Nevada Department of Health and Human Services

Minority Health in Nevada 2010

Nevada State Health Division

Bureau of Health Statistics, Planning

Epidemiology & Response

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Introduction

This report intends to highlight existing health disparities by race/ethnicity in Nevada, with a focus upon the most current state and national final data available. The race/ethnic groups used in this report are White, Black, American Indian/Alaskan Native (AI/AN), Asian, Native Hawaiian/Pacific Islander (NH/PI), Hispanic, and Other.

Racial and ethnic minorities are disproportionately affected by health problems and disease in Nevada and throughout the nation. Minorities often have higher rates of infectious and chronic diseases due to a variety of reasons and disparities in access to healthcare are many. The most common are listed below.

Low Socio-economic Status:

Low Socio-economic status, which includes income, education, and occupation, may be linked to poorer health outcomes, higher rates of disease, and less availability, accessibility, affordability, and utilization of healthcare. Minorities are more likely to have a lower socio-economic status.

Lack of Access to Care:

- Lack of health insurance, which results in postponed diagnosis and medical care and less chance of using prescription drugs.
- Lack of a primary source of care, which means more emergency room and clinic visits and less preventive care.
- Lack of financial resources to pay for healthcare.
- Legal barriers, such as no Medicaid coverage to immigrants who have been in the country for less than 5 years or who are here illegally.
- Challenges with the built environment, which includes a lack of public transportation as well as the inability to make appointments due to time.
- Few providers in inner city areas with high concentrations of minorities, or rural areas.
- Social barriers due to language differences causing difficulties in scheduling healthcare appointments, preventing communication with the providers and medical staff, and limiting access to health literature which would otherwise inform patients on topics such as good healthcare and prevention strategies.
- Lack of diversity among physicians, who need to understand cultural differences with minorities.

Environment:

Unhealthy living conditions are often faced by minorities. These include crime, crowding, pollution, lead, and toxic waste. These environmental factors lead to higher rates of disease and stress related health problems. Minorities also often have jobs that are physically dangerous and/or involve exposure to chemicals and pesticides. The lack of access to services, including grocery stores, safe housing, and recreational facilities, also contribute to health disparities.

Culture and Tradition:

Language and cultural barriers may lead to low rates of disease diagnosis and medical treatment.
Culture may contribute to unhealthy lifestyles or traditions that can adversely affect health or may inhibit the seeking of care in certain areas such as mental health.

Discrimination & Distrust:

Discrimination and distrust can limit quality and quantity of heathcare, including diagnosis, treatment and preventive care. Stress from discrimination and distrust may cause additional physical and mental health problems. Distrust of physicians may prevent minorities from seeking care or following physician advice or treatment.

Genetics:

Genetics also play an important part in some health differences among minorities. The increased prevalence of high blood pressure in African Americans is thought, but not proven, to be due in part to genetic differences.

Data Sources and Methodologies

American Cancer Society (ACS) – A community based, national voluntary health organization. Utilizes high-quality information and disseminates cancer prevention information and raises awareness via control programs and activities to address the global health problem of cancer. Their data is provided by sources such as the World Health Organization, the U.S. Department of Health and Human Services, American Lung Association, the U.S. Public Health Service, and medical researchers.

Henry J. Kaiser Family Foundation – A private, non-profit foundation and leading communicator of health based information and policy with a focus upon serious healthcare issues in the United States. The Foundation runs and develops its own communications and research programs, at times in partnership with other researchers or companies. Kaiser is a data clearinghouse of health news and information for both their own data and data from the federal government and others, including major media companies.

National Cancer Institute (NCI), Surveillance Epidemiology and End Results (SEER) – Part of the National Institutes of Health, is one of eleven agencies which make up the U.S. Department of Health and Human Services. The Institute is the federal government's primary agency for cancer treatment training and research. The Institute is mandated to collect and disseminate new cancer information and assess the implementation of cutting edge cancer treatments into clinical practice. The Institute operates the National Cancer Program, to support and conduct research, training, and health information dissemination relating to the causes, diagnosis, prevention, treatment and rehabilitation of cancer patients and their families. The Institute supports research conducted by universities, hospitals, research foundations, private companies in the U.S. and globally. SEER is just one of many web based tools used by the National Cancer Institute to disseminate cancer information.

Nevada State Health Division (NSHD), Bureau of Health Statistics, Planning, Epidemiology and Response, HIV/AIDS Reporting System (eHARS) – First deployed by the Centers for Disease Control and Prevention, eHARS is a web browser based application utilized for the collection, storage, and retrieval of HIV/AIDS related data, maintained and monitored by the Nevada State Health Division's HIV/AIDS Surveillance Program. Capabilities include the monitoring of the HIV/AIDS epidemic, current trends in the epidemic, and evaluation of HIV prevention, care, and treatment planning and programs. Through the collaboration of several state and local agencies, the Nevada HIV/AIDS Program monitors the HIV/AIDS epidemic, collects, stores and provides data for prevention and care efforts. Data sources include: Nevada State Health Division, Nevada State Department of Corrections, Carson City Health and Human Services, Washoe County Health District, and Southern Nevada Health District.

Nevada State Health Division (NSHD), Office of Health Statistics and Surveillance (OHSS) – Part of the state's Bureau of Health Statistics, Planning, Epidemiology and Response, the Office serves as a central repository for data and surveillance activities within the Nevada State Health Division. The Office's Population and Vital Statistics Mortality Databases were used in this state based, minority health report.

Susan G. Komen for the Cure – Formerly known as the Susan G. Komen Breast Cancer Foundation, is a widely known and well funded breast cancer charity. The Foundation disseminates information, raises awareness, and supports research and health services for the prevention and elimination of breast cancer worldwide. Data is collected from medical researchers, the federal government, state health departments, and private companies.

United States Census Bureau – Federal government agency responsible for the United States Census; the official decennial (10 year period) count of people living in the United States of America. Collected data is disseminated through web browser based tools like the American Community Survey which provides quick facts on frequently requested data collected from population estimates, census counts and surveys of population and housing for the nation, states, counties, and large cities. The Bureau also offers the American Fact Finder, which profiles the American population and economy every five years.

United States Department of Health and Human Services – Federal government's primary agency for protecting the health of all Americans and for providing essential human services nationwide. Comprised of eleven divisions, eight of which are in the U.S. Public Health Service, providing research, public health, and food and drug safety, among other services. The Department's Medicare program is the nation's greatest source of health insurance. Medicaid and Medicare provide insurance for one out of every four Americans. Department programs offer equitable treatment of beneficiaries nationwide, and they enable the collection of national health and other data. The Department works closely with state and county government agencies and via private sector sub-grantees.

United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC) – Federal agency under the Department of Health and Human Services, whose mission is to protect public health and safety by disseminating information to health policy makers and planners and to promote public health through partnerships with local, state and county health agencies and other organizations. The CDC facilitates focus upon the following areas of public health: infectious diseases, environmental health, occupational safety and health, injury prevention and education, and health promotion. Data is provided by states and local health agencies, and collected and distributed by the CDC through means such as these:

Behavioral Risk Factor Surveillance System (BRFSS) – BRFSS is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and healthcare access primarily related to chronic disease and injury. BRFSS was established in 1984 by the Centers for Disease Control and Prevention (CDC); currently prevalence and trends data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. More than 350,000 adults are interviewed each year, making the BRFSS the largest telephone health survey in the world. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors. States use BRFSS data to identify emerging health problems, establish and track health objectives, and develop and evaluate public health policies and programs. Many states also use BRFSS data to support health-related legislative efforts. The BRFSS survey is operated by the CDC and conducted by the individual state health agencies, including the health departments of The District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. The survey consists of a set of federally grant funded core questions and the states may include and pay for their own questions in the survey. While the survey's focus is chronic disease and injury, topics covered by the survey include car safety, obesity, and exercise among many others. The CDC or individual states can compare states and other jurisdictions, and then focus upon public health interventions where the greatest need is apparent.

National Center for Health Statistics (NCHS), National Vital Statistics System (NVSC) – Organization of the CDC which collects, stores, and provides U.S. public health statistics including diseases, mortality, pregnancies, births, aging, and obesity. Information is disseminated across the World Wide Web and via 'FASTSTATS' and other reports.

Office of Minority Health Disparities (OMHD) – Federal agency taking the lead in accelerating the CDC's health impact upon the American population and to eliminate health disparities for underserved populations as defined by race/ethnicity, socio-economic status, geography, gender, age, risk due to sex and gender, or disability status, and among other populations identified to be at-risk for health disparities.

Healthy People 2020 – A nationwide health promotion and disease prevention plan; developed through a broad consultation process and built upon leading scientific knowledge by the Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. The plan is designed to measure public health and health programs via 190 sources and leading health indicators for major health concerns such as overweight, obesity, tobacco and alcohol use, substance abuse, mental health, immunization, sexual behavior, environmental quality, injury and violence, and access to healthcare nationwide over time. The plan has four primary goals and forty-two focus areas, which strive towards high quality, longer lives free of preventable disease, disability, injury, and premature death. Health equity, the elimination of disparities, and improving the health of all socio-economic and racial/ethnic groups is another goal. The plan also endeavor's to create social and physical environments that promote good health for all. And finally, the plan helps to promote positive quality of life, healthy development, and healthy behaviors across all life stages.

Population

The U.S. Census Bureau estimated Nevada's population to be 2,643,085 in 2009, 1.32 times the reported population of 1,998,257 in the 2000 census. Nevada's population grew 32.3 percent between 2000 and 2009, a rate of over three and a half times the national average of 9.1 percent. Nevada averaged an overall ranking of tenth in the nation in population growth during the entire decade of 2000 to 2009. Nevada ranked first in the nation for population growth for 19 years from 1986 to 2005.

Per the U.S. Census, Nevada ranks nineteenth in the nation in the growth of minority populations between the years 2000 and 2009. The percentage of overall minority population in the state increased by 7.8 percent. Nevada's population is diverse; with a White majority, a significant and rapidly growing Hispanic population, and a variety of other racial and ethnic populations. The U.S. Census Bureau's American Community Survey provides extensive information regarding racial and ethnic demographics and the breakdown of Nevada compared to the United States is listed below.

Table 1. General Population by Race/Ethnicity*, Nevada and US, 2009

	Nevada		United States	
	NV#	%	US#	%
2009 Population Total	2,643,085	100.0%	307,006,550	100.0%
White	1,475,518	55.8%	244,298,393	79.6%
Black	196,682	7.4%	39,641,060	12.9%
American Indian and Alaskan Native	27,617	1.0%	3,151,284	1.0%
Asian	168,728	6.4%	14,013,954	4.6%
Native Hawaiian and Other Pacific Islander	12,356	0.5%	578,353	0.2%
Two or More Races:	61,890	2.3%	5,323,506	1.7%
Hispanic or Latino	700,294	26.5%	48,419,324	15.8%

Source: U.S. Census Bureau, 2009 American Community Survey
*See Appendix A for Definitions

Table 2. Hispanic or Latino Population, Nevada Residents, 2005 and 2009

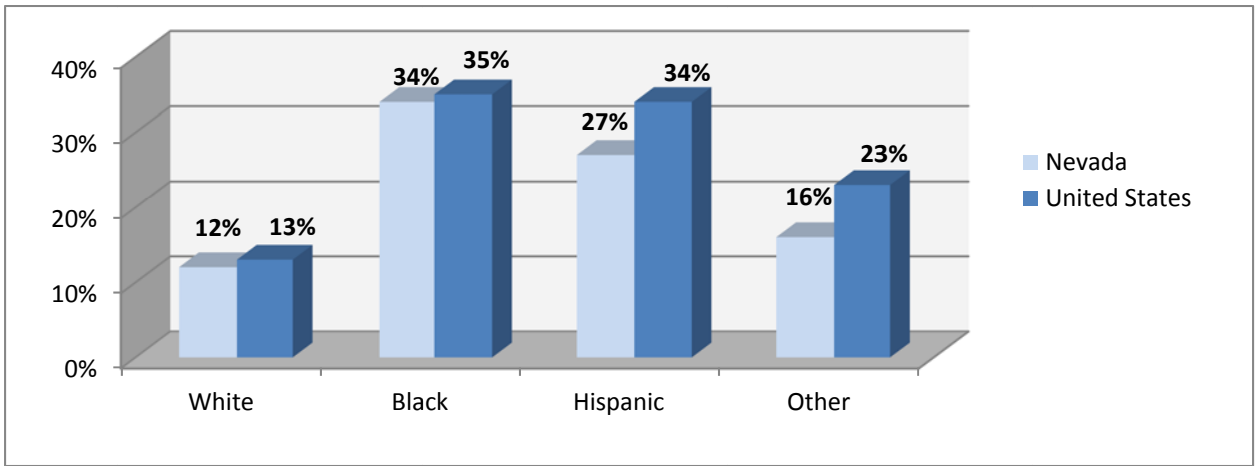
	2005 NV #	2005 NV %	2009 NV #	2009 NV %
Hispanic or Latino	563,999	23.7%	700,294	26.5%
All Others	1,817,282	76.3%	1,942,792	73.5%
Total	2,381,281	100.0%	2,643,085	100.0%

Source: U.S. Census Bureau, 2005 and 2009 American Community Survey

According to the U.S. Census Bureau's American Community Survey, the percentage of Hispanics in the overall population of Nevada grew by 2.8 percent between the years 2005 - 2009. The 2009 Hispanic population in the state was comprised of 548,976 (78.4 percent) Mexican, 16,306 (2.3 percent) Puerto Rican, 21,370 (3.1 percent) Cuban and 113,642 (16.2 percent) Other Hispanic or Latino.

