New York State Minority Health Surveillance Report

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Public Health Information Group
Office of Minority Health
Center for Community Health
New York State Department of Health

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INTRODUCTION

Introduction

As part of the overall effort to improve minority health in New York State, statute (Title II F-Section 242, Public Health Law, 1992) requires the NYS Department of Health (NYSDOH) to produce a biennial report that includes an analysis of the health status of minority citizens. Over the years, a number of reports have documented racial and ethnic differences in health status and health care access and quality for the 40% of New Yorkers who are ethnic and racial minorities. In 1906, in the monograph, *The Health and Physique of the Negro American*[1], W.E.B. DuBois and his colleagues documented the poor health status of African Americans in comparison to White Americans. The body of evidence made available since then (e.g. the U.S. Department of Health and Human Services', *Health, United States 1983*[2], *Healthy People 2000*[3] and *Healthy People 2010*[4], the Institute of Medicine's, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*[5] and the Agency for Health Care Research and Quality's 2003,[6] 2005[7] and 2006[8] *National Healthcare Disparities Reports*) reveals that racial and ethnic minorities have less access to health care and poorer treatment outcomes than Whites. The 2006 National Healthcare Disparities Report notes that for most core quality measures, Blacks (73%), Hispanics (77%), and the poor (71%) received worse quality care than their reference groups, with increasing disparities especially prevalent in chronic disease management.

There is growing recognition that the vision for improving health of all people in the United States cannot be realized without addressing health disparities.[9, 10] Accurate and quality data on race, ethnicity and language are important prisms through which quality of care, utilization of health services, health outcomes and satisfaction with health care services can be assessed and compared over time.[11] Furthermore, these data are necessary to design effective targeted interventions.

The literature highlights three major themes regarding use of race and ethnicity data to raise the bar for providing high quality, evidence-based health care services. First, recognizing that disparities cannot be addressed if they are not identified.[12] The Institute of Medicine[5] emphasizes the necessity and importance of better data collection on race and ethnicity by health care organizations. Failure to collect, record and use race and ethnicity data translates into missed opportunities to ensure the best possible care and to measure progress or lack of progress toward desired goals. Second, culturally and linguistically competent health care systems that reduce communication barriers [13, 14] must be data-driven. Third, race and ethnicity data help identify and quantify the impact of interventions to reduce racial and ethnic health disparities. [15]

The challenges associated with collecting race and ethnicity data have been well documented. [8, 11, 12] Two in particular are worth highlighting. First, the distinction that is often made between race and socio-economic status is a false one. There are disparities by race as well as by socio-economic status. These factors, while inter-related, are likely to play distinct, independent roles.[9] Therefore, analysis of minority health status must take both into account.

A second important factor to consider is the availability and quality of the data. There are three types of data showing promise as effective tools to monitor health status of populations: patient and/or population-based assessments, medical/administrative record data audits and health outcome data.[16] The Behavior Risk Factor Surveillance System is one example of a population-based behavioral assessment data source, which is used in this report. Vital records and cancer registry data illustrate objective health outcomes. Existing data sources are used to track health disparities by measuring changes in morbidity, mortality and risky health behaviors over time.

This New York State Minority Health Surveillance Report assesses a total of 49 health indicators by race/ethnicity and, where available, by income for New York State. Indicators illustrate:

- areas where there has been improvement,
- areas where disparities continue to exist,
- areas where significant problems exist across all race/ethnic groups and
- the relationship between income and disease.

It is expected that this New York State Minority Health Surveillance Report will raise awareness about minority health in New York State, including health outcomes where disparities exist for racial and ethnic minorities. These data can be used to develop and direct evidence-based interventions to improve health. It is anticipated that future Minority Health Surveillance Reports will incorporate improved measures and expanded analyses of minority health status in New York State.

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FORMAT

Format of the Report

The 2007 Minority Health Surveillance Report contains information across a wide range of health and socio-demographic indicators. These indicators are presented in the following sections:

- Socio-demographic,
- Mortality,
- Natality,
- General Health,
- Disease Prevalence,
- Risk Factors and
- Access to Health Care.

A description of the sources of data used in this Report is contained in Appendix 1.

All of this Report's socio-demographic and health indicators are presented by race/ethnicity. All graphs, except those generated from the New York State Cancer Registry, use race/ethnicity groups that are mutually exclusive. The following groups are utilized: White non-Hispanic; Black non-Hispanic; Asian/Pacific Islander non-Hispanic; and Hispanic. Indicators generated from the New York State Cancer Registry utilize race/ethnicity groups that are not mutually exclusive. White, Black and Asian categories include Hispanics; Hispanics include all races.

When income data are available, indicators are analyzed by both race/ethnicity and income. While income does not fully represent an individual's or a group's socio-economic status, it does allow for the examination of the extent to which income may impact health, and in turn the relative influence of race/ethnicity.

This Report does not present health indicator information for the American Indian population. The 2005 American Community Survey (U.S. Census Bureau) indicates that less than one percent of New York's population identified themselves as American Indian/Alaskan Native (48,733). Department of Health data sources on the American Indian population are either not available (Youth Risk Behavior Survey), have too small a sample size for reliable estimates (Behavioral Risk Factor Surveillance System) or contains poorly reported data (Vital Records).

EXECUTIVE SUMMARY

Executive Summary

New York State's population has become increasingly diverse due, in large part, to a growing foreign-born population. In order to improve the health of all New Yorkers and to address health disparities in the population, it is critical that there be a base of knowledge and understanding of the variations in health measures that cross racial, ethnic and income groups. This Minority Health Surveillance Report (MHSR), which presents data on a wide variety of health indicators in New York State, serves as an important resource for identifying and addressing health disparities.

The MHSR examines 49 health indicators, 27 refer to health outcomes such as disease and mortality rates, 14 measure behavioral/risk factors and eight correspond to issues of access to health care. Trend data are reported for 24 of the indicators.

For outcome indicators that show trends, many suggest overall improvements over the past decade for all racial/ethnic groups. The age-adjusted rates for death due to AIDS/HIV, asthma, cerebrovascular disease, heart disease, homicide, suicide, motor vehicle injury, non-motor vehicle injury, unintentional injury, male colorectal cancer, female breast cancer and prostate cancer as well as the teenage pregnancy rates are lower for all groups in 2003/2004 than they were ten years earlier. Universal improvements in health access measures are apparent, with the percent of early stage diagnosis of prostate cancer in 2003 close to 90% for all racial/ethnic groups—compared to rates of 68% to 77% in 1994. For all racial/ethnic populations, the percent of pregnant women receiving first trimester prenatal care has risen over the past decade.

Trends also show areas with no significant improvement. White, Black and Hispanic children in the Supplemental Nutrition Program for Women Infants and Children (WIC) had higher rates of obesity in 2004 than they did in 1995. In addition, the percent of low birthweight births (under 2,500 grams) increased for all groups except Hispanics.

Rates for some measures have been increasing in the past few years after experiencing a decrease. In addition, the rates have not decreased equally across racial/ethnic groups, with some groups experiencing much slower or much smaller positive changes. For virtually all the indicators depicting trends, it is obvious that health disparities persist. The population in New York State is made up of several very diverse racial and ethnic groups, and each faces unique strengths and challenges. The following section highlights, for each racial/ethnic group, health indicators that remain a challenge and point to persistent disparities, as well as areas that indicate strengths and improvements.

Black non-Hispanic New Yorkers

The Black non-Hispanic population in New York State increased by 10% between 1990 and 2000. In 2005, 21.6% of Black New Yorkers lived below poverty.

Challenges

Blacks suffer disproportionately compared to other groups on a variety of health indicators, with the worst ranking on 27 of the 49 indicators. Specifically, they have the highest age-adjusted rates of diabetes mortality, female breast cancer mortality, prostate cancer incidence and mortality, female and male colorectal cancer mortality, HIV/AIDS mortality, death due to asthma, cerebrovascular disease deaths, heart disease deaths and homicide. Blacks also experience maternal mortality, infant death and low birthweight rates above the rates for all other groups. Black adults also have the highest prevalence of diabetes. Disparities are especially evident in the case of breast cancer, where incidence is over 40% higher among White women compared to their Black counterparts, but more Black women die from the disease. The same pattern occurs among colorectal cancer incidence and mortality rates, with more Black men and women dying from a disease that is more common among Whites. While adult asthma incidence rates are similar for Whites, Blacks and Hispanics, the death rate due to asthma is more than four times higher among Blacks than it is among Whites.

Blacks do not fare well for many behavioral health indicators, including the highest rates of adult obesity compared to any other racial/ethnic group. Black high school students report the lowest rates of physical activity (in the past seven days), but the highest rates for television watching of three or more hours per day, of ever having had sexual intercourse and of forced sexual intercourse among female students.

Strengths and Improvements

The health status of Black New Yorkers has been improving in several key areas. As noted above, all New Yorkers have experienced decreases in several areas of disease and mortality outcomes. And while Blacks do have the highest rates of disease and mortality for many indicators, the significance of marked improvements cannot be overlooked. For example, over the course of ten years, the age-adjusted AIDS/HIV death rate fell by 75%, the age-adjusted homicide rate decreased by 40% and deaths due to asthma were cut almost in half. The percentage of Black women receiving first trimester prenatal care increased 23% in ten years, reducing the disparity between Blacks and Whites, Asians and Hispanics. The rate of prostate cancer cases diagnosed early among Black men was nine percentage points lower than the rate for White men in 1994; however, in 2003, 87.8% of both Black and White men were diagnosed early. A similar trend occurred for early diagnosis of male colorectal cancer. Black high school students are more likely than White and Hispanic students to have used condoms during the last sexual intercourse, and less likely than their White and Hispanic peers to smoke.

Asian and Pacific Islander non-Hispanic New Yorkers

Asian and Pacific Islander (API) non-Hispanic New Yorkers are the fastest growing population in the state, and made up approximately seven percent of the population in 2005.

Challenges

While the API population fares better than other minority groups on many health measures and outcomes, there are areas in which they do fare poorly, especially low-income Asians. Suicide among APIs has increased over the past five years, and the asthma death rate has steadily increased in the same time period.

Strengths and Improvements

APIs have the lowest rates of infant mortality, AIDS/HIV deaths, cerebrovascular mortality, heart disease mortality, homicide, motor vehicle injury and death, unintentional injury and death, chronic obstructive pulmonary disease/chronic lower respiratory disease death, diabetes mortality, teen pregnancy and of all selected cancer incidences and mortalities.

APIs are least likely to report fair or poor health or mental health in past month, and also have the lowest current asthma prevalence rates. For almost all behavioral measures, APIs have the most favorable rates.

Hispanic New Yorkers

The Hispanic population in New York State grew by almost 30% in the last decade. They are more likely to live in poverty than White non-Hispanics, Black non-Hispanics or API non-Hispanics.

Challenges

Of the 49 health indicators featured in this Report, Hispanic New Yorkers fare worst on 12 indicators. Of indicators measuring health care access, Hispanics fare worse than any other group, with the poorest rate on five of the eight access measures. Hispanics are least likely to have early stage diagnoses of prostate cancer and colorectal cancer for both men and women. Experiencing cost as a barrier to doctor visits, having no regular health care provider and lacking health insurance are challenges faced most often by Hispanic adults.

In terms of health outcomes, Hispanics are most likely to report poor or fair health and mental health in the past month, to have current asthma and to experience premature death (death at younger than 75 years of age). Hispanics fare worst on three of the ten behavioral/risk measures: obesity among high school students, obesity among young children and leisure time physical activity among adults.

Many health outcomes for Hispanics, while trailing those of other groups, are not significantly different. For example, Hispanic New Yorkers suffer similarly from binge drinking among adults and HIV risk indicators, especially for low-income Hispanics, and high school students who have ever had sexual intercourse. The AIDS/HIV death rate for Hispanics is much higher than the corresponding rates for Whites and API, but almost half the Black mortality rate due to AIDS/HIV. The Hispanic homicide death rate is 3.5 times that of Whites and API, but almost a

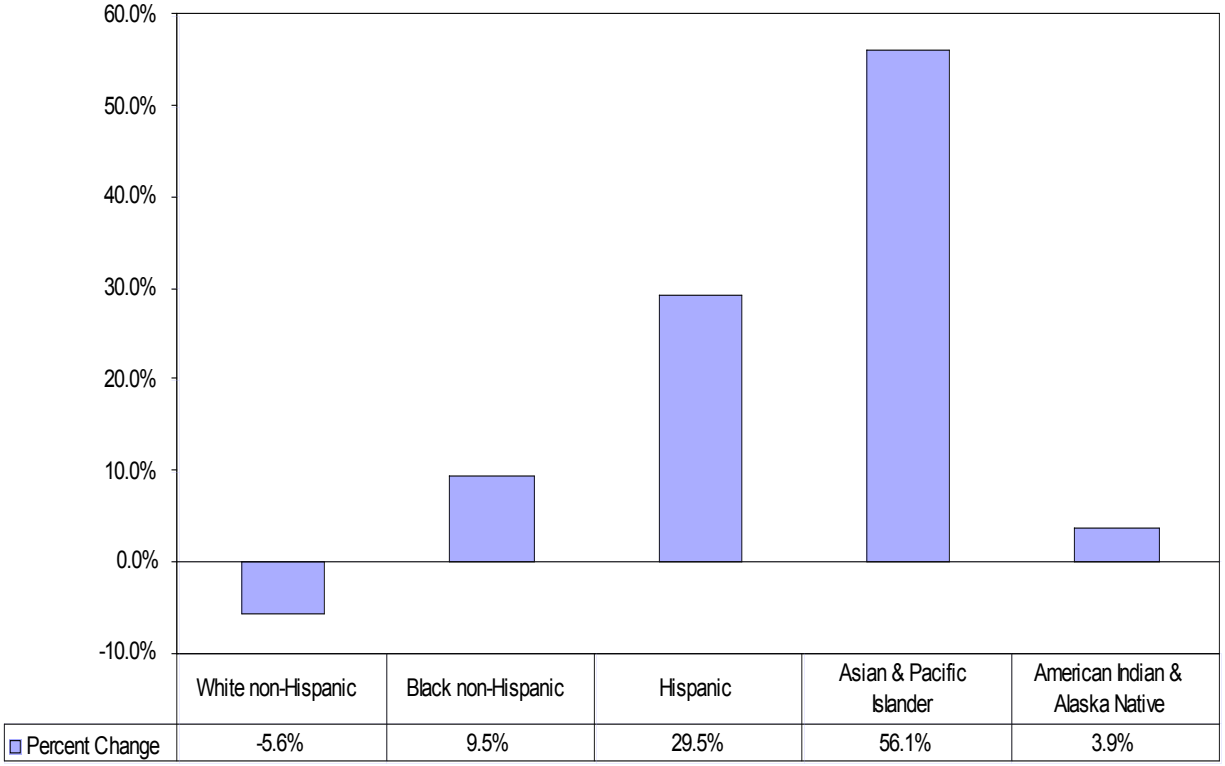
third the rate of Black New Yorkers. The Hispanic teen pregnancy rate is almost equal to that of Black teens, but still five to six times higher than the rates for White and API teens.

Strengths and Improvements

Hispanic New Yorkers fare well on a variety of health outcomes. Hispanics have a female breast cancer mortality rate that is markedly lower than those of Black and White women, a prostate cancer incidence and mortality lower or about equal to White men and an increasing rate of early stage diagnosis of prostate cancer that is almost equal to the rate for all other men. The Hispanic infant mortality rate is 4.5 per 1,000 live births, compared to 4.6 for Whites and 11.1 for Blacks. Hispanics have a relatively low cerebrovascular disease death rate that has also been decreasing over time, and deaths due to chronic obstructive pulmonary disease/chronic lower respiratory disease are 2.5 times lower than deaths among Whites. Hispanics experience the lowest rate of suicide.

SOCIODEMOGRAPHIC

Figure 1 Percent Change in Population by Race/Ethnicity, New York State, 1990 to 2000



	White non-Hispanic	Black non-Hispanic	Hispanic	Asian & Pacific Islander	American Indian & Alaska Native
Percent Change	-5.6%	9.5%	29.5%	56.1%	3.9%

The period between 1990 and 2000 was marked by major population increases among New York's ethnic and racial minorities. In 1990, three of 10 New Yorkers were minorities. In 2000, the number increased to four of 10. (Population Change and Distribution: New York State, 1990-2000, New York State DOH Statistical Brief)

Asian & Pacific Islanders experienced the largest percent increase between 1990 and 2000 (56.1%).

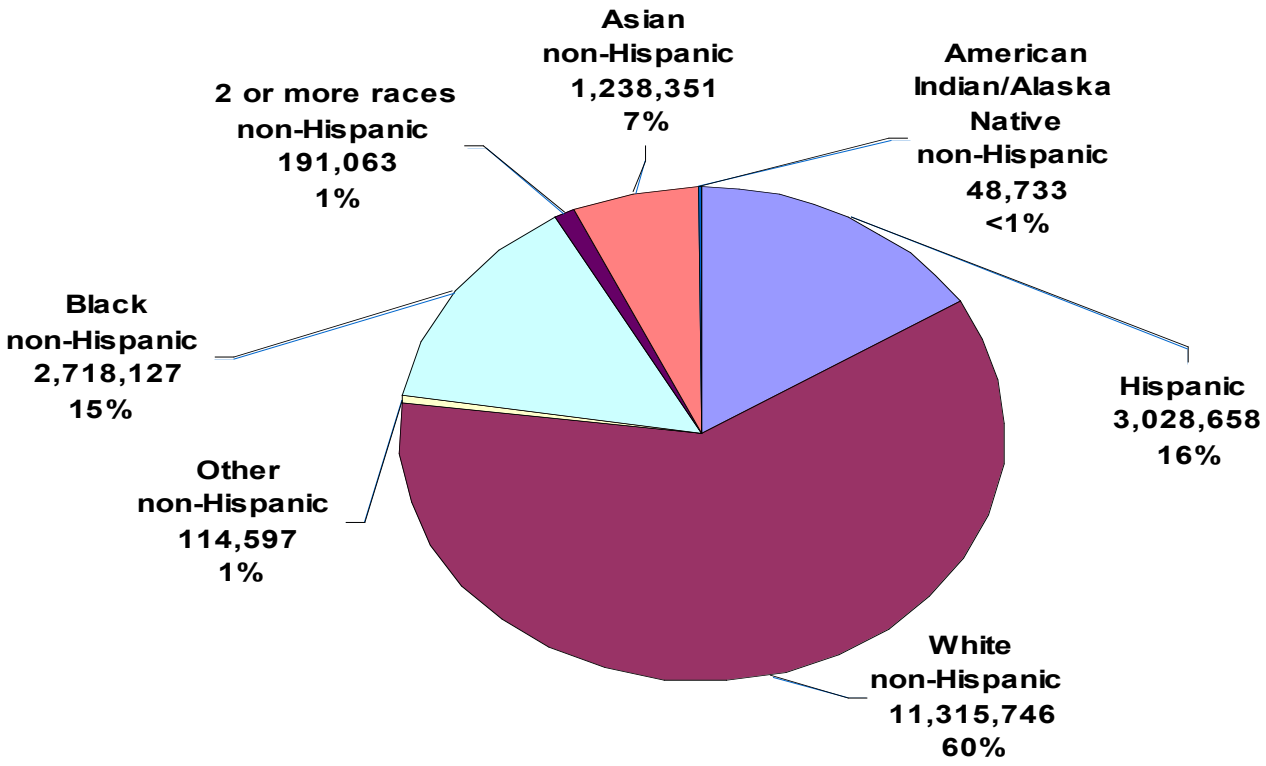
The percent of Hispanics in New York State increased nearly 30% between 1990 and 2000.

Black non-Hispanic (9.5%) and American Indian & Alaska Natives (3.9%) experienced smaller increases as compared to Hispanics and Asian & Pacific Islanders from 1990 to 2000.

White non-Hispanics were the only group to decrease as a percentage of New York's population between 1990 and 2000 (-5.6%).

Source: US Census Bureau, 2000 Census

Figure 2 New York State Population by Race and Hispanic Origin, 2005



To be most effective, health programs and policies must be developed with a focus on differences between population groups.

In 2005, New York's population was estimated at 18,655,275. The largest racial and ethnic groups that make up New York's population are White non-Hispanic (60%) Hispanic (16%), Black non-Hispanic (15%) and Asian non-Hispanic (7%).

Among Hispanics, the largest single population group in New York State is of Puerto Rican descent (34.9% of all Hispanics).

American Indian and Alaska Natives represent less than 1% of New York State's population.

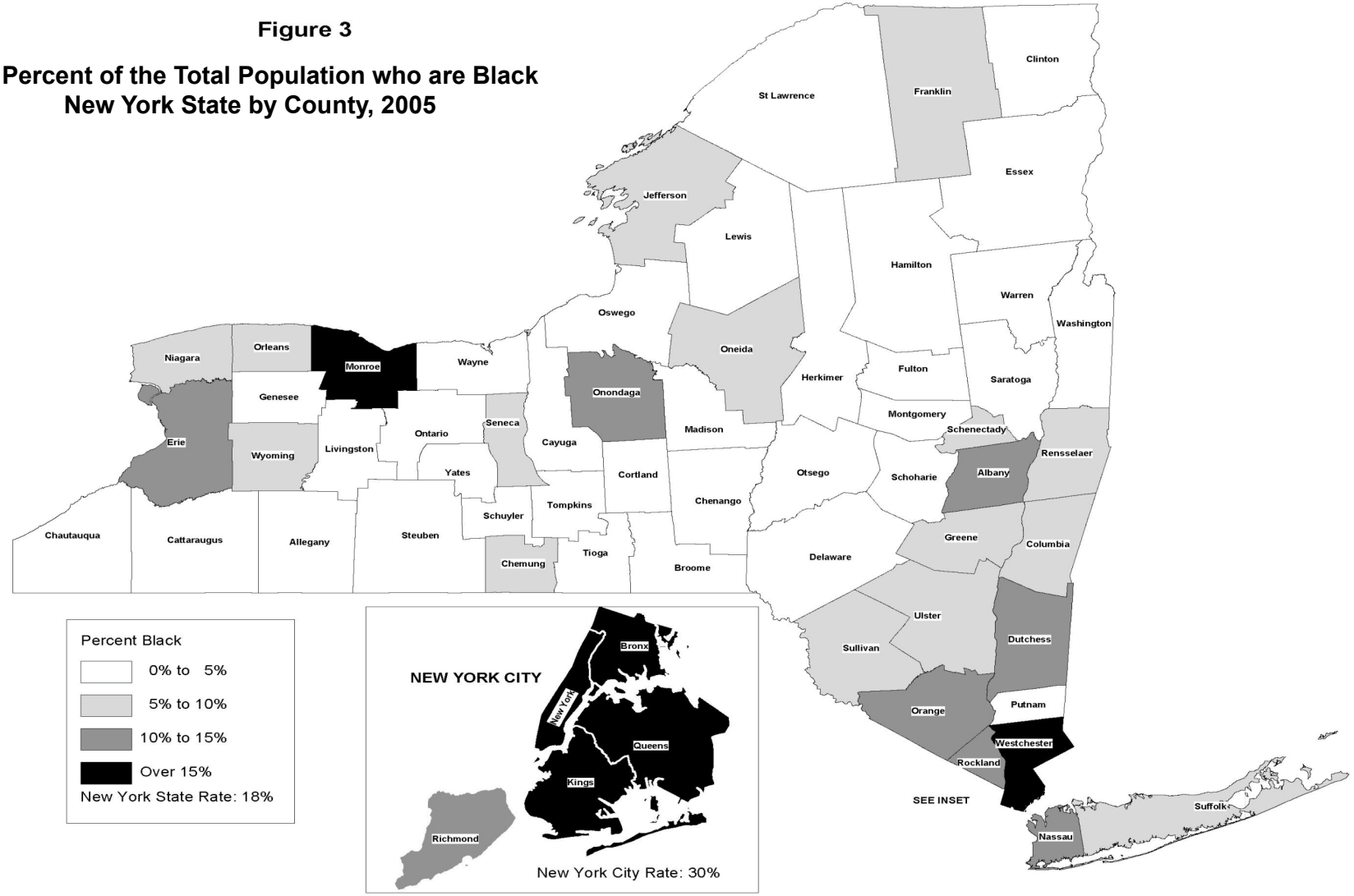
Hispanic Population (3,028,658)

Mexican – 346,783 11.5%
Puerto Rican – 1,057,423 34.9%
Cuban 66,687 2.2%
Other Hispanic – 1,557,765 51.4%

Source: American Community Survey-2005, U.S. Census Bureau

Figure 3

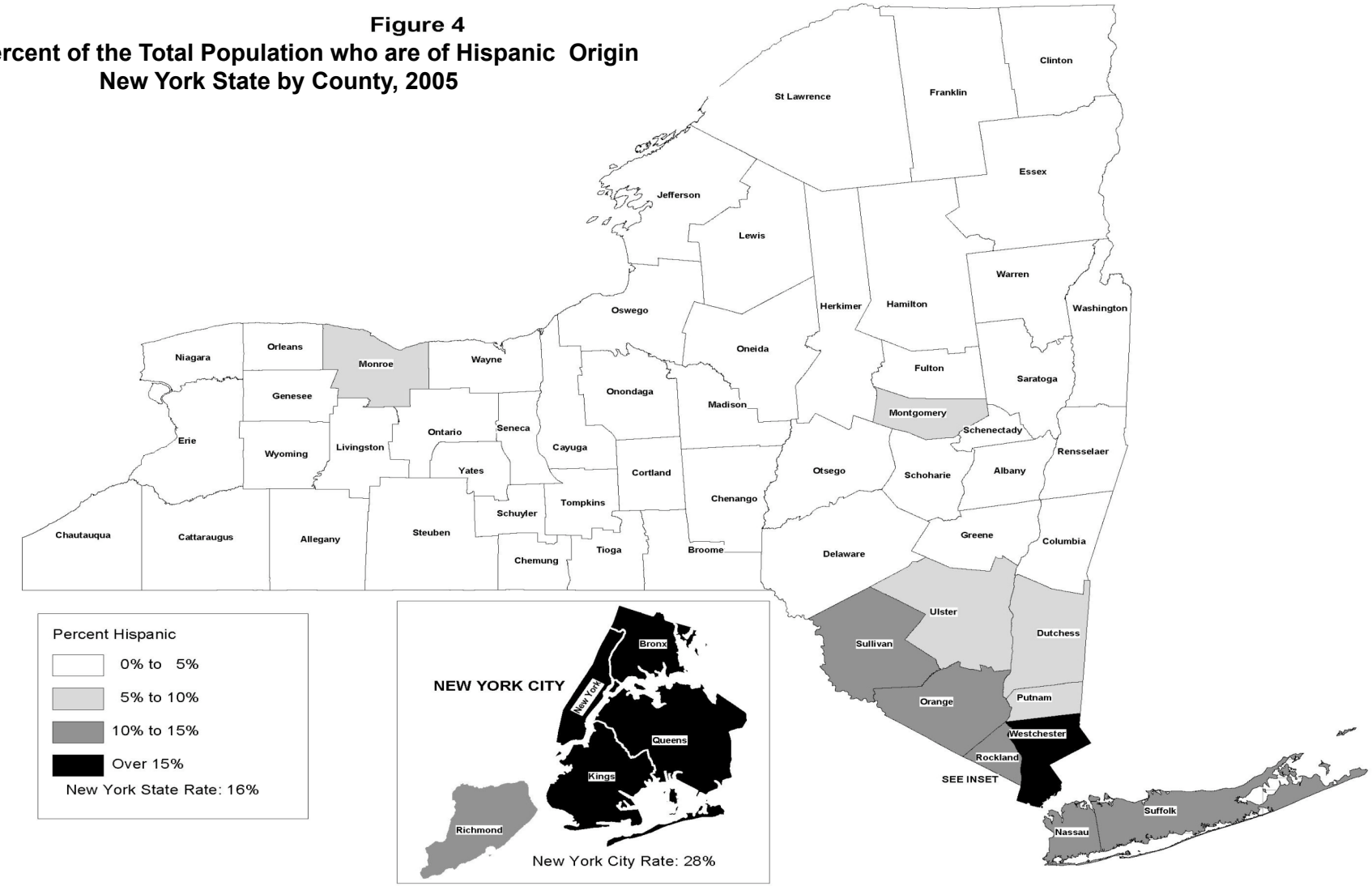
Percent of the Total Population who are Black
New York State by County, 2005



Source: US Census Bureau : Population Estimates by Bridged Race: New York State Counties, July 1, 2005

Counties with the largest percentage of their populations identifying themselves as Black include New York City, the Lower Hudson Valley counties and the urban upstate counties of Albany, Onondaga, Monroe and Erie.

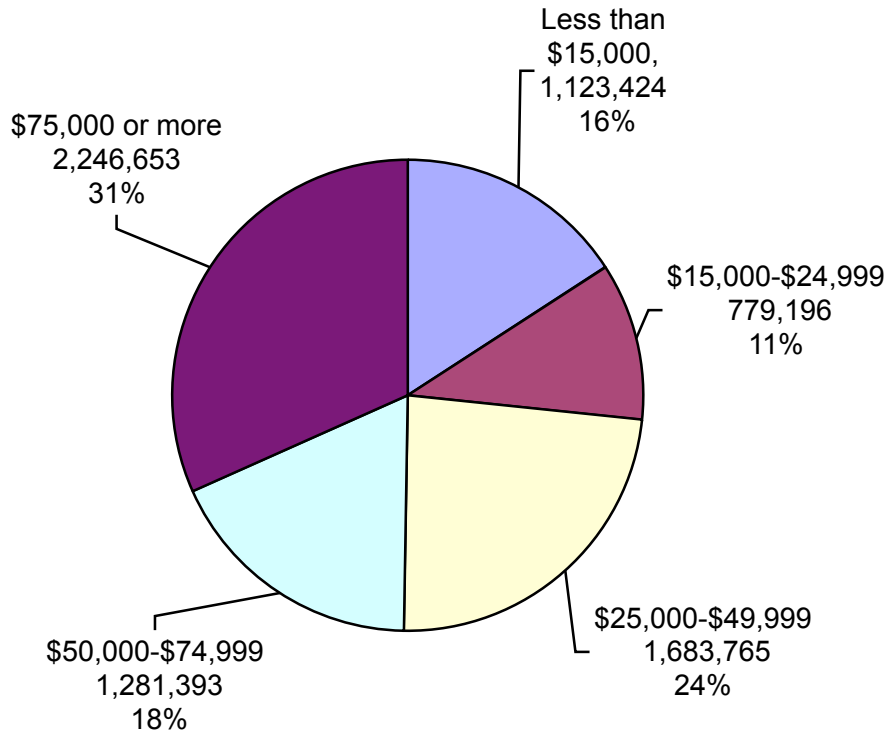
Figure 4
Percent of the Total Population who are of Hispanic Origin
New York State by County, 2005



Source: US Census Bureau: Population Estimates by Bridged Race: New York State Counties, July 1, 2005

Counties with the largest Hispanic populations include New York City and the lower Hudson Valley counties. Montgomery and Monroe counties also have large Hispanic populations.

Figure 5 New York State Households by Income Category, 2005



Source: U.S. Census Bureau, 2005 American Community Survey

People with higher education and income levels live longer, according to calculations from the National Longitudinal Mortality Survey. People whose family income put them in the top 5 percent of incomes had a life-expectancy at all ages that was about 25 percent longer than those in the bottom 5 percent. (Health, Income and Inequality, National Bureau of Economic Research Reporter: Research Summary, Spring 2003)

In 2005, 27% of New Yorkers lived in households earning less than $25,000 per year, 31% percent had household incomes of $75,000 or more and 42% were between $25,000 and $74,999 per year.

Figure 6a Percent of New York State's Population by Poverty Level and Race, 2005

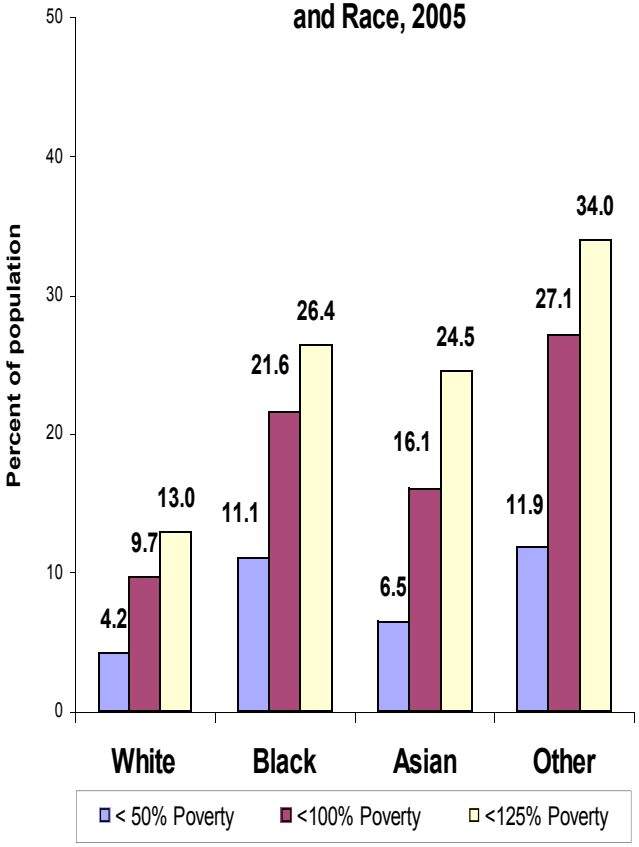
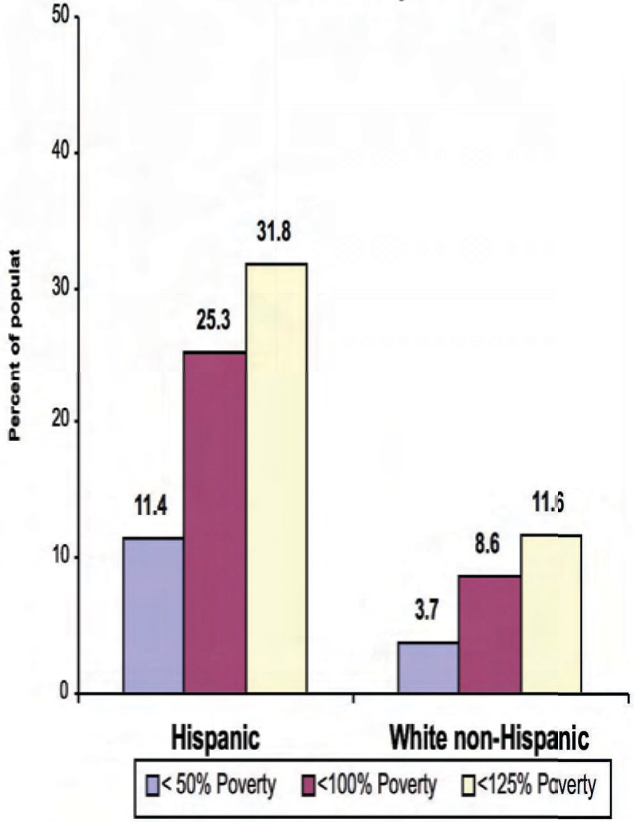


Figure 6b Percent of New York State's Population by Poverty Level and Ethnicity, 2005



The US Census Bureau determines poverty based on income, family size and the number of children living in the household. Each year new poverty thresholds are developed. For example, in 2005, individuals living in a four person household with two children and earning less than $19,806 would be considered living below the federal poverty level.

