

# Unrealized Health Potential: A Snapshot of Tennessee



## UNREALIZED HEALTH POTENTIAL AMONG CHILDREN

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

### INFANT MORTALITY

Tennessee ranks 50th among states based on the size of the gap in infant mortality by mother's education, when comparing the current overall state rate of 8.6 deaths per 1,000 live births with the lower rate—4.9 deaths per 1,000 live births—seen among infants born to the state's most-educated mothers. Even if Tennessee achieved this lower rate overall, infant mortality in the state would still exceed the *national benchmark* of 3.2 deaths per 1,000 live births—the lowest infant mortality rate seen in any state among babies born to mothers with 16 or more years of schooling. In Tennessee, infant mortality rates in every maternal education and racial or ethnic group did not meet the national benchmark.

## CHILDREN'S GENERAL HEALTH STATUS

Tennessee ranks 24th among states based on the size of the gap in children's general health status by family income, when comparing the current overall rate of 14.6 percent of children in less than optimal health with the lower rate—7.9 percent—seen among children in higher-income families. Even if Tennessee achieved this lower rate overall, the state's rate would still exceed the *national benchmark* for children's general health status of 3.5 percent—the lowest rate of less than optimal health seen in any state among children in families that both were higher income and practiced healthy behaviors. In Tennessee, the general health status of children in every income, education and racial or ethnic group did not meet the national benchmark.

## SOCIAL FACTORS AFFECTING CHILDREN'S HEALTH

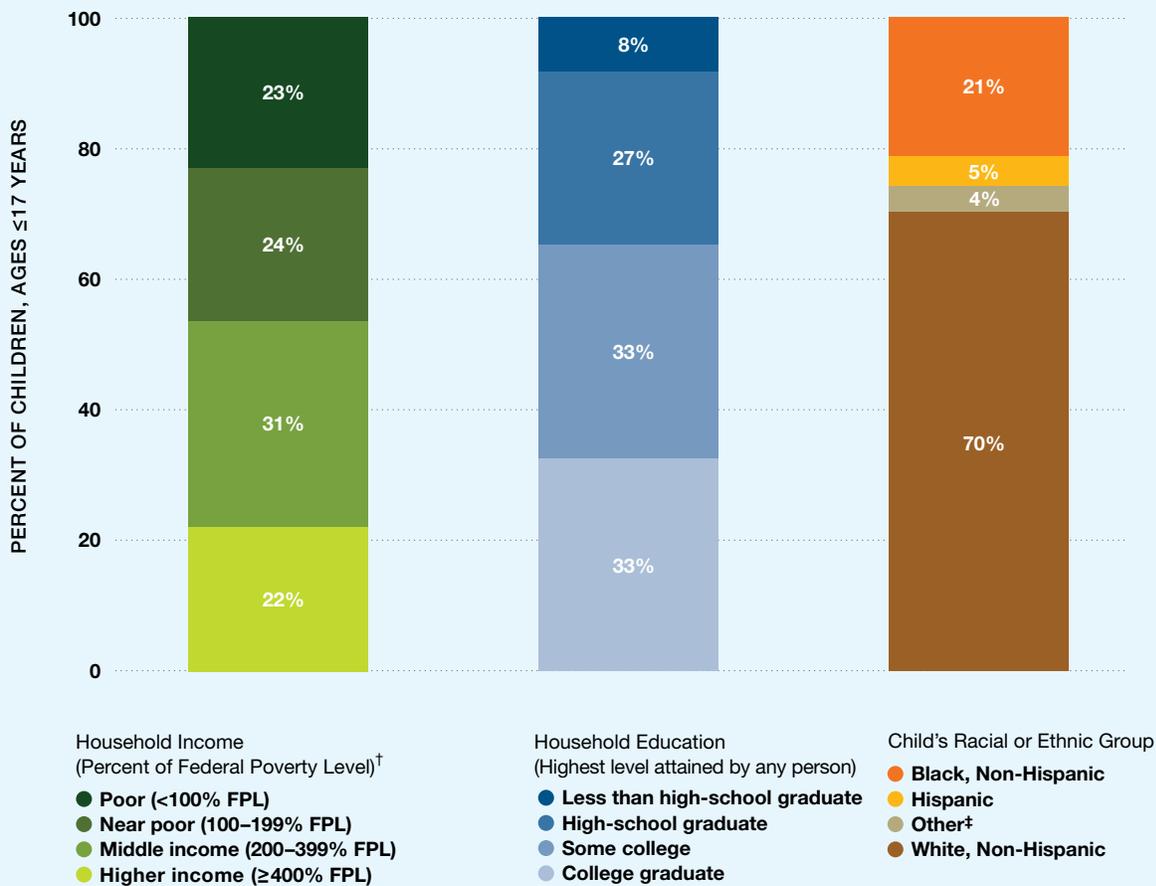
Social factors such as income, education and racial or ethnic group can greatly affect a child's health. This snapshot describes these factors and how they are linked with infant mortality and children's general health status in the state.



