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Foreword

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Since 1946, CDC has monitored and responded to challenges in the nation's health, with particular focus on reducing gaps between the least and most vulnerable U.S. residents in illness, injury, risk behaviors, use of preventive health services, exposure to environmental hazards, and premature death. We continue that commitment to socioeconomic justice and shared responsibility with the release of *CDC Health Disparities and Inequalities in the United States – 2011*, the first in a periodic series of reports examining disparities in selected social and health indicators.

Health disparities are differences in health outcomes between groups that reflect social inequalities. Since the 1980s, our nation has made substantial progress in improving residents' health and reducing health disparities, but ongoing racial/ethnic, economic, and other social disparities in health are both unacceptable and correctable. Some key findings of this report include:

- Lower income residents report fewer average healthy days. Residents of states with larger inequalities in reported number of healthy days also report fewer healthy days on average. The correlation between poor health and health inequality at the state level holds at all levels of income.
- Air pollution-related disparities associated with fine particulates and ozone are often determined by geographical location. Local sources of air pollution, often in urban counties, can impact the health of people who live or work near these sources. Both the poor and the wealthy in these counties can experience the negative health effects of air pollution; racial/ethnic minority groups, who are more likely to live in urban counties, continue to experience a disparately larger impact.
- Large disparities in infant mortality rates persist. Infants born to black women are 1.5 to 3 times more likely to die than infants born to women of other races/ethnicities.
- Men of all race/ethnicities are two to three times more likely to die in motor vehicle crashes than are women, and death rates are twice as high among American Indians/Alaska Natives.
- Men of all ages and race/ethnicities are approximately four times more likely to die by suicide than females. Though American Indians/Alaska Natives, who have a particularly high rate of suicide in adolescence and early adulthood, account for only about 1% of the total suicides, they share the highest rates with Non-Hispanic whites who in contrast account for nearly 5 of 6 suicides. The suicide rate among AI/ANs and non-Hispanic whites is more than twice that of blacks, Asian Pacific Islanders and Hispanics.
- Rates of drug-induced deaths increased between 2003 and 2007 among men and women of all race/ethnicities, with the exception of Hispanics, and rates are highest among non-Hispanic whites. Prescription drug abuse now kills more persons than illicit drugs, a reversal of the situation 15–20 years ago.
- Men are much more likely to die from coronary heart disease, and black men and women are much more likely to die of heart disease and stroke than their white counterparts. Coronary heart disease and stroke are not only leading causes of death in the United States, but also account for the largest proportion of inequality in life expectancy between whites and blacks, despite the existence of low-cost, highly effective preventive treatment.
- Rates of preventable hospitalizations increase as incomes decrease. Data from the Agency for Healthcare Research and Quality indicate that eliminating these disparities would prevent approximately 1 million hospitalizations and save $6.7 billion in health-care costs each year. There also are large racial/ethnic disparities in preventable hospitalizations, with blacks experiencing a rate more than double that of whites.
- Racial/ethnic minorities, with the exception of Asians/Pacific Islanders, experience disproportionately higher rates of new human immunodeficiency virus diagnoses than whites, as do men who have sex with men (MSM). Disparities continue to widen as rates increase among black and American Indian/Alaska Native males, as well as MSM, even as rates hold steady or are decreasing in other groups.
- Hypertension is by far most prevalent among non-Hispanic blacks (42% vs 28.8% among whites), while levels of control are lowest for Mexican Americans. Although men and women have roughly equivalent hypertension prevalence, women are significantly more likely to have the condition controlled. Uninsured persons are only about half as likely to have hypertension under control than those with insurance, regardless of type.
- Rates of adolescent pregnancy and childbirth have been falling or holding steady for all racial/ethnic minorities in all age groups. However, disparities persist as birth rates for Hispanics and non-Hispanic blacks are 3 and 2.5 times those of whites, respectively.
- More than half of alcohol consumption by adults in the United States is in the form of binge drinking (consuming four or more alcoholic drinks on one or more occasion for women and five or more for men). Younger people and men are more likely to binge drink and consume more alcohol than older people and women. The prevalence of binge drinking is higher in groups with higher incomes and

higher educational levels, although people who binge drink and have lower incomes and less educational attainment levels binge drink more frequently and, when they do binge drink, drink more heavily. American Indian/Native Americans report more binge drinking episodes per month and higher alcohol consumption per episode than other groups.

- Tobacco use is the leading cause of preventable illness and death in the United States. Despite overall declines in cigarette smoking, disparities in smoking rates persist among certain racial/ethnic minority groups, particularly among American Indians/Alaska Natives. Smoking rates decline significantly with increasing income and educational attainment.

Differences in health based on race, ethnicity, or economics can be reduced, but will require public awareness and understanding of which groups are most vulnerable, which disparities are most correctable through available interventions, and whether disparities are being resolved over time. These problems must be addressed with intervention strategies related to both health and social programs, and more broadly, access to economic, educational, employment, and housing opportunities. The combined effects of programs universally available to everyone and programs targeted to communities with special needs are essential to reduce disparities. I hope CDC's partners will use this periodic report to better understand and address disparities and help all persons in the United States live longer, healthier, and more productive lives.