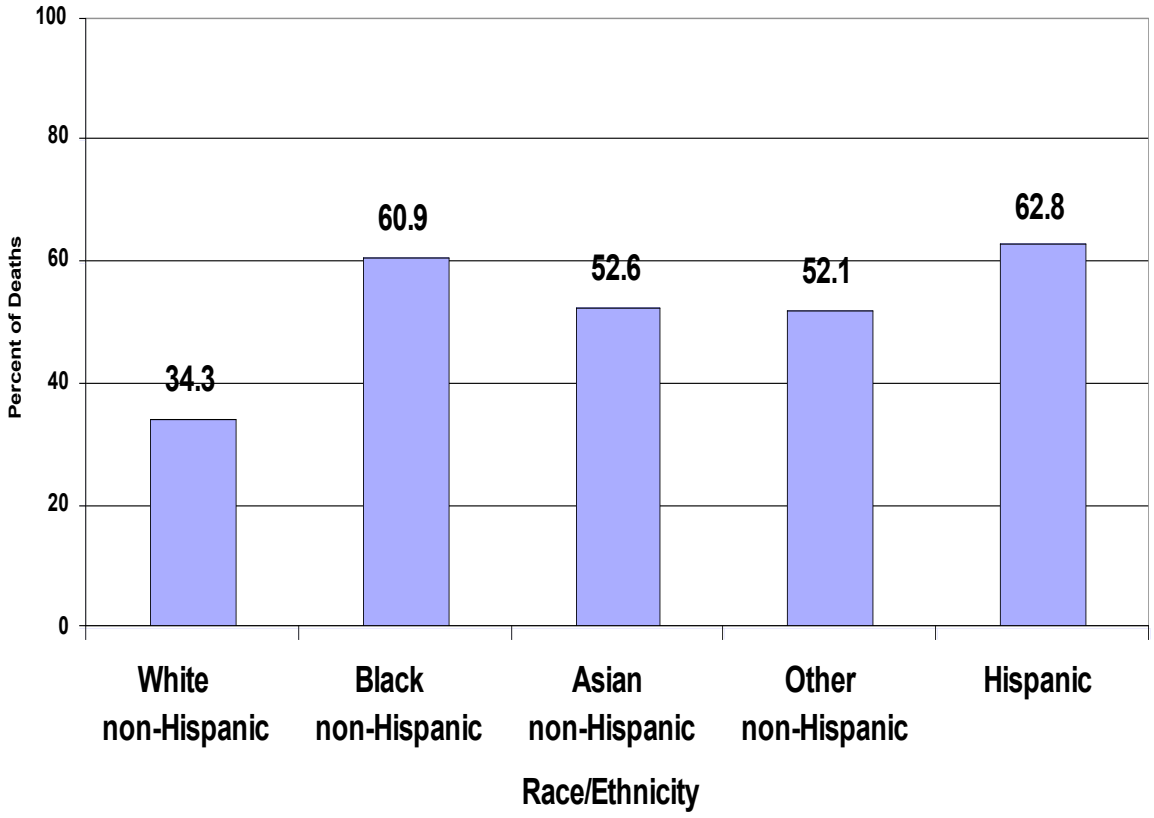
While only 9.7% of New York's White population was living below the poverty level in 2005, 21.6% of the Black population and 16.1% of the Asian population were living below the poverty level.

Poverty also affects Hispanics disproportionately. Among persons of Hispanic origin, 25.3% lived below the poverty level in 2005. This compares to 8.6% of non-Hispanic Whites.

Source: American Community Survey-2005, U.S. Census Bureau

MORTALITY

Figure 7 Percent of Deaths That Were Premature (Deaths of Persons < 75 Years of Age) by Race/Ethnicity, New York State Residents, 2004

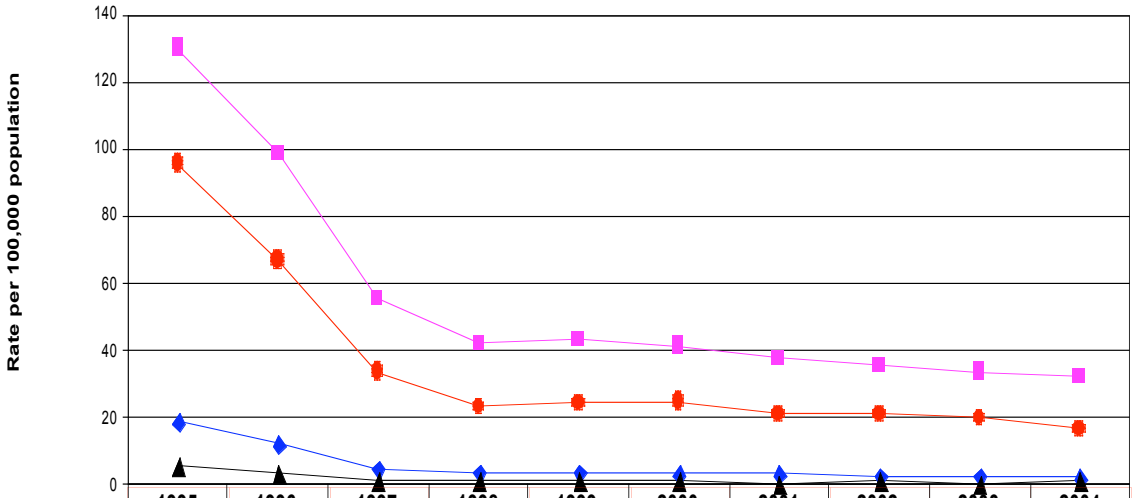


Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Premature deaths can be defined as deaths occurring at an age less than 75 years. Groups with higher rates of premature mortality are more likely to be affected by causes of death that are more common in younger populations such as unintentional injury, homicide and infant mortality.

The Black non-Hispanic and Hispanic premature death rates are almost twice the rate for White non-Hispanics. For Asian non-Hispanics and Other non-Hispanics, the rate is more than 1.5 times the rate for White non-Hispanics.

Figure 8 Age-Adjusted * AIDS/HIV Death Rate per 100,000 by Race/Ethnicity, New York State Residents, 1995-2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	19.1	12.1	5.1	3.8	4.0	3.6	3.3	2.9	2.6	2.4
Black NH	130.2	98.3	55.6	42.1	42.9	41.3	37.5	35.7	33.7	32.0
Asian/PI NH	5.4	3.2	1.9	1.1	1.3	1.3	0.6	1.3	0.7	0.9
Hispanic	95.7	67.0	33.5	23.2	24.2	24.8	20.8	20.8	20.1	16.8

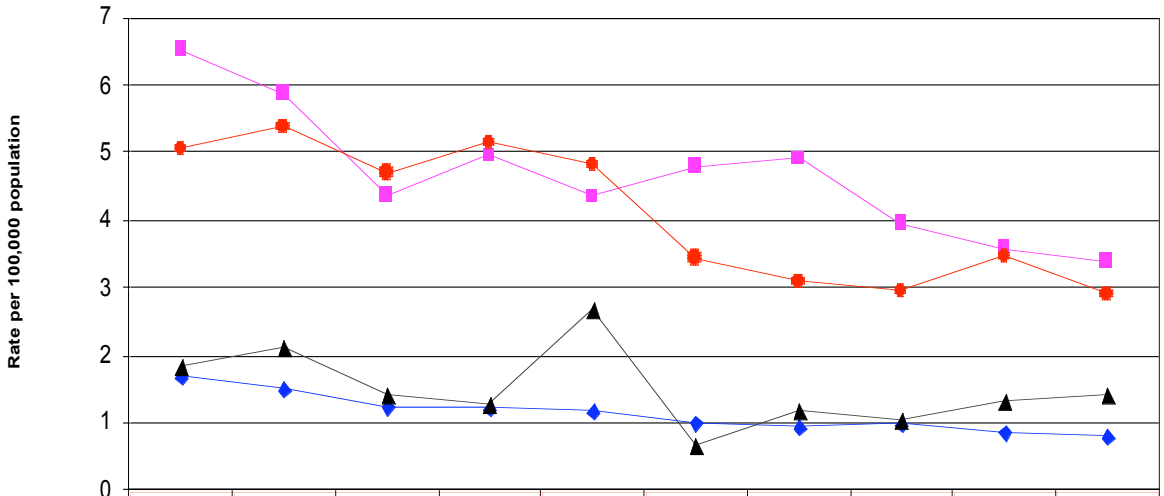
* Rates adjusted to the 2000 US population.
1995 – 1998 rates are based on ICD9 codes 042-044;1999-2004 rates are based on ICD10 codes B20-B24.
Abbreviations: NH - non-Hispanic, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

The AIDS/HIV epidemic has had a great impact on New Yorkers. A tribute to scientific advancements and the work of public health professionals and communities, the AIDS/HIV death rate has declined considerably and disparities have been reduced, although marked gaps between groups still exist. AIDS is still a leading cause of death for Blacks (3rd leading cause) and Hispanics (4th leading cause) in New York State (2004).

The most striking decreases in AIDS deaths between 1995 and 2004 were among Black non-Hispanics (130.2 to 32.0 per 100,000) and Hispanics (95.7 to 16.8 per 100,000).

While not as dramatic as among Black non-Hispanics and Hispanics, Asian non-Hispanics and White non-Hispanic New Yorkers also experienced marked declines in AIDS/HIV death rates (19.1 to 2.4 per 100,000 and 5.4 to 0.9 per 100,000 respectively).

Figure 9 Age-Adjusted * Asthma Death Rate per 100,000 by Race/Ethnicity, New York State Residents, 1995-2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	1.7	1.5	1.2	1.2	1.2	1.0	0.9	1.0	0.9	0.8
Black NH	6.5	5.9	4.4	5.0	4.3	4.8	4.9	4.0	3.6	3.4
Asian/PI NH	1.8	2.1	1.4	1.3	2.7	0.7	1.2	1.0	1.3	1.4
Hispanic	5.1	5.4	4.7	5.1	4.8	3.4	3.1	2.9	3.5	2.9

* Rates adjusted to the 2000 US population
Asthma Death rates between 1995-1998 are based on ICD9 code 493; Rates from 1999-2004 are based on ICD10 codes J45-J46.
Abbreviations: NH - non-Hispanic, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

There are more than 4,000 deaths nationally due to asthma each year, many of which are avoidable with proper treatment and care. In addition, asthma is indicated as a "contributing factor" in nearly 7,000 other deaths each year. (Asthma and Allergy Foundation of America –Facts and Figures).

Between 1995 and 2004, asthma death rates declined almost by half for Black non-Hispanic (6.5 to 3.4 per 100,000) and Hispanic (5.1 to 2.9 per 100,000) New Yorkers. However, rates among these two groups are still approximately three times greater than rates among Asian non-Hispanic (1.4 per 100,000) and White non-Hispanic (0.8 per 100,000) New Yorkers.

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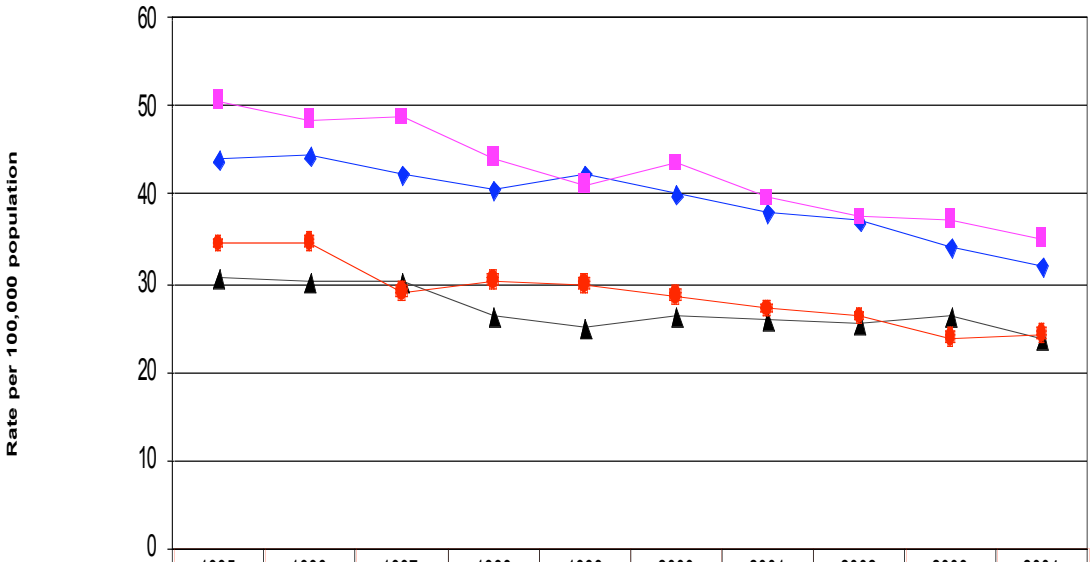
Figure 10 Age-Adjusted * Cerebrovascular Disease Death Rate per 100,000 by Race/Ethnicity, New York State Residents, 1995-2004



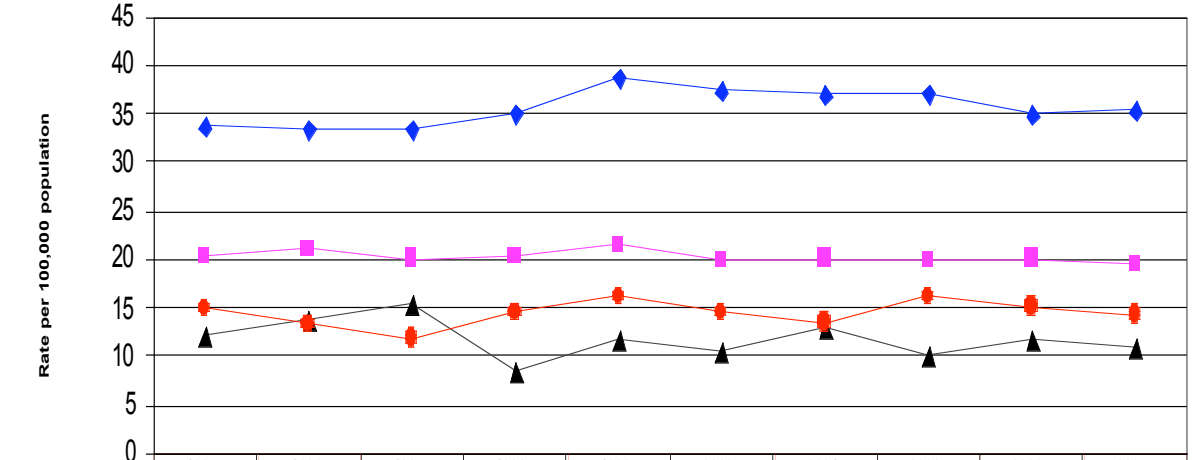
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	43.9	44.4	42.5	40.6	42.5	40.1	38.1	37.1	34.3	32.0
Black NH	50.7	48.6	48.8	44.1	41.2	43.4	39.6	37.4	37.3	35.0
Asian/PI NH	30.5	30.0	30.4	26.5	25.2	26.2	26.0	25.5	26.1	23.7
Hispanic	34.5	34.6	29.1	30.4	29.9	28.7	27.1	26.2	23.8	24.3

* Rates adjusted to the 2000 US population
1995-1998 rates are based on ICD9 codes 430-438. 1999-2004 rates are based on ICD10 codes I60-I69.
Abbreviations: NH - non-Hispanic, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

About 700,000 Americans suffer from new or recurrent strokes each year. Cerebrovascular disease (stroke) is a leading cause of death in New York State and is responsible for close to 7,000 New York State deaths per year (2004).

Rates have declined slightly, more so among Black non-Hispanics (50.7 to 35 per 100,000) and White non-Hispanics (43.9 to 32 per 100,000) compared to Asian/PI non-Hispanics (30.5 to 23.7 per 100,000) and Hispanics (34.5 to 24.3 per 100,000). However, even though their rates of decline are higher, Black non-Hispanic and White non-Hispanic New Yorkers continue to experience higher rates than Asian non-Hispanics and Hispanics.

Figure 11 Age-Adjusted* Chronic Obstructive Pumonary Disease (COPD) / Chronic Lower Respiratory Disease (CLRD) Death Rate per 100,000 by Race/Ethnicity, New York State Residents, 1995-2004



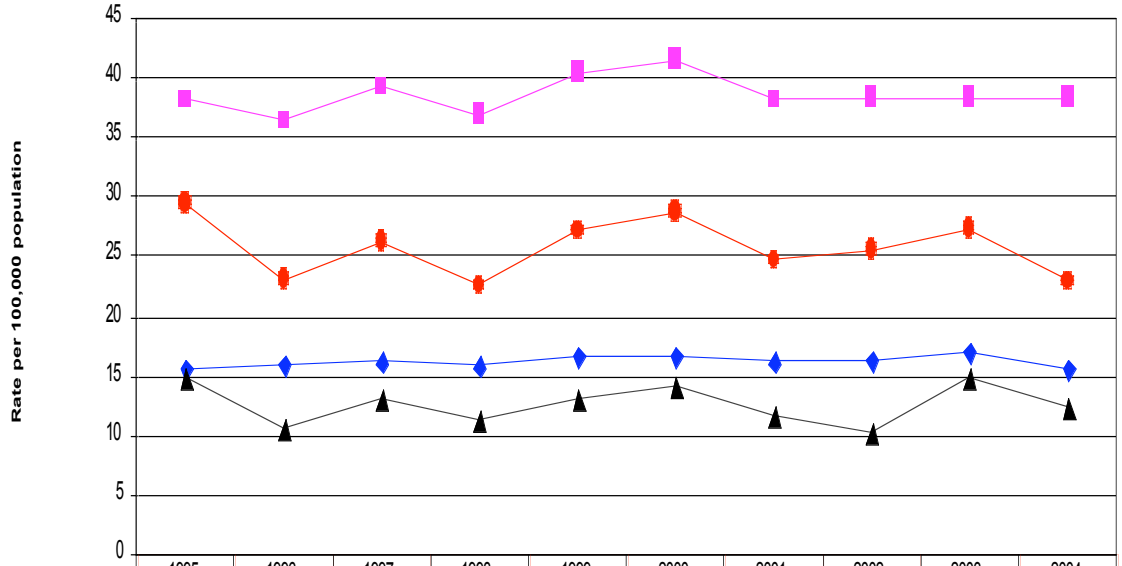
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	33.7	33.6	33.6	35.2	38.9	37.3	37.0	37.2	34.9	35.3
Black NH	20.2	21.1	20.1	20.2	21.4	19.9	20.0	19.8	20.0	19.4
Asian/PI NH	12.3	13.9	15.2	8.6	11.8	10.4	12.8	10.2	11.9	11.0
Hispanic	14.9	13.4	11.9	14.6	16.2	14.5	13.6	16.1	15.0	14.4

* Rates adjusted to the 2000 US population
COPD death rates between 1995-1998 are based on ICD9 codes 490-496. CLRD death rates from 1999-2004 are based on ICD10 codes J40-J47.
Abbreviations: NH - non-Hispanic, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

COPD/CLRD is a leading cause of death and smoking is the primary risk factor.

Over the past 10 years, COPD/CLRD among White non-Hispanics has persisted at a rate two to three times higher than the other three race/ethnic groups.

Figure 12 Age-Adjusted* Diabetes Death Rate per 100,000 by Race/Ethnicity, New York State Residents, 1995-2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	15.7	15.9	16.2	15.8	16.7	16.7	16.1	16.4	17.1	15.7
Black NH	38.2	36.5	39.2	37.0	40.5	41.5	38.2	38.4	38.4	38.5
Asian/PI NH	14.8	10.5	13.0	11.2	13.1	14.2	11.7	10.1	14.9	12.4
Hispanic	29.6	23.1	26.3	22.6	27.3	28.7	24.7	25.6	27.3	23.0

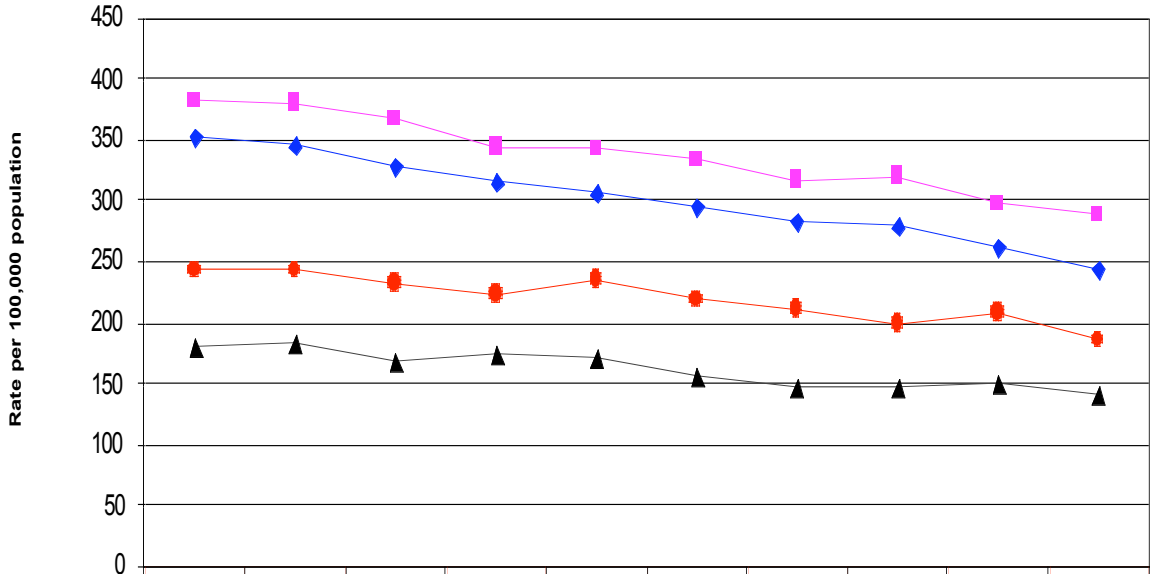
New York is experiencing an epidemic of diabetes, and the disease is most common among ethnic minorities.

Diabetes death rates have been fairly stable over the recent decade, with rates for Hispanics declining slightly. Disparities between groups have remained.

In 2004, Black non-Hispanics (38.5 per 100,000) continued to experience diabetes death rates more than one and one half times greater than Hispanics (23 per 100,000), two and one half times more than White non-Hispanics (15.7 per 100,000) and more than three times higher than Asian/Pacific Islander non-Hispanics (12.4 per 100,000).

* Rates adjusted to the 2000 US population
1995-1998 rates are based on ICD9 code 250. Rates from 1999-2004 are based on ICD10 codes E10-E14.
Rates based on deaths with diabetes as the primary cause of death.
Abbreviations: NH - non-Hispanic, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Figure 13 Age-Adjusted * Heart Disease Death Rate per 100,000 by Race/Ethnicity, New York State Residents, 1995-2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	352.7	345.3	329.6	316.1	306.1	295.3	283.3	278.7	263.1	245.0
Black NH	382.2	379.8	366.4	343.9	342.2	334.4	317.2	320.1	298.1	289.0
Asian/PI NH	181.1	184.5	167.3	173.2	171.1	157.0	148.7	147.2	149.9	142.0
Hispanic	242.7	243.8	233.1	223.7	235.6	219.1	211.4	198.8	208.6	186.0

* Rates adjusted to the 2000 US population
1995-1998 rates are based on ICD9 codes 390-398, 402, 404-429. Rates for 1999-2004 are based on ICD10 codes I00-I09,I11,I13,I20-151.
Abbreviations: NH - non-Hispanics, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

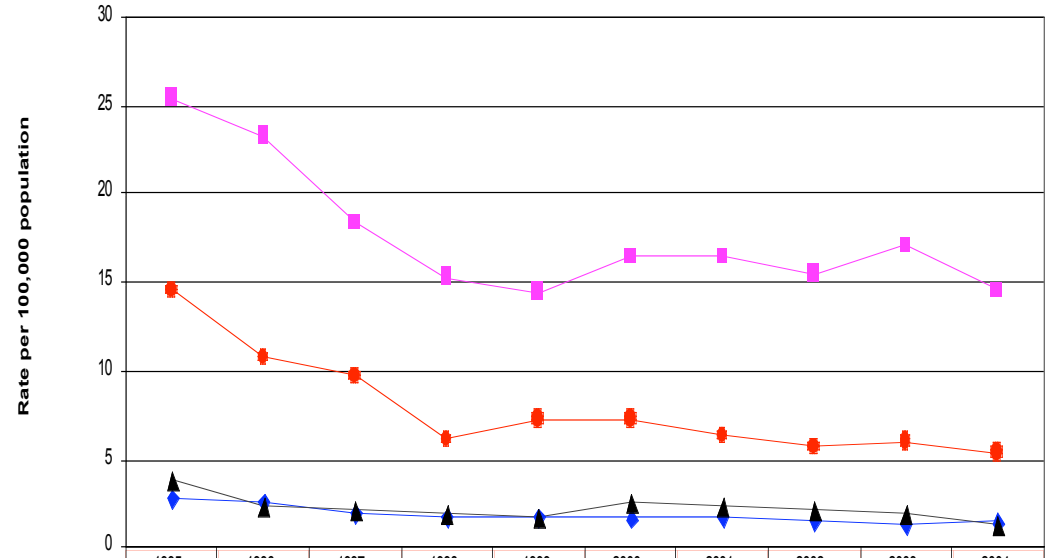
Cardiovascular disease is the leading cause of death in New York State, with a rate higher than cancers and HIV/AIDS combined.

During the past decade, the heart disease mortality rate for all four race/ethnic mortality groups has declined. Disparities between groups remain constant.

Of the four race/ethnic groups, Black non-Hispanics (289 per 100,000) continue to experience the highest mortality rate and Asian non-Hispanics (142 per 100,000) have the lowest mortality rate due to heart disease.

The largest declines in heart disease mortality rates in New York State between 1995 and 2004 have been among White non-Hispanics (31%) and Black non-Hispanics (24%)--the two groups who also experience the highest mortality rates.

Figure 14 Age-Adjusted* Homicide Death Rate per 100,000 by Race/Ethnicity, New York State Residents, 1995-2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	2.8	2.6	2.0	1.8	1.8	1.6	1.8	1.6	1.4	1.5
Black NH	25.4	23.2	18.3	15.3	14.5	16.4	16.4	15.5	17.0	14.5
Asian/PI NH	3.8	2.3	2.1	2.0	1.8	2.6	2.3	2.2	2.0	1.4
Hispanic	14.5	10.8	9.7	6.1	7.3	7.2	6.3	5.7	6.0	5.4

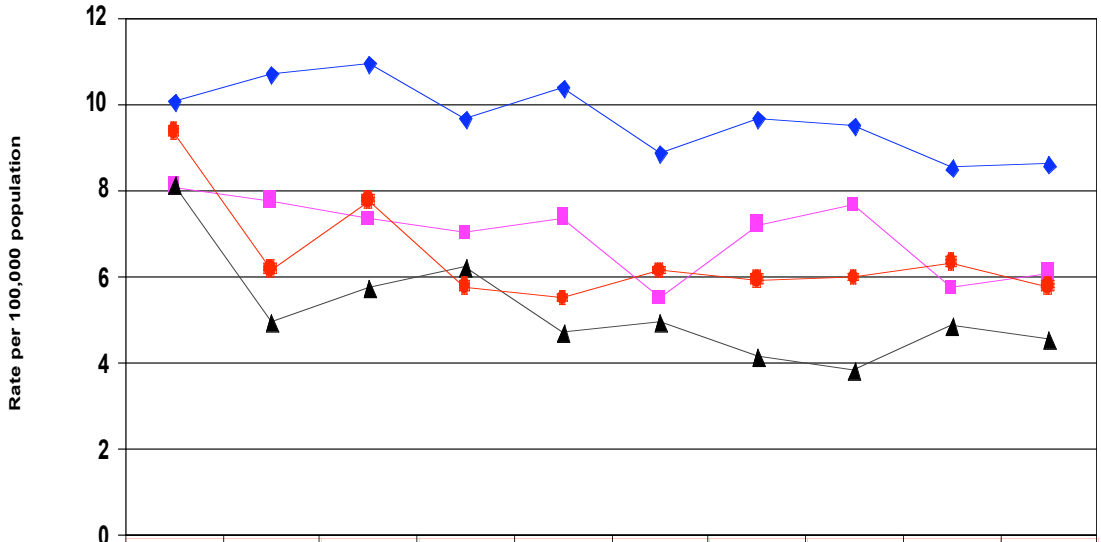
* Rates adjusted to the 2000 US population
1995-1998 rates are based on ICD9 codes E960-E969. Rates from 1999-2004 are based on ICD10 codes X85-Y09,Y87.1. In 2001, World Trade Center deaths are excluded from the rate.
Abbreviations: NH - non-Hispanic, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Homicide still remains a major cause of intentional injury among particular populations. National statistics indicate Blacks, males and persons under 25 are the most likely to be involved in homicides. Specifically, the victimization rates for Blacks were six times higher than those for Whites. Males represent 77% of homicide victims. Approximately one-third of murder victims are under the age of 25. (U.S. Department of Justice – 2004)

Although the overall homicide rate has declined, Black non-Hispanics still die as a result of homicide three times as often as Hispanics, the group with the next highest rate (14.5 per 100,000 compared to 5.4 per 100,000).

Rates for Black non-Hispanic and Hispanic New Yorkers remain stubbornly higher than rates for White non-Hispanics and Asian/Pacific Islander non-Hispanics. Specifically, the rate among Black non-Hispanics is almost ten times the rate for White non-Hispanics and Asian non-Hispanics in New York State.

Figure 15 Age-Adjusted* Motor Vehicle Injury Death Rate per 100,000 by Race/Ethnicity, New York State Residents, 1995-2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	10.1	10.7	11.0	9.7	10.4	8.9	9.7	9.5	8.5	8.6
Black NH	8.1	7.8	7.3	7.0	7.4	5.5	7.2	7.7	5.7	6.1
Asian/PI NH	8.1	5.0	5.8	6.3	4.7	5.0	4.2	3.9	4.9	4.6
Hispanic	9.4	6.2	7.8	5.8	5.5	6.1	5.9	6.0	6.4	5.8

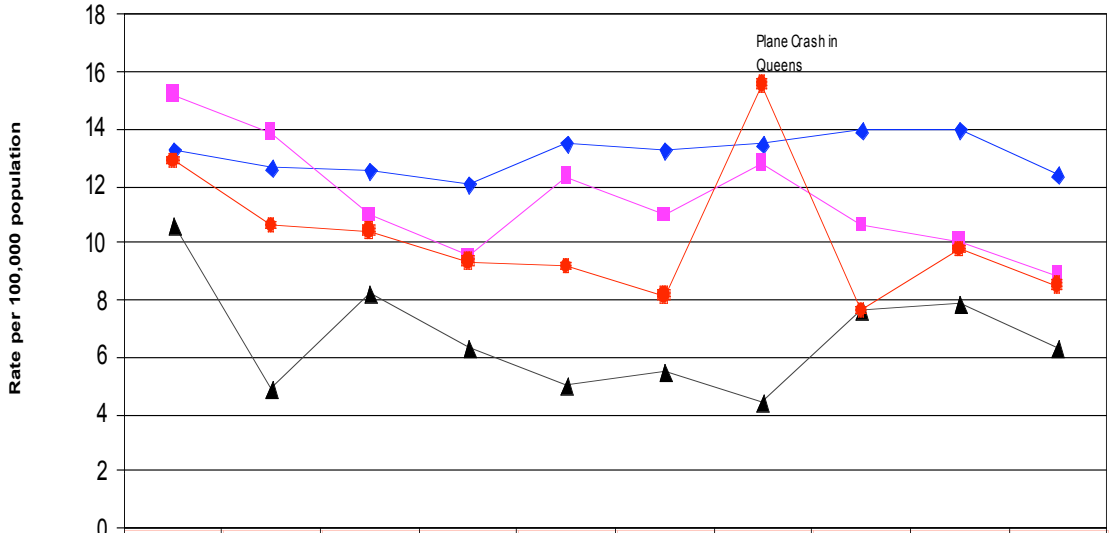
* Rates adjusted to the 2000 US population
1995-1998 rates are based on ICD9 codes E810-E825. Rates from 1999-2004 are based on ICD10 codes V02-V04,V09.0,V09.2,V12-V14,V19.0-V19.2, V19.4-V19.6,V20-V79,V80.3-V80.5,V81.0-V81.1,V82.0-V82.1,V83-V86, V87.0-V87.8,V88.0-V88.8, V89.0, V89.2.
Abbreviations: NH - non-Hispanic, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Health Statistics

One out of every 100 Americans is involved in a serious (causing personal injury) motor vehicle crash each year. Motor vehicle crashes are considered the leading cause of post-traumatic stress disorder (PTSD) in the general population, and car accidents are the number one trauma for men and the second most frequent trauma for women. (American Psychological Association - December 7, 2003)

This mortality statistic contrasts with other disparities in that White non-Hispanics are at most risk for motor vehicle injury mortality (8.6 per 100,000).