The U.S. Census Bureau reported the estimated percentage of the population in Nevada living at or below poverty in 2009 was 12.4 percent, an increase of 2.5 percent since the year 2000. The poverty rate is determined by household size, family size, and composition. In 2009, the poverty rate for a family of four was $22,050, according to the U.S. Department of Health and Human Services Guidelines. Poverty is directly linked to poor health due to unsanitary and stressful living environments, malnutrition, lack of access to care, less preventive care, and lower rates of health insurance or ability to pay for healthcare. Some minorities have considerably higher rates of poverty than the national average. Below are poverty rates for Nevada Whites, Blacks, Hispanics, and Other.

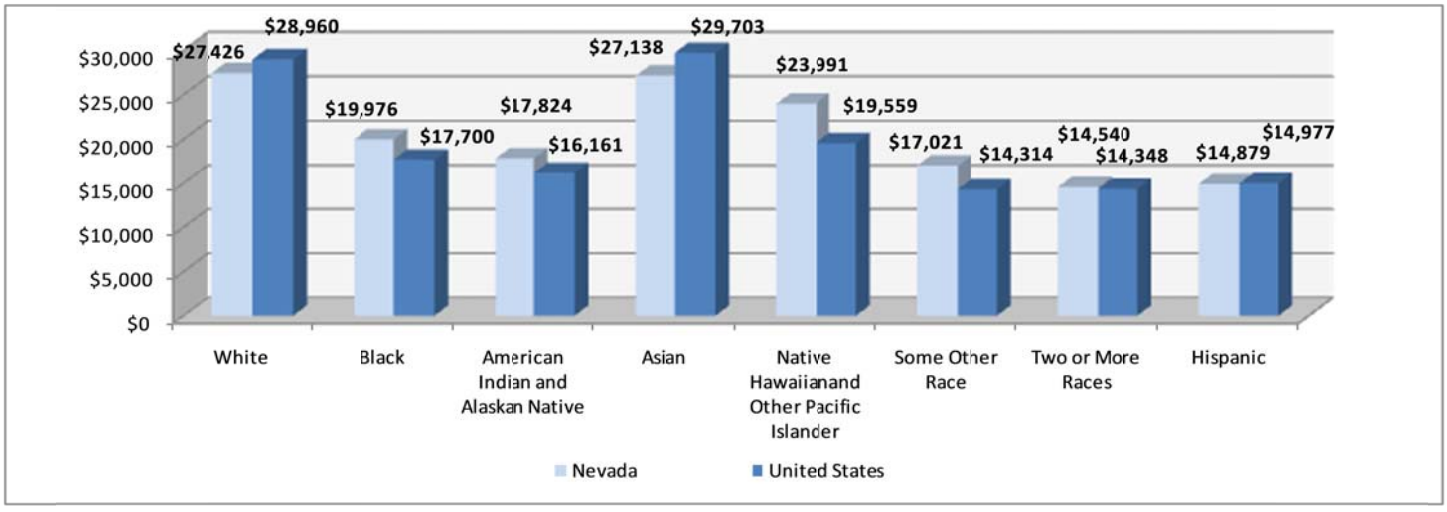
Chart 1. Poverty Percentages by Race/Ethnicity, Nevada and US, 2009



Source: U.S. Census Bureau, 2009 American Community System

The average per capita income in 2009 (in 2009 inflation adjusted dollars) was $25,805 in Nevada and $26,409 in the United States. Median Household Income in 2009 for Nevada was $53,341, slightly higher than the U.S. median of $50,221. The majority of minority income averages throughout Nevada and nationwide are considerably lower than per capita averages and Caucasian incomes.

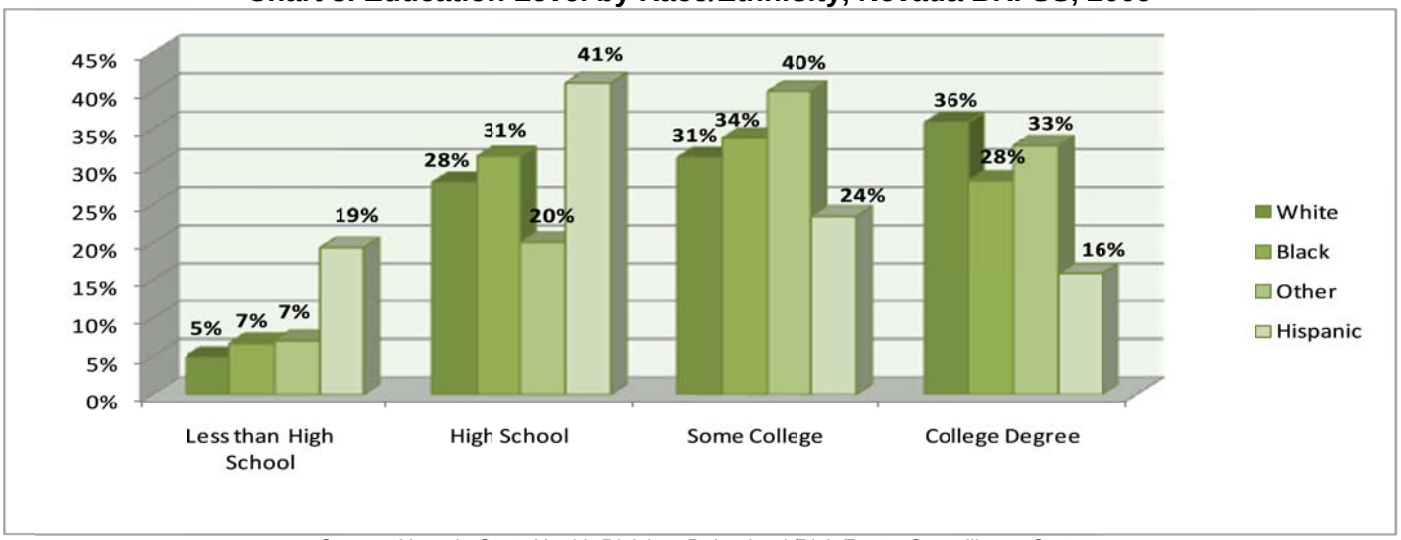
Chart 2. Per Capita Income by Race/Ethnicity, Nevada and US, 2009



Source: U.S. Census Bureau, 2009 American Community System

The Centers for Disease Control and Prevention says people with lower education levels are at greater risk for poor health. Higher education is linked to better health and a longer life span. Chronic disease, infectious disease, and risky behavior is most prevalent in those with less than a high school education, lower in high school graduates, and lowest in those with some college education. Obesity, smoking, cardiovascular disease, stroke, diabetes, sexually transmitted diseases, and tuberculosis are more common in populations with lower education rates. Those with less than a high school education are also less likely to seek preventive care such as immunizations, mammograms, and pap smears than those with a higher education level, and they are also more likely to report poor or fair health.

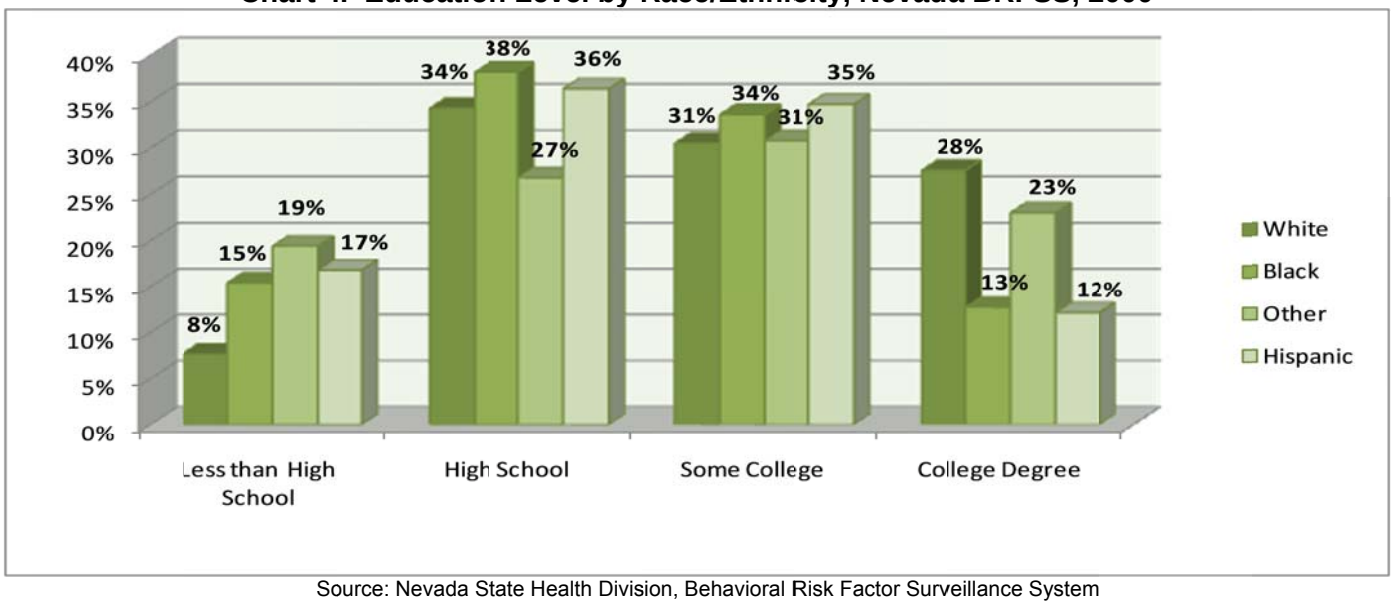
Chart 3. Education Level by Race/Ethnicity, Nevada BRFSS, 2009