TENNESSEE:  
**Social Factors Affecting Children's Health**

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

- Nearly half of Tennessee's children live in poor or near-poor households, nearly one third live in middle-income households and one fifth live in higher-income households.
- One third of children in Tennessee live in households where no one has education beyond high school, one third live with at least one person who has attended but not completed college and one third live with at least one college graduate.
- Over two thirds of Tennessee's children are non-Hispanic white, 21 percent are non-Hispanic black and 5 percent are Hispanic.



Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.  
 Source: 2006 American Community Survey (for data on income and racial or ethnic group); 2005–2007 Current Population Survey (for education data).  
<sup>†</sup> Guidelines set by the U.S. government for the amount of income providing a bare minimum of food, clothing, transportation, shelter and other necessities. In 2006, the U.S. FPL was \$16,079 for a family of three and \$20,614 for a family of four.  
<sup>‡</sup> "Other" includes children in any other racial or ethnic group or in more than one group.

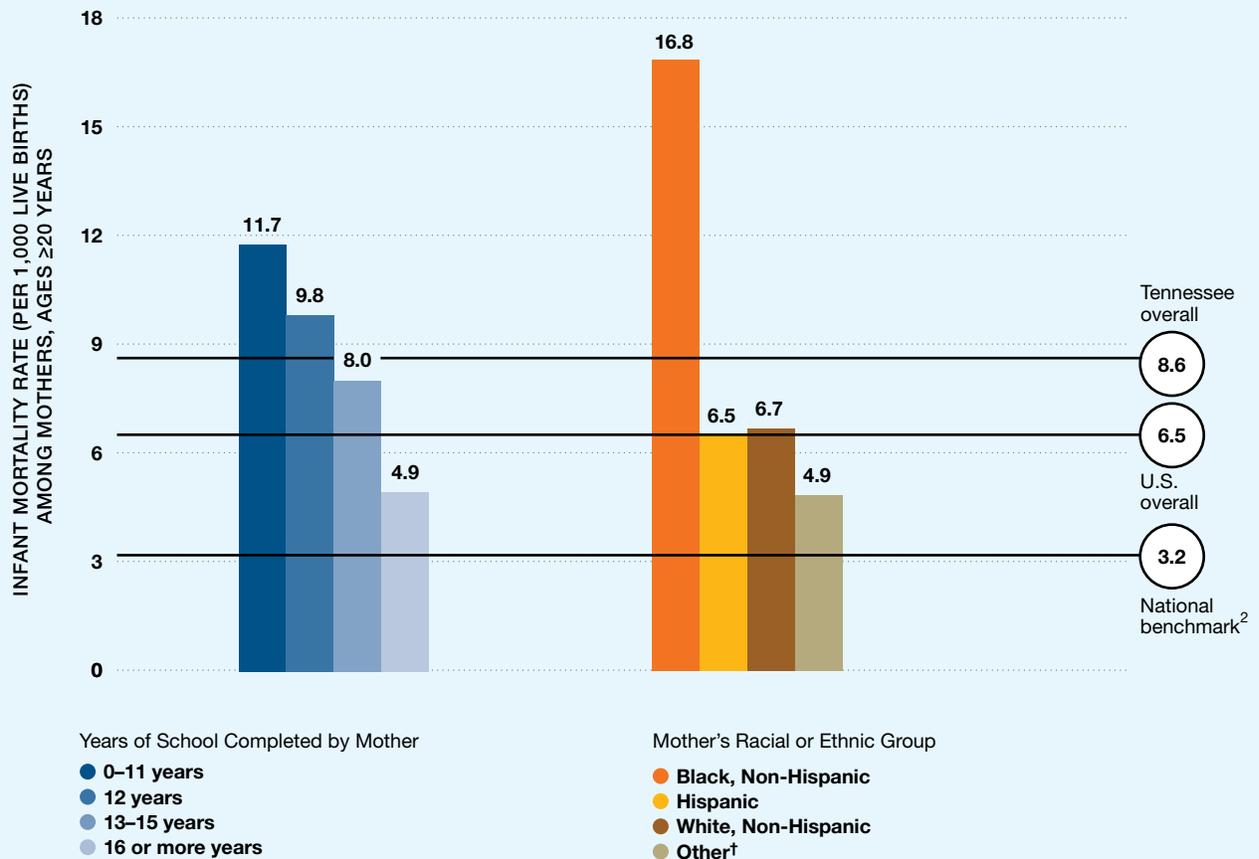
## TENNESSEE: Gaps in Infant Mortality

Infant mortality rates<sup>1</sup>—a key indicator of overall health—vary by mother’s education and racial or ethnic group in Tennessee.

- Compared with babies born to the most-educated mothers, babies born to mothers with less education are more likely to die before reaching their first birthdays. While the infant mortality rate is highest among babies born to mothers with less than 12 years of education, the rate for babies born to mothers with 13-15 years of schooling is approximately 60 percent higher than that for babies born to more educated mothers.

- The infant mortality rate among babies born to non-Hispanic black mothers is approximately 2.5 times the rates seen among babies of non-Hispanic white or Hispanic mothers.

Comparing Tennessee’s experience against the national benchmark<sup>2</sup> for infant mortality reveals unrealized health potential among Tennessee babies across maternal education and racial or ethnic groups. Infants in every group could do better.