Between 1995 and 2004, motor vehicle-related deaths declined among all racial/ethnic groups. The rate declined about 40% among Asian/Pacific Islander non-Hispanic and Hispanic New Yorkers, 25% among Black non-Hispanics and 15% among White non-Hispanic New Yorkers.

Figure 16 Age-Adjusted* Unintentional Injury Non-Motor Vehicle Death Rate per 100,000 by Race/Ethnicity, New York State Residents, 1995-2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	13.3	12.6	12.6	12.1	13.5	13.3	13.5	14.0	14.0	12.4
Black NH	15.2	13.9	11.0	9.5	12.3	11.0	12.8	10.6	10.1	8.9
Asian/PI NH	10.6	4.9	8.3	6.3	5.0	5.6	4.4	7.7	7.9	6.4
Hispanic	12.9	10.6	10.4	9.3	9.2	8.2	15.6	7.6	9.8	8.5

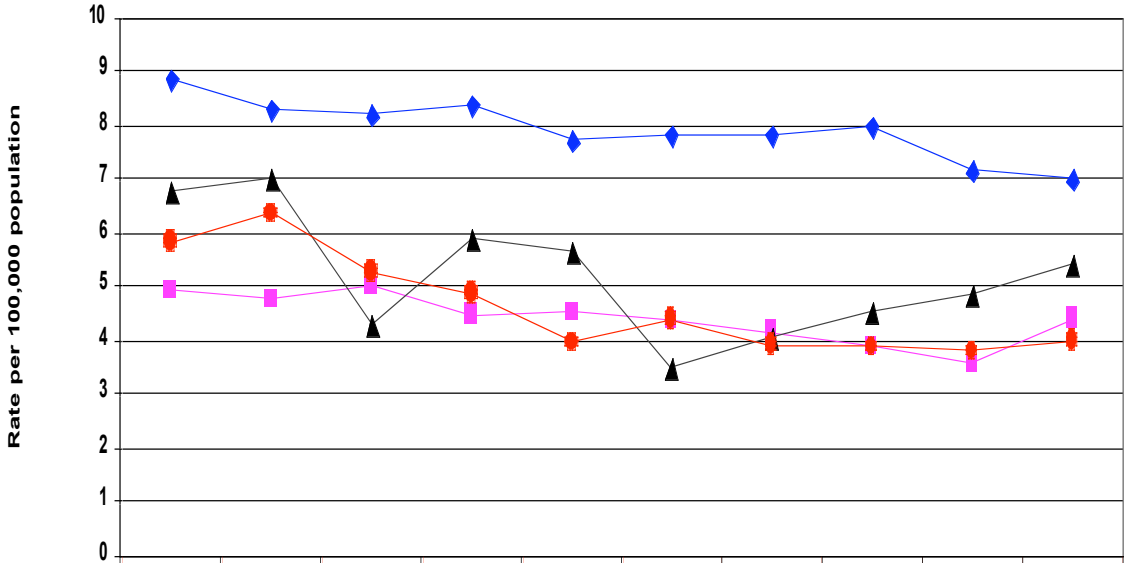
* Rates adjusted to the 2000 US population
1995-1998 rates are based on ICD9 codes E800-809, E826-E949. Rates from 1999-2004 are based on ICD10 codes (V01,V05-V08, V09.1, V09.3-V09.9,V10, V11, V15-V18, V19.3,V19.7-V19.9, V80.0-V80.2,V80.6-V80.9, V81.2-V81.9, V82.2-V82.9,V87.9, V88.9, V89.1, V89.3-V89.9, V90-X59, Y85-Y86.).
Abbreviations: NH - non-Hispanic, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Unintentional injury is the leading cause of death for those under 35 years of age.

In 2004, White non-Hispanic New Yorkers (12.4 per 100,000) experienced the highest non-motor vehicle unintentional injury death rates as compared to Black non-Hispanic (8.9 per 100,000), Hispanic (8.5 per 100,000) and Asian/Pacific Islander non-Hispanic (6.4 per 100,000) New Yorkers.

In New York State between 1995 and 2004, the non-motor vehicle unintentional injury death rate for White non-Hispanics declined only 7%. White non-Hispanics did not experience the same decline in their rate as Black non-Hispanics (41%), Asian/Pacific Islander non-Hispanics (40%) and Hispanics (34%).

Figure 17 Age-Adjusted* Suicide Death Rate per 100,000 by Race/Ethnicity, New York State Residents, 1995-2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	8.9	8.3	8.2	8.4	7.7	7.8	7.8	8.0	7.2	7.0
Black NH	4.9	4.8	5.0	4.5	4.5	4.4	4.1	3.9	3.6	4.4
Asian/PI NH	6.8	7.0	4.3	5.9	5.7	3.5	4.0	4.5	4.8	5.4
Hispanic	5.8	6.4	5.3	4.9	4.0	4.4	3.9	3.9	3.8	4.0

* Rates adjusted to the 2000 US population
1995-1998 rates are based on ICD9 codes E950-E957.Rates from 1999-2004 are based on ICD10 codes X60-X84, Y87.0
Abbreviations: NH - non-Hispanic, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

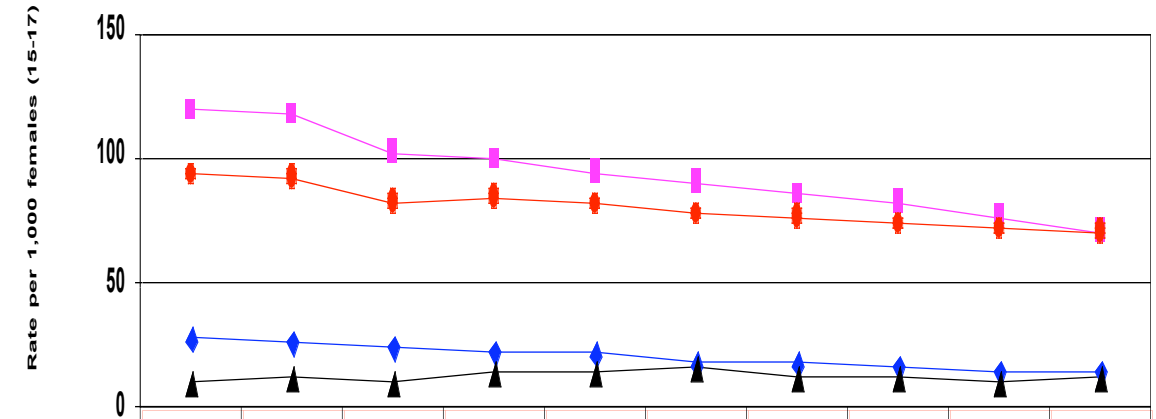
More than 1,300 lives are lost each year in New York as a result of suicide.

Suicide continues to be much more prevalent among White non-Hispanics compared to all other race/ethnic groups. White non-Hispanics commit suicide twice as often as Black non-Hispanics and one and a half times more often than Asian/Pacific Islander non-Hispanics and Hispanics.

Although trends show improvement, disparate ratios remain. Asian/Pacific Islander non-Hispanics have emerged more prominently as the second highest race/ethnic grouping to White non-Hispanics over the past five years.

NATALITY

Figure 18 New York State Pregnancy Rate per 1,000 Females Ages 15-17 by Race/Ethnicity, New York State Residents, 1995 - 2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	28.3	26.8	24.4	23.0	21.5	18.3	17.5	16.5	15.1	14.5
Black NH	119.5	117.1	102.6	99.3	94.8	90.5	85.7	82.5	76.3	71.0
Asian/PI NH	9.7	11.6	10.9	13.9	14.1	15.5	12.4	11.4	11.2	11.6
Hispanic	93.9	92.3	82.9	84.6	81.7	77.8	76.1	73.2	71.1	70.4

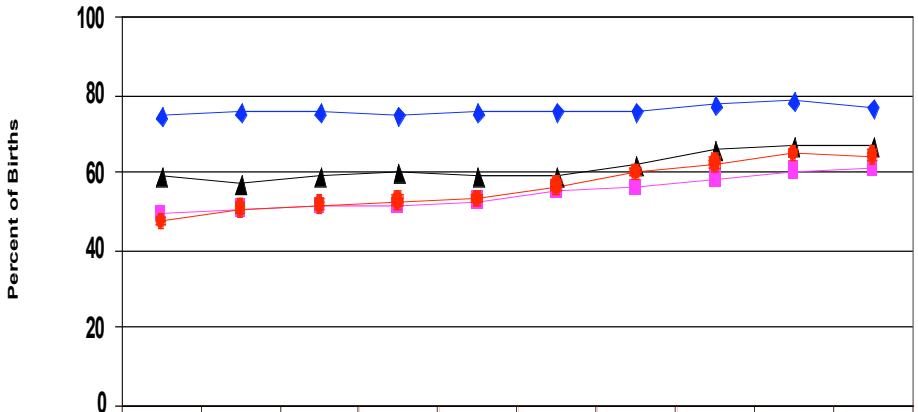
Abbreviations: NH - non-Hispanics, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

The United States has the highest rates of teen pregnancy and births in the western industrialized world. Teen pregnancy costs the United States at least $9 billion annually. Thirty-one percent of young women in the United States become pregnant at least once before they reach the age of 20. Eight in 10 of these pregnancies are unintended and 81% are among unmarried teens. (General Facts and Stats - www.Teenpregnancy.org)

Adolescent pregnancy rates were highest among Black non-Hispanics and Hispanics (71 per 1,000) as compared to White non-Hispanics and Asian/Pacific Islander non-Hispanics, with rates of 14.5 and 11.6 per 1,000 respectively.

Although adolescent pregnancy has gradually declined among all racial/ethnic groups except non-Hispanic Asian/Pacific Islanders, it is still unacceptably high.

Figure 19 Percent of Births Receiving Early (1st Trimester) Prenatal Care by Race/ Ethnicity, New York State Residents, 1995 - 2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	74.7	75.8	75.4	75.3	75.6	76.0	76.3	77.7	78.6	77.0
Black NH	49.4	50.9	51.0	51.5	52.5	55.3	56.3	58.3	60.5	60.9
Asian/PI NH	59.6	57.5	59.6	59.8	59.2	59.0	62.0	66.6	67.4	66.9
Hispanic	47.4	50.5	51.9	52.5	53.1	56.8	60.1	62.5	65.1	64.4

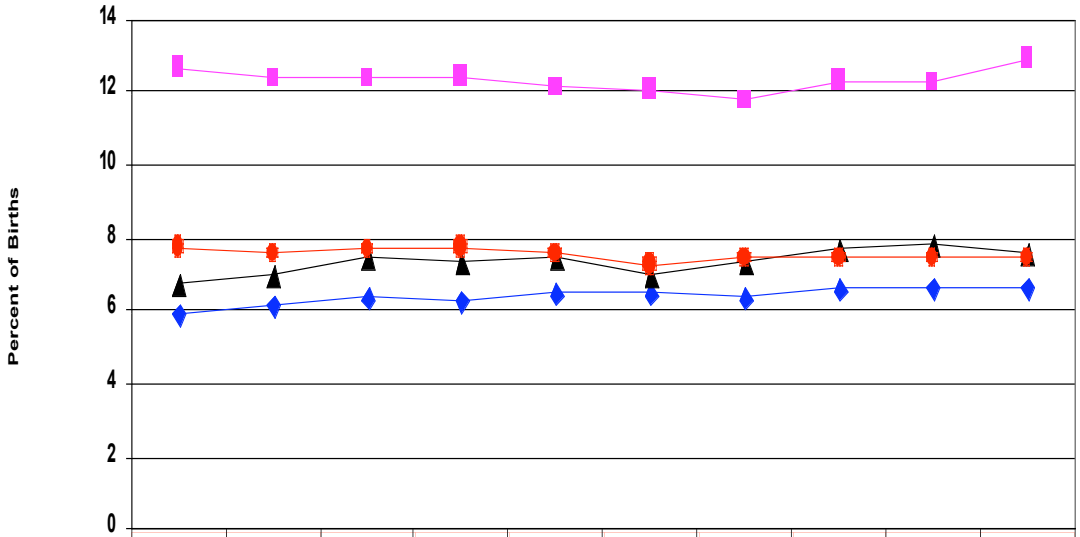
Women with unknown entry into prenatal care are excluded.
Abbreviations: NH - non-Hispanics, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Babies born to mothers who receive no prenatal care are three times more likely to be born at low birth weight and five times more likely to die than those whose mothers receive prenatal care (www.womenshealth.gov - Health Topics - Prenatal care). In New York State, mothers with early entry (first trimester) into prenatal care had a low birth weight rate of 7.8% compared to the rate of 22% for mothers with no care (2004-2005).

Between 1995 and 2004, early prenatal care rates for Black non-Hispanic and Hispanic New York State women giving birth improved significantly (+23.3% and +35.9%), reducing the racial and ethnic disparity between these two groups and Asian/Pacific Islander non-Hispanic and White non-Hispanic New York women. The rate of early prenatal care for Asian/Pacific Islander non-Hispanic women improved 12.2% and 3% among White non-Hispanic women during this time period.

Although racial and ethnic differences were still noticeable in 2004, they were less than they had been in the previous 10 years. White non-Hispanic women giving birth were the most likely to receive early prenatal care (77.0%). Among Asian/Pacific Islander non-Hispanic women, 66.9% received early care, among Hispanic women 64.4% received early care and among Black non-Hispanic women 60.9% received early care.

Figure 20 Percent of Births Under 2,500 Grams by Race/ Ethnicity, New York State Residents, 1995 - 2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	6.0	6.2	6.4	6.3	6.5	6.5	6.4	6.6	6.6	6.7
Black NH	12.7	12.4	12.4	12.4	12.1	12.1	11.7	12.3	12.2	12.9
Asian/PI NH	6.7	7.0	7.5	7.4	7.4	7.0	7.4	7.7	7.8	7.6
Hispanic	7.7	7.6	7.7	7.7	7.6	7.3	7.5	7.5	7.4	7.4

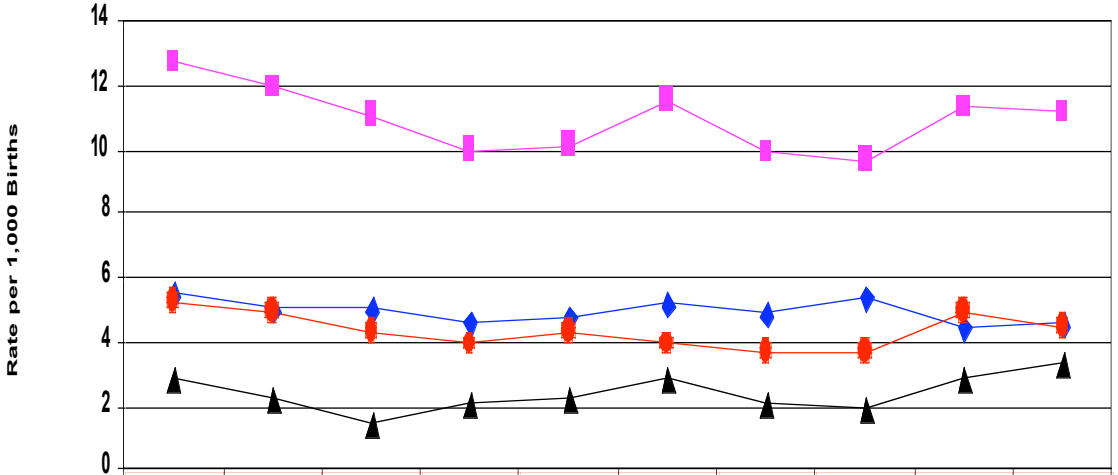
Infants weighing less than 2,500 grams are at greater risk of death within the first month of life, as well as at increased risk for developmental disabilities and illness throughout their lives.

Black non-Hispanics (12.9%) continue to experience nearly twice the rate of low birth weight births compared to the other groups.

There has been very little change in low birth weight rates over the past 10 years.

Abbreviations: NH - non-Hispanic, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health statistics.

Figure 21 Infant Death Rate per 1,000 Live Births by Race/ Ethnicity, New York State Residents, 1995 - 2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	5.5	5.0	5.0	4.7	4.8	5.2	4.9	5.5	4.5	4.6
Black NH	12.8	12.0	11.1	10.0	10.1	11.5	9.9	9.7	11.3	11.1
Asian/PI NH	2.8	2.3	1.5	2.1	2.2	2.8	2.1	1.9	2.9	3.4
Hispanic	5.2	5.0	4.3	3.9	4.4	3.9	3.7	3.7	5.0	4.5

Abbreviations: NH - non-Hispanic, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

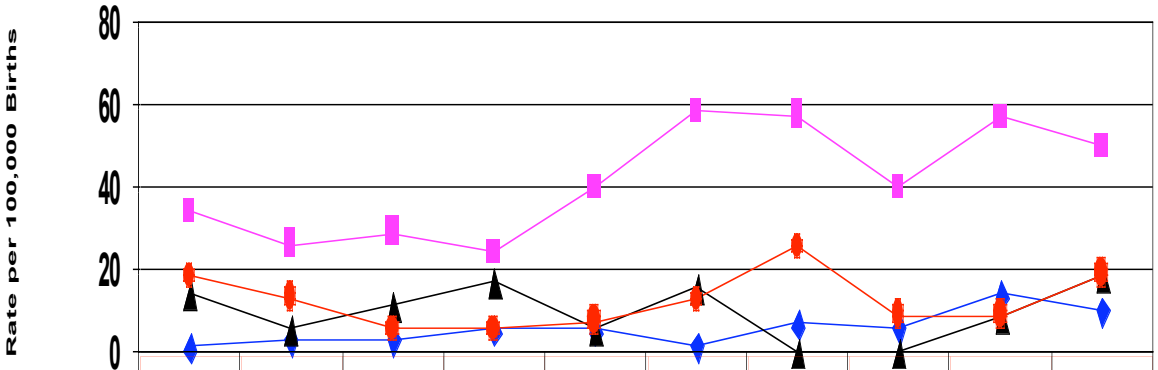
Infant mortality is one of the most widely used indicators of the health and welfare of a population because it reflects the general state of maternal health and effectiveness of primary health care. Infant mortality is related to many factors including the health of the mother, prenatal care and quality of health services.

Although rates for Black non-Hispanic, White non-Hispanic and Hispanic infants in New York State have declined steadily, the disparity in mortality between Black non-Hispanic infants and infants of other races remains significant.

In 2004, Black non-Hispanic infant mortality (11.1 per 1,000 births) was more than double the rate among Hispanic (4.5 per 1,000 births) and White non-Hispanic (4.6 per 1,000 births) infants and triple the rate among Asian/Pacific Islander non-Hispanic (3.4 per 1,000 births) infants.

Although infant mortality among Asian/Pacific Islander non-Hispanics increased slightly between 1995 and 2004, rates among Asian/Pacific Islander non-Hispanics are still lower than among all other racial groups.

Figure 22 Maternal Mortality Rate per 100,000 Live Births by Race/Ethnicity, New York State Residents, 1995 - 2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	1.4	3.5	3.6	5.8	5.9	2.2	6.8	6.2	14.4	10.8
Black NH	34.6	26.2	29.0	24.6	40.0	58.5	57.8	40.0	57.1	50.2
Asian/PI NH	15.0	6.6	12.4	17.8	5.7	15.5	0.0	0.0	9.5	18.6
Hispanic	18.5	13.4	5.9	5.8	7.5	13.0	25.7	9.2	9.1	19.1

More than half of all maternal deaths can be prevented through early diagnosis and appropriate medical care of pregnancy complications. Hemorrhage, pregnancy-induced hypertension, infection and ectopic pregnancy continue to account for most (59%) maternal deaths. ("Maternal Mortality - United States, 1982-1996", MMWR National Center for Health Statistics)

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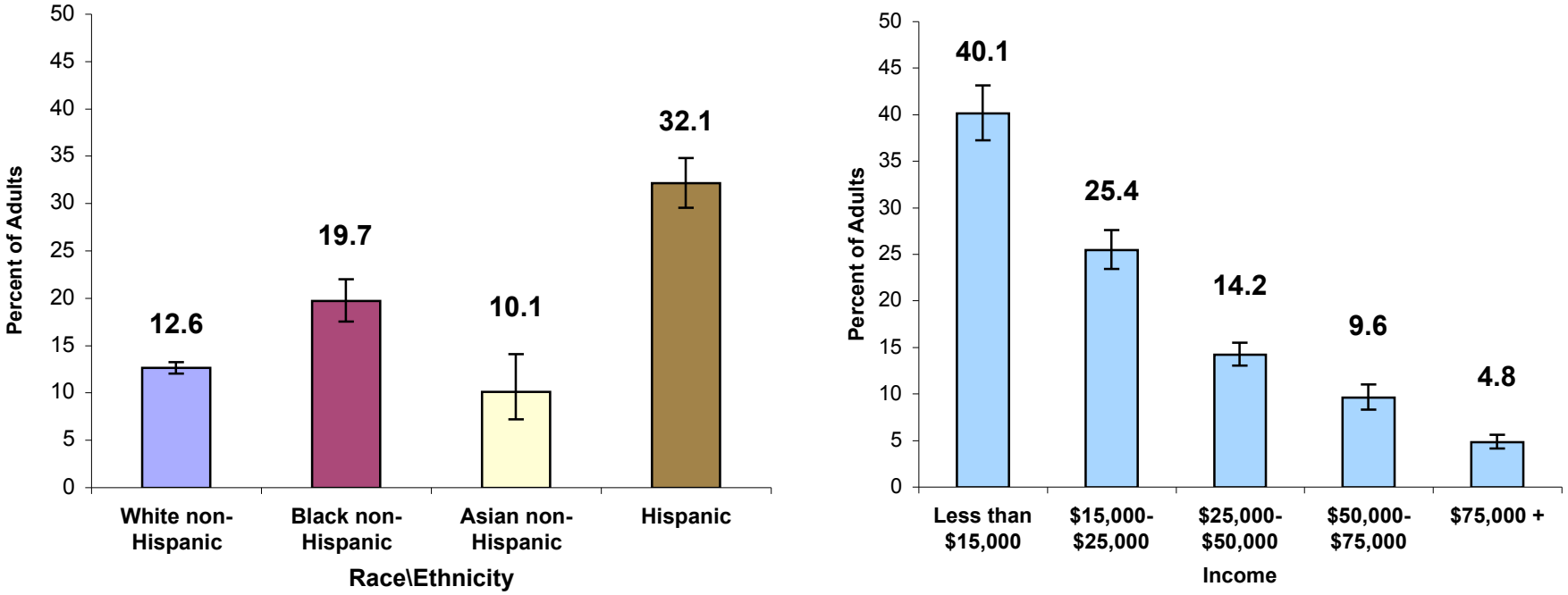
Because maternal deaths are rare events, rates are based on very small numbers. Small changes in numbers cause large fluctuations in rates. In 2004, there were 21 Black non-Hispanic, 14 White non-Hispanic, 4 Asian/Pacific Islander non-Hispanic and 11 Hispanic maternal deaths in New York State.

In New York State during 2004 the maternal mortality rate for Black non-Hispanics (50.2 per 100,000 births) was 2.5 times the rate for Asian/Pacific Islander non-Hispanics (18.6 per 100,000 births) and Hispanics (19.1 per 100,000 births) and five times the rate for White non-Hispanics (10.8 per 100,000 births).

1995-1998 rates are based on ICD9 codes 630-676. Rates for 1999-2004 are based on ICD10 codes P00-P96.
Abbreviations: NH - non-Hispanic, PI - Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics.

GENERAL HEALTH

Figure 23a Percent of Adults 18 Years or Older Reporting Fair or Poor Health During the Past Month by Race/Ethnicity and Income, New York State Residents, 2003-2005



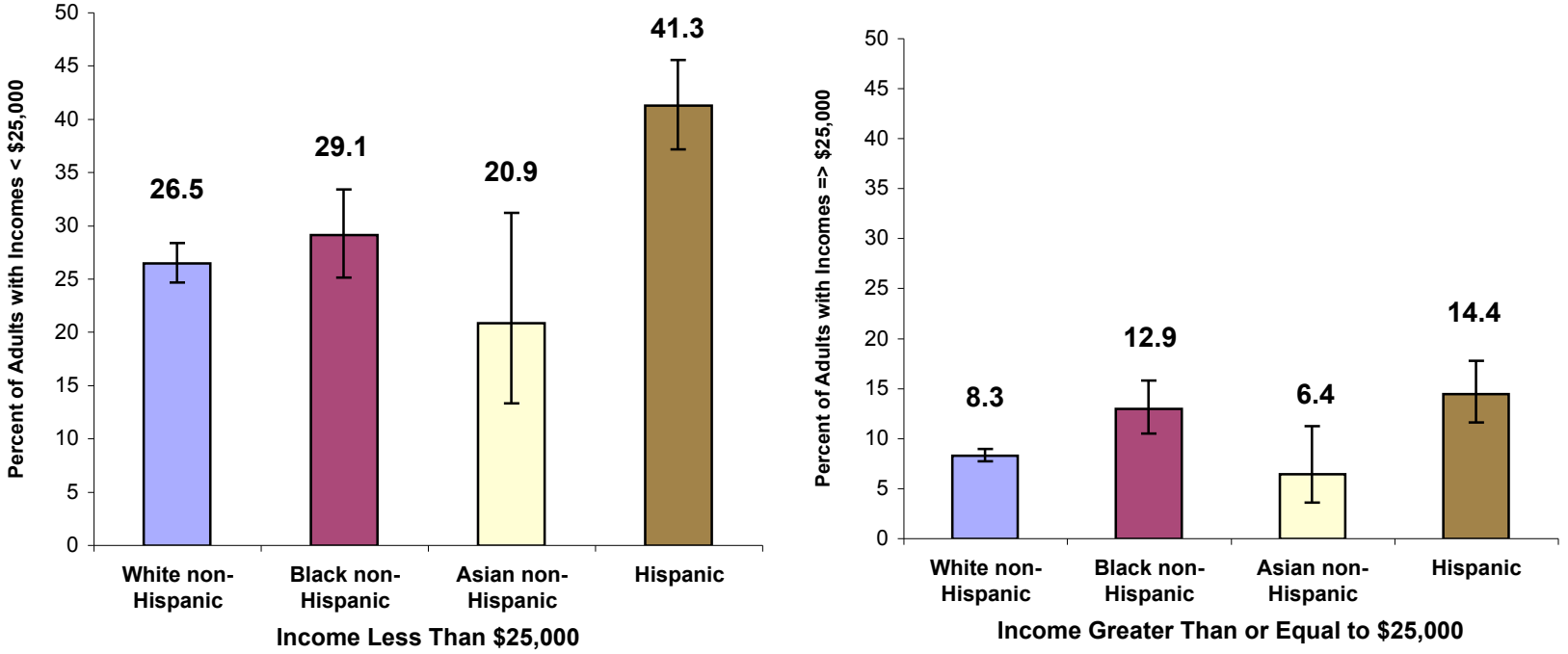
Source: Behavioral Risk Factor Surveillance System (2003-2005)

Self Reported Health is one indicator used as a general guide to the heath and well being of New Yorkers. Since it is based on a personal perception rather than on specific measures, it is usually used in conjunction with other measures.

Hispanics were the most likely to report their health as poor or fair (32.1%) while White non-Hispanics (12.6%) and Asian non-Hispanics (10.1%) were the least likely to categorize their health in this way. In addition to the Hispanic population, Black non-Hispanic New Yorkers reported fair or poor health at a significantly higher level (19.7%) compared to their White non-Hispanic counterparts (12.6%).

The reporting of fair or poor health was inversely related to annual income levels. Of persons earning less than $15,000 per year, 40.1% reported having fair or poor health. Of persons surveyed earning greater than $75,000 per year, 4.8% reported fair or poor health.

Figure 23b Percent of Adults 18 Years or Older Reporting Fair or Poor Health During the Past Month by Race/Ethnicity by Income, New York State Residents, 2003 - 2005



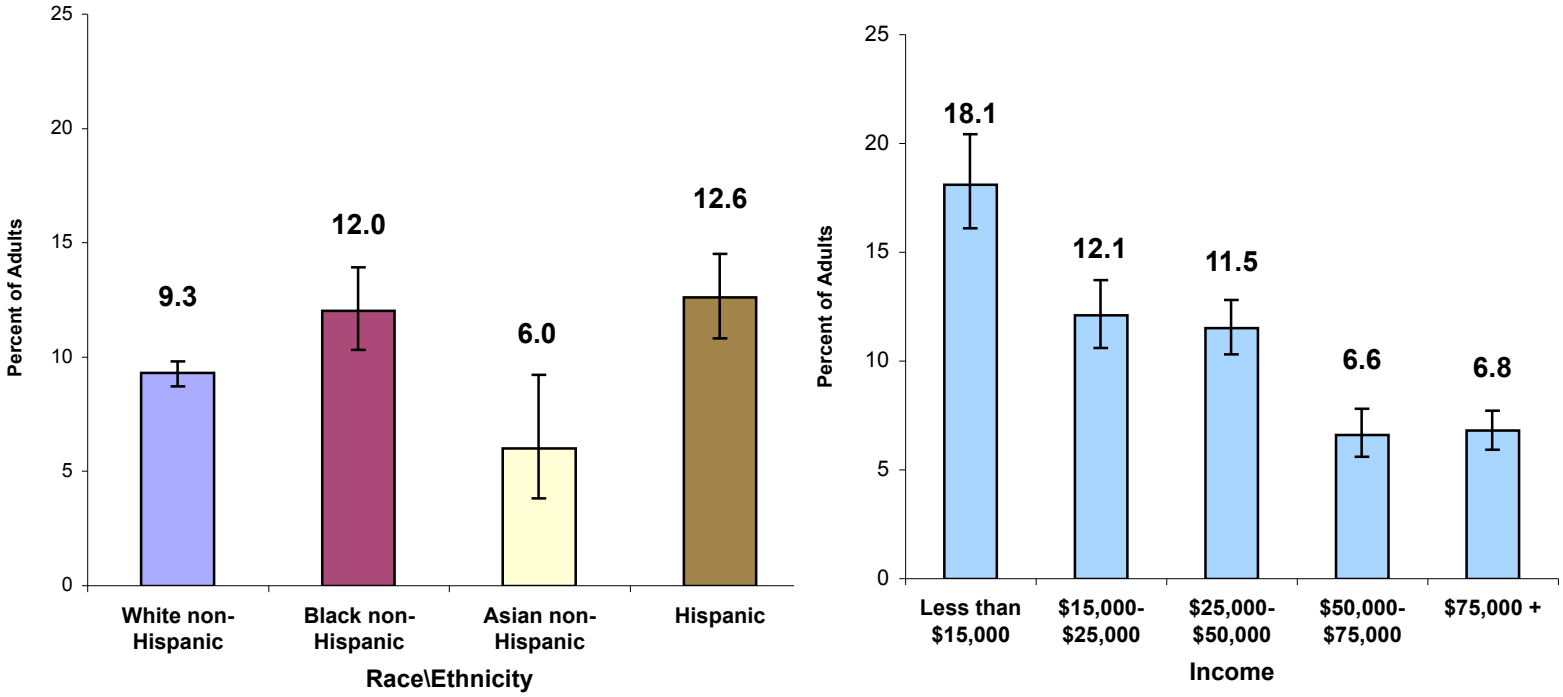
Source: Behavioral Risk Factor Surveillance System (2003-2005)

Fair or poor health was significantly more likely to be reported by individuals earning less than $25,000 per year as compared to their higher income counterparts for all race/ethnic groups.

Among Hispanic New Yorkers earning less than $25,000 per year, more than 40% reported their health to be fair or poor. This percentage was significantly higher than the percentages for other race/ethnic groups.

Among Hispanic New Yorkers earning more than $25,000 per year, only 14.4% reported fair or poor health. However, this was still significantly higher than White non-Hispanic (8.3%) and Asian non-Hispanic (6.4%) New Yorkers in this income category. Almost 13% of Black non-Hispanics in this income category reported fair or poor health. This was significantly higher than the rate for White non-Hispanics (8.3%).

Figure 24a Percent of Adults 18 Years or Older Reporting Poor Mental Health (14 or More Days) During the Past Month by Race/Ethnicity and Income, New York State Residents, 2003-2005



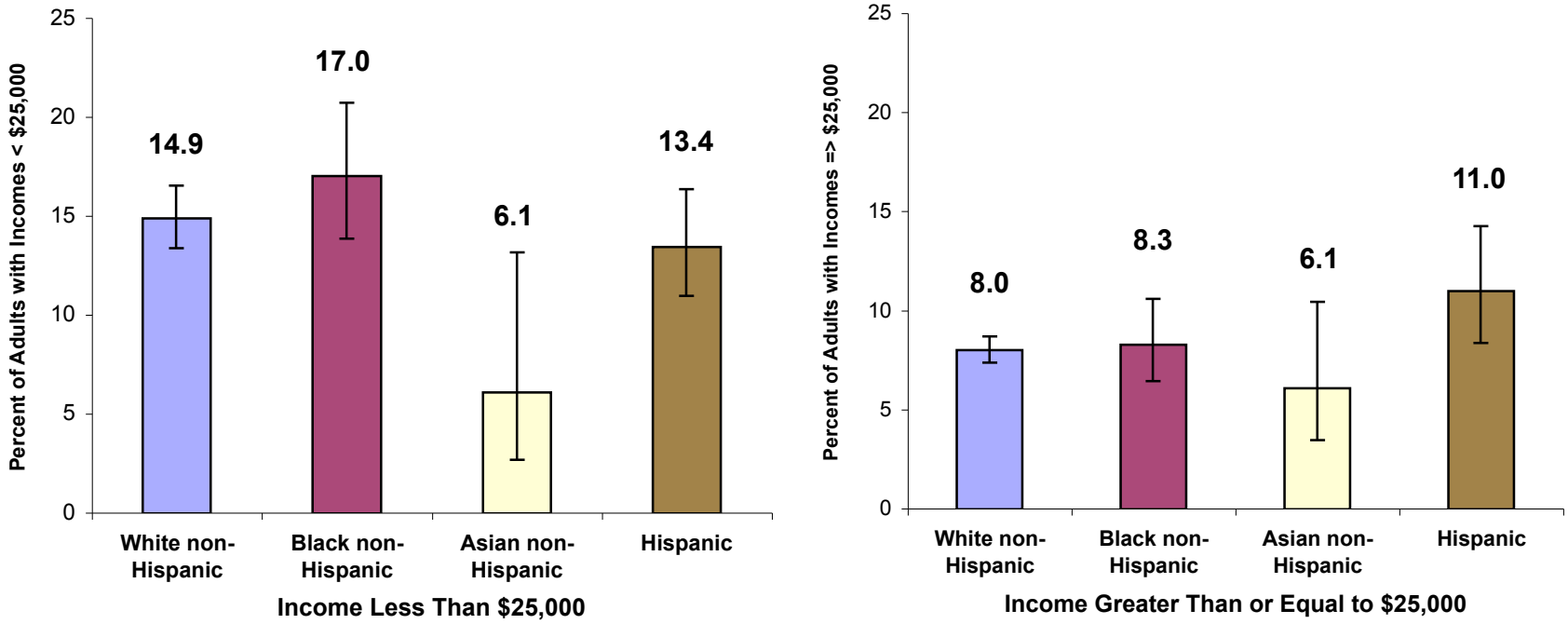
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

About 12% of Black non-Hispanic and Hispanic New Yorkers surveyed reported their mental health was poor for 14 or more days during the past month. These rates were significantly higher than the 9.3% of White non-Hispanics and 6% of Asian non-Hispanics who also reported poor mental health for at least 14 days in the past month.