Source: Nevada State Health Division, Behavioral Risk Factor Surveillance System

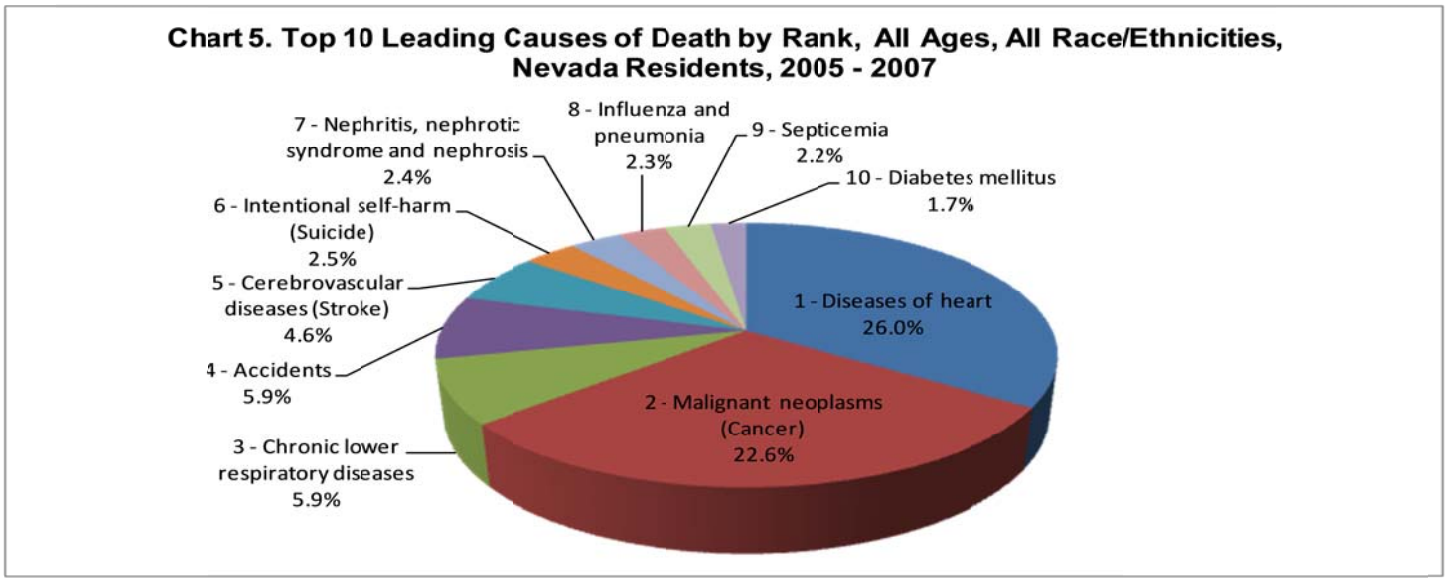
Nevada Hispanics have increased their percentage of high school graduates this decade. Nevada Whites, Blacks, and Other populations however, show increasingly lower percentages of high school graduates. College graduate percentages for Nevada Whites, Blacks and Others are increasing. The percentage of Hispanics with a college education has increased since the year 2000. The U.S. Census Bureau reports education level impacts earning potential across all race/ethnic groups and gender.

Chart 4. Education Level by Race/Ethnicity, Nevada BRFSS, 2000



Source: Nevada State Health Division, Behavioral Risk Factor Surveillance System

The ten leading causes of death accounted for about 76.1 percent of all deaths of Nevadans between 2005 and 2007. Heart disease and malignant neoplasms (cancer) were the top two leading causes of death overall in Nevada. Chronic Lower Respiratory Disease (CLRD), including emphysema, bronchitis and smoking related disorders ranked third, and unintentional injury (motor vehicle accidents, poisonings, falls, etc.) ranked fourth. Cerebrovascular disease (stroke) was reported by the Nevada State Health Division as the closely following fifth leading cause of death.



Source: Nevada State Health Division, Vital Statistics Mortality Data

Unintentional injury (accidents) ranked fourth in Nevada's White population and third or fourth among minority populations. Suicide was a leading cause of death for Whites and all minorities except for Blacks. Liver disease was the fourth leading cause of death for American Indians/Alaskan Natives (AI/AN), and diabetes mellitus was the ninth leading cause of death for Blacks and the tenth leading cause of death for all other minorities during the years 2005 to 2007.

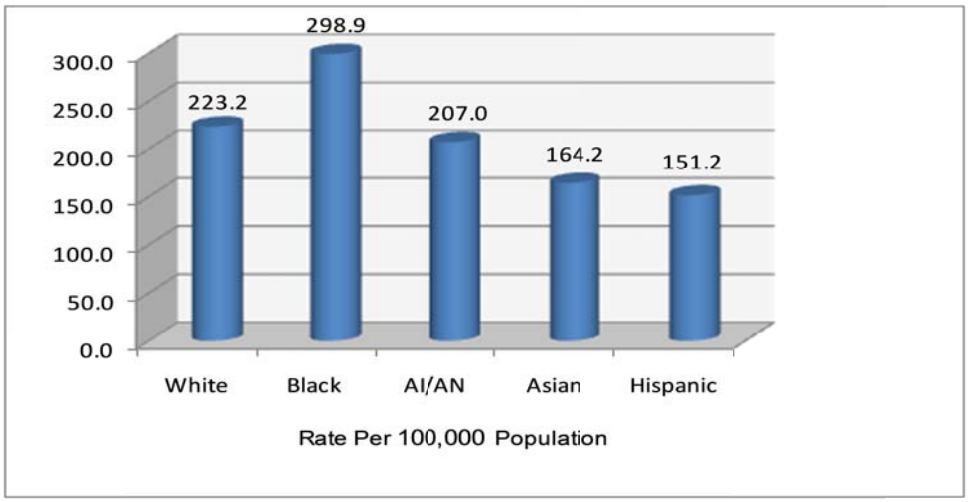
Table 3. Leading Causes of Death by Race/Ethnicity, Nevada Residents, 2005-2007

Race/Ethnicity	1	2	3	4	5	6	7	8	9	10
Whites	Heart Disease	Cancer	Chronic Lower Respiratory Disease	Accidents	Stroke	Suicide	Influenza and Pneumonia	Nephritis	Septicemia	Alzheimer's Disease
Blacks	Heart Disease	Cancer	Accidents	Stroke	Homicide	Nephritis	Septicemia	Chronic Lower Respiratory Disease	Diabetes Mellitus	Influenza and Pneumonia
American Indian/ Alaskan Native	Heart Disease	Cancer	Accidents	Liver Disease	Stroke	Chronic Lower Respiratory Disease	Influenza and Pneumonia	Suicide	Nephritis	Diabetes Mellitus
Asian	Cancer	Heart Disease	Stroke	Accidents	Nephritis	Septicemia	Influenza and Pneumonia	Chronic Lower Respiratory Disease	Suicide	Diabetes Mellitus
Hispanic, All Races	Heart Disease	Cancer	Accidents	Stroke	Homicide	Suicide	Liver Disease	Nephritis	Septicemia	Diabetes Mellitus
Nevada, All Races	Heart Disease	Cancer	Chronic Lower Respiratory Disease	Accidents	Stroke	Suicide	Nephritis	Influenza and Pneumonia	Septicemia	Diabetes Mellitus

Source: Nevada State Health Division, Vital Statistics Mortality Data

Cardiovascular disease (CVD), primarily heart disease and stroke (cerebrovascular disease), causes more deaths across gender, race, and ethnicity than any other disease. The Centers for Disease Control and Prevention reports CVD also leads in disability rates and costs an estimated $503 billion in 2010, an increase of over $203 billion dollars since 2007, for healthcare expenditures, medications, and lost productivity due to disability and death. Minorities have disproportionately high rates of death and disability from CVD. Per the American Heart Association, Blacks are more likely to have high blood pressure, a symptom of CVD, and to develop it at a younger age than other populations. Socioeconomic status, reflected in income and education, contributes to a substantial portion, but not all, of the higher rate of heart disease in minority populations.

Chart 6. Age-Adjusted Heart Disease Mortality Rates by Race/Ethnicity, Nevada Residents, 2005-2007



Source: Nevada State Health Division, Vital Statistics Mortality Data

Between 2005-2007, Blacks had the highest age-adjusted rate of heart disease mortality in Nevada at 298.9 deaths per 100,000. Blacks also had the highest rate of deaths due to stroke, at 61.0 deaths per 100,000, as compared to the White rate of 39.0 deaths per 100,000. Approximately 137,000 Americans die of stroke every year. In 2007, the Nevada Behavioral Risk Factor Surveillance Survey (BRFSS) reported Blacks are more likely to be told they have been diagnosed with high blood pressure compared to Whites (35 percent versus 27 percent). In Nevada, stroke ranked as the fourth leading cause of death for Blacks and Hispanics, third for Asian/Pacific Islanders, and fifth for Whites and American Indians/Alaskan Natives. Heart Disease is the leading cause of death for all racial ethnic groups except Asians, where it ranks second in Nevada for the combined years 2005-2007.

Table 4. Number and Percentage of Deaths from Heart Disease by Race/Ethnicity, Nevada Residents, 2005–2007 and US, 2005 – 2006

	NV 2005 - 2007	NV %	US 2005 - 2006*	US %
White	12,087	26.3%	1,110,770	26.6%
Black	1,111	28.2%	146,412	25.1%
AI/AN	146	30.7%	5,395	19.3%
Asian	445	24.1%	21,150	24.1%
Hispanic, All Races	683	19.5%	58,476	22.1%

Note: * Final US 2007 mortality data was unavailable.

Table 5. Number and Percentage of Deaths from Stroke by Race/Ethnicity, Nevada Residents, 2005-2007 and US, 2005-2006

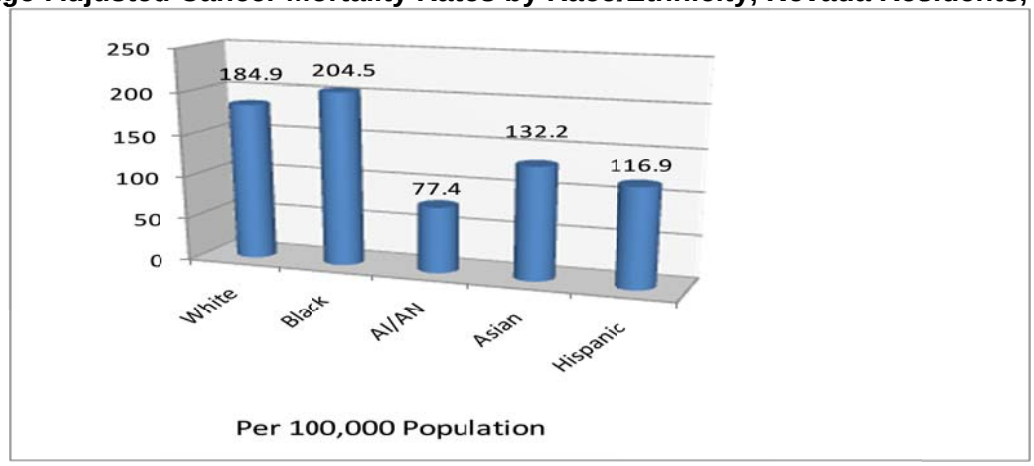
	NV 2005 - 2007	NV %	US 2005 - 2006*	US %
White	2,004	4.4%	195,466	4.7%
Black	212	5.4%	34,586	5.9%
AI/AN	15	3.2%	1,175	4.2%
Asian	158	8.6%	7,205	8.2%
Hispanic, All Races	192	5.5%	13,835	5.2%

Note: * Final US 2007 mortality data was unavailable.

Sources: Nevada State Health Division, Vital Statistics Mortality Data & CDC/NCHS National Vital Statistics System

Cancer is the second leading cause of death in the United States and Nevada, causing more than an estimated 562,875 deaths in 2007 nationwide. The National Cancer Institute reports, based on rates from 2005-2007, 40.8 percent of men and women born today will be diagnosed with cancer at some time during their lifetime. Nationally, Blacks have higher rates of cancer and are less likely to survive cancer than the general population.

Chart 7. Age-Adjusted Cancer Mortality Rates by Race/Ethnicity, Nevada Residents, 2005-2007



Source: Nevada State Health Division, Vital Statistics Mortality Data

Cancer deaths in Nevada have decreased across all races, with the greatest decreases occurring among Black men (336.0 per 100,000 in 1990 to 318.0 per 100,000 in 2000 to 179.2 per 100,000 in 2007). This decade, Blacks had the highest death rate from cancer in both the United States and the state. For the years 2005–2007, Nevada Blacks had a cancer rate of 204.5 per 100,000.

Table 6. Percentage and Rank of Deaths from Cancer by Race/Ethnicity, Nevada Residents, 2005-2007 and US, 2005-2006

	NV 2005-2007	Mortality Rank	US 2005-2006*	Mortality Rank
White	23.6%	2	23.2%	2
Black	19.9%	2	21.7%	2
AI/AN	11.3%	2	17.6%	2
Asian	26.0%	1	26.6%	1
Hispanic	17.9%	2	20.0%	2

Note: * Final US 2007 mortality data was unavailable.

