births, seen in New Jersey and Washington state—is the lowest statistically-reliable rate among babies born to the most-educated mothers in any state.

† Defined as any other or unknown racial or ethnic group, including any group representing fewer than 3 percent of all infants born in the state during 2000-2002.

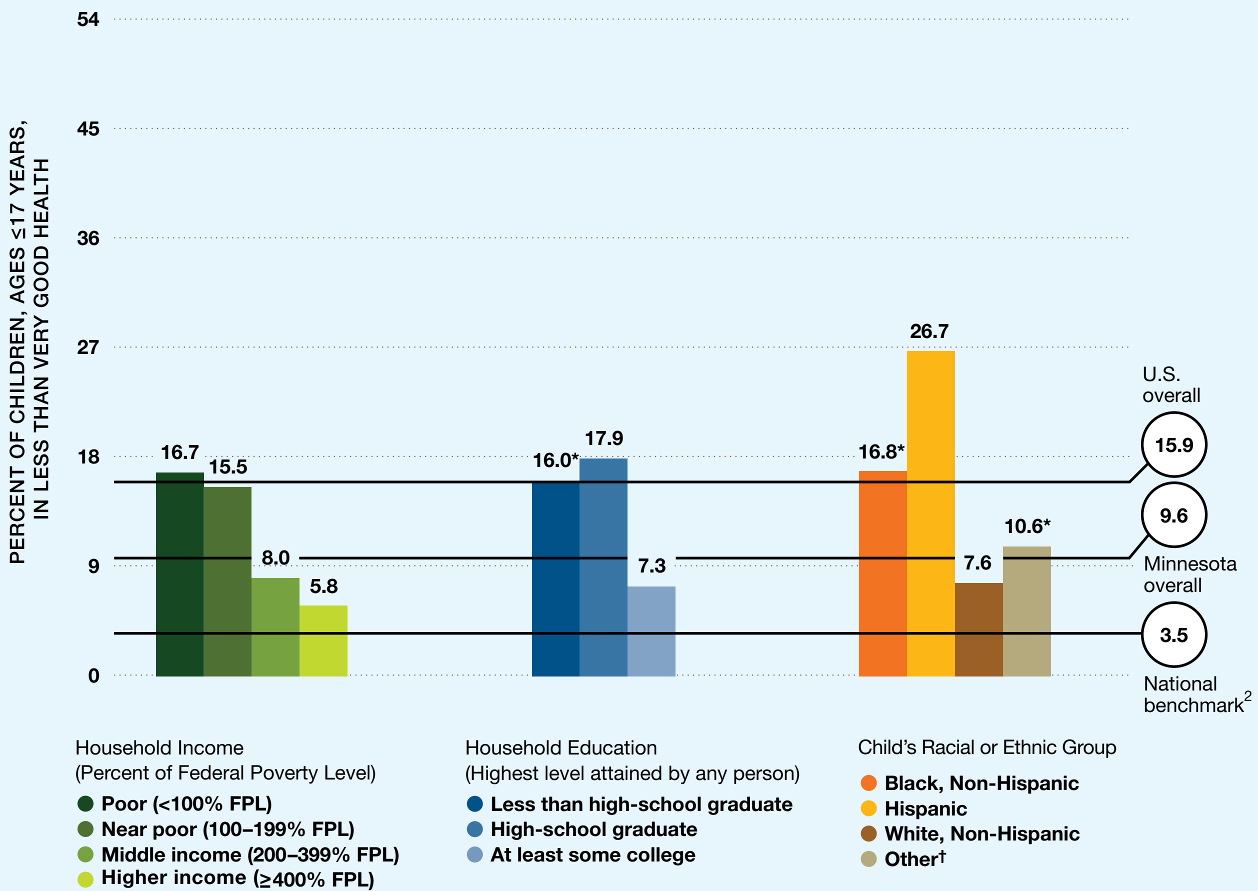
MINNESOTA:

Gaps in Children's General Health Status

Within Minnesota, children's general health status[1] varies by family income and education and by racial or ethnic group. Children in less-advantaged groups typically experience worse health than those with greater advantages.

- Children in poor and near-poor families are nearly three times as likely to be in less than optimal health as children in higher-income families.
- Children living in households where no one has schooling beyond high school are nearly 2.5 times as likely to be in less than optimal health as children living with someone who has completed some college.
- Hispanic children are 3.5 times as likely as non-Hispanic white children to be in less than optimal health.

Comparing Minnesota's experience against the national benchmark[2] reveals unrealized health potential among Minnesota children in every income, education and racial or ethnic group.



Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.

Source: 2003 National Survey of Children's Health.

1 Based on parental assessment and measured as poor, fair, good, very good or excellent. Health reported as less than very good was considered to be less than optimal.

2 The national benchmark for children's general health status represents the level of health that should be attainable for all children in every state. The benchmark used here—3.5 percent of children with health that was less than very good, seen in Colorado—is the lowest statistically-reliable rate observed in any state among children whose families were not only higher income but also practiced healthy behaviors (i.e., non-smokers and at least one person who exercised regularly).

* Rate has a relative standard error greater than 30 percent and is considered statistically unreliable.

† Defined as any other or more than one racial or ethnic group, including any group with fewer than 3 percent of children in the state in 2003.

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