As with physical health, there was an inverse relationship between income and poor mental health. As annual income increased, the reporting of poor mental health decreased.

Of persons earning less than $15,000 per year, 18.1% experienced poor mental health for 14 or more days in the past month. Only 6.8% of persons earning over $75,000 annually reported 14 or more days of poor mental health in the past month.

Figure 24b Percent of Adults 18 Years or Older Reporting Poor Mental Health (14 or More Days) During the Past Month by Race/Ethnicity by Income, New York State Residents, 2003-2005



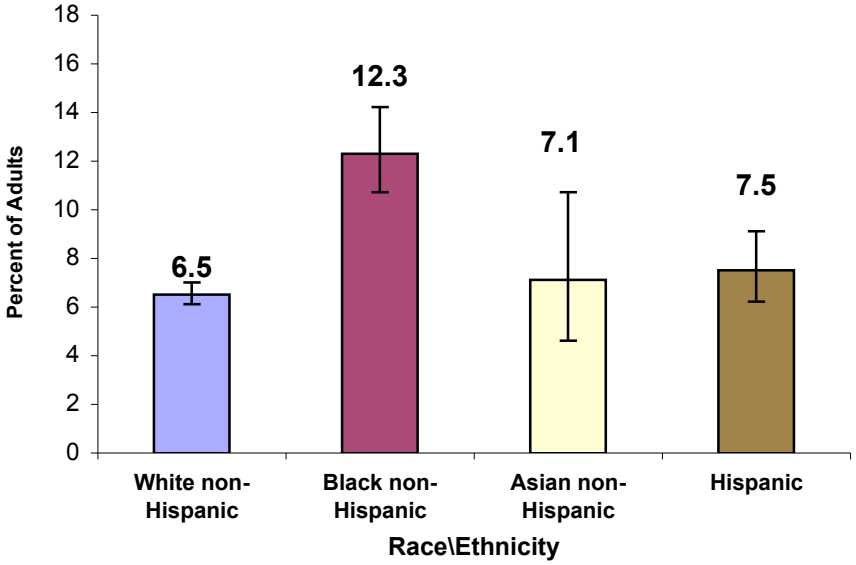
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

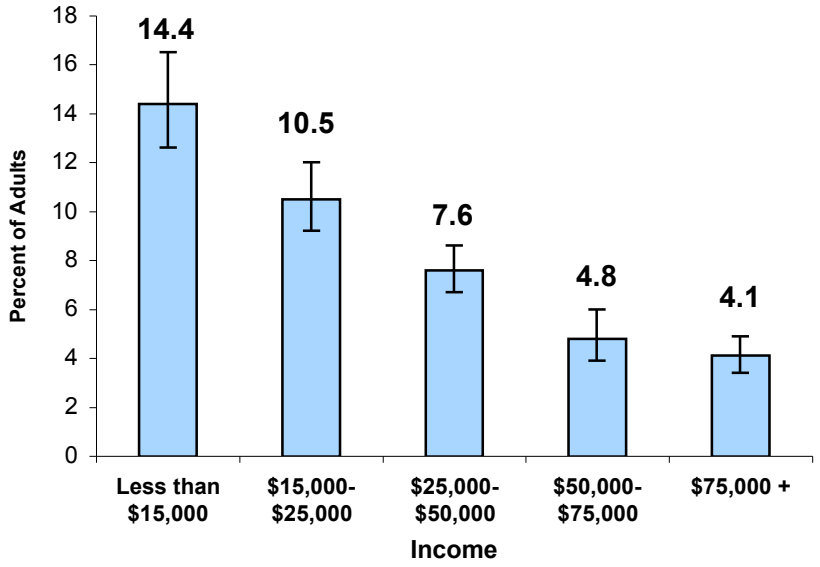
Among Black non-Hispanic New Yorkers earning less than $25,000 per year, 17% reported poor mental health 14 or more days in the past month. This was significantly higher and almost three times the rate reported for Asian non-Hispanic (6.1%) New Yorkers in this income group. The Asian non-Hispanic rate was also significantly lower than the rate for White non-Hispanics (14.9%).

Among New Yorkers earning $25,000 or more per year, rates of 14 or more days of poor mental health in a month by race/ethnicity were not statistically different from each other. However, both White non-Hispanic (8.0%) and Black non-Hispanic New Yorkers in this income category had rates significantly different from their lower income counterparts.

DISEASE PREVALENCE

Figure 25a Percent of Adults 18 Years or Older Diagnosed with Diabetes by Race/Ethnicity and Income, New York State Residents, 2003-2005





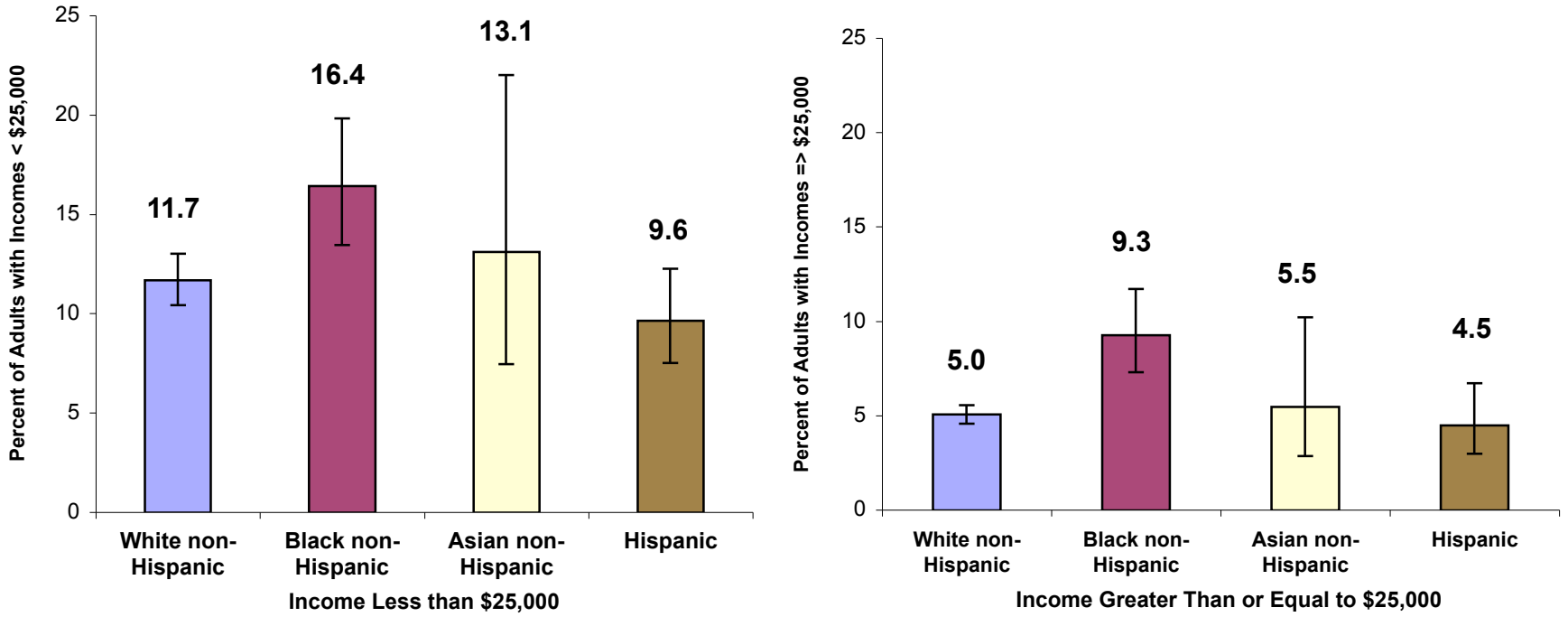
Diagnosed diabetes is defined as the respondent having ever been told by a doctor, nurse or health professional that he or she has diabetes – not including gestational diabetes.
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

There are 20.8 million children and adults in the United States, or 7% of the population, who have diabetes. Nationally, diabetes is more common in African Americans, Latinos, Native Americans, Asian Americans and Pacific Islanders. (Centers for Disease Control and Prevention, US Department of Heath and Human Services)

Of Black non-Hispanic New Yorkers surveyed, 12.3% said they had been diagnosed with diabetes. The Black non-Hispanic rate was significantly higher than the rate for White non-Hispanic (6.5%), Asian non-Hispanic (7.1%) and Hispanic (7.5%) New Yorkers.

Persons earning less than $15,000 per year in New York State had the highest rate of diagnosed diabetes (14.4%) as compared to other income groups. Persons in the highest income group (earnings more than $75,000) were least likely to have been diagnosed with diabetes (4.1%).

Figure 25b Percent of Adults 18 Years or Older Diagnosed with Diabetes by Race/Ethnicity by Income, New York State Residents, 2003-2005

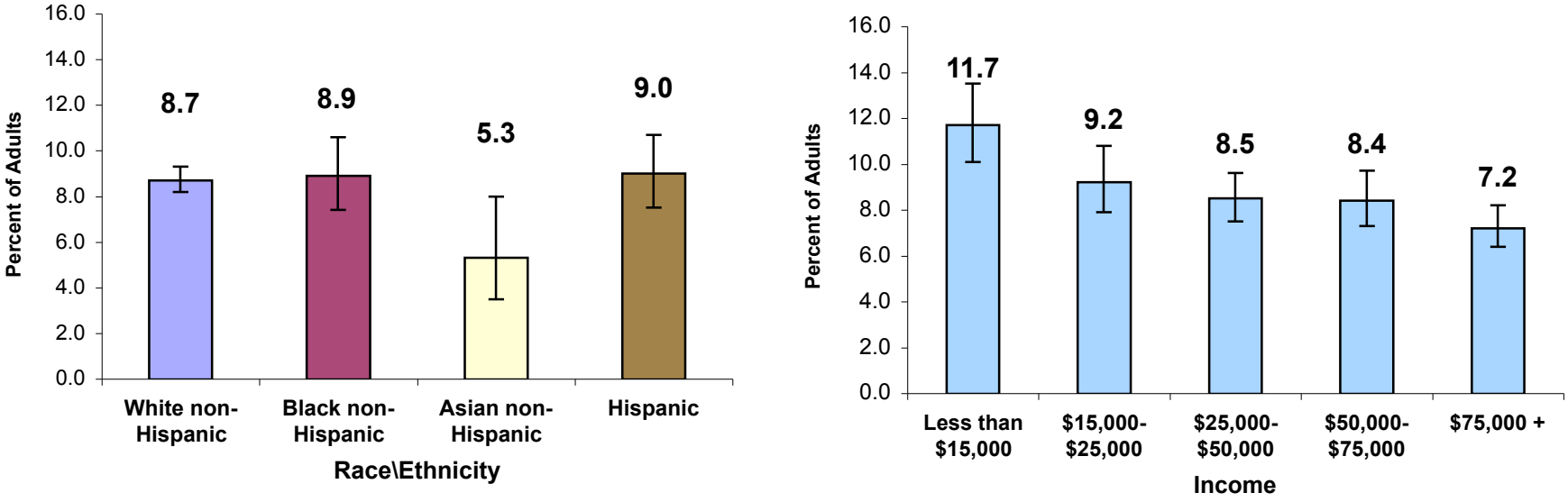


Diagnosed diabetes is defined as the respondent having ever been told by a doctor, nurse or health professional that he or she has diabetes – not including gestational diabetes.
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

Among persons earning less than $25,000 per year, rates among Black non-Hispanic New Yorkers (16.4%) were significantly higher than rates for White non-Hispanics (11.7%) and Hispanics (9.6%). There were no other statistical differences between rates for the race/ethnic groups in this income category.

Persons of all race/ethnic groups, except Asian non-Hispanics, earning $25,000 or more per year had significantly lower rates of diagnosed diabetes as compared to their lower income counterparts. As with persons earning less than $25,000 annually, Black non-Hispanic New Yorkers with incomes of at least $25,000 per year had significantly higher rates of diabetes (9.3%) than White non-Hispanic (5.0%) and Hispanic (4.5%) New Yorkers.

Figure 26a Percent of Adults 18 Years or Older Diagnosed with Current Asthma by Race/Ethnicity and Income, New York State Residents, 2003-2005



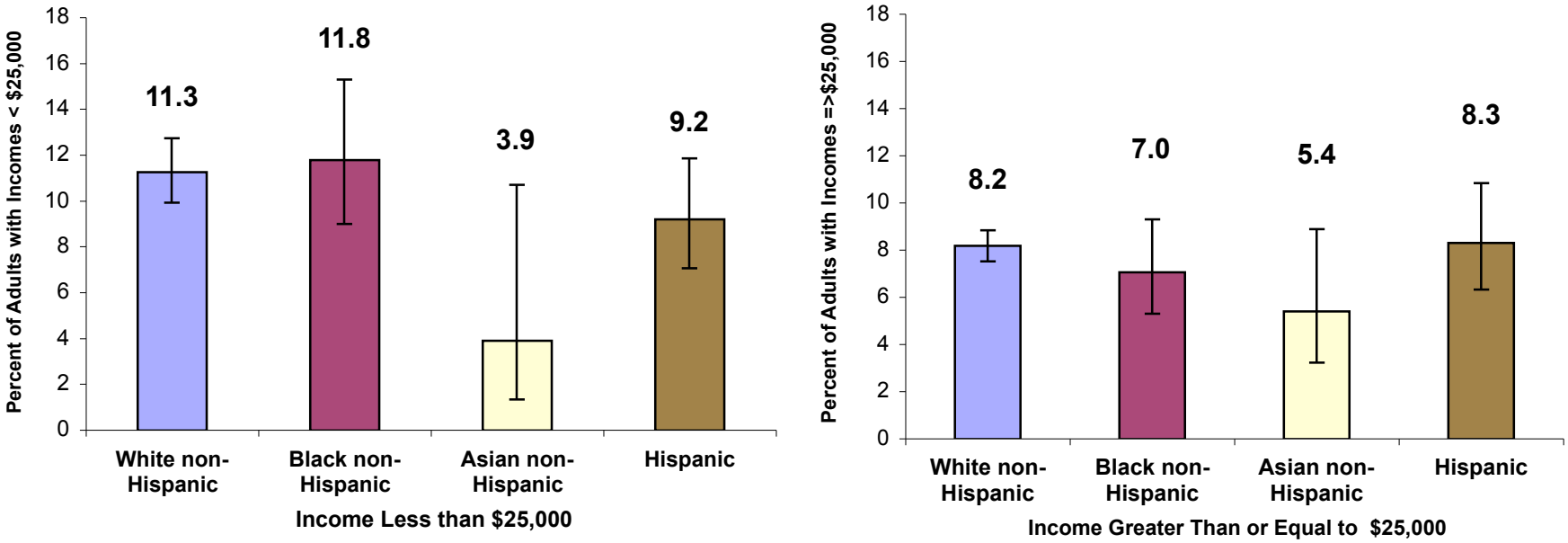
Current Asthma is defined as the respondent having ever been told by a doctor, nurse or health professional that he or she had asthma and still has asthma.
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

Ethnic differences in asthma prevalence, morbidity and mortality are highly correlated with poverty, urban air quality, indoor allergens, lack of patient education and inadequate medical care. Nationally, Black women have the highest asthma mortality rate of all groups, more than 2.5 times higher than White women (Asthma and Allergy Foundation of America – Facts and Figures).

Rates of current asthma were similar among White non-Hispanic, Black non-Hispanic and Hispanic New Yorkers (9%). Current asthma was reported among 5.3% of Asian non-Hispanic New Yorkers. The Asian non-Hispanic rate was significantly lower than the White non-Hispanic rate.

Persons earning less than $15,000 annually had the largest rate of current asthma (11.7%) compared to the other income groups. The percentage of the population with current asthma decreases as income increases. Among New Yorkers earning more than $75,000 per year, 7.2% reported current asthma.

Figure 26b Percent of Adults 18 Years or Older Diagnosed with Current Asthma by Race/Ethnicity by Income, New York State Residents, 2003-2005

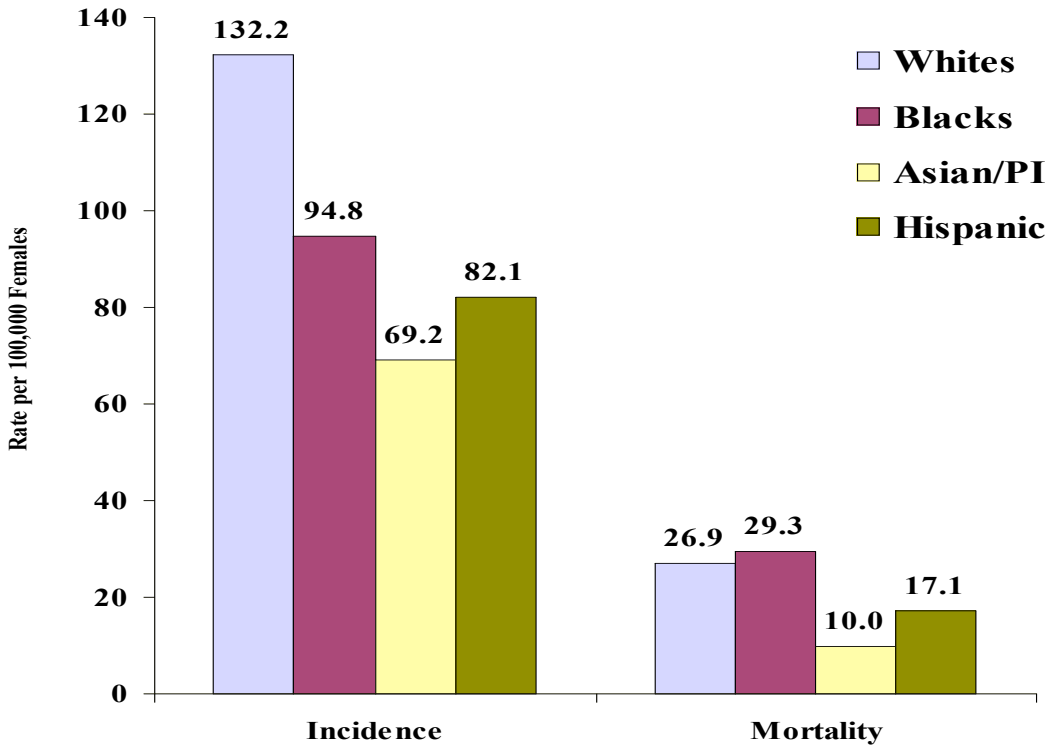


Current Asthma is defined as the respondent having ever been told by a doctor, nurse or health professional that he or she had asthma and still has asthma.
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

Among White non-Hispanic and Black non-Hispanic New Yorkers earning less than $25,000 annually, about 11.3% and 11.8% respectively, reported current asthma. Hispanic and Asian non-Hispanic New Yorkers in this income category reported current asthma rates of 9.2% and 3.9% respectively. There were no statistically significant differences between these rates.

Among New Yorkers earning $25,000 or more per year, rates of current asthma did not differ statistically by race ethnicity. White non-Hispanic New Yorkers in this income category were the only race/ethnic group with significantly different (lower) current asthma rates as compared to their counterparts earning less than $25,000 per year.

Figure 27a Age- Adjusted Female Breast Cancer Incidence and Mortality Rates by Race/Ethnicity, New York State Residents, 1999-2003



Rates are age-adjusted to the 2000 US standard population. White, Black and Asian/PI categories include Hispanics. Hispanic includes all races in this ethnic group.
Abbreviation: PI - Pacific Islander
Source: New York State Cancer Registry

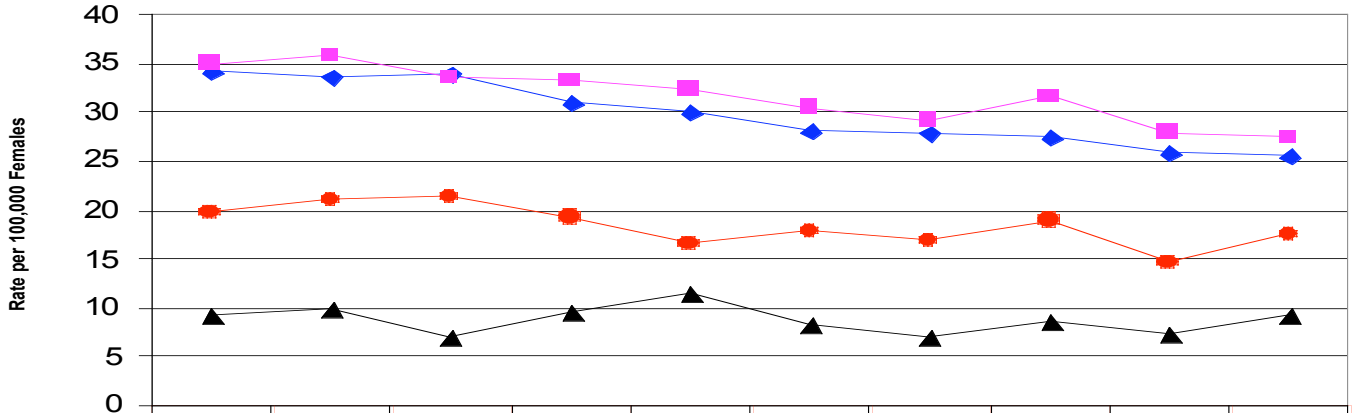
Among women, breast cancer is the most frequently diagnosed cancer and second most common cause of a cancer-related death (lung cancer is the leading cause). (American Cancer Society – Facts and Figures 2007).

In New York State, White women had the highest incidence of breast cancer as compared to women of other race and ethnic groups. Specifically, during 1999-2003, the incidence of breast cancer among White women (132.2 per 100,000 white females) was 40% higher than Black women, 91% higher than Asian/Pacific Islander women and 61% higher than Hispanic women.

However, breast cancer mortality rates during this same time period did not follow the same pattern. Even though Black women had an incidence rate 40% lower than White women, their breast cancer mortality rate (29.3 per 100,000 Black females) was 9% higher than the mortality rate for White women (26.9 per 100,000 White females).

Mortality rates among Asian/Pacific Islander (10.0 per 100,000 Asian/Pacific Islander females) and Hispanic (17.1 per 100,000 Hispanic females) women were markedly lower than the rates among White and Black women.

Figure 27b Age- Adjusted Female Breast Cancer Mortality Rates by Race/Ethnicity, New York State Residents, 1994 - 2003

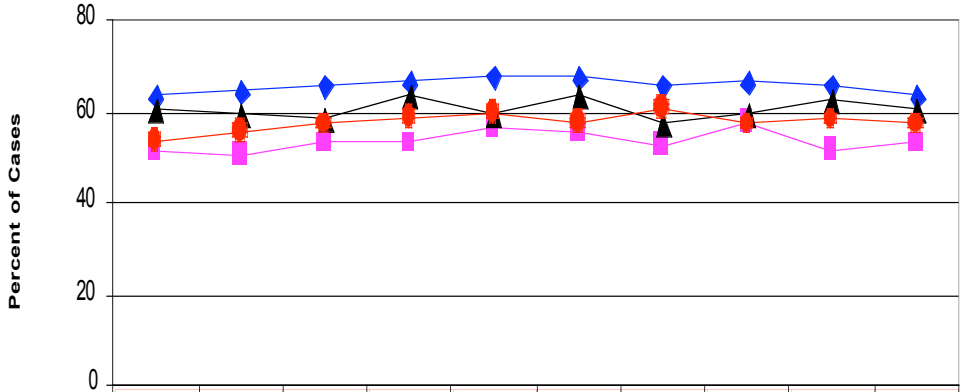


	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	34.2	33.8	34.0	31.0	30.1	28.1	27.9	27.4	25.9	25.6
Black	35.0	35.9	33.5	33.3	32.4	30.5	29.2	31.6	28.0	27.4
Asian/PI	9.1	10.0	6.9	9.4	11.4	8.3	7.0	8.5	7.3	9.3
Hispanic	19.7	21.1	21.4	19.3	16.5	17.9	16.8	18.9	14.6	17.5

Rates are age-adjusted to the 2000 US standard population. White, Black and Asian/PI categories include Hispanics. Hispanic includes all races in this ethnic group.
Abbreviation: PI - Pacific Islander
Source: New York State Cancer Registry

Although breast cancer mortality rates have declined slightly between 1994 and 2003, rates among White and Black New York women are disproportionately high compared to Hispanic and Asian/Pacific Islander women who experience consistently lower rates.

Figure 27c Percent of Female Breast Cancer Cases Diagnosed in Early Stages by Race/ Ethnicity, New York State Residents, 1994 - 2003



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	63.6	64.8	66.0	66.6	68.2	67.8	66.1	66.8	66.1	63.7
Black	51.5	50.8	53.3	53.3	57.0	55.5	52.7	57.9	51.9	53.4
Asian/PI	61.1	60.1	59.2	63.5	59.6	63.4	57.4	59.9	62.7	60.7
Hispanic	53.8	56.1	57.5	58.9	59.8	58.1	60.8	57.3	58.3	57.2

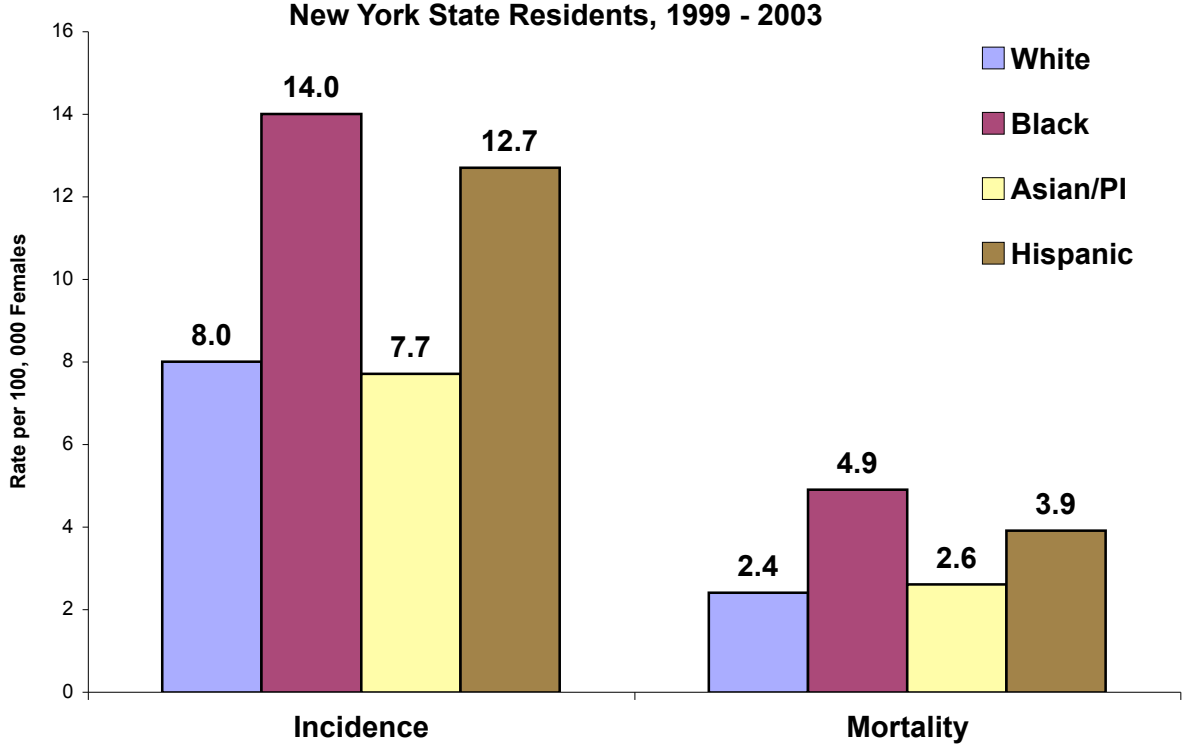
For several types of cancer, detection at an early stage greatly increases the likelihood that treatment will be successful, and improves the treatment options that are available to persons with cancer. The five-year survival rate for breast cancer that is in its earliest stages is 97.0%, while at late stage it is only 23.3%. (NYS Comprehensive Cancer Control Plan)

Early stage diagnosis remains at less than 70% of women with Blacks far below the average, at less than 60%.

The percent of early stage diagnosis for breast cancer has changed very little for all race/ethnic groups over the past decade.

Based on tumors with known stages at diagnosis. Early stage cancers are those which are confined to the organ of origin. White, Black and Asian/PI categories include Hispanics. Hispanics include all races in this ethnic group.
Abbreviation: PI - Pacific Islander
Source: New York State Cancer Registry

Figure 28a **Age-Adjusted Cervical Cancer Incidence and Mortality Rates by Race/Ethnicity, New York State Residents, 1999 - 2003**



Rates are age-adjusted to the 2000 US standard population. White, Black and Asian/PI categories include Hispanics. Hispanic includes all races in this ethnic group.
Abbreviation: PI - Pacific Islander
Source: New York State Cancer Registry

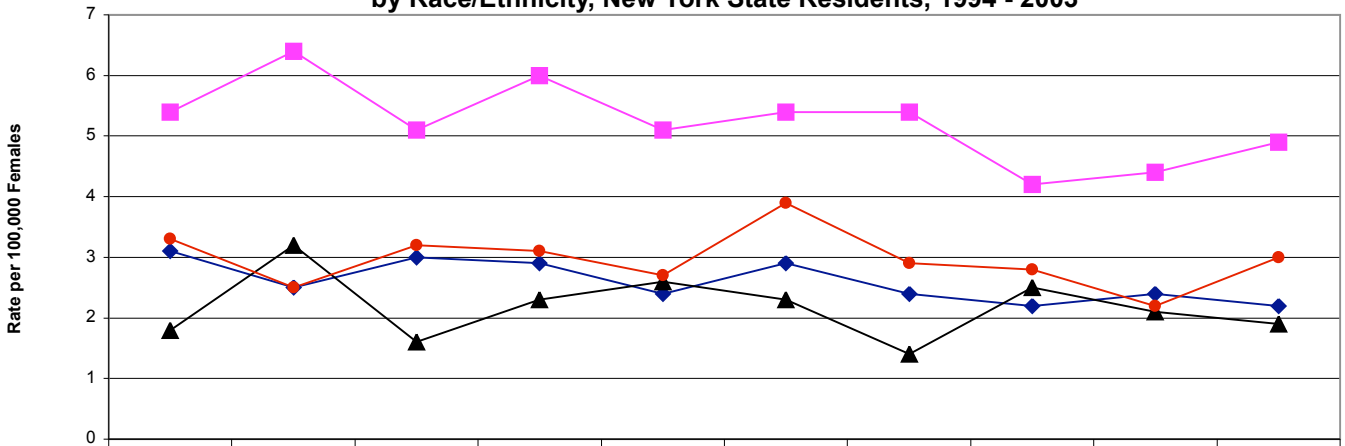
Although cervical cancer incidence and mortality rates have declined approximately 50 percent in the United States over the past three decades, the disease remains a serious health threat. (National Cancer Institute, A Snapshot of Cervical Cancer)

Cervical cancer incidence rates for Black (14.0 per 100,000 Black females) and Hispanic (12.7 per 100,000 Hispanic females) women in New York were more than 50% higher than rates for White (8.0 per 100,000 White females) and Asian/Pacific Islander (7.7 per 100,000 Asian/Pacific Islander females) New York women.

Black women in New York State, with death rates of 4.9 per 100,000 Black females, died of cervical cancer at about double the rate for White (2.4 per 100,000 White females) and Asian/Pacific Islander (2.6 per 100,000 Asian Pacific Islander females) female New Yorkers.

A total of 3.9 per 100,000 Hispanic New York females died from cervical cancer. This rate is about 50% higher than the rates for White and Asian/Pacific Islander and 20% lower than the rate for Black female New Yorkers.