Source: Nevada State Health Division, Vital Statistics Mortality Data & CDC/NCHS National Vital Statistics System

American Indian/Alaskan Natives had the lowest percentage of cancer deaths in Nevada at 11.3 percent. Nevada Asians had the highest percentage of cancer mortality at 26.0 percent.

In the United States, Black women continue to have the highest rates of mortality from breast and cervical cancer, though deaths in all race/ethnic groups have decreased. Black men also have more cancers of the lung, prostate, colon, and rectum than do White or Hispanic men. This disparity is also reflected for Nevada minorities. In 2008, the Centers for Disease Control and Prevention (CDC) reported, Vietnamese American women had a higher cervical cancer incidence rate than any ethnic group in the United States - five times that of non-Hispanic White women. The CDC and the American Cancer Society estimates have been combined to demonstrate the possible mortality impact of cancer during 2009 in Table 7.

Table 7. Estimated Cancer Deaths, All Race/Ethnicities, NV and US, 2009

Cause of Death	NV 2009	NV %	US 2009	US %
All Cancers	4,600	100.0%	562,340	100.0%
Breast (female)	330	7.2%	40,170	7.1%
Colorectal	500	10.9%	49,920	8.9%
Lung & Bronchus	1,340	29.1%	159,390	28.3%
Prostate (male)	230	5.0%	27,360	4.9%

Sources: American Cancer Society (Nevada), CDC/NCHS National Vital Statistics System (US)

Site Specific Cancers

Breast Cancer: Between 2003 and 2007, White females had a significantly higher incidence rate of breast cancer, with a rate of 126.5 per 100,000 population, than Black females with a rate of 118.3, Asian females with a rate of 90.0 and Hispanic and American Indian females with rates of 86.0 and 76.4 respectively in the United States.

Nationally, in 2010, Asian and White females had the highest five-year survival rates (91.0), followed by Hispanics and Pacific Islanders (86.0), and American Indian/Alaskan Native women (84.0) and then Black females (79.0) per 100,000 population.

According to the Nevada Cancer Institute, race is a known factor which increases a woman's chances of having breast cancer for Whites and Blacks. Rates of developing and dying of breast cancer do differ among ethnic groups, which may be due to breast cancer screening and treatment rates, specific risk factors, or the biology of breast cancer. Costs of health insurance, access to screening facilities, and lack of awareness about screening tests are likely contributing factors to rate differences between racial and ethnic groups.

Prostate Cancer: The Nevada Cancer Institute reports almost 2,000 men will be diagnosed with prostate cancer and more than 200 will die from the disease. The National Cancer Institute reports, from 2003-2007, the median age at diagnosis of prostate cancer was 67 years of age and the median age at time of death due to prostate cancer was 80 years nationally. Black males had the lowest median age at time of diagnosis of prostate cancer (65 years) and the largest difference (11 years) between the median age at diagnosis and median age at time of death (77 years) during this period. American Indian males had the highest median age at diagnosis of prostate cancer (70 years). In the United States, Blacks and Whites had the highest age-adjusted incidence for prostate cancer with rates of 234.6 and 150.4 per 100,000, respectively, while Hispanics, Asians, and American Indian/Alaskan Natives, followed with rates of 125.8, 90.0, and 77.7 per 100,000 population.

Unintentional injury includes motor vehicle accidents, poisoning, falls, drowning, fires, other vehicle accidents, environmental accidents, pedestrian accidents, firearms, and cuts or piercing. Unintentional injury is the third leading cause of death for the American Indian/Alaskan Native and Hispanic populations in Nevada and nationwide. Unintentional injury is the third leading cause of death in Nevada and the fourth leading cause of death nationally for Blacks. It is the fourth leading cause of death both in Nevada and the United States for Asian populations. Comparatively, unintentional injury is the fourth leading cause of death for Whites in Nevada and the fifth leading cause of death for Whites nationwide.

Table 8. Percentage and Rank of Deaths from Unintentional Injury by Race/Ethnicity, Nevada Residents, 2005-2007 and US, 2005-2006

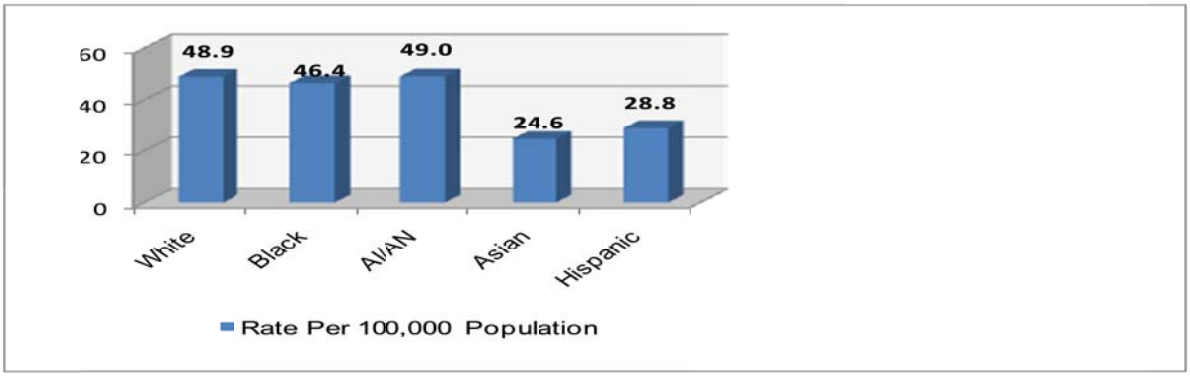
	NV 2005-2007	Mortality Rank	US 2005-2006*	Mortality Rank
White	5.4%	4	4.9%	5
Black	6.0%	3	4.7%	4
AI/AN	10.6%	3	11.9%	3
Asian	5.8%	4	4.8%	4
Hispanic	11.8%	3	8.9%	3

Note: * Final US 2007 mortality data was unavailable.

Sources: Nevada State Health Division, Vital Statistics Mortality Data & CDC/NCHS National Vital Statistics System

The mortality rate for unintentional injury in 2005-2007 is highest for the American Indian/Alaskan Native population as compared to other minorities in Nevada at a rate of 49.0. Nationwide in 2006 the rate was 54.2 per 100,000 population according to the Centers for Disease Control and Prevention (CDC). The Nevada Office of Health Statistic's and Surveillance's, Healthy People 2010 Report for Nevada documents in 2006, 24.6 percent of the unintentional injury deaths reported for Nevadan American Indian/Alaskan Natives were due to motor vehicle accidents and 22.1 percent were from poisoning. Race/ethnic groups at the highest risk for injury from falls include American Indians/Alaskan Natives and Whites.

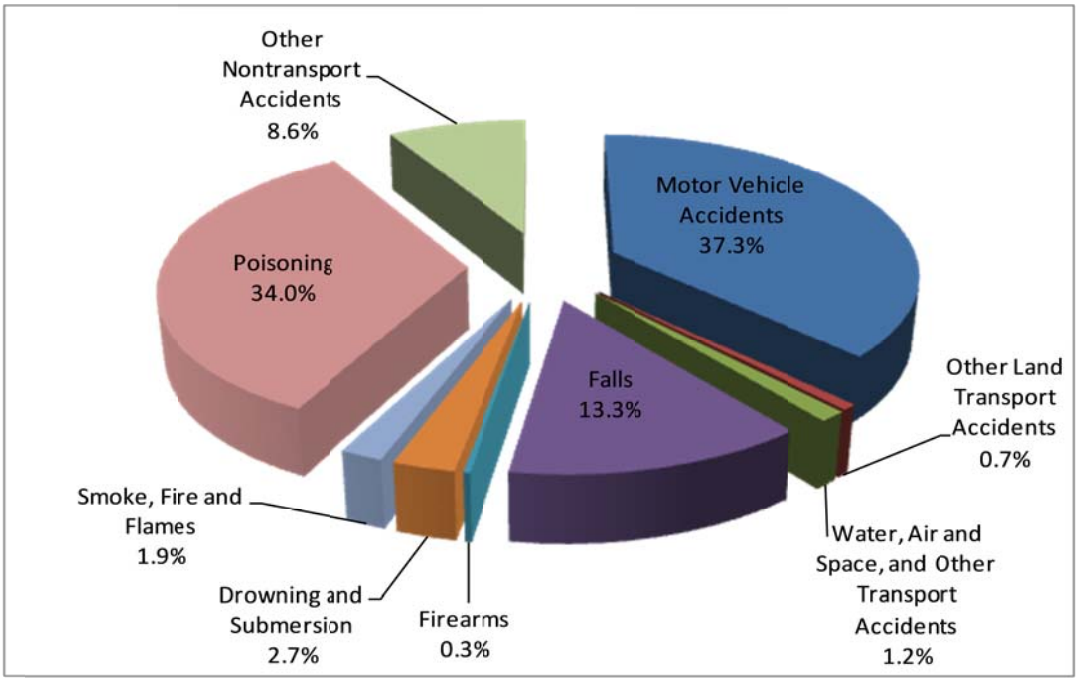
Chart 8. Age-Adjusted Unintentional Injury Mortality Rates by Race/Ethnicity, Nevada Residents, 2005-2007



Source: Nevada State Health Division, Vital Statistics Mortality Data

Nevada has multiple risk factors which may contribute to high rates of unintentional injury. Nevada's population has high rates of alcohol use, firearm ownership, poor mental health, and drug use. In 2006, Nevada's injury mortality rate ranked fifteenth in the United States. Unintentional injury is the leading cause of death among Nevada Whites and Hispanics between the ages of 1 and 44. Blacks are most likely to die from unintentional injury as children, but then homicide leads as the top cause of death for ages 15-34.

Chart 9. Percentages of Deaths from Unintentional Injuries by Type, Nevada Residents, 2005-2007



Source: Nevada State Health Division, Vital Statistics Mortality Data

During 2000 - 2006, the University of Nevada Las Vegas stated in their 'Injury in Nevada' report, Hispanic males were at the highest risk of mortality from occupational injury in Nevada, around 30 percent greater than Whites. Whites, the largest race/ethnic population in Nevada, suffered more accidental deaths overall than any other racial group during the years 2005-2007 with 2,468, followed by Hispanics (406), Blacks (233), Asians (106), and American Indians/Alaskan Natives (50).

Table 9. Mortality Counts for Unintentional Injury by Race/Ethnicity and Type, Nevada Residents, 2005-2007

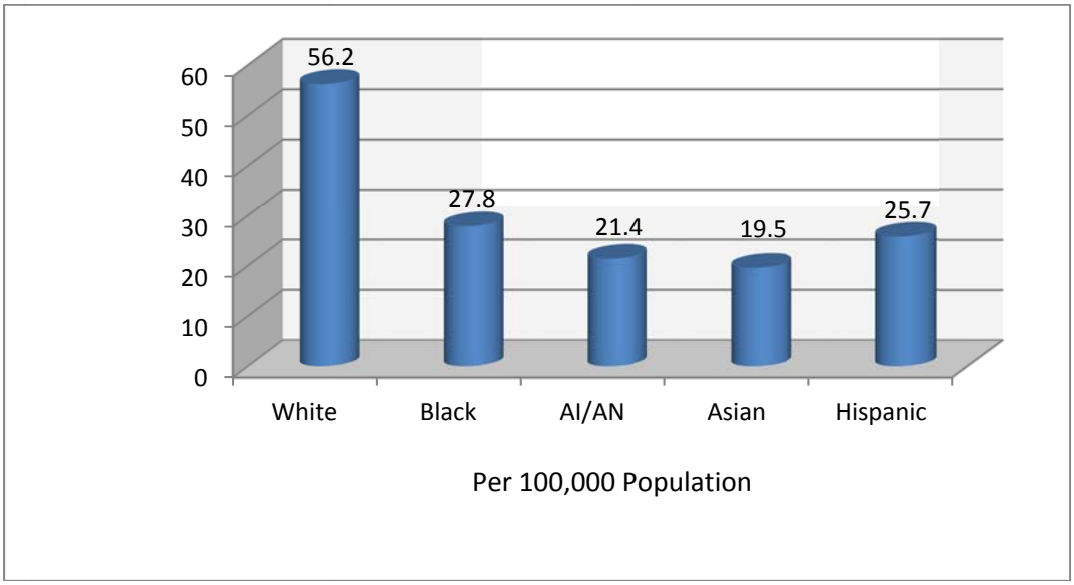
	Motor Vehicle Accidents	Other Land Transport Accidents	Water, Air and Space, and Other Transport Accidents	Falls	Firearms	Drowning and Submersion	Smoke, Fire and Flames	Poisoning	Other Nontransport Accidents	Total
White	825	14	36	359	5	54	45	927	203	2,468
Black	75	≤5	≤5	18	≤5	7	8	92	24	233
AI/AN	27	0	0	6	0	≤5	≤5	11	≤5	50
Asian	62	0	0	17	0	6	3	8	10	106
Hispanic	229	7	0	37	≤5	20	5	70	37	406
Other	8	0	0	≤5	0	≤5	0	9	≤5	23
Total	1,226	22	40	438	10	90	62	1,117	281	3,286

Source: Nevada State Health Division, Vital Statistics Mortality Data

Note: ≤5 means Less than or equal to 5. Counts above 0 and less than 5 are not reported to protect privacy.

