Abstract
This dissertation is composed of three empirical papers on ethnic disparities in chronic disease morbidity. Data come from Health and Retirement Study (HRS) participants aged 51+ from 1995-2006. The first paper analyzes intra- and interpersonal differences in comorbidity burden reported by white, black and Mexican Americans. Hierarchical linear models are employed to analyze ethnic variations in temporal changes of reported comorbidities. On average, participants have nearly two chronic diseases at the baseline, which increased to almost three conditions over 11 years. Mexican Americans demonstrate lower initial levels and slower accumulation of comorbidities relative to whites. In contrast, blacks show an elevated level of comorbidity, although their rate of change decelerated over time relative to whites. The second paper examines ethnic variations in the onset of hypertension diagnosis for white, black and Mexican Americans age 51 and over. Data came from HRS respondents who report being hypertension-free at the baseline. Discrete-time survival models are used to analyze ethnic variations in the probability of developing hypertension. We find the risk of newly diagnosed hypertension increased for all participants. Relative to white and Mexican Americans, black Americans had an elevated risk of incident hypertension throughout the 11-year period of observation. These variations persisted even when differences in demographic, health and socioeconomic status were adjusted. The third paper examines the onset of new diabetes mellitus diagnosis for HRS participants. Discrete-time survival models are used to analyze ethnic variations in the probability of developing diabetes. We find the risk of newly diagnosed diabetes increased for all study participants. Relative to white and black Americans, Mexican Americans have a significantly elevated risk of diabetes. Increases in diabetes incidence for Mexican Americans persist through adjustment of demographic, health and socioeconomic status. In contrast, increases in incident risk for black Americans relative to white Americans operate largely through changes in health status. Our findings of continued racial/ethnic disparities in chronic diseases suggest there are still improvements to be made in prevention efforts aimed at older minorities. These papers highlight the importance of social/structural factors as policy levers for mitigating chronic disease burden for minorities in the U.S.