Figure 28b Age-Adjusted Cervical Cancer Mortality Rates by Race/Ethnicity, New York State Residents, 1994 - 2003



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	3.1	2.5	3	2.9	2.4	2.9	2.4	2.2	2.4	2.2
Black	5.4	6.4	5.1	6	5.1	5.4	5.4	4.2	4.4	4.9
Asian/PI	1.8	3.2	1.6	2.3	2.6	2.3	1.4	2.5	2.1	1.9
Hispanic	3.3	2.5	3.2	3.1	2.7	3.9	2.9	2.8	2.2	3

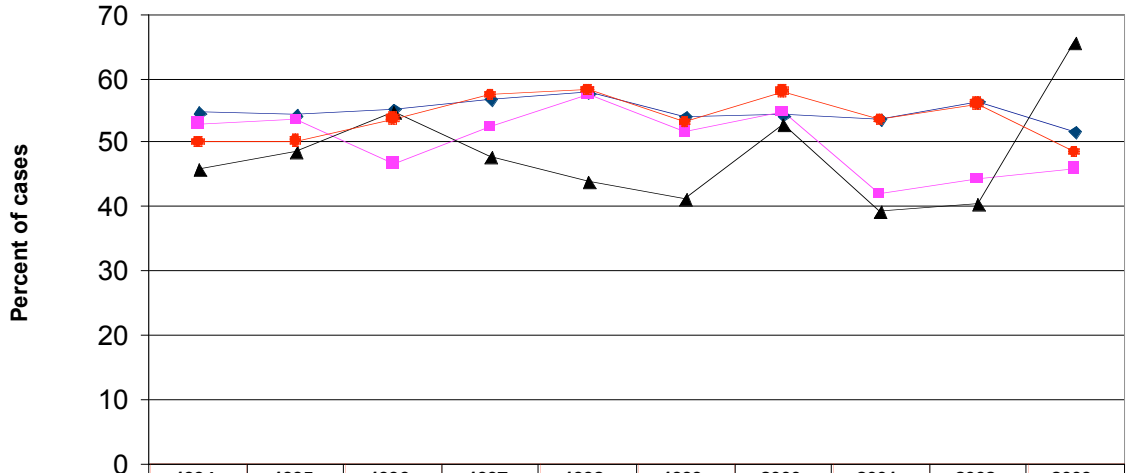
Rates are age-adjusted to the 2000 US standard population. White, Black and Asian /PI categories include Hispanics. Hispanic includes all races in this ethnic group.
Abbreviation: PI - Pacific Islander
Source: New York State Cancer Registry

Since screening programs using the Papanicolaou test (Pap test) were implemented widely more than 50 years ago, cervical cancer deaths have declined 75 percent nationwide. Yet cervical cancer still takes the lives of approximately 4,000 women in the United States each year. This is particularly disturbing since virtually all cervical cancers should be avoidable with proper screening. (National Cancer Institute, A Snapshot of Cervical Cancer)

Between 1994 and 2003, cervical cancer rates fluctuated while following a general downward trend among White (3.1 to 2.2 per 100,000 White females), Black (5.4 to 4.9 per 100,000 Black females) and Hispanic (3.3 to 3.0 per 100,000 Hispanic females) women in New York. Rates for Asian/Pacific Islander women, which were generally the lowest compared to the other race/ethnic groups, also fluctuated over the time period and were at about the same level in 2003 (1.9 per 100,000 Asian/Pacific Islander females) as in 1994 (1.8 per 100,000 Asian/Pacific Islander females).

Black women throughout this time period, experienced cervical cancer mortality rates that were at least double the rates for White and Asian/Pacific Islander women and consistently higher than the rate for Hispanic women.

Figure 28c **Percent of Cervical Cancer Cases Diagnosed in Early Stages by Race/Ethnicity, New York State Residents, 1994 - 2003**



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	54.8	54.3	55.3	56.8	57.9	54.1	54.3	53.7	56.4	51.9
Black	52.9	53.6	46.8	52.4	57.7	51.9	54.7	41.9	44.2	46.1
Asian/PI	45.9	48.6	54.8	48.0	43.9	41.2	52.8	39.4	40.4	65.8
Hispanic	50.0	50.3	53.8	57.4	58.2	53.2	58.0	53.5	56.1	48.5

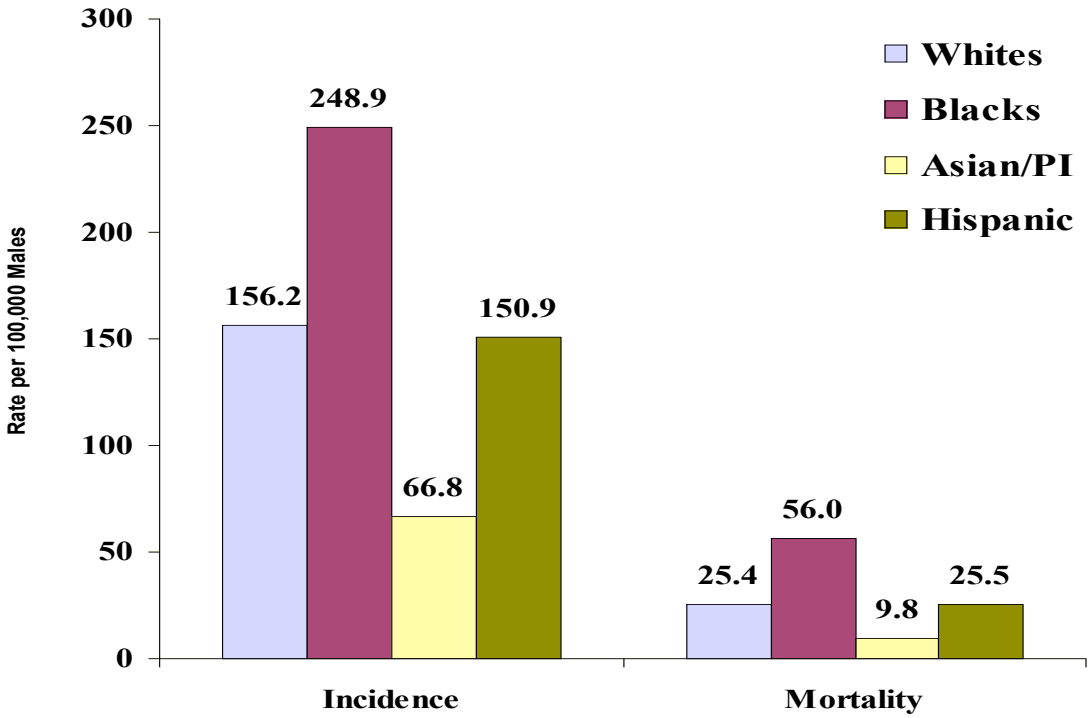
Based on tumors with known stages at diagnosis. Early stage cancers are those which are confined to the organ of origin. White, Black and Asian/PI categories include Hispanics. Hispanics include all races in this ethnic group.
Abbreviation: PI - Pacific Islander
Source: New York State Cancer Registry

Between 1994 and 2002, rates of early stage diagnosis of cervical cancer among White and Hispanic women ranged between 50% and just under 60%. In 2003, early diagnosis rates declined among White New York women to 51.9% and among Hispanic women to 48.5%.

Early stage diagnosis rates for Black New York women with cervical cancer were above 50% for all but one year from 1994 to 2000, and then dropped to 41.9% in 2001. In 2003 the rate among Black females improved to 46.1%.

Rates of early stage diagnosis cervical cancer for Asian/Pacific Islander women during this time period ranged from a low of 39.4% in 2001 to a high of 65.8% in 2003.

Figure 29a **Age-Adjusted Prostate Cancer Incidence and Mortality Rates by Race/Ethnicity, New York State Residents, 1999-2003**



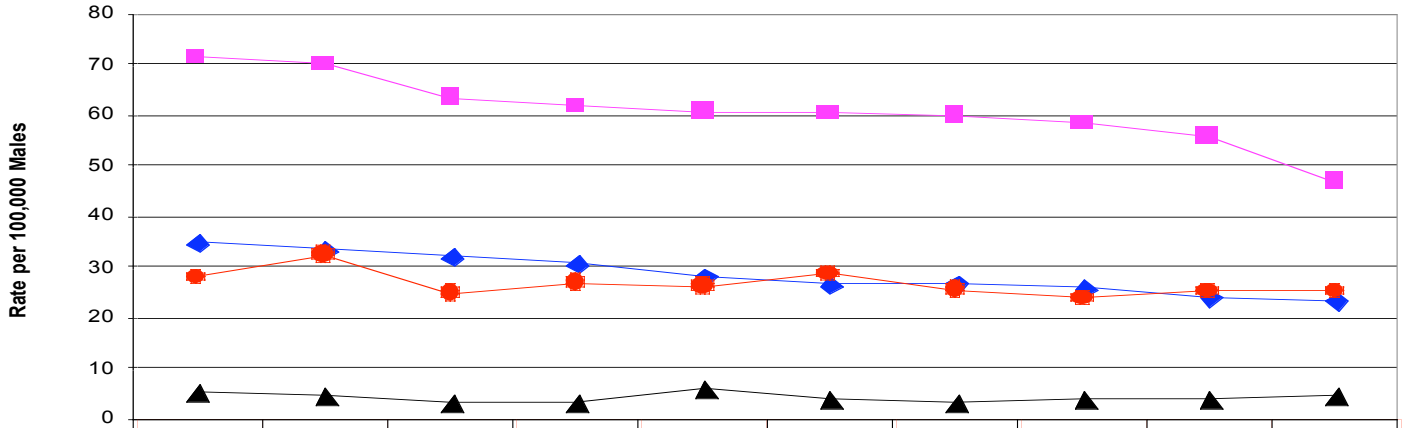
Rates are age-adjusted to the 2000 US standard population. White, Black and Asian/PI categories include Hispanics. Hispanics includes all races in this ethnic group.
Abreviation: PI - Pacific Islander
Source: New York State Cancer Registry

Prostate cancer is the most frequently diagnosed cancer in men. Nationally, incidence rates are significantly higher in Black men as compared to other groups. Prostate cancer is a leading cause of cancer death among men. (American Cancer Society – Facts and Figures 2007)

In New York State during the 1999-2003 time period, similar to the nation, the incidence of prostate cancer among Black men (248.9 per 100,000 Black males) averaged about 60% higher than rates among White (156.2 per 100,000 White males) and Hispanic (150.9 per 100,000 Hispanic males) men and almost four times the rate among Asian/Pacific Islander (66.8 per 100,000 Asian/Pacific Islander males) men.

Mortality rates in New York State for prostate cancer were also highest among Black men. Black men, with a mortality rate of 56 per 100,000 Black males, died of prostate cancer at more than double the rate of White and Hispanic men and almost six times the rate of Asian/Pacific Islander men.

Figure 29b Age- Adjusted Prostate Cancer Mortality Rates by Race/Ethnicity, New York State Residents, 1994 - 2003

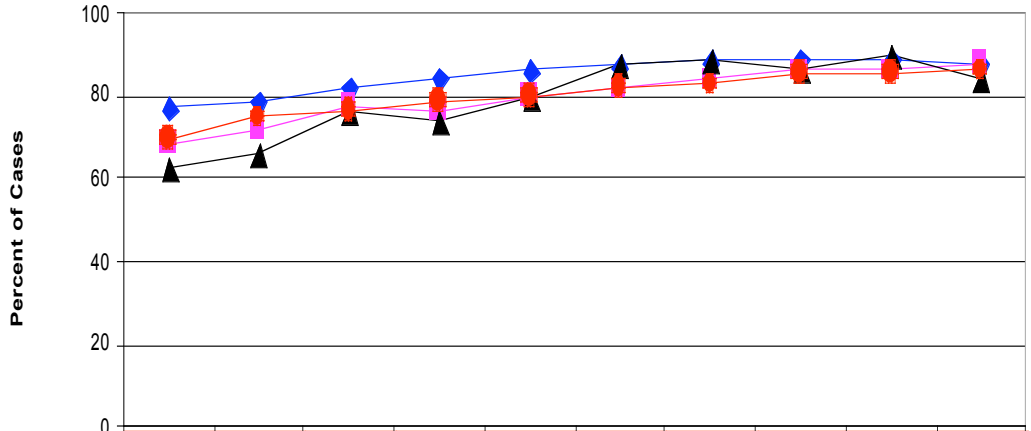


	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	34.9	33.3	32.1	30.8	28.3	26.4	26.9	25.9	24.2	23.6
Black	71.4	69.9	63.5	61.6	60.8	60.3	60.1	58.4	55.8	46.9
Asian/PI	5.1	4.9	3.1	3.5	5.8	4.0	3.4	3.7	3.9	4.6
Hispanic	28.1	32.5	24.8	26.8	26.2	28.7	25.5	23.8	25.1	25.2

Rates are age-adjusted to the 2000 US standard population. White, Black and Asian/PI categories include Hispanics. Hispanics include all races in this ethnic group.
Abbreviation: PI - Pacific Islander
Source: New York State Cancer Registry

In New York State, over the past decade, prostate cancer mortality rates have decreased across all race/ethnic groups. However, Black men (46.9 per 100,000 Black males) continue to experience prostate cancer mortality rates two times the rate of Whites (23.6 per 100,000 White males) and Hispanics (25.2 per 100,000 Hispanic males) and ten times the rate of Asian/Pacific Islander men (4.6 per 100,000 Asian/Pacific Islander males).

Figure 29c Percent of Prostate Cancer Cases Diagnosed in Early Stages by Race/Ethnicity, New York State Residents, 1994 - 2003



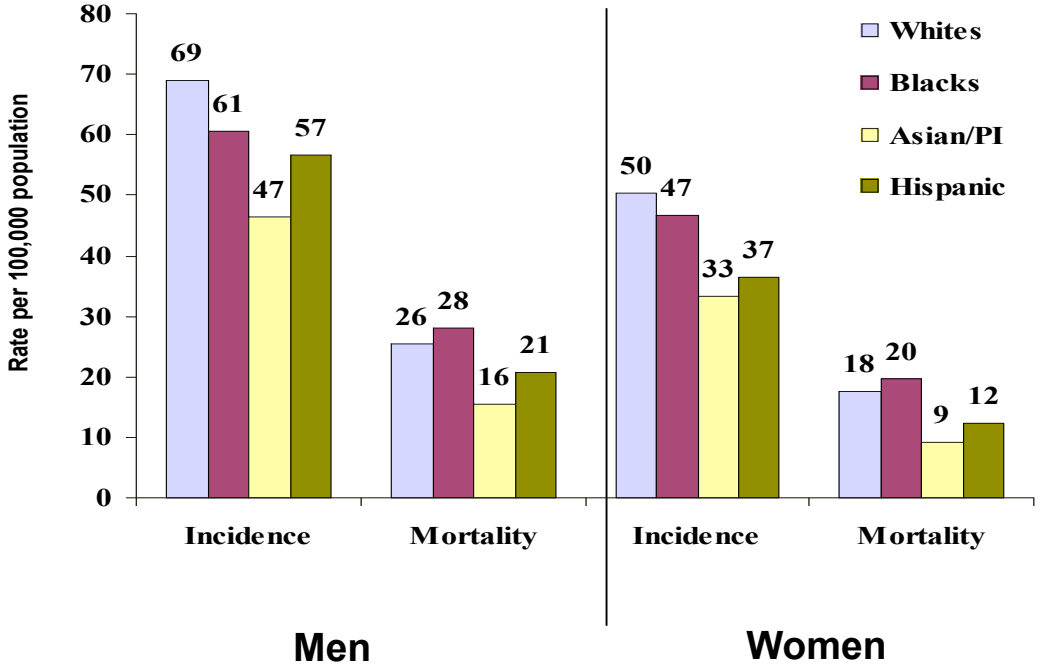
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	77.4	78.9	82.4	84.4	86.3	87.3	88.4	89.3	89.4	87.8
Black	68.5	71.4	77.9	76.5	80.2	81.8	84.0	86.2	86.2	87.8
Asian/PI	62.5	65.8	75.9	73.6	80.0	87.7	89.3	86.2	89.9	84.2
Hispanic	69.7	74.8	76.5	78.7	80.0	82.3	83.2	85.8	85.7	86.5

For several types of cancer, detection at an early stage greatly increases the likelihood that treatment will be successful. Early detection also improves the treatment options that are available to persons with cancer.

In New York State, between 1994 and 2003, early stage diagnosis of prostate cancer has increased for males of all race and ethnic groups. In 2003, new cases of prostate cancer, regardless of race, were diagnosed early almost 90% of the time.

Based on tumors with known stages at diagnosis. Early stage cancers are those which are confined to the organ of origin. White, Black and Asian/PI categories include Hispanics. Hispanics include all races in this ethnic group.
Abbreviation: PI - Pacific Islander
Source: New York State Cancer Registry

Figure 30a **Age-Adjusted Colorectal Cancer Incidence and Mortality Rates by Gender and Race/Ethnicity, New York State Residents, 1999-2003**



Rates are age-adjusted to the 2000 US standard population. White, Black, and Asian/PI Categories include Hispanics. Hispanic includes all races in this ethnic group.
Abbreviation: PI - Pacific Islander
Source: New York State Cancer Registry

Colorectal cancer is the third most common cancer in both men and women. Incidence rates have been declining since 1985 partly due to increased screening and polyp removal, which prevents the progression of polyps to cancer. (American Cancer Society – Facts and Figures 2007)

Among males, incidence rates were highest for White (69 per 100,000 White males) men. Black (61 per 100,000 Black males), Hispanic (57 per 100,000 Hispanic males) and Asian/Pacific Islander (47 per 100,000 Asian/Pacific Islander males) men had lower incidence rates.

Colorectal cancer incidence rates among females were lower as compared to their male counterparts, and they followed a similar racial and ethnic pattern.

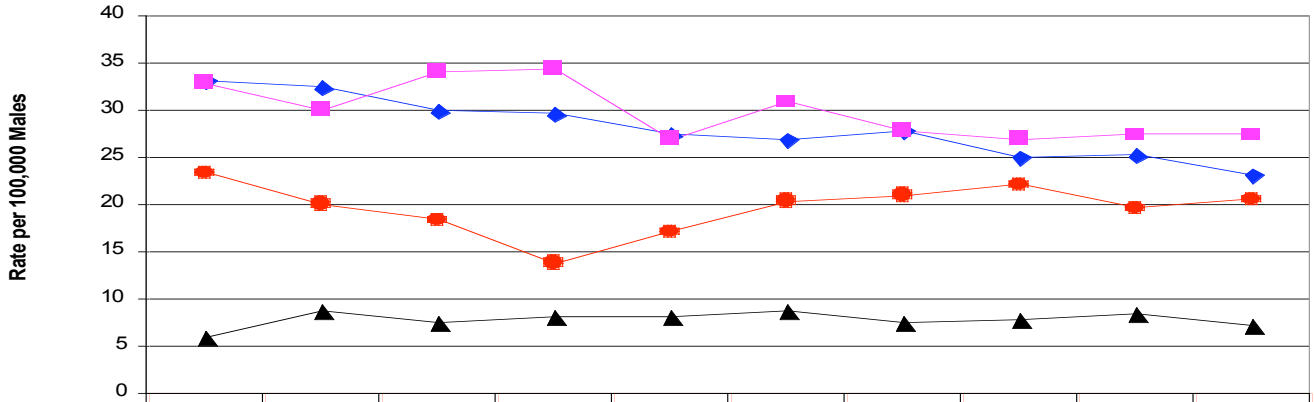
Colorectal cancer mortality rates were highest among Black and White men with Black men experiencing slightly higher mortality rates as compared to White men (28 per 100,000 Black males vs. 26 per 100,000 White males).

Similar to men, Black and White women also had the highest mortality rates with Black women experiencing slightly higher mortality compared to White women (20 per 100,000 Black females vs. 18 per 100,000 White females).

Among both men and women, Whites experienced the highest incidence rates of colorectal cancer while Blacks experienced the highest mortality rates of the disease.

Mortality rates for both Hispanic and Asian/Pacific Islander men and women were markedly lower than rates for Whites and Blacks.

Figure 30b Age- Adjusted Male Colorectal Cancer Death Rates by Race/Ethnicity, New York State Residents, 1994 - 2003



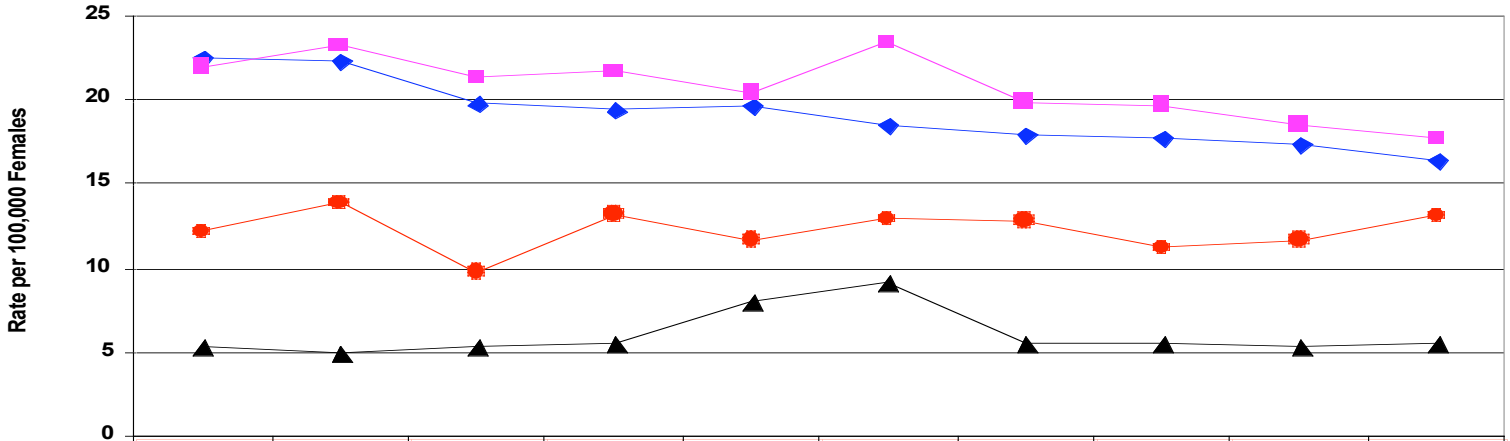
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	33.1	32.3	29.9	29.6	27.3	26.9	27.8	25.0	25.1	23.1
Black	32.8	30.0	34.0	34.3	26.9	30.8	27.8	26.9	27.3	27.4
Asian/PI	6.0	8.8	7.4	8.0	8.1	8.8	7.4	7.7	8.4	7.2
Hispanic	23.3	20.0	18.3	13.8	17.0	20.3	21.0	22.1	19.5	20.5

Rates are age-adjusted to the 2000 US standard population. White, Black and Asian/PI categories include Hispanics. Hispanics include all races.
Abbreviation: PI - Pacific Islander
Source: New York State Cancer Registry

Between 1994 and 2003, colorectal cancer mortality rates in New York State have decreased from 33.1 to 23.1 per 100,000 in White men--the most of any racial/ethnic group. Black and Hispanic men experienced smaller reductions in rates. The colorectal cancer mortality rate among Asian/Pacific Islander men was slightly higher in 2003 as compared to 1994, but was still more than 60% lower than the rates for all other race/ethnic groups.

In 2003, colorectal cancer mortality rates were highest among Black men (27.4 per 100,000 Black males) followed by White (23.1 per 100,000 White males) and Hispanic men (20.5 per 100,000 Hispanic males). Asian/Pacific Islander men (7.2 per 100,000 Asian/Pacific Islander males) experienced the lowest rate.

Figure 30c Age- Adjusted Female Colorectal Cancer Death Rates by Race/Ethnicity, New York State Residents, 1994 - 2003



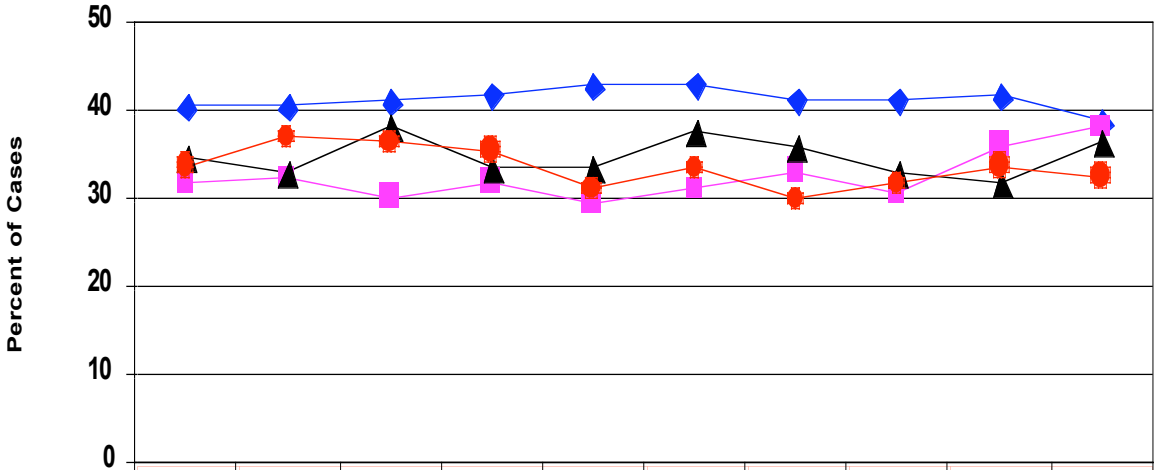
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	22.5	22.3	19.8	19.4	19.7	18.5	18.0	17.8	17.4	16.4
Black	22.0	23.2	21.3	21.7	20.4	23.4	19.9	19.7	18.5	17.7
Asian/PI	5.3	4.9	5.3	5.6	8.1	9.2	5.6	5.6	5.3	5.6
Hispanic	12.2	13.9	9.8	13.2	11.7	12.9	12.8	11.2	11.7	13.1

Rates are age-adjusted to the 2000 US standard population. White, Black and Asian/PI categories include Hispanics. Hispanics include all races in this ethnic group.
Abbreviation: PI - Pacific Islander
Source: New York State Cancer Registry

Colorectal cancer death rates in New York State decreased between 1994 and 2003 for Black and White women and slightly increased for Asian/Pacific Islander and Hispanic women.

In 2003, Black and White women experienced the highest rates (17.7 per 100,000 Black females and 16.4 per 100,000 White females) followed by Hispanic (13.1 per 100,000 Hispanic females) and Asian/Pacific Islander (5.6 per 100,000 Asian/Pacific Islander females) women.

Figure 30d Percent of Male Colorectal Cancer Cases Diagnosed in Early Stages by Race/Ethnicity, New York State Residents, 1994 - 2003



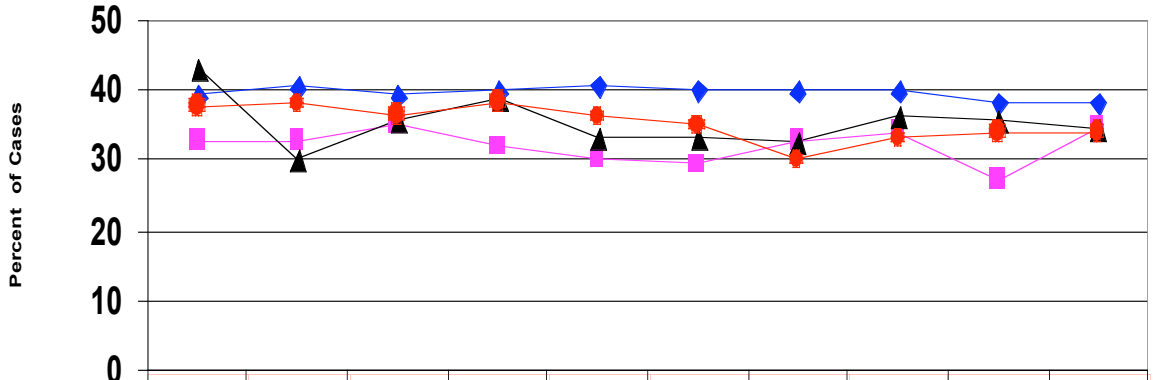
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	40.7	40.5	41.3	42.0	43.0	43.2	41.6	41.5	41.8	38.8
Black	32.2	32.3	30.3	32.2	29.5	31.1	33.3	30.7	36.2	38.1
Asian/PI	34.6	33.3	38.2	33.7	33.9	37.7	35.9	32.9	32.2	36.4
Hispanic	33.7	37.2	36.6	35.5	31.1	33.4	30.1	31.8	33.9	32.7

Early stage diagnosis of colorectal cancer remains a serious challenge. Although it has improved for Black (32.2 to 38.1% of Black males) and Asian/Pacific Islander (34.6 to 36.4% of Asian/Pacific Islander males) men, the percentages for White and Hispanic men have decreased slightly (40.7 to 38.8% of White males and 33.7 to 32.7% of Hispanic males).

No race/ethnic group has a rate of early stage diagnosis of colorectal cancer above 40%.

Based on tumors with known stages at diagnosis. Early stage cancers are those which are confined to the organ of origin. White, Black and Asian/PI categories include Hispanics. Hispanics include all races in this ethnic group.
Abbreviation: PI - Pacific Islander
Source: New York State Cancer Registry

Figure 30e Percent of Female Colorectal Cancer Cases Diagnosed in Early Stages by Race/Ethnicity, New York State Residents, 1994 - 2003



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
White	39.3	40.5	39.2	39.8	40.8	40.2	39.8	39.9	38.4	38.3
Black	32.8	32.9	35.0	31.8	30.2	29.6	32.9	33.9	27.3	34.6
Asian/PI	42.9	30.3	35.8	39.0	33.0	33.1	32.9	36.3	35.9	34.8
Hispanic	37.6	38.0	36.6	38.3	36.1	35.0	30.1	33.2	34.0	34.1

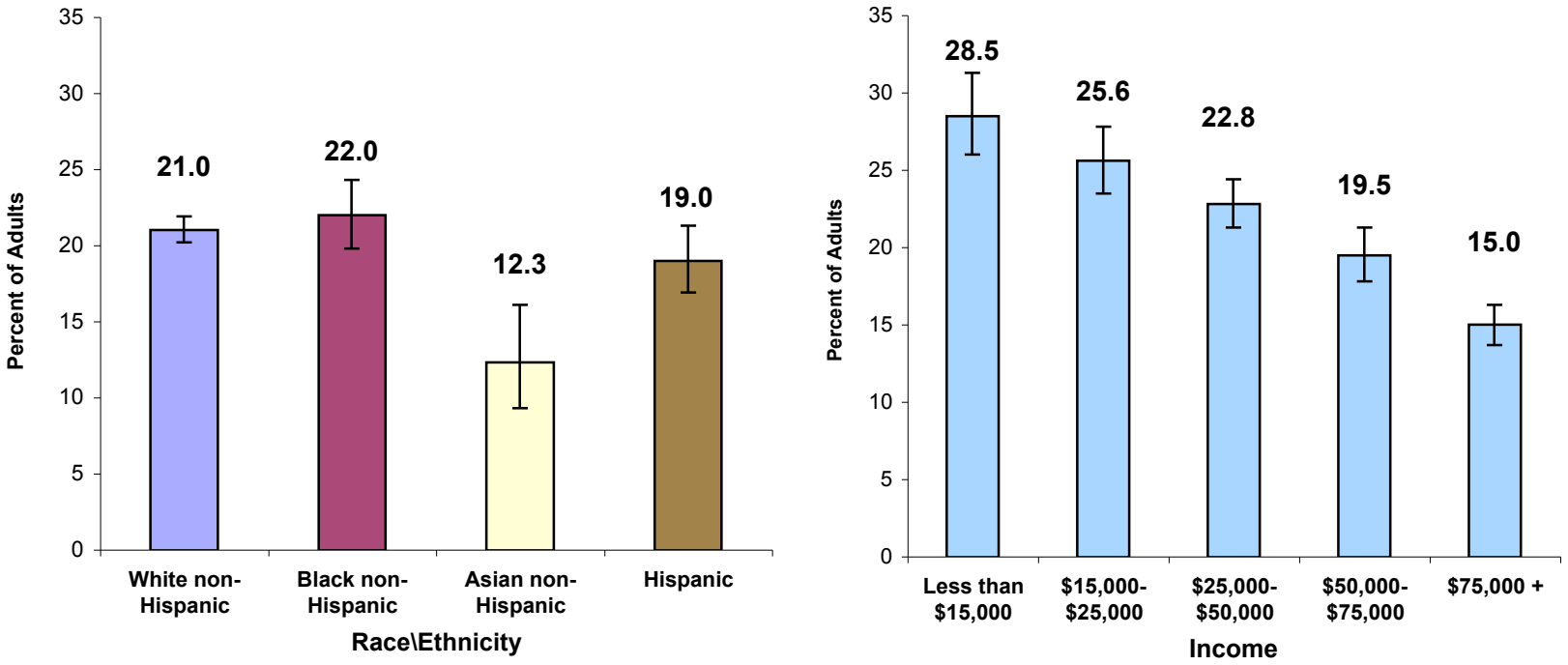
The gap between Black and White women regarding early stage diagnosis of colorectal cancer has narrowed, but rates still remain at less than 40%.

The percent of colorectal cancer cases diagnosed at early stage for White, Asian/Pacific Islander and Hispanic women actually decreased between 1994 and 2003.

Rates are based on tumors with known stages at diagnosis. Early stage cancers are those which are confined to the organ of origin. White, Black and Asian/PI categories include Hispanics. Hispanics include all races in this ethnic group.
Abbreviation: PI - Pacific Islander
Source: New York State Cancer Registry

RISK FACTORS

Figure 31a Percent of Adults 18 Years or Older Who Were Current Smokers by Race/Ethnicity and Income, New York State Residents, 2003 - 2005



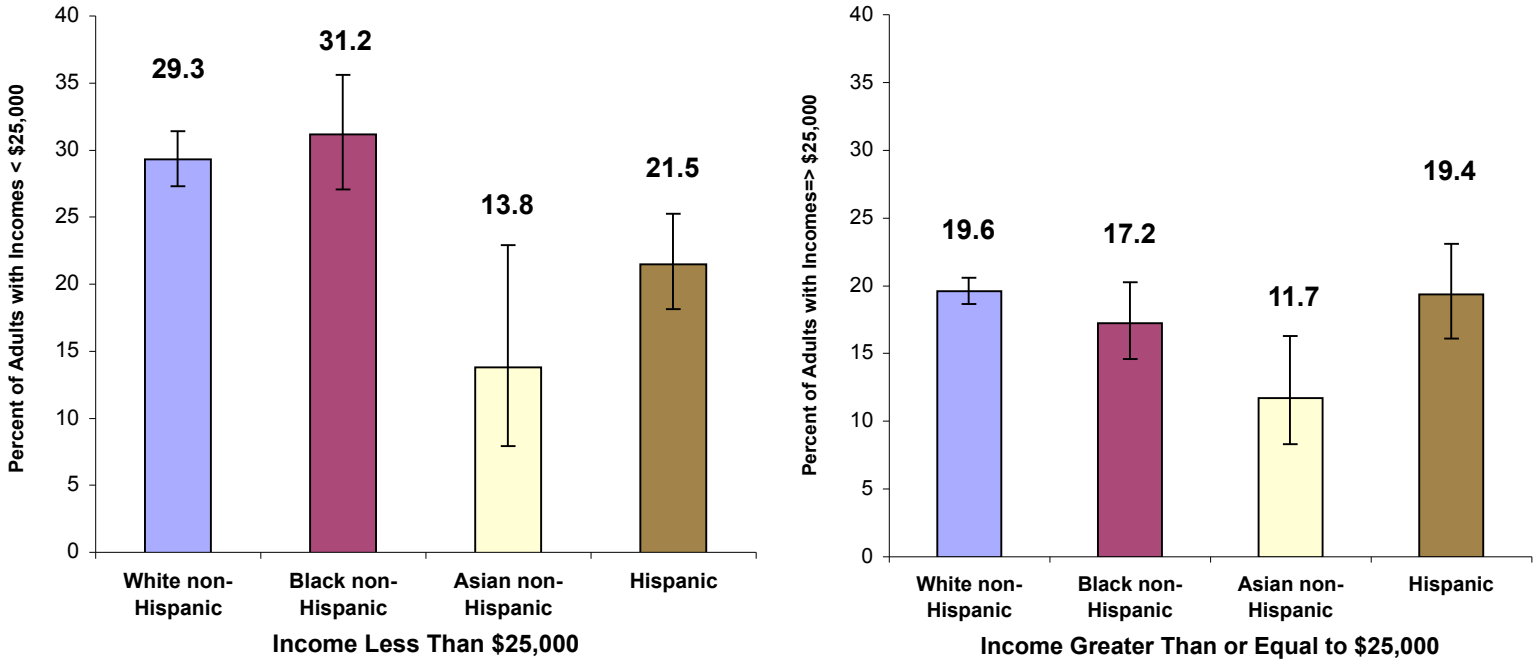
Current smoker is defined as having smoked at least 100 cigarettes in their lifetime and currently smokes everyday or some days.
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

The American Cancer Society estimates cigarette smoking alone is directly responsible for approximately 30% of all cancer deaths and about 87% of all lung cancer deaths.