Chronic Lower Respiratory Disease (CLRD) is the third leading cause of death in Nevada and the fourth leading cause of death nationally. Previously called Chronic Obstructive Pulmonary Disease (COPD), CLRD is a chronic lung disease where breathing is slowed or forced and can include chronic bronchitis, emphysema, and asthma. CLRD is usually linked to smoking and may also be caused by second-hand smoke. In 2009, the Nevada State Health Division's, Office of Health Statistics and Surveillance, Healthy People 2020 Report documents a higher than average prevalence of smoking in Nevada, at 22.0 percent, according to Behavioral Risk Factor Surveillance data. The U.S. smoking prevalence was reported at 17.9 percent in 2009. Smoking results in higher rates of CLRD compared to national averages. In 2006, the age-adjusted mortality rate for CLRD was 48.2 per 100,000 in Nevada compared to the national rate of 41.6.

Chart 10. Age-Adjusted Chronic Lower Respiratory Disease Mortality Rates by Race/Ethnicity, Nevada Residents, 2009

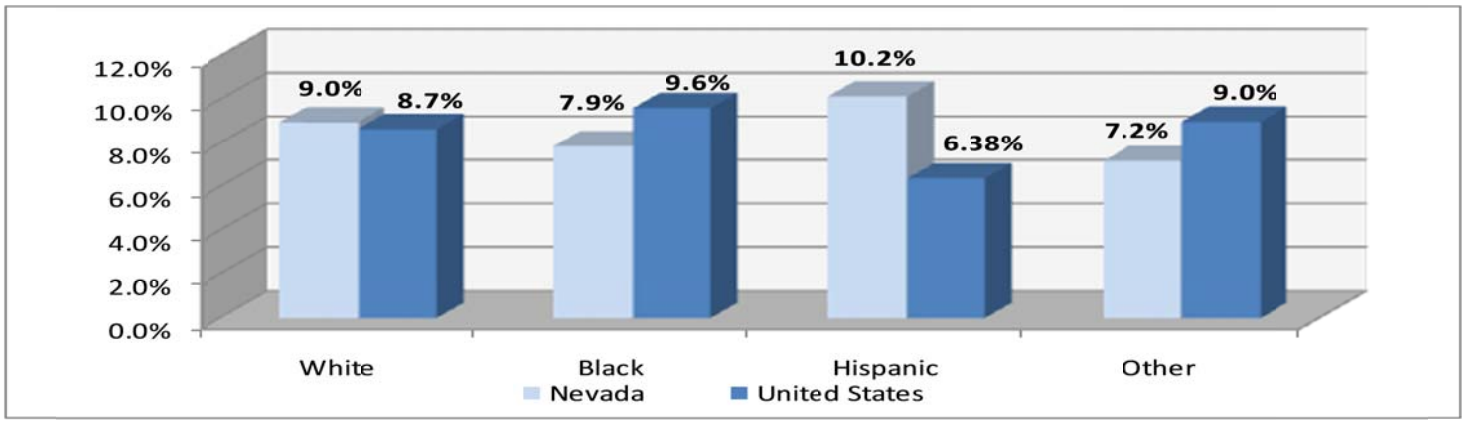


Source: Nevada State Health Division, Vital Statistics Mortality Data

Whites in Nevada have the highest rate of mortality from CLRD at 56.2 per 100,000 population, followed by Blacks, Hispanics, American Indian/Alaskan Natives, and Asians, who had the lowest rate of mortality from CLRD in 2009 at 19.5 per 100,000 population. CLRD was the third leading cause of death for Whites in Nevada, the sixth leading cause of death for American Indian/Alaskan Natives, the eighth leading cause of death for Blacks and Asians, and the eleventh leading cause of death for Hispanics in Nevada during the combined reported years of 2005-2007.

People with asthma, a contributing factor of CLRD, have swelling and inflammation of air passages in the lungs. When an irritant such as dust or pollen is present, there is a potential for bronchial tube spasm and possible asthma attack. The CDC's National Center for Chronic Disease Prevention and Health Promotion reports minorities, low income populations, and inner city children are more likely to experience more emergency department visits, hospitalizations, and deaths due to asthma than the general population. This is due to a variety of reasons and disparities in access to healthcare. Lack of medical care may also result in a failure to diagnose asthma and control it, and more crowded living conditions may result in a greater exposure to allergens.

Chart 11. Adults Who Have Been Told They Have Asthma by Race/Ethnicity, Nevada and US, BRFSS, 2009



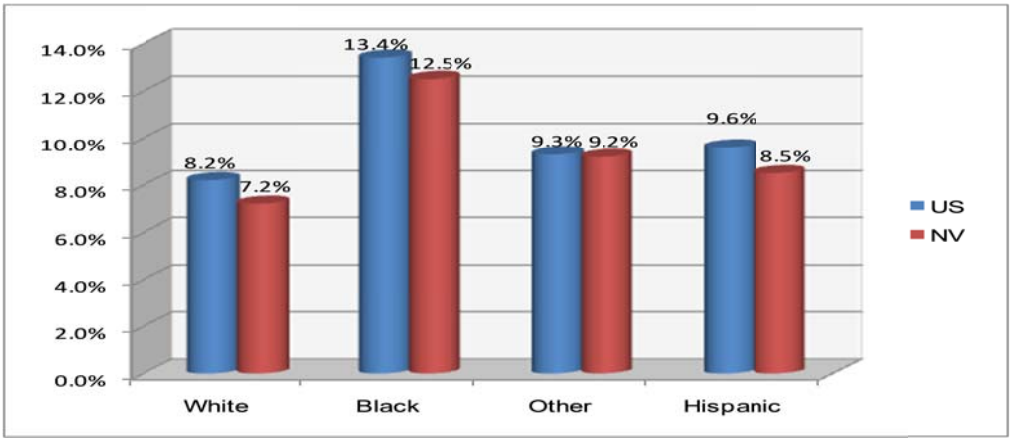
Source: Nevada State Health Division, Behavioral Risk Factor Surveillance System

Blacks have higher asthma rates than any other racial/ethnic group nationwide at 9.6 percent. Nevada Whites have a slightly higher prevalence of asthma at 9.0 percent than Whites nationally at 8.7 percent. Nevada Blacks have a lower prevalence of 7.9 percent vs. 9.6 percent nationally. Hispanics have the highest prevalence of asthma in Nevada at 10.2 percent, much higher than the national asthma prevalence for Hispanics of 6.3 percent. Nevada's Other racial group had the lowest prevalence for the state at 7.2 percent and an asthma prevalence of 9.0 percent nationally.

The American Journal of Respiratory and Critical Care Medicine suggests, the disturbingly higher prevalence of asthma among Black children in the United States is not attributable to race, but to living in an urban environment. All children living in an urban setting, regardless of race or income, are at increased risk of asthma. This is consistent with other findings which indicate that asthma should not be thought of as an irremediable genetic problem of some population subgroups, but rather as a consequence of exposure to a modern urban environment. This would imply that while nationally, black children have more asthma, this is because they are more likely to live in urban, poor neighborhoods. Thus, investigating specific urban environmental factors that contribute to asthma should lead to insights that will help to correct persisting racial disparities in asthma, and reduce the prevalence and severity of this illness for all children.

Diabetes is defined as a group of diseases described by high levels of blood glucose resulting from defects in insulin secretion, insulin action, or both. In 2006, diabetes was the sixth leading cause of death nationwide. According to the Centers for Disease Control and Prevention's 2007 National Diabetes Fact Sheet, more than 23.6 million or 7.8 percent of Americans had diabetes, of which 5.7 million people were undiagnosed. Blacks and Hispanics are twice more likely to have type 2 diabetes than Whites of similar age. Type 2 diabetes is defined as diabetes mellitus type 2 or type 2 diabetes (formerly called non-insulin-dependent diabetes mellitus (NIDDM), or adult-onset diabetes) is a disorder that is characterized by high blood glucose in the context of insulin resistance and relative insulin deficiency. American Indians and Alaskan Natives are more than two and a half times as likely to have type 2 diabetes as Whites. Premature death can result from diabetes. But lifestyle changes, glucose monitoring, and medication may control rates of disability and death.

Chart 12. Percent of Population with Diabetes by Race/Ethnicity, Nevada and US, BRFSS, 2009



Source: Nevada State Health Division, Behavioral Risk Factor Surveillance System

Since the 1960s, diabetes has disproportionately affected American Indians/Alaskan Natives in comparison with other ethnic/racial populations. In Nevada, diabetes was the tenth leading cause of death in the Asian, Hispanic, and American Indian populations and the ninth leading cause of death in the Black population. Diabetes was the eleventh leading cause of death in the White population in Nevada during the years 2005-2007.

Table 10. Percentage and Rank of Deaths from Diabetes by Race/Ethnicity, Nevada Residents, 2005–2007 and US, 2005-2006

	NV 2005-2007	Mortality Rank	US 2005-2006*	Mortality Rank
White	1.6%	11	2.8%	7
Black	2.2%	9	4.4%	5
AI/AN	2.3%	10	5.8%	4
Asian	1.7%	10	3.6%	5
Hispanic	2.4%	10	4.9%	5

Note: * Final US 2007 mortality data was unavailable.

Source: Nevada State Health Division, Vital Statistics Mortality Data & CDC/NCHS National Vital Statistics System

High rates of obesity and the introduction of the western diet are believed to contribute to the disproportionate number of (Hispanic 2.4 percent, American Indian/Alaskan Native 2.3 percent, and Black 2.2 percent) diabetes deaths in Nevada. This also applies to the high national percentages in these three minority populations.

Nationally, in 2006, Blacks and American Indian/Alaskan Natives had a higher age-adjusted mortality rate from diabetes at 33.6 and 25.3 per 100,000 population compared to a mortality rate of 25.4 for Whites, 14.2 for Hispanics, and 11.1 per 100,000 population for Asians.

Both racial/ethnic minorities and Whites are less likely to die from diabetes in Nevada than the same populations nationwide. This may be due to under reporting.

Blacks, Hispanic/Latino Americans, American Indians/Alaskan Natives, and some Asian Americans and Pacific Islanders are at particularly high risk for developing type 2 diabetes. Diabetes is largely under reported in Nevada as a contributing factor in death.