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

Source: 2000-2002 Period Linked Birth/Infant Death Data Set.

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

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

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

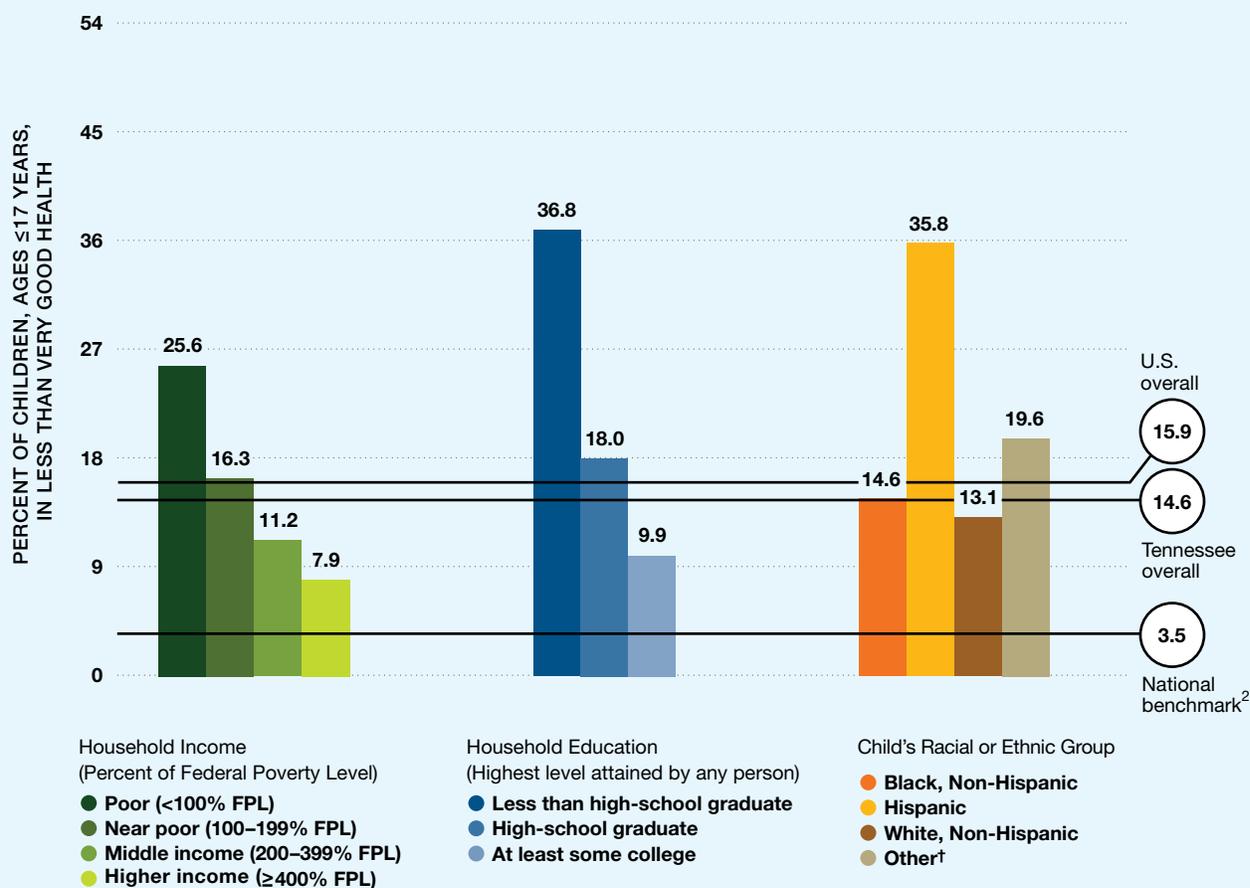
## TENNESSEE: Gaps in Children's General Health Status

Within Tennessee, children's general health status<sup>1</sup> varies by family income and education and by racial or ethnic group. Children in the least-advantaged groups typically experience the worst health, but even children in middle-class families appear to be less healthy than those with greater advantages.

- Children in poor families are approximately three times as likely and children in near-poor families are twice as likely to be in less than optimal health as children in higher-income families.

- Children in households without a high-school graduate are approximately 3.5 times as likely to be in less than optimal health as children living with an adult who has completed some college.
- Hispanic children are approximately 2.5 times as likely as non-Hispanic white and black children to be in less than optimal health.

Comparing Tennessee's experience against the national benchmark<sup>2</sup> reveals unrealized health potential among Tennessee children in every income, education and racial or ethnic group.



Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.  
Source: 2003 National Survey of Children's Health.

<sup>1</sup> Based on parental assessment and measured as poor, fair, good, very good or excellent. Health reported as less than very good was considered to be less than optimal.  
<sup>2</sup> The national benchmark for children's general health status represents the level of health that should be attainable for all children in every state. The benchmark used here—3.5 percent of children with health that was less than very good, seen in Colorado—is the lowest statistically-reliable rate observed in any state among children whose families were not only higher income but also practiced healthy behaviors (i.e., non-smokers and at least one person who exercised regularly).

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