Current smoking rates for White non-Hispanic (21%), Black non-Hispanic (22%) and Hispanic (19%) New Yorkers surveyed were similar. Significantly lower current smoking rates were reported by Asian non-Hispanics (12.3%).

Income was inversely related to current smoking. Persons with the highest incomes were the least likely to report being a current smoker. In fact, persons earning less than $15,000 per year were nearly twice as likely to smoke as compared to persons earning more than $75,000 per year.

Figure 31b Percent of Adults 18 Years or Older Who Were Current Smokers by Race/Ethnicity by Income, New York State Residents, 2003 - 2005



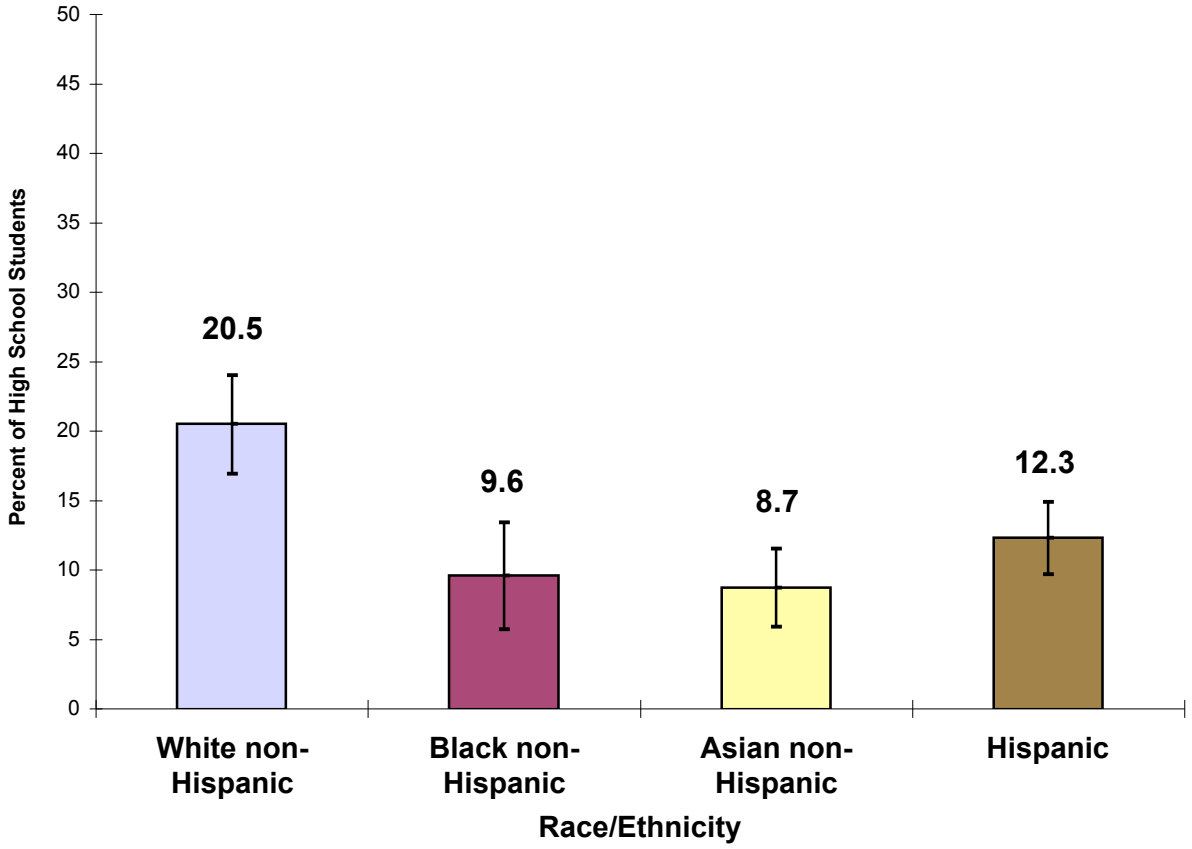
Current smoker is defined as having smoked at least 100 cigarettes in their lifetime and currently smokes everyday or some days.
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

Among New Yorkers earning less than $25,000 per year, smoking rates were highest for White non-Hispanic (29.3%) and Black non-Hispanic (31.2%) New Yorkers in this income category. These rates were significantly higher than the rates for Hispanics (21.5%) and Asian non-Hispanics (13.8%).

Among New Yorkers earning $25,000 or more per year, significantly lower rates of current smoking exist for White non-Hispanics (19.6%) and Black non-Hispanics (17.2%) as compared to their lower income counterparts.

The percentage of current smokers among Asian non-Hispanics (11.7%) earning at least $25,000 annually was significantly lower than current smoking rates for White non-Hispanics (19.6%). There were no other statistical differences between the current smoking rates in this income category.

Figure 32 High School Students Who Smoked Cigarettes on One or More of the Past 30 Days by Race/Ethnicity, New York State Residents, 2005



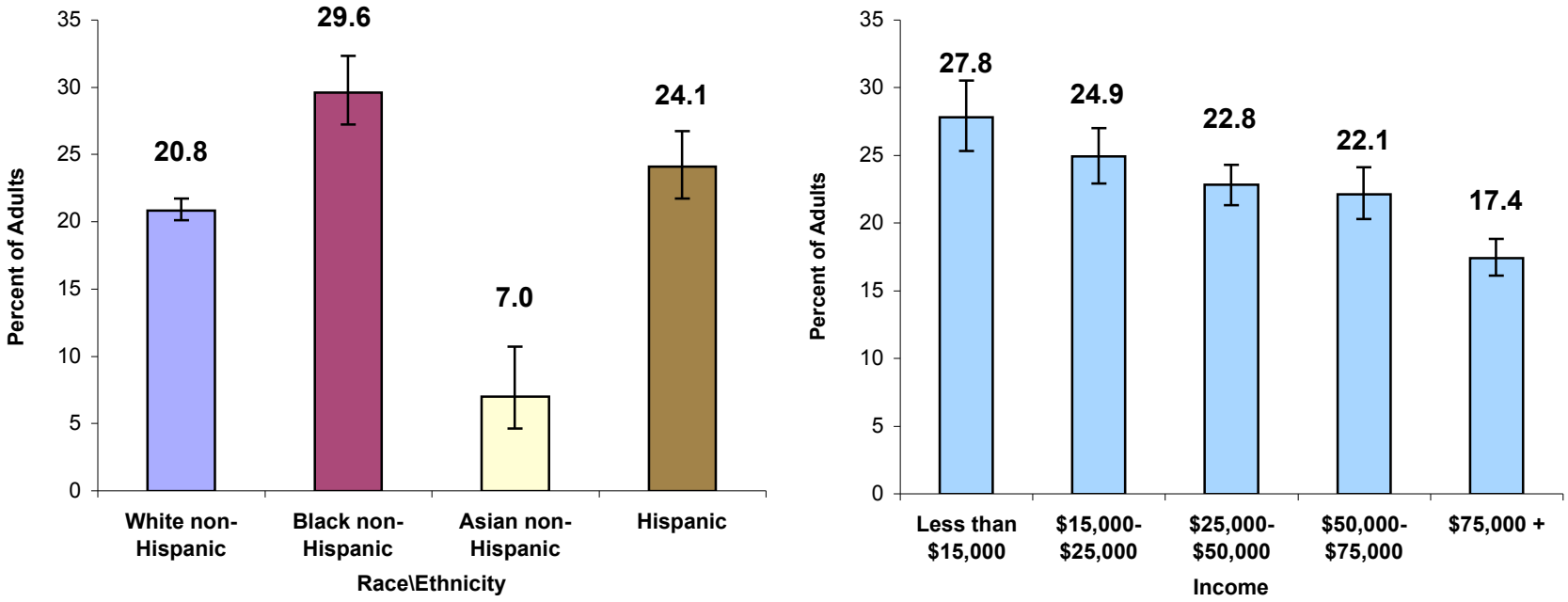
Source: Youth Risk Behavior Survey (2005)

Nearly all first use of tobacco occurs before high school graduation. So if adolescents don't start smoking by age 18, odds are they never will.
(American Cancer Society)

Twenty percent of White non-Hispanic high school students in New York State smoke cigarettes. This is more than double the percent of Black non-Hispanic (9.6%) and Asian non-Hispanic (8.7%) student smokers.

Hispanic high school students have the next highest rate of smoking (12.3%) but it is still significantly less than the rate for White non-Hispanic students.

Figure 33a Percent of Adults 18 Years of Age or Older Who Were Obese (BMI Greater than or Equal to 30) by Race/Ethnicity and Income, New York State Residents, 2003 - 2005



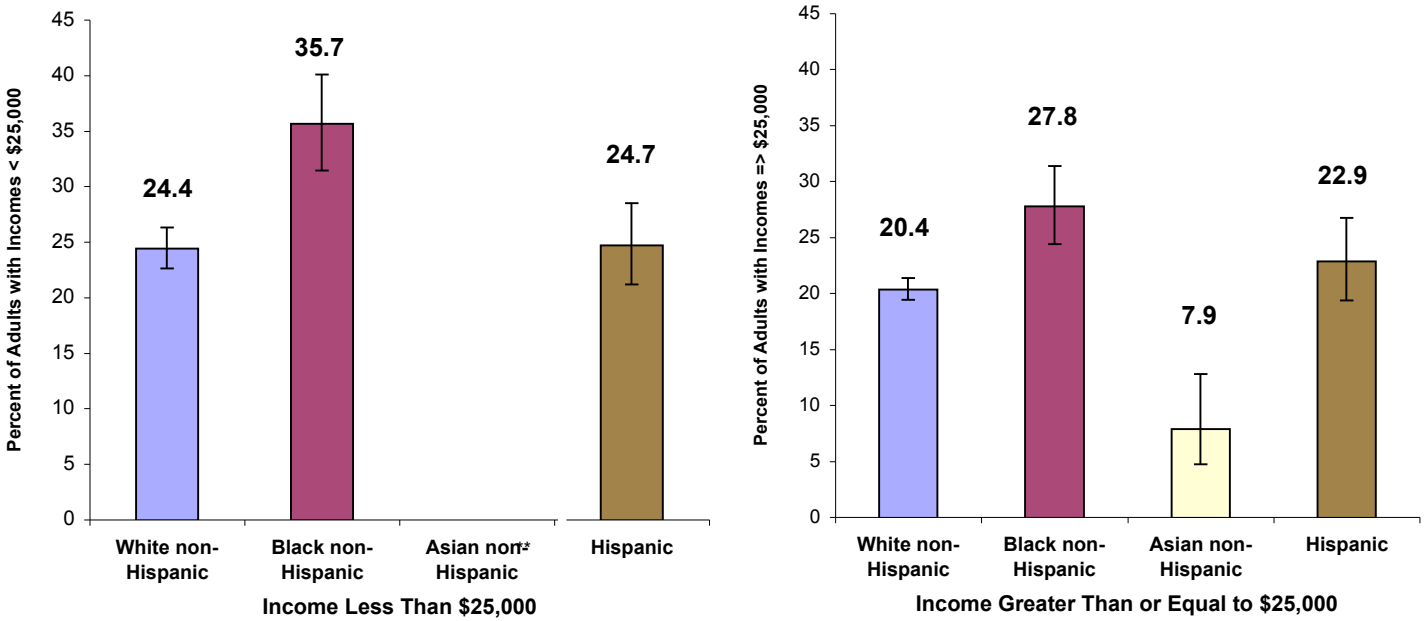
Obesity among adults is defined as having a body mass index (BMI) greater than or equal to 30. (BMI is calculated by dividing weight in pounds by height in inches squared and multiplying by a conversion factor of 703.)
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

During the past 20 years, obesity among adults has risen significantly in the United States. Being overweight or obese increases the risk of many diseases and health conditions. (Centers for Disease Control and Prevention, US Department of Heath and Human Services)

About 30% of Black non-Hispanic New Yorkers surveyed reported being obese. This was significantly higher than the rate for Hispanic (24.1%) and White non-Hispanic (20.8%) New Yorkers and four times the rate for Asian non-Hispanics (7%).

Obesity was inversely related to income. As income increased the rates of obesity declined. Among persons in New York State earning less than $15,000 per year, 27.8% were obese. Among New Yorkers earning more than $75,000 per year, 17.4% were obese.

Figure 33b Percent of Adults 18 Years of Age or Older Who Were Obese (BMI Greater than or Equal to 30) by Race/Ethnicity by Income, New York State Residents, 2003 - 2005



Obesity among adults is defined as body mass index (BMI) greater than or equal to 30. (BMI is calculated by dividing weight in pounds by height in inches squared and multiplying by a conversion factor of 703.)
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

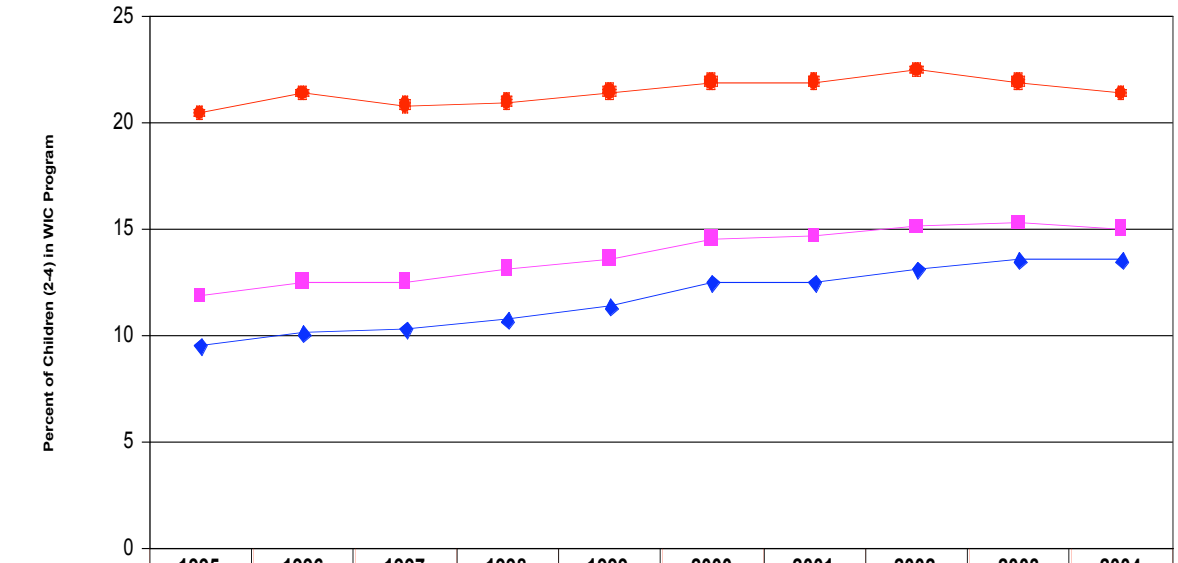
Among persons earning less than $25,000 annually, 35.7% of Black non-Hispanics reported being obese. The Black non-Hispanic rate was significantly higher than the rate among White non-Hispanic (24.4%) and Hispanic (24.7%) New Yorkers in this income category.

Among persons earning $25,000 or more per year, both White non-Hispanic (20.4%) and Asian non-Hispanic (7.9%) New Yorkers experienced significantly lower obesity rates as compared to Black non-Hispanic (27.8%) New Yorkers. Obesity rates for Asian non-Hispanics were also significantly lower than the rates for White non-Hispanics and Hispanics (22.9%).

The percentage of Black non-Hispanic and White non-Hispanic New Yorkers reporting obesity was significantly lower in the $25,000 or more per year income group as compared to Black non-Hispanics and White non-Hispanics in the the group earning less than $25,000 per year.

**Data are not reported if the confidence interval is greater than plus or minus 10.

Figure 34 Obesity by Race/Ethnicity, Children Ages 2 - 4 In the WIC Program New York State Residents, 1995 - 2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White NH	9.5	10.1	10.3	10.7	11.3	12.5	12.5	13.1	13.5	13.5
Black NH	11.8	12.5	12.5	13.1	13.6	14.5	14.6	15.1	15.2	15.0
Hispanic	20.4	21.3	20.8	20.9	21.4	21.9	21.9	22.4	21.9	21.3

Obesity is defined as at or above the 95th percentile of sex-specific BMI for age based on 2000 National Center for Health Statistics, Center for Disease Control and Prevention growth charts.
Abbreviations: NH - non Hispanics
Source: New York State Division of Nutrition WIC program, Pediatric Nutrition Surveillance System

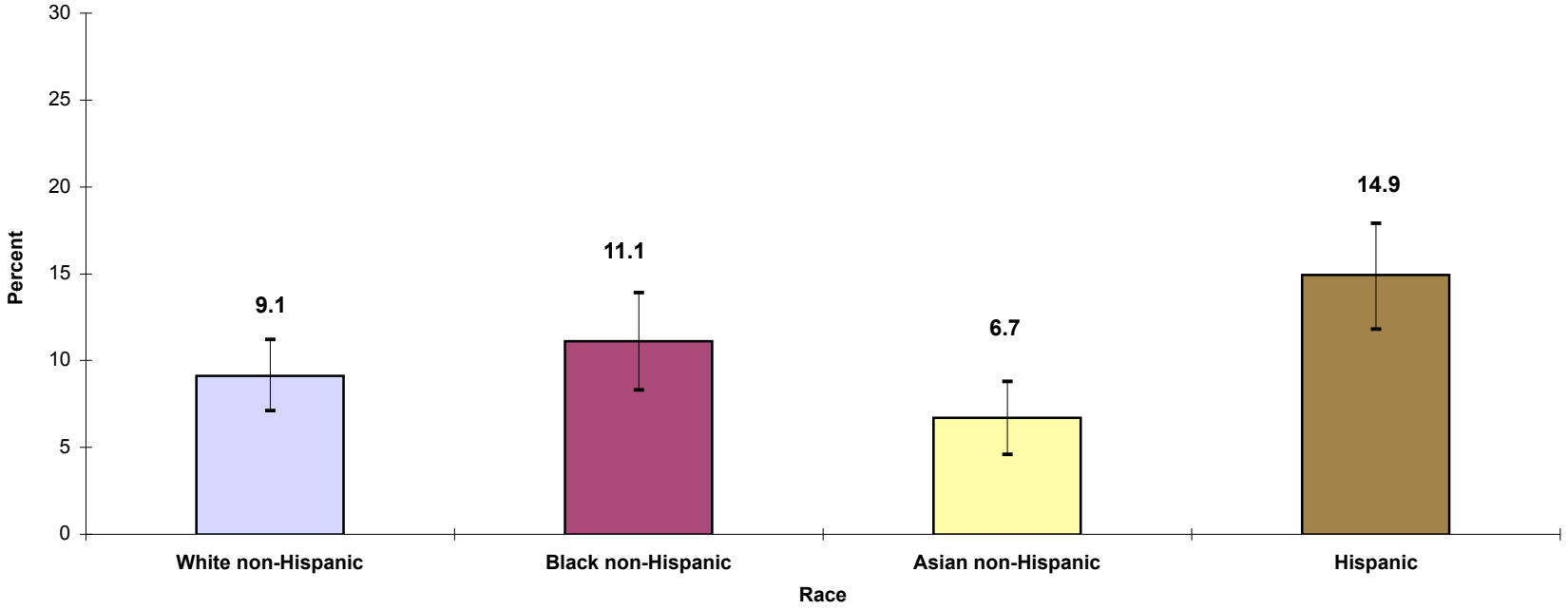
There is growing concern about the national epidemic in childhood and adult obesity.

For preschool children the only trend data available are for children from low-income families enrolled in the Special Nutrition Program for Women, Infants and Children (WIC).

Among children ages two to four participating in New York State's WIC program, the percentage of obese children has increased 42% for White non-Hispanic children and 27% for Black non-Hispanic children since 1995.

Among Hispanic children, rates have been relatively unchanged but have been consistently higher than rates for both White non-Hispanic and Black non-Hispanic children.

Figure 35 Percent of High School Students Who Were Overweight by Race/Ethnicity, New York State Residents, 2005

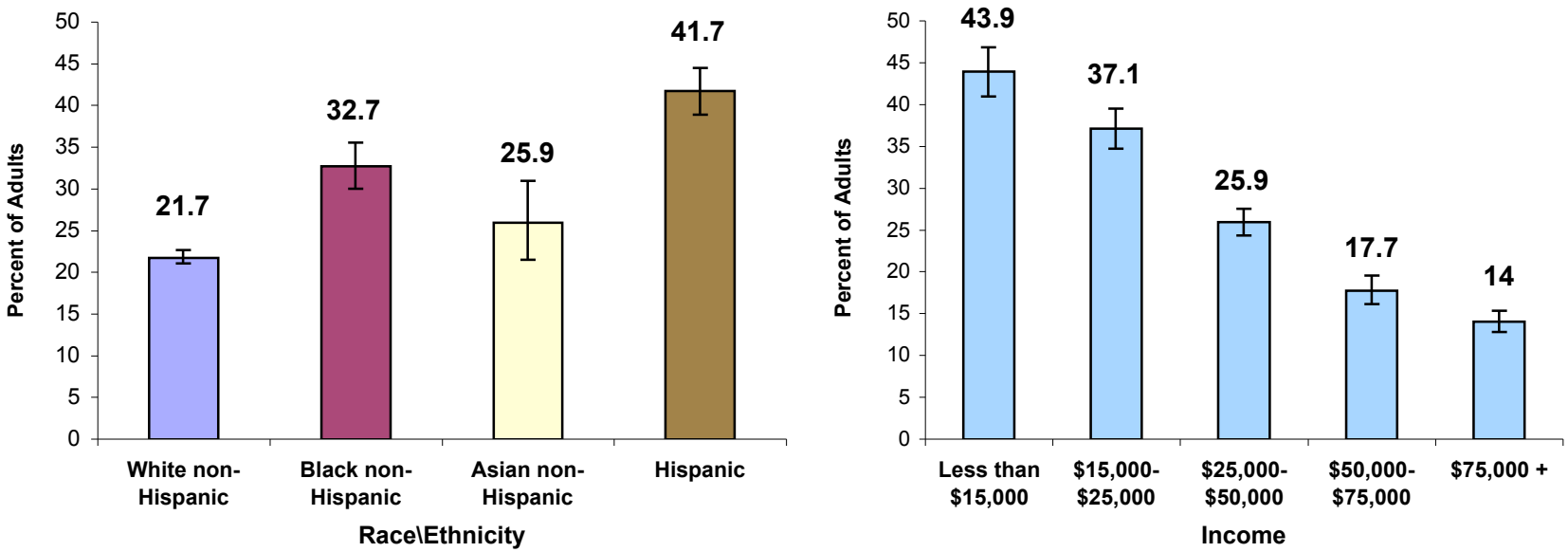


Obesity in children is defined as at or above the 95th percentile of sex-specific body mass index (BMI) for age.
Source: Youth Risk Behavior Survey, NYS

Obesity among children and adolescents has tripled over the past three decades. In addition to a higher risk of chronic diseases, being overweight is also associated with low self-esteem and depression. (New York State Department of Health – Strategic Plan for Overweight and Obesity Prevention)

Hispanic students were significantly more likely to report being obese (14.9%) as compared to White non-Hispanic (9.1%) and Asian non-Hispanic (6.7%) students. Among Black non-Hispanic students, 11.1% were obese.

Figure 36a Percent of Adults 18 Years or Older Reporting No Leisure Time Physical Activity by Race/Ethnicity and Income, New York State Residents, 2003 - 2005



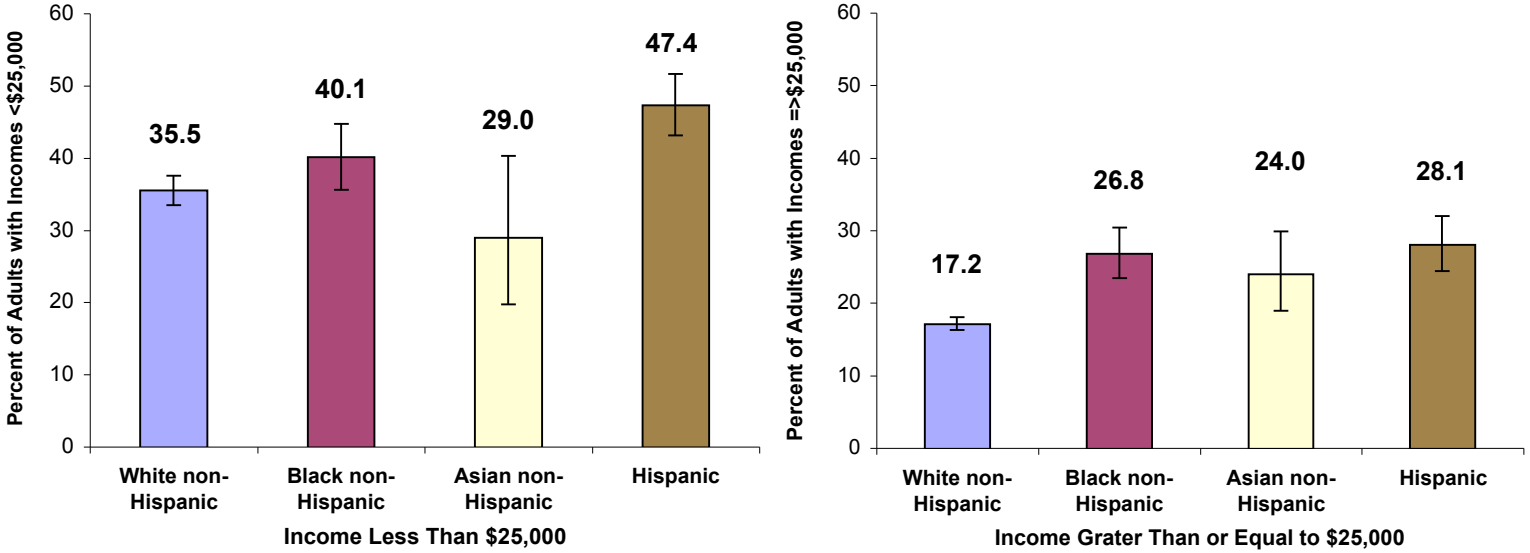
Leisure time physical activity is defined as participating in physical activities or exercises (such as running, calisthenics, golf, gardening or walking for exercise) during the past month, not including activities that are part of a regular job.
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

Poor diet and physical inactivity are the second leading causes of preventable death in the United States. Regular physical activity provides significant benefits for persons with chronic diseases and disabilities. (New York State Department of Health – Strategic Plan for Overweight and Obesity Prevention)

More than 40% of Hispanic New Yorkers surveyed said they did not participate in any regular leisure time physical activity, which is significantly higher than other race/ethnic groups. Of Black non-Hispanic New Yorkers, 32.7% reported no leisure time physical activity. This was significantly more than what was reported by White non-Hispanic New Yorkers (21.7%). Among Asian non-Hispanics, 25.9% reported no leisure time physical activity.

Persons most likely to report participating in leisure time activity were in the highest income group. Persons earning less than $15,000 annually were three times more likely to report no leisure time physical activity than those earning more than $75,000 (43.9% versus 14.0%).

Figure 36b Percent of Adults 18 Years or Older Reporting No Leisure Time Physical Activity by Race/Ethnicity by Income, New York State Residents, 2003 - 2005



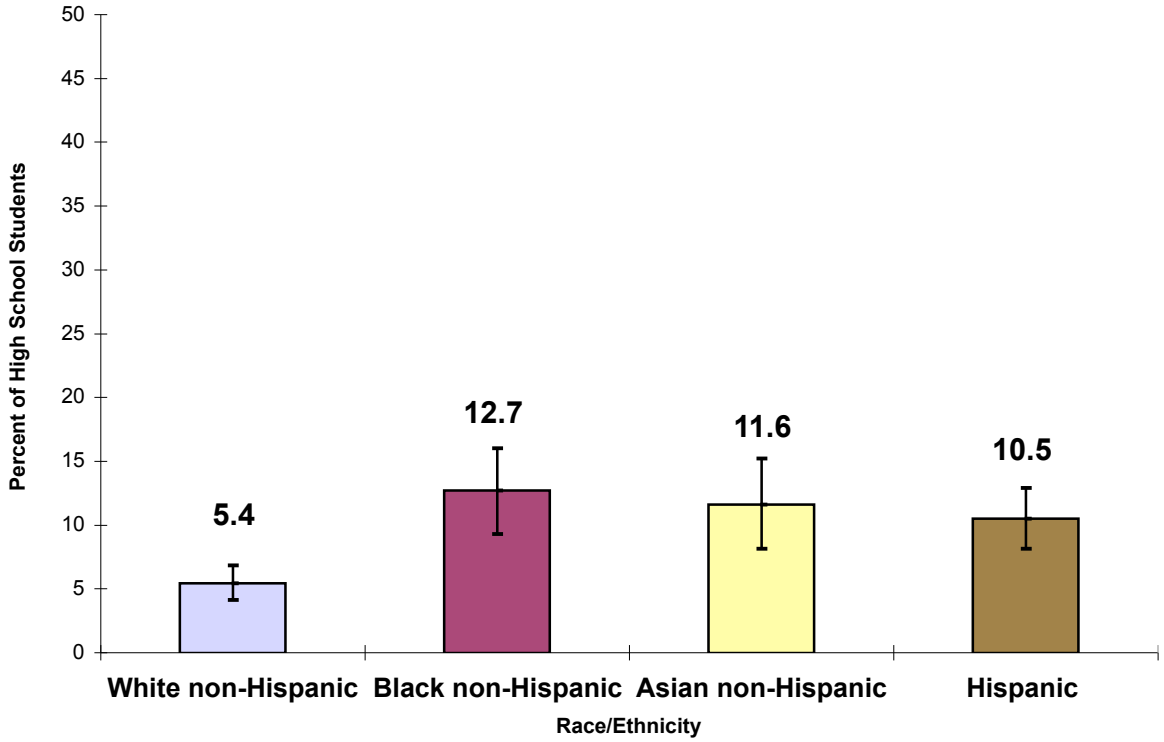
Leisure time physical activity is defined as participating in physical activities or exercises (such as running, calisthenics, golf, gardening or walking for exercise) during the past month, not including activities that are part of a regular job.
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

Of Hispanic New Yorkers earning less than $25,000 annually, 47.4% did not participate in leisure time physical activity. White non-Hispanic and Asian non-Hispanic New Yorkers reported significantly lower rates of no leisure time physical activity (35.5% and 29.0%, respectively). The Black non-Hispanic rate (40.1%) was not statistically different from the other rates in this income category.

Among New Yorkers earning at least $25,000 per year, persons in all race/ethnic categories except Asian non-Hispanics reported significantly lower percentages of no leisure time physical activity as compared to their lower income counterparts.

Hispanic, Black non-Hispanic and Asian Non-Hispanic New Yorkers earning $25,000 or more per year experienced similar rates of no participation (26.8%, 28.1% and 24.0%, respectively) and were not significantly different from each other. Rates of no participation were significantly lower for White non-Hispanics (17.2%) than all other race/ethnic groups in this income category.

Figure 37 High School Students With No Vigorous or Moderate Physical Activity During the Past 7 Days by Race/Ethnicity New York State Residents, 2005



Moderate physical activity is defined as physical activity or exercise that does not make one sweat or breathe hard for 30 minutes or more on five of the past seven days.
Vigorous physical activity is defined as physical activity or exercise that makes one sweat and breathe hard for 20 minutes or more on three of the past seven days.

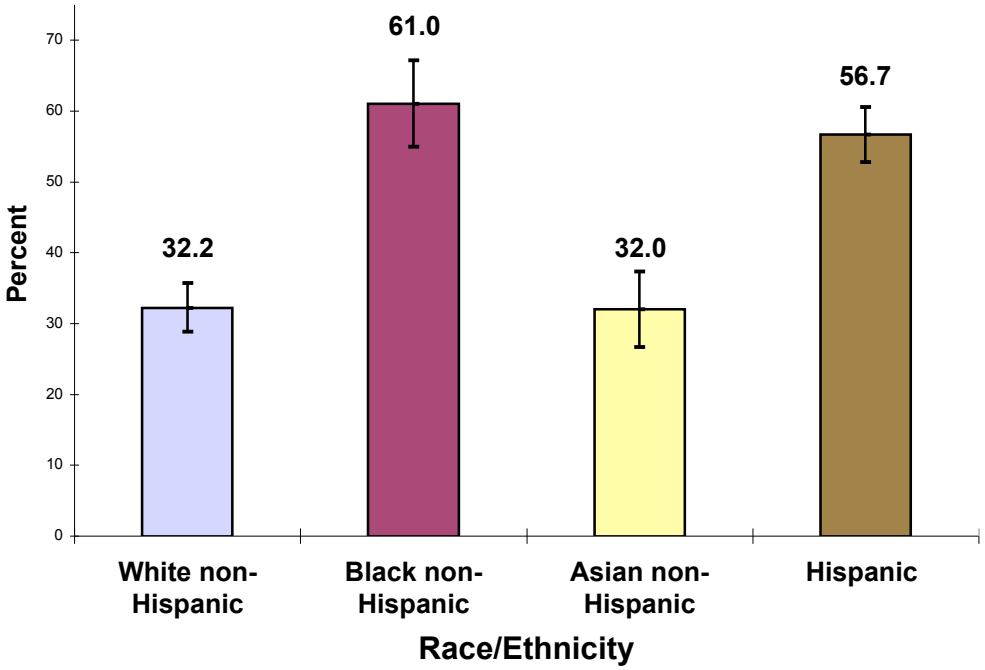
Source: Youth Risk Behavior Survey (2005)

The 2005 U.S. Dietary Guidelines recommend that teens get at least one hour of physical activity on most, and preferably, all days of the week.