Table 11. Age-Adjusted Diabetes Mortality by Gender and Race/Ethnicity, Nevada Residents, 2005, 2006, and 2007

	2005		2006		2007	
	Age Adj. Rate	Number of Deaths	Age Adj. Rate	Number of Deaths	Age Adj. Rate	Number of Deaths
Male	72.6	758	63.5	688	50.2	585
Female	40.8	485	34.7	433	31.1	401
White	54.4	981	46.5	875	38.9	767
Black	93.2	116	72.9	100	77.1	99
AI/AN	76.0	16	68.9	18	23.1	6
Asian	43.6	46	41.7	44	35.4	42
Hispanic	47.0	82	54.4	83	40.9	68

Source: Nevada State Health Division, Office of Health Statistics and Surveillance, Healthy People 2020 Rpt., Diabetes Focus Area

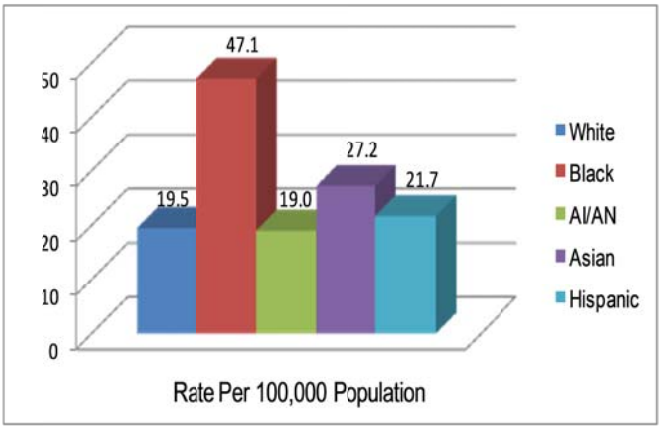
Nephritis, or inflammation of the kidney, was the ninth leading cause of death nationwide in 2006. Nephritis was the seventh leading cause of death for Nevadans during 2005-2007. Blacks, Asians, and Hispanics in Nevada had higher mortality rates than Whites for nephritis in Nevada during 2005-2007, with Native American Indian/Alaskan Natives (AI/AN) having the lowest age-adjusted death rate of 19.0 per 100,000 population, compared to Whites at 19.5 per 100,000 population. Blacks have the highest percentage of deaths due to Nephritis at 47.1 per 100,000 population.

Table 12. Percentage and Rank of Nephritis Mortality by Race/Ethnicity, Nevada Residents, 2005-2007

	Nephritis	Mortality Rank
White	2.3%	8
Black	3.9%	6
AI/AN	2.5%	9
Asian	3.8%	5
Hispanic	2.5%	8

Source: Nevada State Health Division, Vital Statistics Mortality Data

Chart 13. Age-Adjusted Nephritis Mortality Rates by Race/Ethnicity, Nevada Residents, 2005-2007



Source: Nevada State Health Division, Vital Statistics Mortality Data

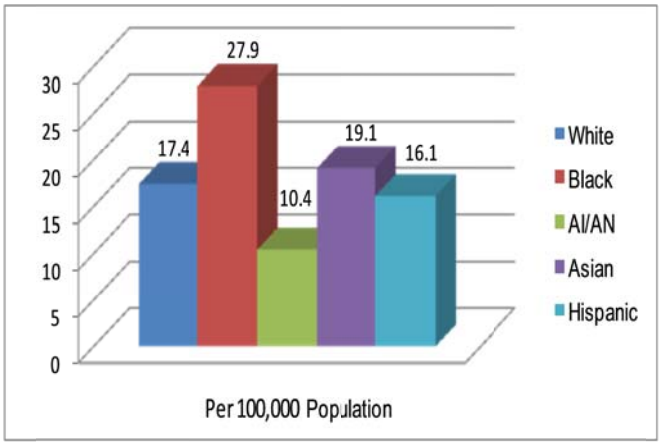
Septicemia, blood poisoning or infection in the bloodstream, was the tenth leading cause of death nationwide in 2006. Septicemia was the ninth leading cause of death for Nevadans during 2005-2007. The age-adjusted mortality rate for Septicemia was highest for African Americans in Nevada at 27.9 per 100,000 population, whereas Native American Indian/Alaskan Natives (AI/AN) had the lowest rate at 10.4 per 100,000 population in 2005-2007.

Table 13. Percentage and Rank of Septicemia Mortality by Race/Ethnicity, Nevada Residents, 2005-2007

	Septicemia	Mortality Rank
White	2.1%	9
Black	2.7%	7
AI/AN	1.5%	12
Asian	3.2%	6
Hispanic	2.4%	9

Source: Nevada State Health Division, Vital Statistics Mortality Data

Chart 14. Age-Adjusted Septicemia Mortality Rates by Race/Ethnicity, Nevada Residents, 2005-2007



Source: Nevada State Health Division, Vital Statistics Mortality Data

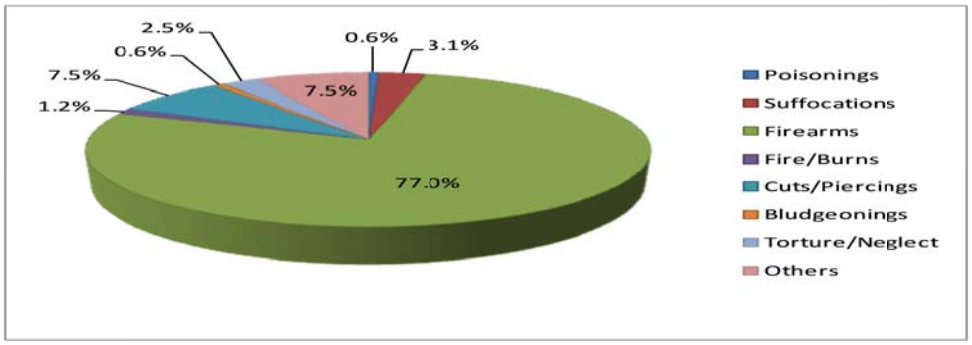
The National Center for Injury Prevention and Control provides information and ranking information regarding the causes of death and other related data and statistics.

Homicide ranked as the thirteenth leading cause of death in Nevada between the years 2005-2007. A large portion of the deaths due to homicide in Nevada and nationwide disproportionately affect minority populations. Of the 176 deaths from homicide in the 15-24 age group between the years 2005-2007 in Nevada, 26.1 percent were Hispanic and 26.6 percent were Black. Homicide was the leading cause of death for Blacks and the second leading cause of death for Hispanics between the ages of 15-24. Homicide is the fifth leading cause of death in the Black and Hispanic populations of all ages in Nevada. The higher rates of homicide among minority populations may cause lower rates or lower mortality ranking of other diseases. It is suspected, a portion of the population will die from homicide before another disease that takes time to progress such as HIV/AIDS, heart disease, or cancer.

In Nevada, between the years 2005-2007, the age-adjusted death rate for homicides and legal intervention was 27.9 per 100,000 population for Blacks, compared to 7.2 per 100,000 for Hispanics, 6.9 per 100,000 population for Native Americans, 5.5 per 100,000 population for Whites, and 2.1 per 100,000 population for Asians.

Firearms, the leading homicide mechanism among Nevada Blacks, accounted for 77.0% or over 3 out of 4 of all homicides for Nevada Blacks during the years 2005-2007.

Chart 15. Percentages of Homicide Deaths by Mechanism, Blacks, Nevada Residents, 2005-2007



Source: Nevada State Health Division, Vital Statistics Mortality Data

Between 2005 and 2007, Nevada had 606 deaths attributed to homicide; there were 1,401 suicides during this period. More people died from suicide than homicide in Nevada. Nevada saw 1,226 deaths due to motor vehicle accidents in 2005-2007. Nevada is one of the few states where more people die from suicide than car accidents. In 2006, Nevada ranked fourth highest in the nation, with a rate of 18.4 deaths per 100,000 population for suicides, after leading the nation for many years until 2003. This is approaching double the 2006 national rate for suicide of 11.1 per 100,000 people. Suicide was the sixth leading cause of death in the overall population in Nevada between the years 2005 and 2007.

Table 14. Percentage and Rank of Homicide Mortality by Race/Ethnicity, Nevada Residents, 2005-2007 and US, 2005-2006

	NV 2005-2007	Mortality Rank	US 2005-2006*	Mortality Rank
White	0.6%	15	N/A	N/A
Black	4.1%	5	3.1%	6
AI/AN	1.7%	11	1.8%	11
Asian	0.6%	13	1.0%	14
Hispanic	4.5%	5	2.7%	7

Note: * Final US 2007 mortality data was unavailable. N/A – Rank did not make the top 15 national causes of death

Source: Nevada State Health Division, Vital Statistics Mortality Data

Whites had the highest rate of suicide at 22.1 per 100,000 population in Nevada during 2005-2007, followed by American Indians at 10.8 per 100,000 population, Blacks at 10.3 per 100,000, Hispanics at 8.6 per 100,000, and Asians at 8.1 per 100,000 population from suicide.

Table 15. Percentage and Rank of Suicide Mortality by Race/Ethnicity, Nevada Residents, 2005–2007 and US, 2005-2006

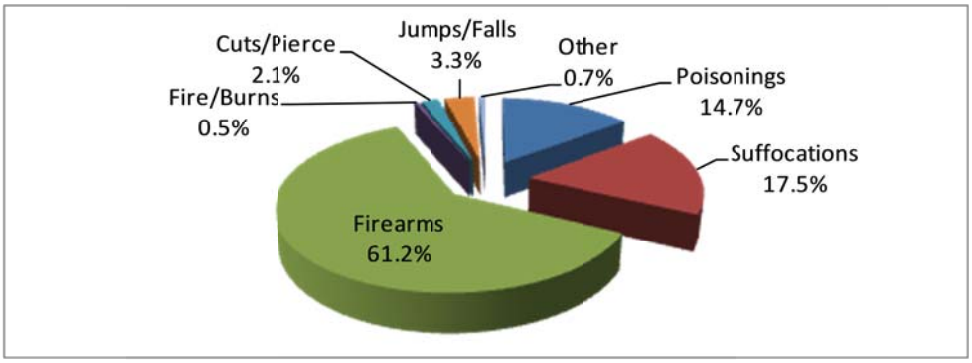
	NV 2005-2007	Mortality Rank	US 2005-2006*	Mortality Rank
White	2.5%	6	1.5%	10
Black	1.4%	11	NA	NA
AI/AN	2.5%	8	2.8%	8
Asian	2.2%	9	1.8%	9
Hispanic	3.6%	6	1.7%	13

Note: * Final US 2007 mortality data was unavailable.

Source: Nevada State Health Division, Vital Statistics Mortality Data & CDC/NCHS National Vital Statistics System

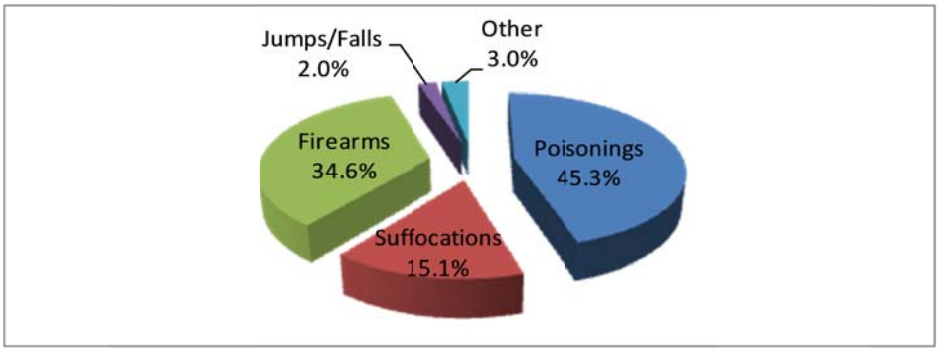
In Nevada during 2005 to 2007, suicide was the sixth leading cause of death for Whites and Hispanics, the eighth leading cause of death for American Indian/Alaska Natives, the ninth leading cause of death for Asian/Pacific Islanders, and the eleventh leading cause of death for Blacks. Between 2005 and 2007, 78.7 percent of suicides occurred among males in Nevada, of which 61.2 percent were facilitated by firearms. Experts commonly assert that high rates of divorce and high rates of alcohol and drug use may contribute to Nevada's high suicide rate.