Only 5.4% of White non-Hispanic high school students reported no vigorous or moderate physical activity in the past week. This was significantly lower than the rates reported for Black non-Hispanic, Hispanic and Asian non-Hispanic students.

Rates of no vigorous or moderate activity during the past week among Black non-Hispanic (12.7%), Asian non-Hispanic (11.6%) and Hispanic (10.5%) students did not differ statistically from each other.

Figure 38 High School Students Who Watched Three or More Hours of Television per Day on An Average School Day by Race/Ethnicity, New York State Residents, 2005

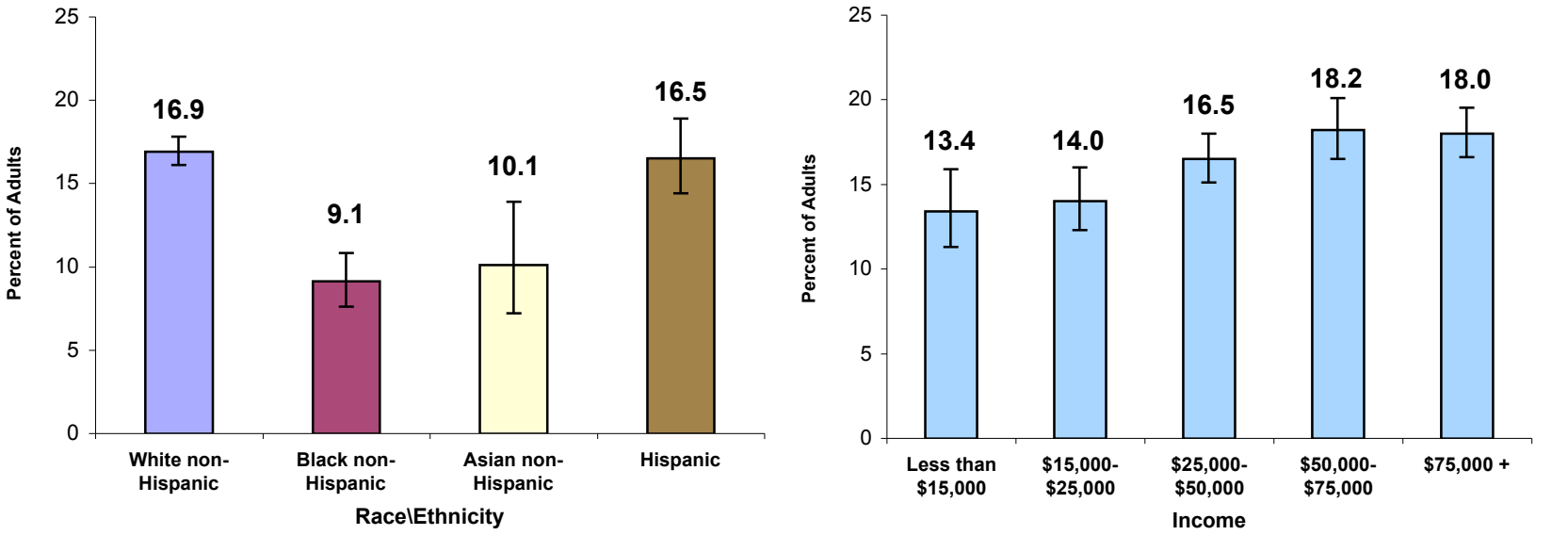


Source: Youth Risk Behavior Survey (2005)

Watching television for more than three hours per day is associated with an increased risk of becoming overweight or obese. (New York State Department of Health - Strategic Plan for Overweight and Obesity Prevention)

More than half of all Black non-Hispanic (61%) and Hispanic (56.7%) high school students reported watching more than three hours per day of television. These rates were significantly higher than the rates for White non-Hispanic and Asian non-Hispanic students (both 32%).

Figure 39a Percent of Adults 18 Years or Older Binge Drinking by Race/Ethnicity and by Income, New York State Residents, 2003 - 2005



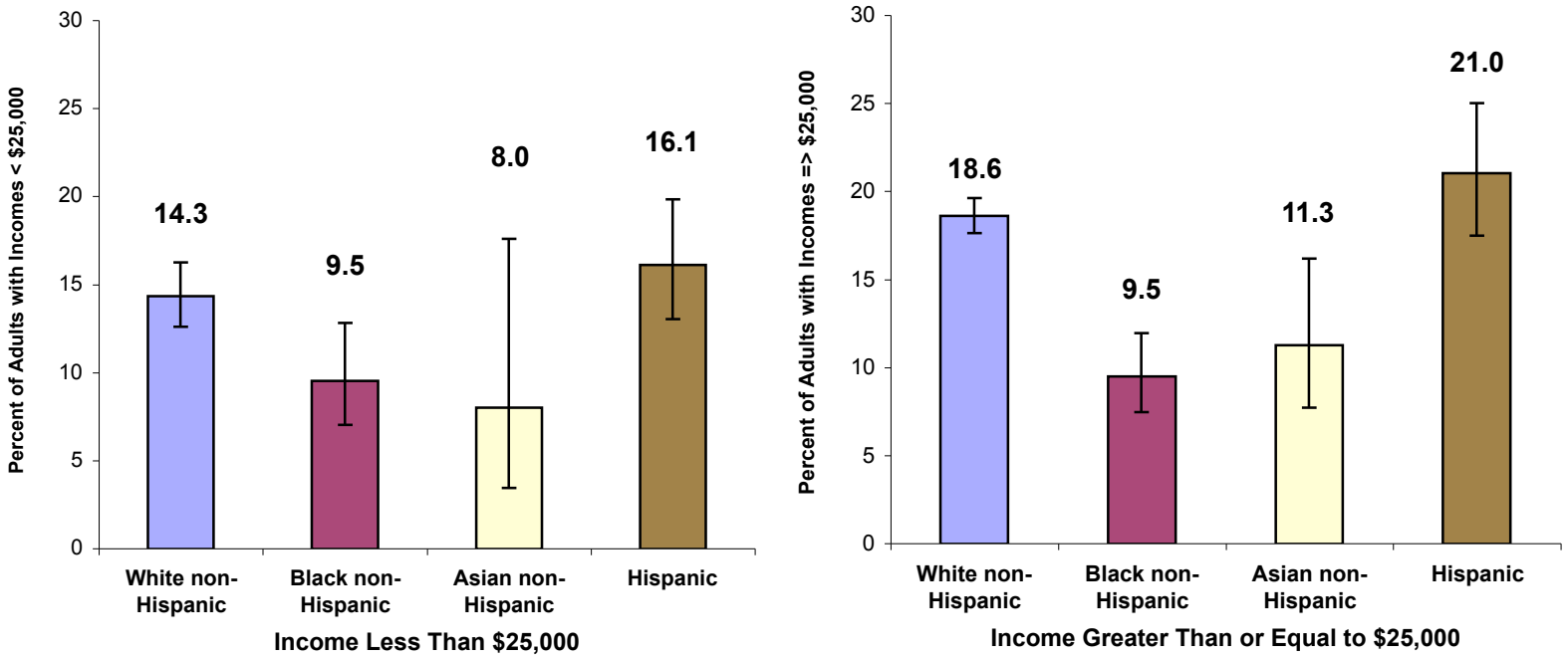
Binge Drinking is defined as five or more alcohol drinks on at least one occasion in the past month.
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

There are approximately 75,000 deaths attributable to excessive alcohol use each year in the United States. This makes excessive alcohol use the third leading lifestyle-related cause of death for the nation. (Centers for Disease Control and Prevention, Alcohol and Public Heath, Quick Stat.)

The highest rate of binge drinking in New York State was among White non-Hispanics (16.9%) and Hispanics (16.5%). Asian non-Hispanic (10.1%) and Black non-Hispanic (9.1%) New Yorkers reported binge drinking at significantly lower rates.

The rate of binge drinking was higher among high income groups as compared to low income groups. Of New York State residents earning less than $15,000 per year, 13.4% reported binge drinking during the past month. Of New Yorkers earning more than $50,000 per year, 18% said they engaged in binge drinking during the past month.

Figure 39b Percent of Adults 18 Years or Older Binge Drinking by Race/Ethnicity by Income, New York State Residents, 2003 - 2005

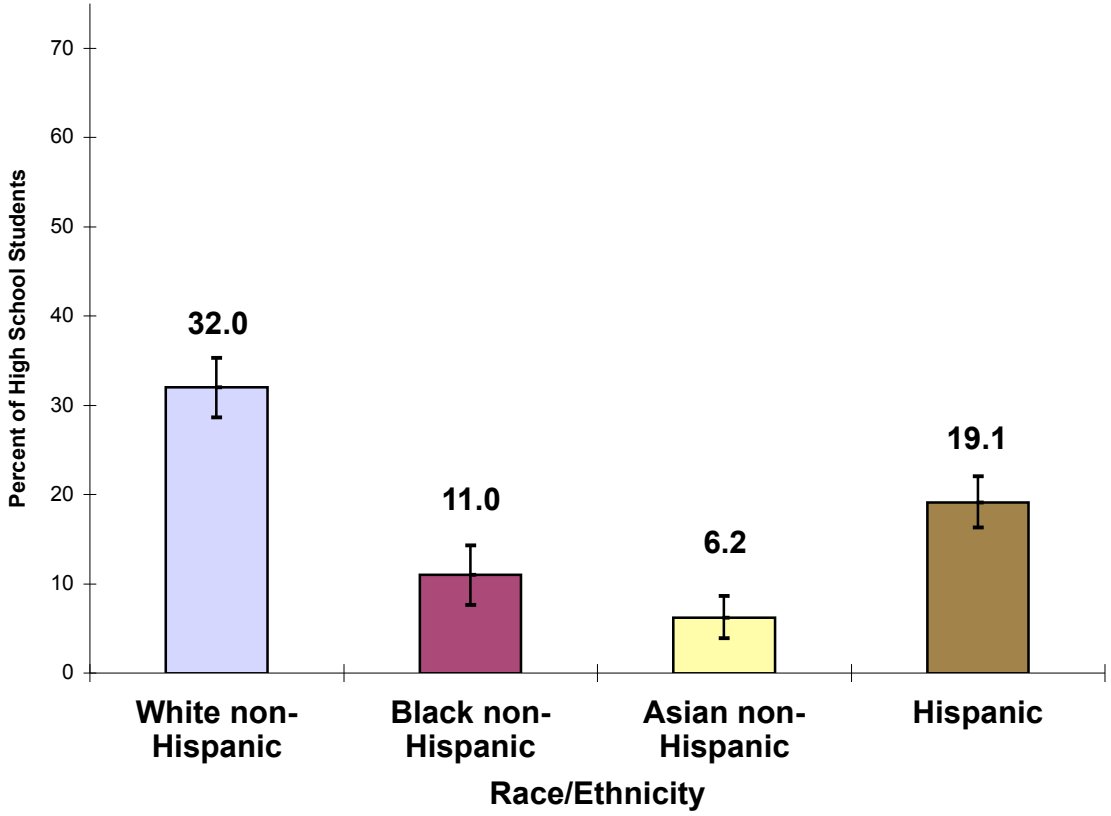


Binge Drinking is defined as five or more alcohol drinks on at least one occasion in the past month.
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

Among Hispanics earning less than $25,000 per year, 16.1% reported binge drinking during the past month. The Hispanic binge drinking rate was significantly higher than the rate reported by Black non-Hispanic New Yorkers (9.5%) earning less than $25,000 per year. White non-Hispanic and Asian non-Hispanic New Yorkers reported binge drinking rates of 14.3% and 8.0% respectively. These rates did not differ statistically from each other or from the other rates in this income category.

Among New Yorkers earning $25,000 or more per year, all race/ethnic groups except Black non-Hispanics reported a higher percentage of binge drinking than their lower income counterparts. Hispanic and White non-Hispanic New Yorkers (21.0% and 18.6%, respectively) reported significantly higher binge drinking rates in this income category, as compared to Black non-Hispanic and Asian non-Hispanic New Yorkers.

Figure 40 Binge Drinking Among High School Students During the Past 30 Days by Race/Ethnicity, New York State Residents, 2005



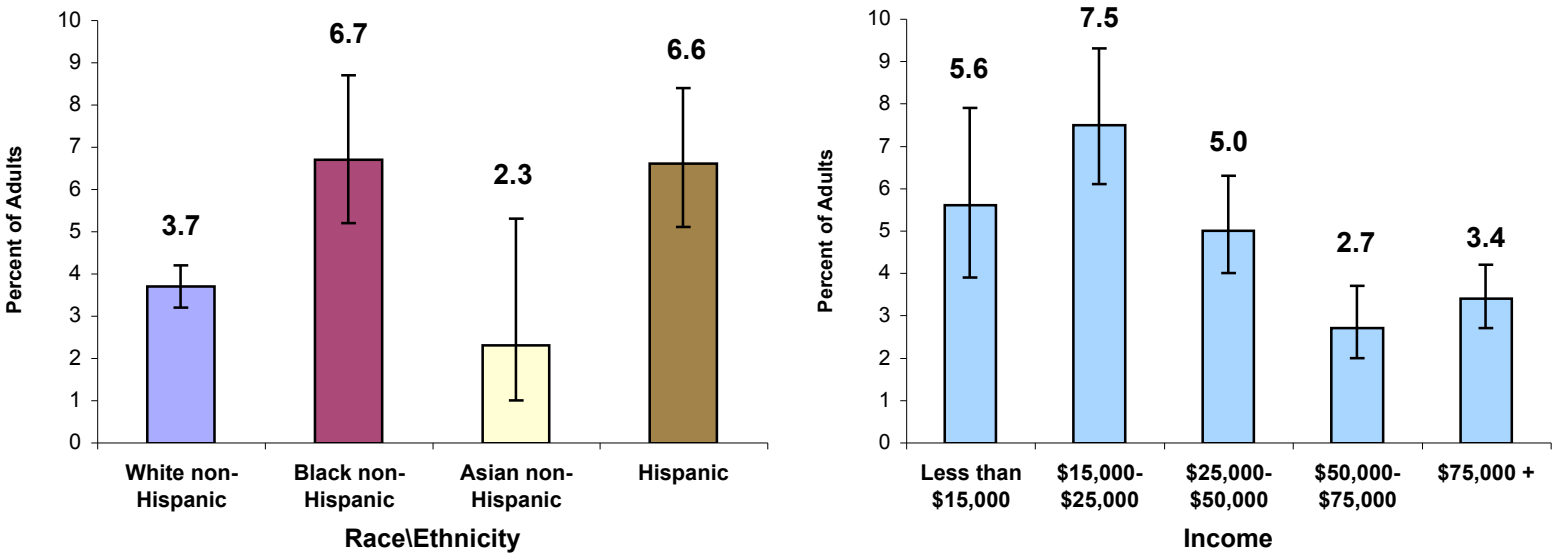
Binge drinking is defined as five or more drinks of alcohol in a row at least once in the past month.
Source: Youth Risk Behavior Survey (2005)

Alcohol use among youth is associated with a wide variety of risky behaviors and poor outcomes, including unprotected sexual intercourse, vulnerability to coerced sexual activity, the use of marijuana and poor academic performance. In 2003, nearly a third of all traffic deaths among youth ages 15 to 20 were alcohol-related. (Child Trends Data Bank - Binge Drinking)

White non-Hispanic high school students are three times more likely than Black non-Hispanic students and five times more likely than Asian non-Hispanic students to report binge drinking during the past 30 days.

Hispanic high school students reported significantly more binge drinking than Black non-Hispanic and Asian non-Hispanic students but significantly less than White non-Hispanic students.

Figure 41a Percent of Adults 18 Years of Age or Older With HIV Risk Indicators by Race/Ethnicity and Income, New York State Residents, 2003 - 2005



HIV risk indicators are defined as having used intravenous drugs; been treated for a sexually transmitted disease; given or received money or drugs in exchange for sex; or had anal sex without a condom in the past year.
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

We are entering a new era in HIV prevention, one in which scientific research provides cutting-edge behavioral and biomedical approaches to prevention. Effective risk reduction strategies, combined with new treatments for HIV and other sexually transmitted diseases, offer more hope than ever of further reducing the spread of HIV. (Centers for Disease Control and Prevention, US Department of Heath and Human Services)

Slightly less than 7% of Black non-Hispanic and Hispanic New Yorkers surveyed reported they engaged in behaviors putting them at elevated risk of HIV infection. White non-Hispanic New Yorkers were significantly less likely to report engaging in these behaviors (3.7%). Of Asian non-Hispanic New Yorkers, 2.3% reported engaging in these behaviors but their rate was not statistically different from the rates for other race/ethnic groups.

Generally, New Yorkers in lower income categories were more likely to report these behaviors as compared to New Yorkers in higher income categories. New Yorkers earning between $15,000 - $25,000 per year were more likely to report they engaged in high risk HIV behaviors (7.5%), and New Yorkers earning between $50,000 – $75,000 had the lowest percent of individuals reporting these behaviors (2.7%).

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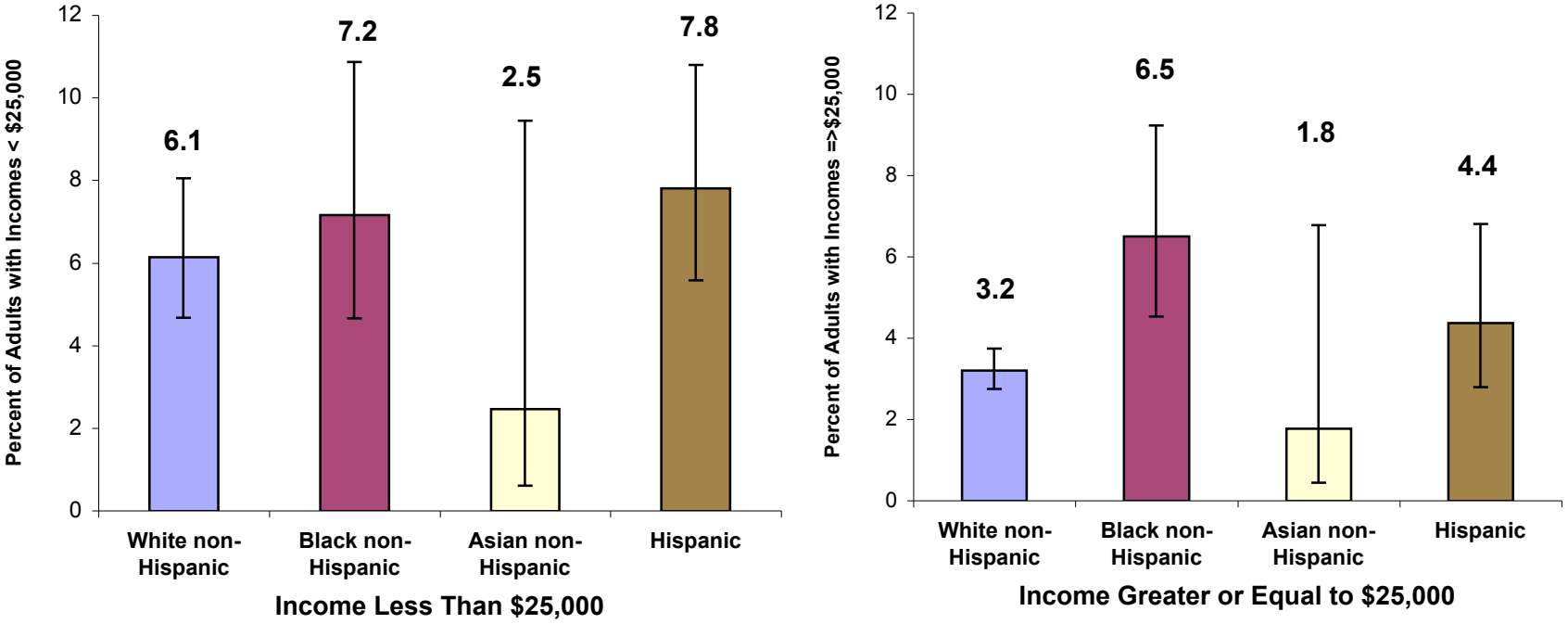
Figure 41b Percent of Adults 18 Years of Age or Older With HIV Risk Indicators by Race/Ethnicity by Income, New York State Residents, 2003 - 2005

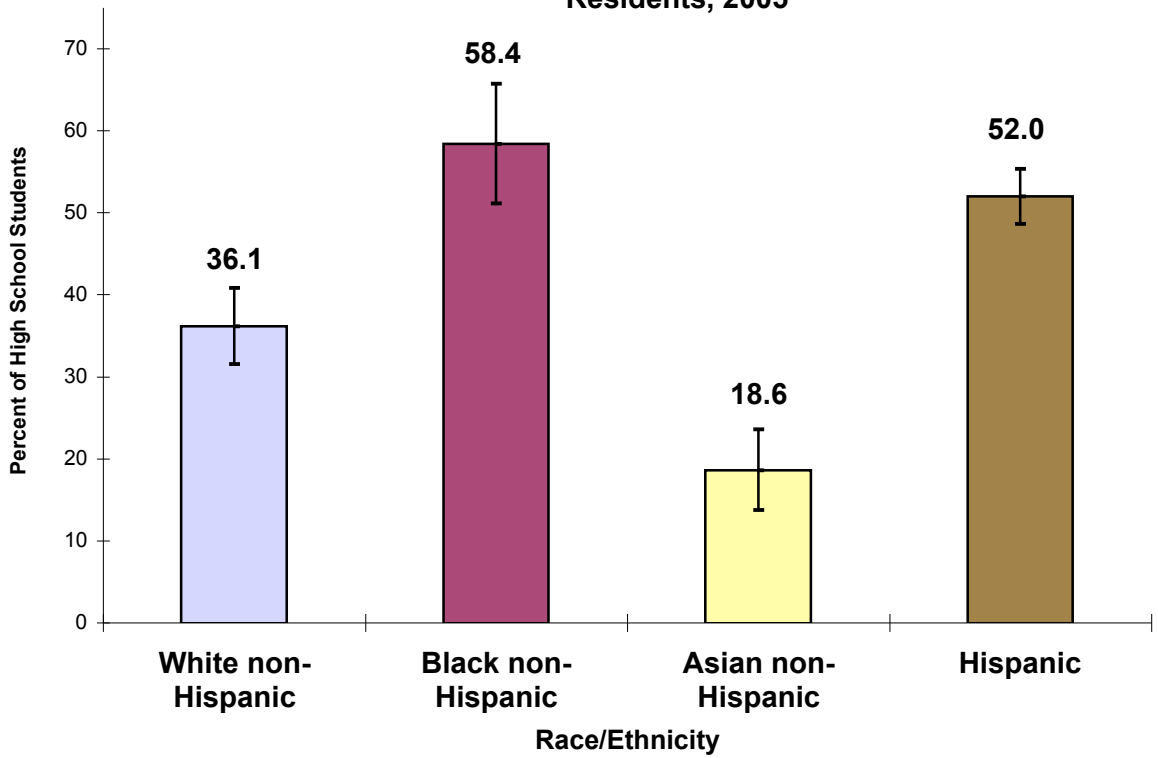


HIV risk indicators are defined as having used intravenous drugs; been treated for a sexually transmitted disease; given or received money or drugs in exchange for sex; or had anal sex without a condom in the past year.
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

Among Black non-Hispanic, White non-Hispanic and Hispanic New Yorkers earning less than $25,000 annually, 6% to 8% reported they engaged in high risk HIV behaviors. Of Asian non-Hispanic New Yorkers in this income category, 2.5% reported engaging in these behaviors. However, the Asian non-Hispanic rate was not statistically different from the rates for the other groups.

Among New Yorkers earning $25,000 or more per year, 6.5% of Black non-Hispanics reported engaging in high risk HIV behaviors. Two percent of Asian non-Hispanics in this income group reported these behaviors as did 3% of White non-Hispanics and 4% of Hispanics.
The only statistically significant difference in rates in this income group was between White non-Hispanics and Black non-Hispanics.

Figure 42 **High School Students Who Ever Had Sexual Intercourse During Their Lifetime by Race/Ethnicity, New York State Residents, 2005**

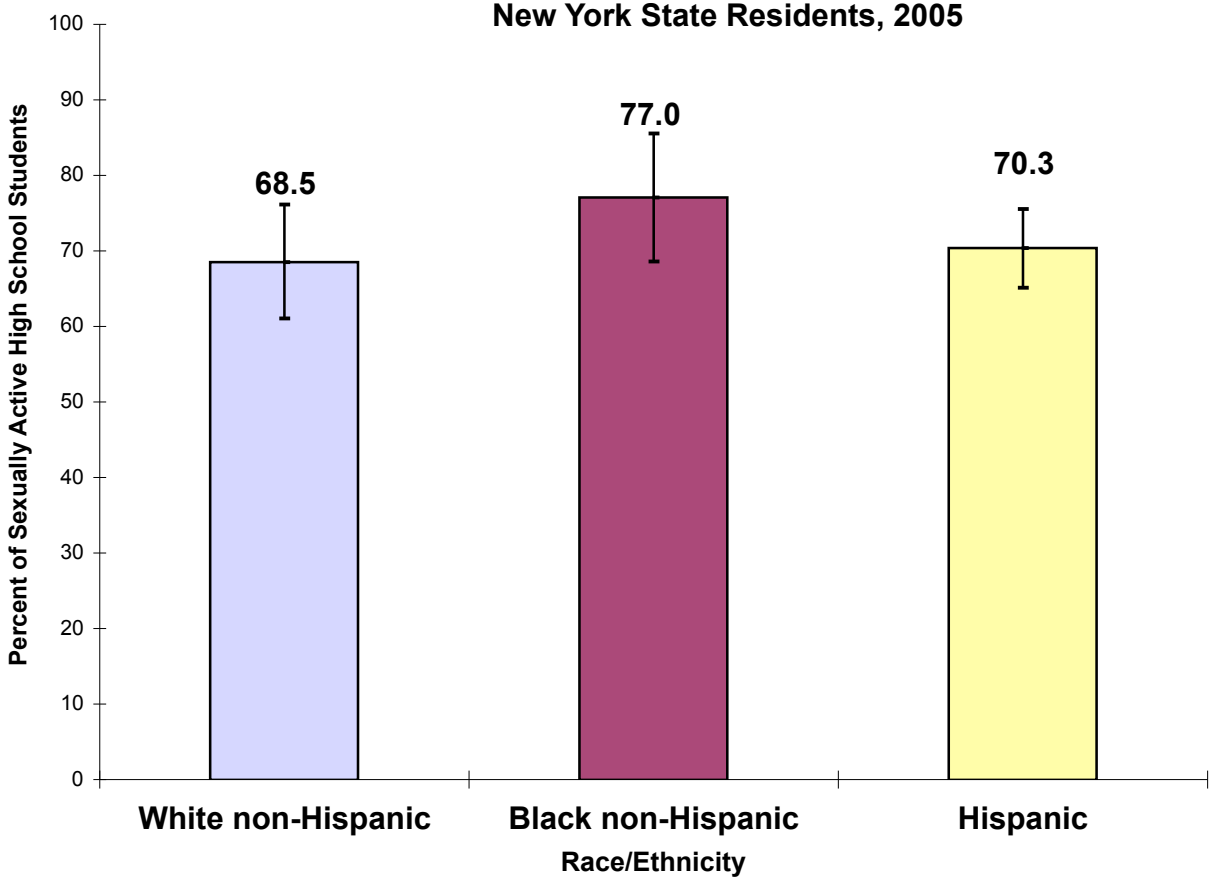


Among non-Hispanic Black fathers, 25 percent fathered their first child before they were 20 years old, 19 percent of Hispanic fathers became fathers as teenagers and 11 percent of non-Hispanic White men became fathers while they were teens. (National Survey of Family Growth)

Black non-Hispanic (58.4%) and Hispanic (52.0%) high school students in New York State reported the highest rates of ever having had sexual intercourse in their lifetime. Both had rates that were significantly higher than White non-Hispanic (36.1%) and Asian non-Hispanic (18.6%) students.

Source: Youth Risk Behavior Survey (2005)

Figure 43 Percent of Sexually Active High School Students Who Used a Condom During Last Sexual Intercourse by Race/Ethnicity, New York State Residents, 2005



Source: Youth Risk Behavior Survey (2005)

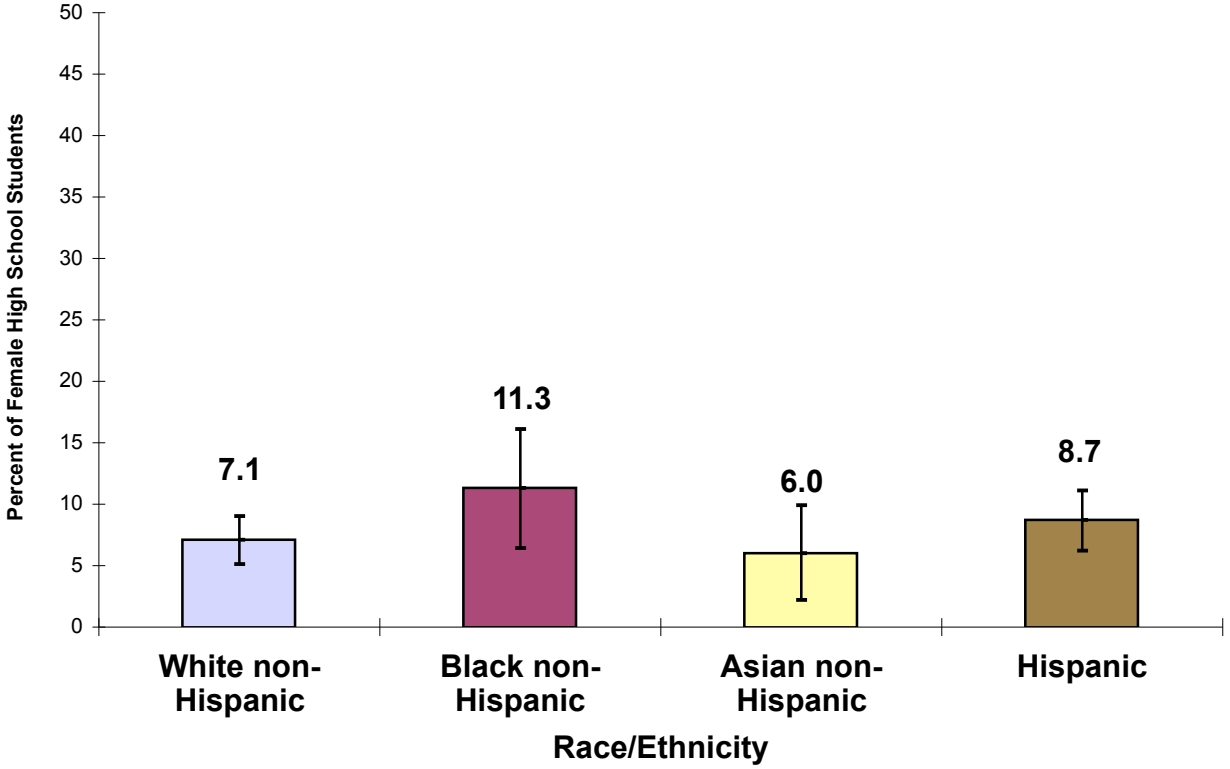
Condom use has been proven effective in reducing unwanted pregnancy and the transmission of STDs including HIV.

Seventy-seven percent of Black non-Hispanic high school students that were sexually active in New York State reported using a condom during their last intercourse.

White non-Hispanic (68.5%) and Hispanic (70.3%) sexually active high school students reported using a condom at last sexual intercourse. The differences in condom use among the three race/ethnic groups were not statistically significant.

Data for Asian non-Hispanic students were not available due to the small sample size in this category.

Figure 44 Female High School Students Who Have Ever Been Forced to Have Sexual Intercourse During their Lifetime by Race/Ethnicity, New York State Residents, 2005



Source: Youth Risk Behavior Survey (2005)

Sexual coercion in childhood and adolescence has multiple consequences with links to adverse reproductive health and HIV-related outcomes, subsequent experience of violence at the hands of intimate partners and mental health problems. (Family Health International - 2005)

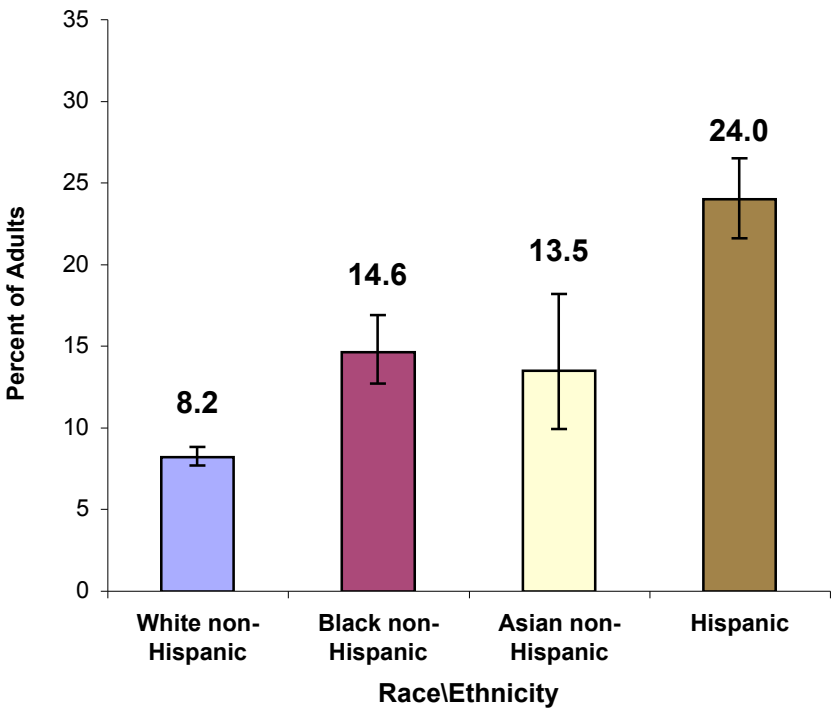
More than one out of every ten Black non-Hispanic high school girls in New York State reported she was forced to have sex when she did not want to.

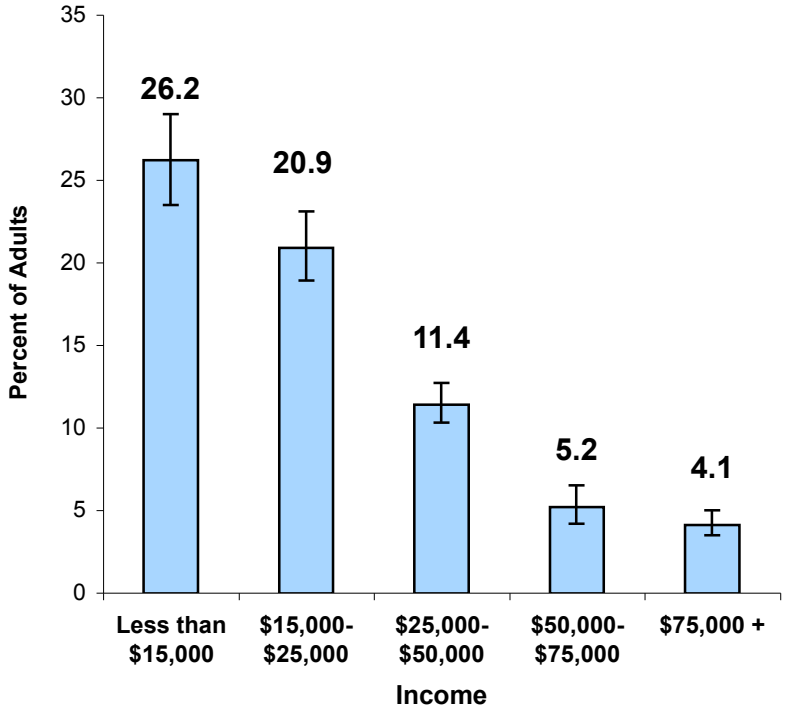
Among female Hispanic students, 8.7% reported forced sex. Seven percent of White non-Hispanic and 6% of Asian non-Hispanic female students also reported forced sexual intercourse.

Forced sex also occurred among male high school students but at much lower rates (4.1%).

ACCESS TO HEALTH CARE

Figure 45a Percent of Adults 18 Years or Older for Whom Cost Prevented Doctor Visits by Race/Ethnicity and Income, New York State Residents, 2003 - 2005





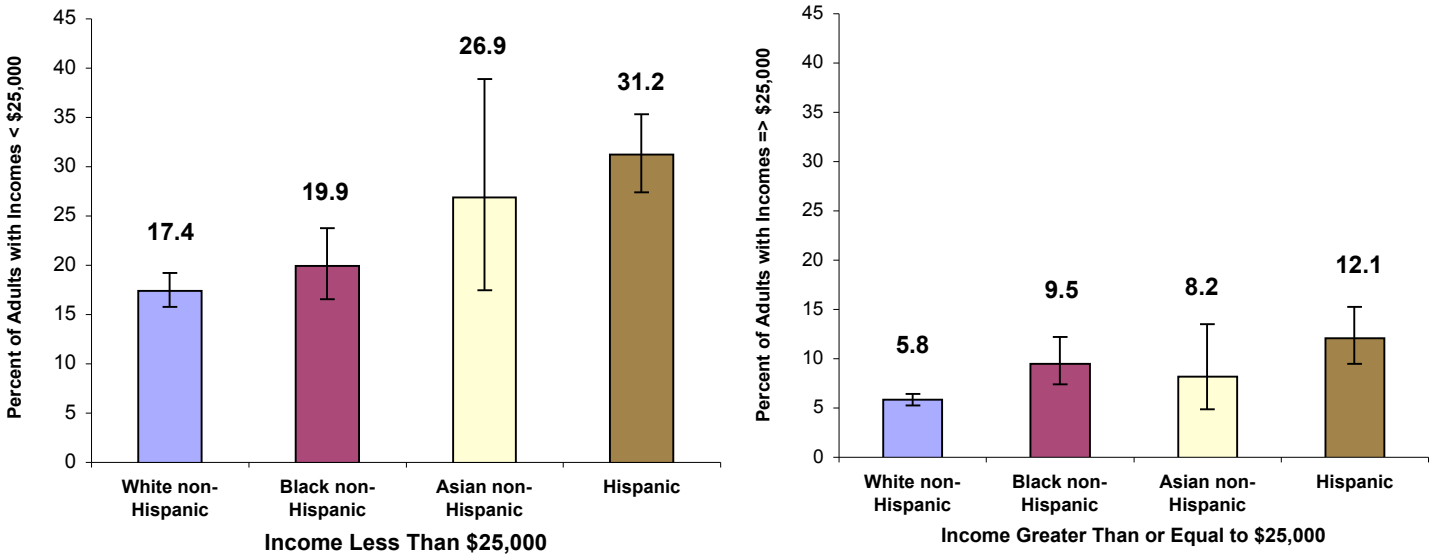
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

When financial barriers to medical care exist, care is often not well coordinated or as effective as it should be. Delays in seeking treatment or not receiving appropriate screenings reduce overall heath care quality.

Cost was a factor in preventing doctor visits for 24.0% of Hispanic New Yorkers. This was significantly higher than the rates for Black non-Hispanic and Asian non-Hispanic New Yorkers (14.6% and 13.5%, respectively). Among White non-Hispanic New Yorkers, the percentage not seeing a doctor due to cost was significantly lower (8.2%) than all race/ethnicity groups.

Not surprisingly, persons in the lowest income groups were the most likely to not see a doctor due to cost as compared to the higher income groups.

Figure 45b Percent of Adults 18 Years or Older for Whom Cost Prevented Doctor Visits by Race/Ethnicity by Income, New York State Residents, 2003 - 2005

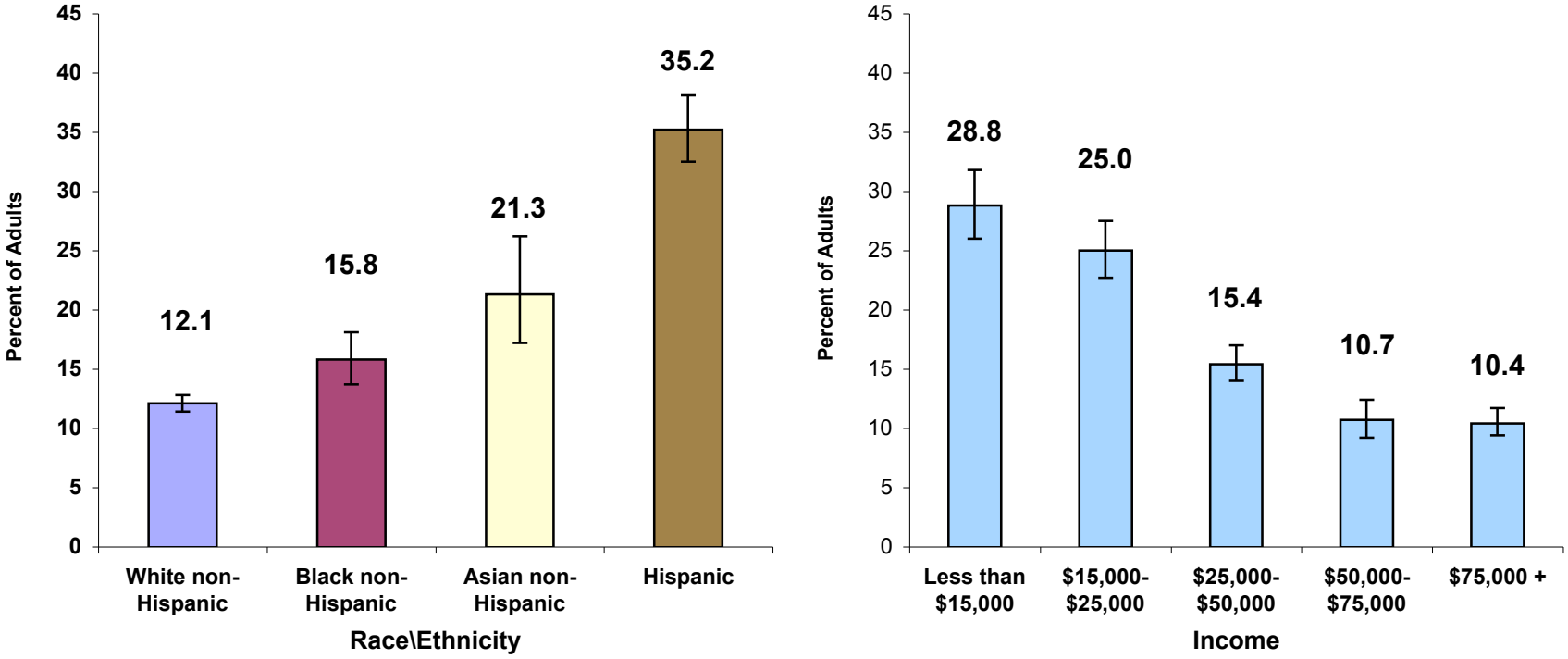


Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

For all racial/ethnic groups in New York, those with incomes under $25,000 per year were significantly more likely to report that cost prevented doctor visits than those with incomes of $25,000 or more.

In the less than $25,000 income category, Hispanics (31.2%) reported not visiting a doctor due to cost significantly more than White non-Hispanic (17.4%) and Black non-Hispanic (19.9%) New Yorkers. Among individuals earning at least $25,000 per year, 12.1% of Hispanics reported cost prevented doctor visits, but the rate was only significantly higher than the rate for White non-Hispanics (5.8%).

Figure 46a Percent of Adults 18 Years of Age or Older With No Regular Health Care Provider by Race/Ethnicity and Income, New York State Residents, 2003 - 2005



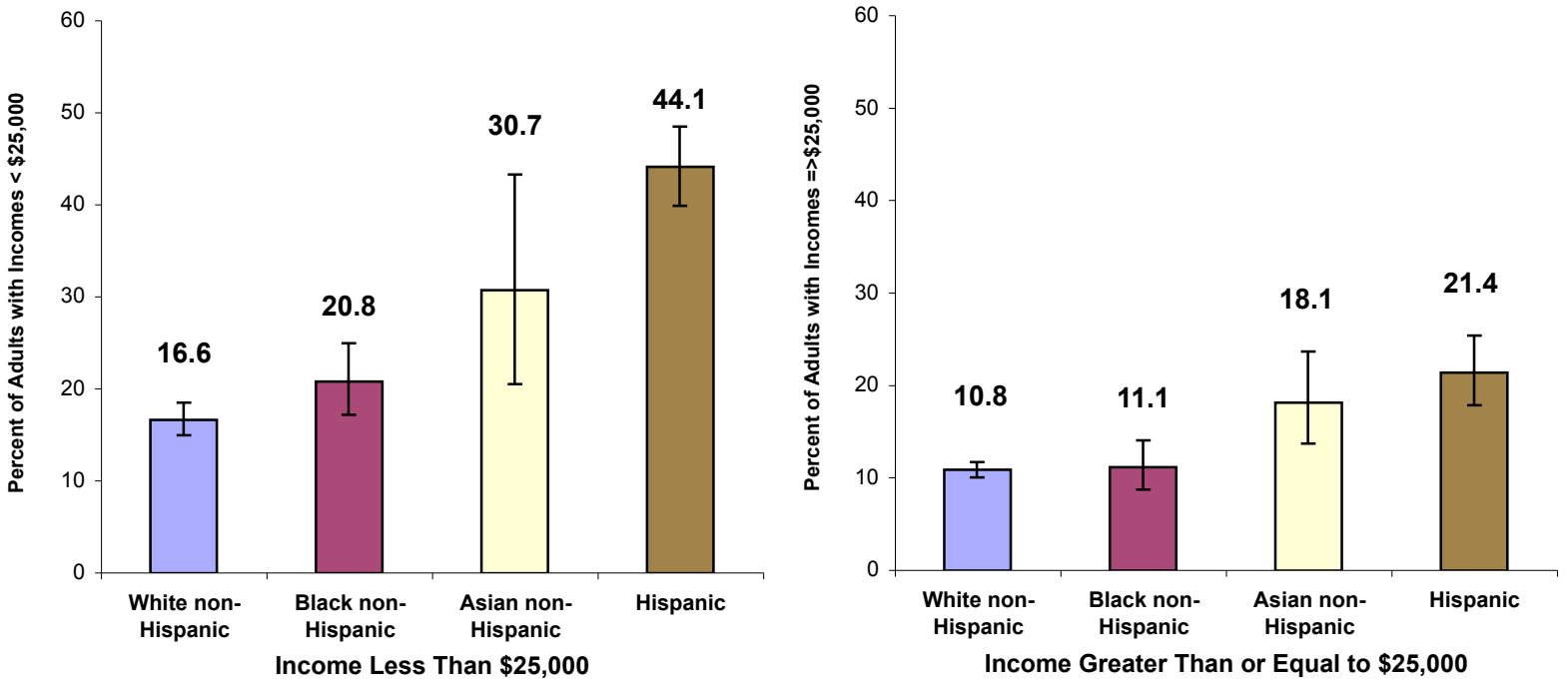
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

Persons with a usual source of health care are more likely than those without a usual source of care to receive a variety of preventive health care services. (Healthy People 2010 – Conference Edition Volume 1)

Thirty-five percent of Hispanic New Yorkers surveyed reported they did not have regular health care providers. This is more than double the percent of White non-Hispanic and Black non-Hispanic New Yorkers reporting no regular providers. Among Asian non-Hispanic New Yorkers, 21.3% had no regular providers.

As income increases so does the likelihood of having regular heath care providers. However, even among persons earning greater than $75,000 per year, 10% reported they did not have a regular heath care provider.

Figure 46b Percent of Adults 18 Years of Age or Older With No Regular Health Care Provider by Race/Ethnicity by Income, New York State Residents, 2003 - 2005

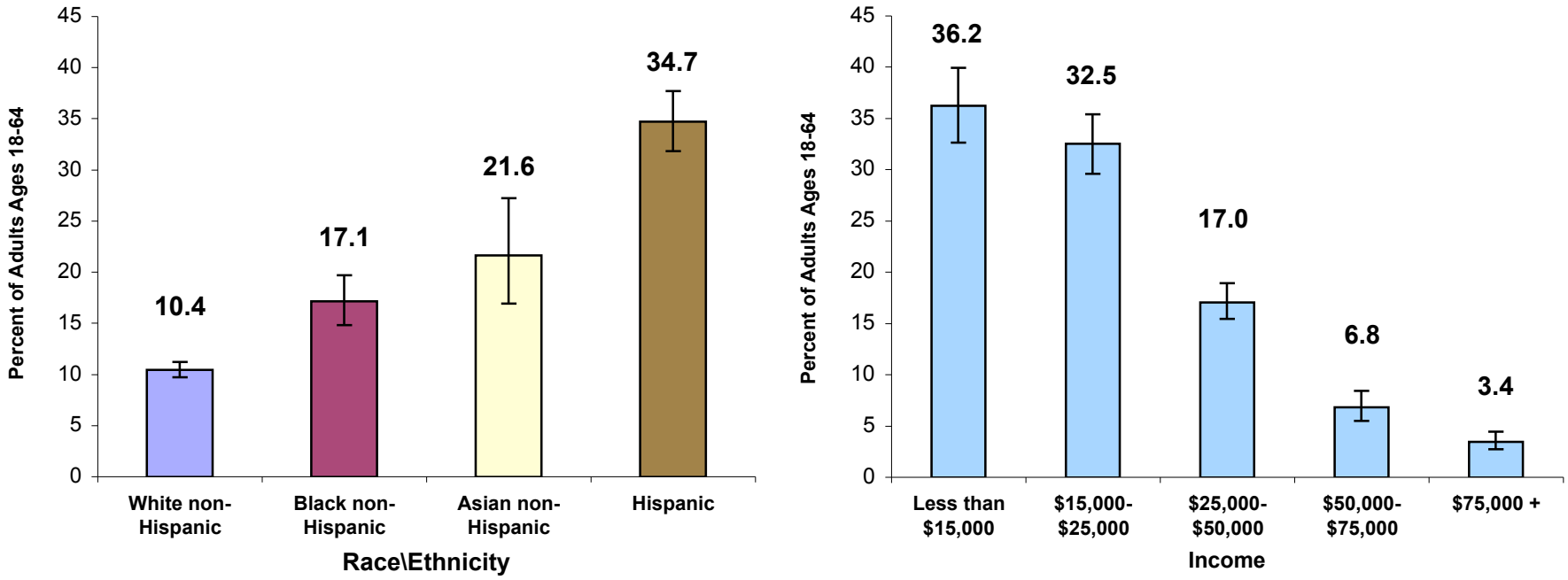


Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

When comparing persons earning less than $25,000 per year to those earning $25,000 or more per year, the percentages of respondents reporting they did not have regular health care providers were significantly higher for White Non-Hispanics, Black non-Hispanics and Hispanics in the lower income groups. Among Asians, differences between the two income groups were not statistically significant.

In the less than $25,000 income category Hispanics (44.1%) reported not having regular health care providers significantly more than White non-Hispanics (16.6%) and Black non-Hispanics (20.8%). Although the rates are much lower among individuals earning $25,000 or more, the same racial/ethnic pattern exists with Hispanics (21.4%) reporting significantly higher rates of no regular health care providers than White non-Hispanics (10.8%) and Black non-Hispanics (11.1%). Asian non-Hispanics were significantly higher than White non-Hispanics for both income groups.

Figure 47a Percent of Adults Between 18 and 64 Years of Age with No Health Insurance by Race/Ethnicity and by Income, New York State Residents, 2003 - 2005



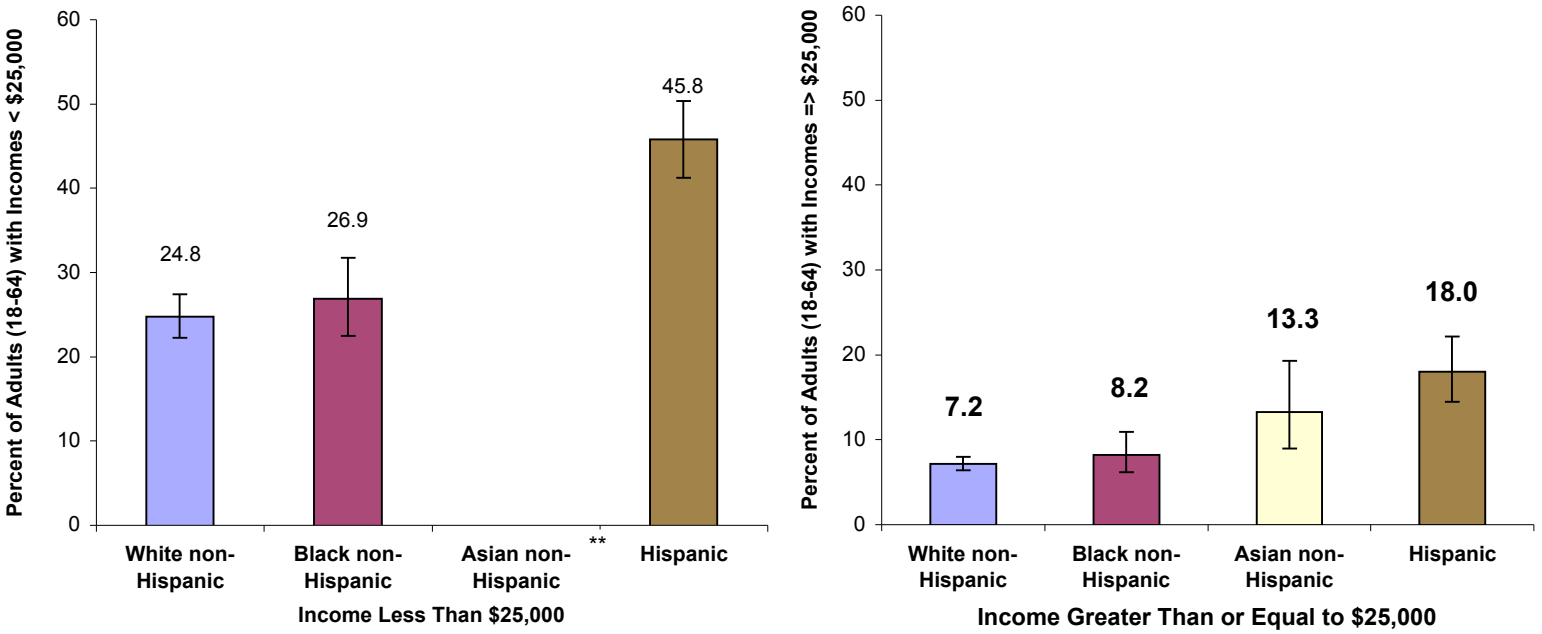
Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

Health insurance provides access to health care. Persons with health insurance are more likely to receive appropriate routine check-ups and preventive care. (Healthy People 2010 - Conference Edition Volume 1)

Approximately 35% of New York State Hispanics had no health insurance coverage. This was more than three times the proportion of White non-Hispanic New Yorkers without coverage (10.4%) and significantly higher than all other race/ethnic categories. Among White non-Hispanics, the proportion reporting no health insurance coverage was significantly lower than the rate for all other race/ethnic groups. Rates of no coverage for Asian non-Hispanic and Black non-Hispanic New Yorkers were 21.6% and 17.1% respectively.

As one would expect, the likelihood of having insurance coverage is directly related to annual income. Of persons earning less than $15,000 annually, 36% had no health insurance. Among persons earning more than $75,000 per year, only 3.4% were without coverage.

Figure 47b Percent of Adults Between 18 and 64 Years of Age with No Health Insurance by Race/Ethnicity by Income, New York State Residents, 2003 - 2005



Source: Behavioral Risk Factor Surveillance System (2003 - 2005)

White non-Hispanic, Black non-Hispanic and Hispanic New Yorkers earning less than $25,000 per year were significantly more likely to report they did not have any health insurance as compared to their counterparts earning $25,000 or more per year.

Within the group earning less than $25,000 annually, Hispanics (45.8%) reported the highest rate of no health insurance. The Hispanic rate was significantly higher than what was reported by both White non-Hispanic (24.8%) and Black non-Hispanic (26.9%) New Yorkers. The sample size for Asians in this income category was not sufficient to report on this indicator.

Among New Yorkers earning $25,000 or more per year, Hispanics (18%) again reported a rate of no health insurance that was significantly higher than what was reported by White non-Hispanics (7.2%) and Black non-Hispanics (8.2%). The percentage of Asian non-Hispanic respondents (13.3%) reporting they had no health insurance was significantly higher than the rate for White non-Hispanics in this income category.

**Data are not reported if the confidence interval is greater than plus or minus 10%.

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APPENDICES

Appendix 1 - Sources of Data

U.S. Census Bureau

The U.S. Census Bureau serves as the leading source of quality data about the nation's population and economy. Since 1790, data on gender, age, race, ethnicity and marital status are collected every ten years. Information on income, education, housing, occupation and industry is also collected from a representative sample of the population.

New York population figures, by race and ethnicity, used for reviewing population shifts and for the calculation of rates, are generated from the decennial census and the Census Bureau's population estimates. New York county population estimates by race and Hispanic origin are from the Census Bureau's "bridged race" population estimates. These estimates are generated using the National Center for Health Statistics (NCHS) methodology that redistributes multiple race populations into single race categories.

American Community Survey

The American Community Survey is part of the Census Bureau's re-engineered census process. It is designed to provide communities with a fresh look at how they are changing. The survey collects housing, demographic, social and economic information annually from a representative sample of not only the nation, but also of states and large urban counties.

New York State 2005 population and poverty figures are generated from the Census Bureau's 2005 American Community Survey.

Vital Records

Information on mortality and natality are generated from birth, death and fetal death files managed by the NYSDOH Bureau of Biometrics and Health Statistics (BBHS). These files also include records from New York City, a separate vital registration district.

Mortality rates contained in this report are from the BBHS death files from 1994 to 2004. The cause of death is the underlying cause classified according to the International Classification of Diseases (ICD-9 from 1994 -1998 and ICD-10 from 1999-2004). All mortality rates are age-adjusted using the standard 2000 U.S. population.

Infant mortality rates are presented from 1995 to 2004, and are based on all live births regardless of birth weight or gestation. Rates for a specific year are based on deaths and live births that occurred during that year. Maternal mortality rates, defined as maternal deaths per 100,000 live births, are presented from 1995 to 2004. Rates for a specific year are based on deaths and live births that occurred during that year.

Natality rates are generated from the BBHS birth files from 1995 to 2004. Pregnancy rates also include the 1995-2004 fetal death (spontaneous and induced) files.

To make current year mortality and natality rates comparable with the past, the NCHS has initiated a program of Race Code Bridging. In this method, the new race categories are converted into pre-census 2000 categories (for natality rates 2003 and earlier, and for mortality rates 2002 and earlier).

Mortality and natality graphs contained in this report use the following race/ethnicity groupings: White non-Hispanic, Black non-Hispanic, Asian/Pacific Islander non-Hispanic and Hispanic. Because of the poor data quality and low numbers, the "Other" category is excluded from the analysis.

Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS is an annual statewide telephone survey system designed by the Centers for Disease Control and Prevention (CDC). New York State has participated annually since 1985. BRFSS monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality. The BRFSS sample represents the non-institutionalized adult household population, aged 18 years and older.

BRFSS race and ethnicity information is collected using two questions:

- Are you Hispanic or Latino? (Yes, No, Don't know/Not Sure, Refused); and
- Which one or more of the following would you say is your race? (White, Black or African American, Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native, Other, Don't know/Not sure, Refused).

BRFSS-based graphs contained in this report use the following race/ethnicity groupings: White non-Hispanic; Black non-Hispanic; Asian non-Hispanic and Hispanic. The "Other" category, which includes multiple races, is excluded from the Report because the mix of racial/ethnic groups does not lend itself to interpretation.

BRFSS income information is collected using the following question:

- Is your annual household income from all sources: less than $10,000; $10,000 to less than $15,000; $15,000 to less than $20,000; $20,000 to less than $25,000; $25,000 to less than $35,000; $35,000 to less than $50,000; $50,000 to less than $75,000; $75,000 or more; Don't know/Not sure; and Refused.

BRFSS-based graphs contained in this report use the following income grouping: <$15,000; $15,000 to <$25,000; $25,000 to <$50,000 $50,000 to <$75,000 and $75,000 or more. When graphs present race/ethnicity by income, this report uses the income break of less than $25,000 and $25,000 or more. The groupings were chosen to have a comparison with the low socio-economic population and to ensure sufficient numbers in the race/ethnicity categories for reasonable precision.

New York State Cancer Registry

The Cancer Registry collects, processes and reports cancer statistics on incidence, mortality and stages of diagnoses by site. In addition to collecting information on the anatomic site of the tumor and stage of diagnosis, the registry also collects socio-demographic information, such as age, gender, ethnicity, race and residence for each individual diagnosed with cancer.

This report presents incidence, mortality and stage of diagnosis information from the NYS Cancer Registry. Incidence and mortality rates are age-adjusted using the standard 2000 U.S. population. Five year (1999-2003) incidence and mortality rates for selected sites are presented, with mortality rates also being presented annually from 1994 to 2003. This report also contains early stage diagnoses for the selected cancer sites. Early stage cancers are those which are confined to the organ of origin. These percentages are presented annually from 1994 to 2003.

Cancer Registry-based graphs contained in this report use the following race/ethnicity groupings: White, Black, Asian and Hispanic. Note that as opposed to the other race/ ethnicity groupings utilized in this report, the registry groupings are not mutually exclusive. The White/Black/Asian categories include Hispanics; the Hispanic category includes all races.

Youth Risk Behavior Survey (YRBS)

The YRBS is a survey of public high school students using a methodology and questionnaire designed by the federal Centers for Disease Control and Prevention (CDC). The YRBS collects information on risk factors and behaviors for this adolescent population. The YRBS is a probability sample of schools and students using an anonymous self-administered questionnaire. It is conducted every two years in New York State and is administered by the NYS Department of Education.

YRBS race and ethnicity information is collected using two questions:

- Are you Hispanic or Latino? (Yes, No); and
- What is your race? Select one or more responses (American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White).

YRBS-based graphs contained in the report use the following race/ethnicity groupings: White non-Hispanic, Black non-Hispanic, Asian non-Hispanic, and Hispanic. Because of small numbers, the "Other" category, which includes multiple race, is excluded from the analysis. All YRBS-based prevalence rates are presented with their 95% confidence intervals. (Since the YRBS information is based on a sample, the confidence interval is the range where the true prevalence is likely to fall with a 95% degree of assurance.)

Pediatric Nutrition Surveillance System

The Pediatric Nutrition Surveillance System provides nutrition-related information on low-income infants and children served by the New York State Nutrition Program for Women, Infants and Children (WIC). The Pediatric Nutrition Surveillance System is maintained by the New York State Department of Health's Division of Nutrition.

This Report contains a graph for overweight WIC children aged two to four years from 1995–2004. Overweight is defined as at or above the 95th percentile sex-specified body mass index (BMI) for age based on the 2000 NCHS/CDC growth charts. The race/ethnicity groupings used are: White non-Hispanic, Black non-Hispanic and Hispanic.

Appendix 2 - Glossary / Technical Notes

Age-adjustment – Age-adjustment is a statistical process applied to rates of death, hospitalization, disease or other health outcomes, which allows areas with different age structures to be compared. Age confounding occurs when the two populations being compared have different age distributions, and the risk of the outcome varies across age groups. The process of age adjustment (Direct Method) used for this report changes the amount that each age group contributes to the average rate in each area, so that the overall rates are based on the same age structure. Rates based on the same age distribution can be compared to each other without the presence of confounding by age. Adjustment was accomplished by first multiplying the age-specific rates of death or hospitalization by age-specific weights. The weights used in the age adjustment of asthma data are the proportion of the Standard Population (the U.S. population as enumerated by the Bureau of the Census, 2000) within each age group. The weighted rates are then summed across the age groups to give the age-adjusted rate.

Aggregating BRFSS data – BRFSS charts combine 2003-2005 data to have a sufficient sample to report by race/ethnicity and to improve precision. Sample weights were adjusted using standard procedures for analysis of the combined data.

Confidence Intervals (BRFSS) – Confidence intervals are useful to assess precision of probability surveys according to the sample size of the survey design. A 95% confidence interval refers to the range where the true prevalence is likely to fall with a 95% degree of assurance. Confidence intervals presented in this report were generated using Sudaan 9.0. Sudaan subjects the proportional data to a log transformation in order to approximate a normal distribution. Then the resulting symmetric confidence intervals are transformed back to the numeric scale to facilitate interpretation. One consequence of this transformation is that some intervals around the estimate may be asymmetric.

ICD-9CM – The International Classification of Diseases, 9th revision Clinical Modification.

ICD-10 – The International Classification of Diseases, 10th revision.

Incidence – The number of new cases of the disease or condition within a specified period of time.

Incidence rate – Cases of disease or condition in the given year(s) divided by the population at risk in given year(s).

Mortality – Death due to the disease or condition in question.

Mortality rate – Total number of deaths from the disease or condition in given year(s) divided by the population at risk in given year(s).

Percent Change – By accessing base and current period data, the user is able to determine the percent of change between two periods of time. To calculate a percent change, find the difference between the current year and base year rate (subtract the base rate from the current rate), then divide the difference by the base year and multiply by a standardized multiplier (100 is used as the multiplier to present the change as a percent). The difference between the rates can show an increase (positive number) or decrease (negative number) and depending on the indicator, can depict a negative or positive change.

Prevalence – The number of existing cases with disease or condition in given year(s) divided by the population at risk in given year(s).

Race Code Bridging – The Census 2000 permitted respondents to fill out as many categories of race as they wanted. Prior to that, it was required to fill only one category of race. As a result, the data from 2000 Census are not comparable from any past data on race. To bridge this gap (i.e., to make the 2000 and post 2000 populations by race comparable with the past populations) the National Center for Health Statistics (NCHS) devised a method to redistribute the multiple race populations into single race categories. Some other categories were also collapsed. The bridged estimates are produced by the Census Bureau according to the race algorithm provided by the NCHS. The data set is derived from the Census Bureau estimates available at the time. The dataset is updated annually on the NCHS website (http://wonder.cdc.gov/wonder/help/bridged-race/estimates2000-03.html).

Race Coding – Birth File – Beginning in January 1, 2004, a web-based birth registration system was implemented in New York State, excluding New York City (New York City is its own vital registration district). New York City continues to use an older version of the live birth certificate. One major change associated with adoption of the revised birth certificate is the way the variable race is reported. Prior to 2004, a mother was allowed to select only one race category (1990 Census scheme), even when she identified herself with more than one race due to her multiple race heritage. Beginning in 2004, the Census 2000 coding scheme for race was used for New York State, excluding New York City, recorded births. With the Census 2000 scheme, the mother is allowed to report more than one race from among 15 race categories. For reporting purposes, only respondents selecting a single race are included in tabulations by specific race categories (White alone, Black alone, Asian/PI alone). Respondents selecting more than one race category are reported as "Other" race. Under both data systems, Hispanic origin is a separate tabulation equal to the total of Hispanic White, Hispanic Black, Hispanic Asian and Hispanic Other. The selection of race for statistical reporting of live births is based upon the race of the mother only.

Significance Testing – Confidence intervals are presented at the 95% level. When comparing two rates, if the confidence intervals overlap, the difference is not statistically significant at the 95% level. If they do not overlap the difference is statistically significant.

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