Chart 16. Percentage of Suicide Mortality in Males by Mechanism, Nevada Residents, 2005-2007



Source: Nevada State Health Division, Vital Statistics Mortality Data

Chart 17. Percentage of Suicide Mortality in Females by Mechanism, Nevada Residents, 2005-2007

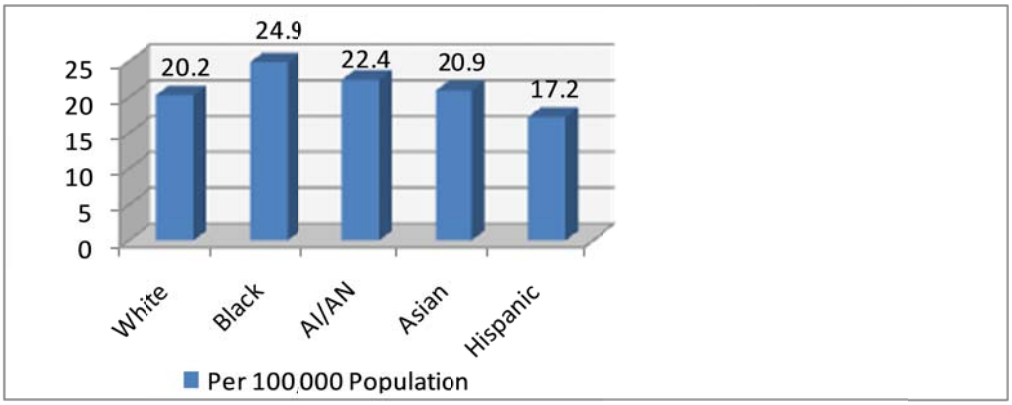


Source: Nevada State Health Division, Vital Statistics Mortality Data

Males preferred methods of suicide were by percentage of use: firearms at 61.2 percent, suffocation at 17.5 percent, and poisoning at 14.7 percent. Females preferred methods were: poisonings at 45.3 percent, firearms at 34.6 percent, and suffocations at 15.1 percent.

Influenza and pneumonia together were the eighth leading cause of death in Nevada during the years 2005-2007 and the eighth leading cause of death nationally in 2006. In addition, the Centers for Disease Control and Prevention reports 3,300 to 49,000 people die from influenza annually in the United States. Older adults, children, and those with compromised immune systems are most vulnerable to influenza. Seniors age 65 and older account for close to 90 percent of the deaths. In Nevada and nationwide, Blacks have the highest rates of influenza and pneumonia mortality. Hispanics have the lowest rates of influenza and pneumonia mortality.

Chart 18. Age-Adjusted Influenza and Pneumonia Mortality Rates by Race/Ethnicity, Nevada Residents, 2005-2007



Source: Nevada State Health Division, Vital Statistics Mortality Data

Nevada Blacks had the highest rate of deaths from influenza and pneumonia in 2005-2007 at 24.9 deaths per 100,000 population. Native American Indians/Alaskan Natives (AI/NA) followed with a rate of 22.4, then Asians with a rate of 20.9. Whites reported a rate of 20.2 per 100,000 population and Hispanics had the lowest rate of deaths from pneumonia and influenza at 17.2 per 100,000 population.

Table 16. Percentage and Rank of Mortality from Influenza and Pneumonia by Race/Ethnicity, Nevada Residents, 2005-2007 and US, 2005-2006

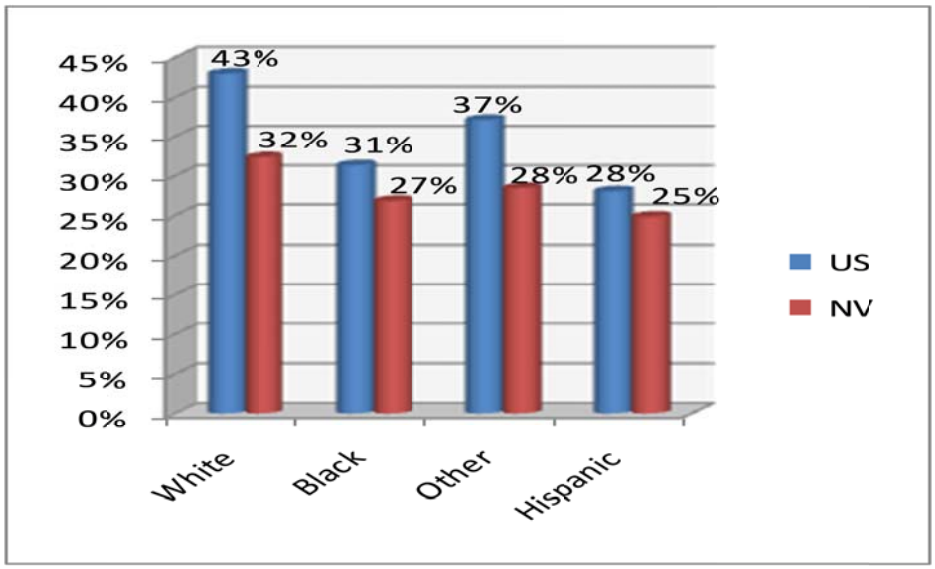
Race	NV 2005-2007	Mortality Rank	US 2005-2006*	Mortality Rank
White	2.3%	7	2.5%	8
Black	2.2%	10	1.9%	11
AI/AN	2.7%	7	2.2%	10
Asian	2.6%	7	3.1%	7
Hispanic	1.9%	12	2.3%	9

Note: * Final US 2007 mortality data was unavailable.

Source: Nevada State Health Division, Vital Statistics Mortality Data & CDC/NCHS National Vital Statistics System

Influenza and pneumonia were the seventh leading cause of death in White, Asian, and American Indian/Alaskan Native populations in Nevada in 2005-2007. They were the tenth leading cause of death of Nevada Blacks and the twelfth leading cause of death among Nevada Hispanics. Influenza is largely preventable with preventative measures and vaccine and vaccine controls the major form of pneumonia as well. However, minorities are less likely to obtain vaccinations than Whites, as shown in the charts that follow.

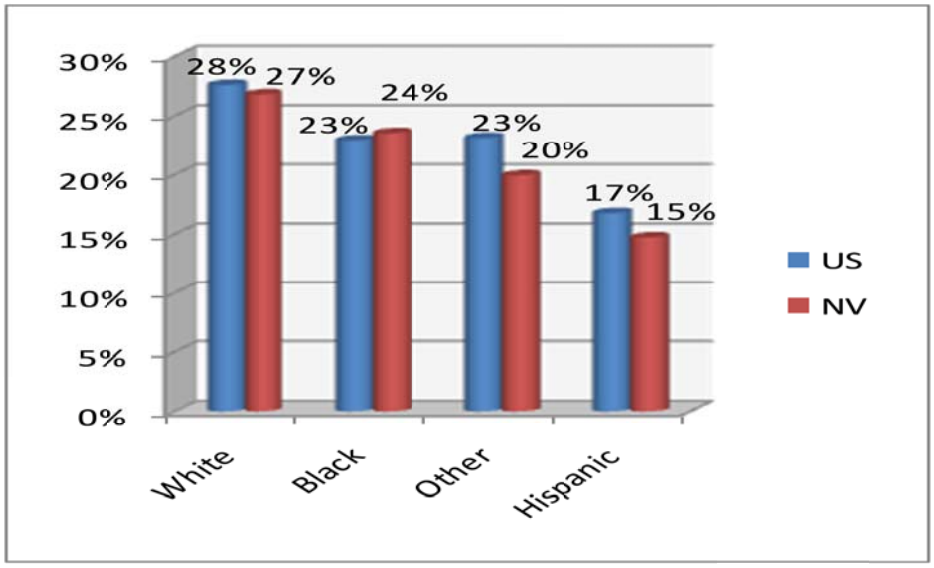
Chart 19. Percent of Population Who Reported a Flu Shot Within the Past Year by Race/Ethnicity, Nevada and US, BRFSS 2009



Source: Nevada State Health Division, Behavioral Risk Factor Surveillance System

In 2009, minorities of all racial/ethnic groups reported receiving a flu or pneumonia vaccination at percentages less than Whites in both Nevada and the United States. This is likely due to factors such as lack of access to preventive care.

Chart 20. Percent of Population Who Reported a Pneumonia Vaccination by Race/Ethnicity, Nevada and US, BRFSS 2009



Source: Nevada State Health Division, Behavioral Risk Factor Surveillance System

HIV/AIDS

Globally, the numbers of new HIV infections decreased by 20 percent from 2004 to 2009, indicating less people are becoming infected with HIV. In spite of such recent progress, the annual number of new HIV infections in the United States has remained at a relatively high level. An estimated 56,300 Americans become infected with HIV each year and more than 18,000 people with AIDS still die each year in the U.S.

Gay, bisexual, and other men who have sex with men (MSM) represent the majority of persons with HIV/AIDS who have died (53 percent). Racial and ethnic minorities, primarily Blacks and Hispanics, continue to be disproportionately affected by HIV/AIDS throughout the nation, with estimated incidence rates more than 7 times as high as the incidence rate among Whites.

Table 17. Nevada Residents, HIV/AIDS Infections by Race/Ethnicity, 2009

	New HIV Infections			Persons Living with HIV/AIDS		
Race/Ethnicity	N	%	Rate	N	%	Rate
White	133	36%	7.8	4,332	53%	254.8
Black	106	28%	56	1,930	24%	1,020.2
Hispanic	105	28%	16.4	1,595	20%	249.6
Asian	20	5%	11.5	204	2%	117.3
AI/AN	6	2%	16.5	77	1%	211.4
Multi-race	2	1%	N/A	34	0%	N/A
Total	372	100%	13.6	8,172	100%	298.4

Source: Nevada State Health Division, HIV/AIDS Surveillance Program, Nevada HIV/AIDS Fast Facts, 2009, Nevada Health Division HIV/AIDS Reporting System (eHARS), (Feb 2010)

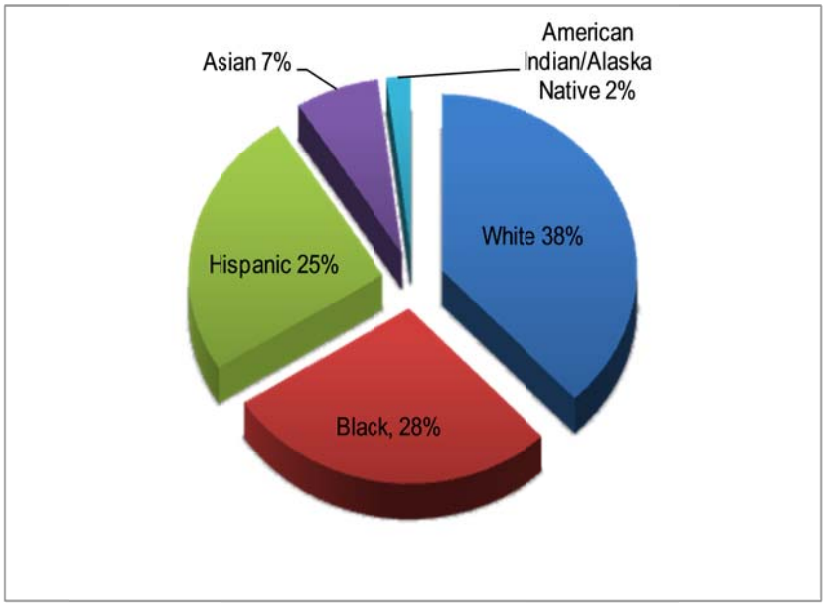
HIV/AIDS statistics represent only a portion of the epidemic in the United States. Data presented only include the HIV cases that were confirmed through testing and reporting; thus, it does not reflect the size and demographics of the HIV positive population that has not yet been tested or reported.

It is estimated that one in five (21 percent) of those people living with HIV are unaware of their infection. Nevada has been disproportionately represented in the nation's AIDS population, particularly among racial/ethnic populations and adult/adolescent cases. Native Hawaiian/Other Pacific Islander and American Indian/Alaskan Native (AI/AN) rates are approximately 3 and 2 times higher, respectively, among Nevadans than the overall United States case rates per 100,000 people.

Table 18. Newly Diagnosed HIV/AIDS Infections by County, Nevada 2009

Nevada		
	AIDS	**HIV**
Clark County:	190	327
Washoe County:	24	31
Other Counties:	13	14

Chart 21. New AIDS Cases by Race/Ethnicity, Nevada 2009



Source: Nevada State Health Division, HIV/AIDS Surveillance Program, Nevada HIV/AIDS Fast Facts, 2009, Nevada Health Division HIV/AIDS Reporting System (eHARS), (Feb 2010)

Additionally, Black and Hispanic MSM are disproportionately affected among new HIV infections. Among Hispanics, males accounted for 90 percent of new HIV infections in 2009. Of notable interest among modes of transmission, 30 percent of MSM risk was among Hispanic men in Nevada in 2009.

Blacks in Nevada have a disproportionate number of new HIV infections and AIDS cases compared to their percentage in the overall population. In Nevada, Black males continue to dominate the epidemic, yet new HIV infections are rising among females. Blacks made up 8.3 percent of Nevada's population and 28 percent of the reported new AIDS cases in 2009. In 2009 in Nevada, males accounted for 74 percent, while females accounted for about a quarter (26 percent), of the new HIV infections among Blacks. HIV was ranked as the ninth leading cause of death among Blacks nationwide in 2006.

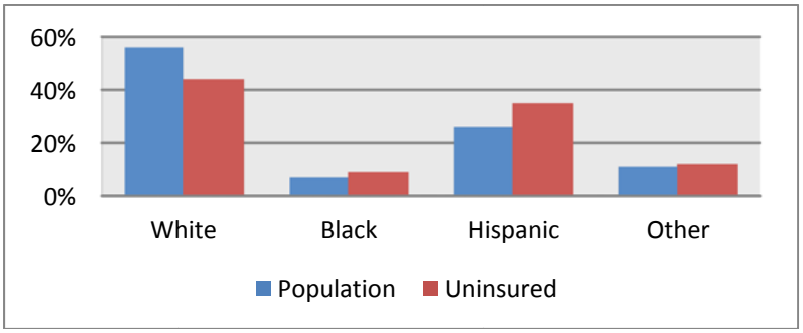
The Henry J. Kaiser Family Foundation reports a lack of health insurance leads to poor health through delayed diagnosis and treatment and lack of healthcare. Minorities of all age groups combined are less likely to have health insurance coverage than their White counterparts. In 2009, 12.0 percent of Whites nationwide were uninsured, compared to 32.4 percent of Hispanics, 21.0 percent of Blacks, and 17.2 percent of Asians. Reasons for the lower rates of health insurance coverage may be that minorities are more likely to have low wage or part-time jobs that do not include insurance and minorities have a higher unemployment rate. American cities with the highest uninsured rates also have the largest minority and immigrant populations. Non-elderly is defined by the Kaiser Foundation as persons 0 to 64 years of age.

Table 19. Distribution of Uninsured (non-elderly) by Race/Ethnicity, Nevada, 2008-2009 and US 2009

	NV #	NV %	US #	US %
White	224,300	44.0%	23,379,400	47.0%
Black	43,300	9.0%	7,581,100	15.0%
Hispanic	180,500	35.0%	15,617,700	31.0%
Other	60,800	12.0%	3,419,700	7.0%
Total	509,000	100.0%	49,997,900	100.0%

Source: Henry J. Kaiser Family Foundation

Chart 22. Percent of Population versus Distribution of Uninsured by Race/Ethnicity, Nevada Residents, 2008-2009



Source: Henry J. Kaiser Family Foundation

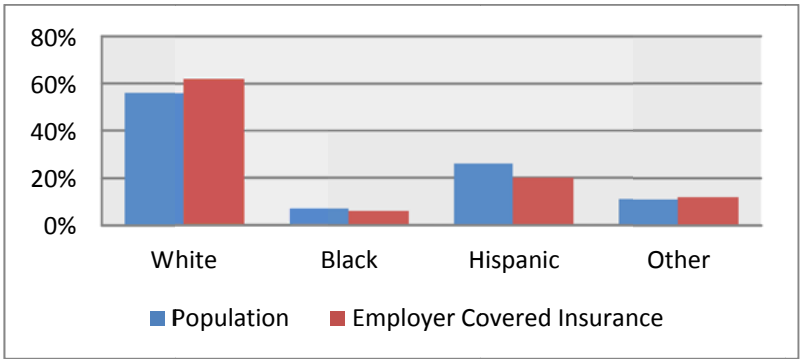
In 2008-2009, 55.6 percent of Nevada's population was White, and 44.0 percent of Nevada's uninsured non-elderly population was White. The largest disparity of uninsured was the Hispanic population, who made up 26.5 percent of the population in Nevada and comprised 35.0 percent of the non-elderly population who were uninsured. Of those populations who received insurance coverage from employer coverage in Nevada in 2008-2009, 62.0 percent was provided to non-elderly Whites, 20.0 percent was provided to non-elderly Hispanics and 6.0 percent was provided to non-elderly Blacks. The Henry J. Kaiser Foundation reports 20 percent of Nevada's population of all ages was uninsured in 2009.

Table 20. Distribution of Employer Coverage (non-elderly) by Race/Ethnicity, Nevada, 2008-2009 and US 2009

	NV #	NV %	US #	US %
White	882,200	62.0%	108,447,900	72.0%
Black	82,700	6.0%	14,445,200	10.0%
Hispanic	284,900	20.0%	16,184,000	11.0%
Other	166,500	12.0%	10,613,000	7.0%
Total	1,416,300	100.0%	149,690,000	100.0%

Source: Henry J. Kaiser Family Foundation

Chart 23. Percent of Population versus Distribution of Employer Covered Insurance by Race/Ethnicity, Nevada Residents, 2008-2009

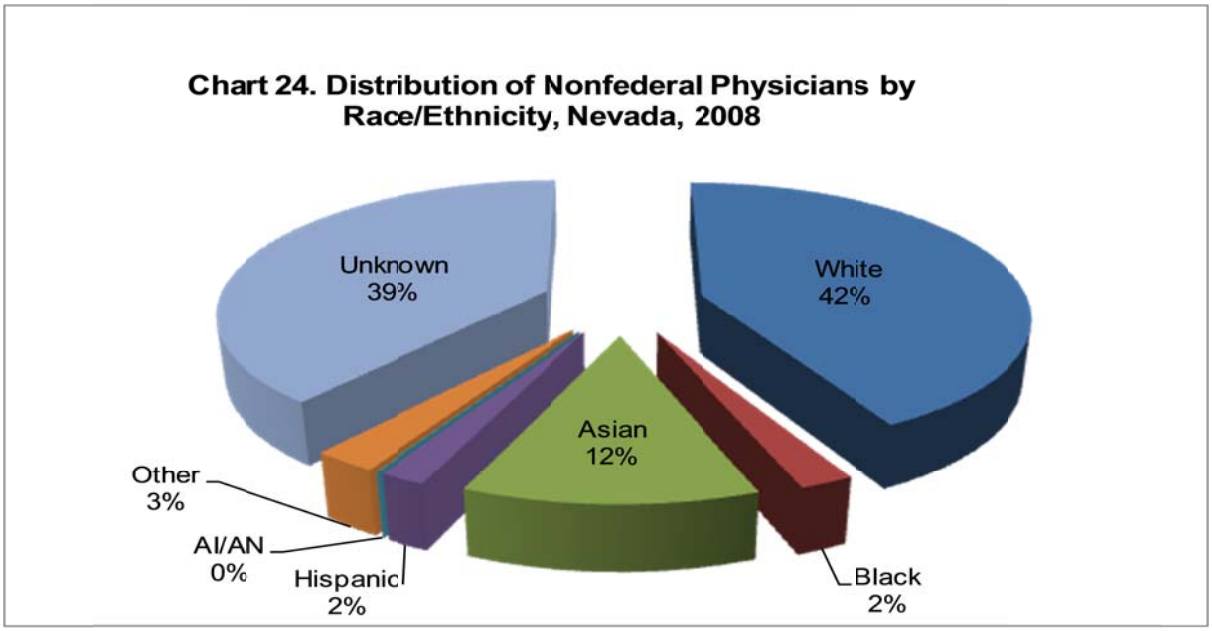


Source: Henry J. Kaiser Family Foundation

Minorities are more likely to choose to be uninsured when employers offer health insurance. Reasons include that they are more likely to decline health insurance if they have to pay a large portion, minorities are more likely to have jobs that require paying a larger share of the premium, and some minority workers may not value health insurance.

Minorities are underrepresented in the healthcare professions. While 7.4 percent of the Nevada population is Black, only 2.0 percent of Nevada physicians are Black. The Hispanic community has a greater disparity, comprising more than one-fourth (26.5 percent) of Nevada's overall population and only 2.0 percent of Nevada's physician population. Minority physicians are critical for a number of reasons.

Minority physicians are more likely to practice in minority communities where there is a shortage of healthcare professionals. Minorities are more likely to distrust the healthcare system than white patients and more likely to trust physicians of their own race. In addition, minority physicians may be more likely to be sensitive to cultural and religious differences and are more likely to speak the culture's primary language, thus eliminating language barriers.



Source: Henry J. Kaiser Foundation, 2008

The number of minorities graduating from medical school in Nevada reflects a continuing shortage of minority physicians, with only one Native American graduate in 2008, and only six Hispanic and one Black graduates in 2009.

Table 21. Medical School Graduates by Race/Ethnicity, Nevada and US, 2009

	NV #	US #
White	37	10,499
Black	1	1,076
Asian	9	3,479
Hispanic	6	1,244
American Indian and Alaska Native	0	130
Native Hawaiian and Other Pacific Islander	2	46
Other Non-Hispanic	0	31
Foreign	0	238
No Response	0	289
Total Graduates	51	16,468

Source: Henry J. Kaiser Foundation, 2009

Appendix A – US Census Race Categories

The concept of race as used and defined by the Census Bureau reflects self-identification by people according to the race or races with which they most closely identify. These categories are sociopolitical constructs and should not be interpreted as being scientific or anthropological in nature. Furthermore, the race categories include both racial and national-origin groups.

The racial classifications used by the Census Bureau adhere to the October 30,1997 Federal Register Notice entitled, "Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity" issued by the Office of Management and Budget (OMB).

Definitions and Technical Notes:

White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as "White" or report entries such as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish. Non-Hispanic.

Black. A person having origins in any of the Black racial groups of Africa. It includes people who indicate their race as "Black, African American, or Negro," or provide written entries such as African American, Afro American, Kenyan, or Nigerian. Non-Hispanic.

American Indian and Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.

Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes "Asian Indian," "Chinese," "Filipino," "Korean," "Japanese," "Vietnamese," and "Other Asian."

Hispanic. People who classified themselves in one of the specific Spanish, Hispanic, or Latino categories listed on the Census 2000 questionnaire -"Mexican, Mexican American, Chicano," "Puerto Rican", or "Cuban" - as well as those who indicate that they are "other Spanish/Hispanic/Latino." Persons who indicated that they are "other Spanish/Hispanic/Latino" include those whose origins are from Spain, the Spanish-speaking countries of Central or South America, the Dominican Republic or people identifying themselves generally as Spanish, Spanish-American, Hispanic, Hispano, Latino, and so on.

The concept of race is separate from the concept of Hispanic origin. Persons of Hispanic origin may be of any race; all other racial/ethnic groups are non-Hispanic. Percentages for the various race categories add to 100 percent, and should not be combined with the percent Hispanic. Tallies that show race categories for Hispanics and non-Hispanics separately are also available.

Native Hawaiian and Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicate their race as "Native Hawaiian," "Guamanian or Chamorro," "Samoan," and "Other Pacific Islander." Combined in this report with Asians.

Some other race or Other. Includes all other responses not included in the White, Black or African American, American Indian and Alaska Native, Asian and Native Hawaiian and Other Pacific Islander race categories described above. Respondents providing write-in entries such as multiracial, mixed, interracial, Wesort, or a Hispanic/Latino group (for example, Mexican, Puerto Rican, or Cuban) in the "Some other race" category are included here.

Two or more races. People may have chosen to provide two or more races either by checking two or more race response check boxes, by providing multiple write-in responses, or by some combination of check boxes and write-in responses.

Comparability. The data on race in Census 2000 are not directly comparable to those collected in previous censuses. Nor is the data on race in Census 2010 directly comparable to those collected in previous censuses.

N/A. Data not available.

Non-elderly. Persons aged 0 to 64 years.

NSD. Not Sufficient Data.

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The vision of the Office of Health Statistics and Surveillance is to play a pivotal role in improving the health of all Nevadans by providing *data that makes a difference*.