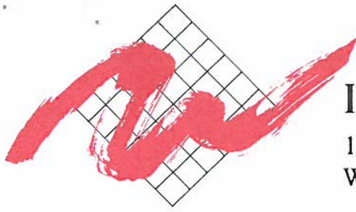

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WOMEN'S HEALTH IN THE UNITED STATES

Statement of Heidi Hartmann, Ph.D.

Director

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At a Briefing for Congressional Staff

Presented by the Campaign for Women's Health:

WOMEN AND HEALTH CARE IN THE UNITED STATES--

A WOMEN'S HEALTH AGENDA FOR HEALTH POLICY

OF THE '90'S

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Why is it important to look specifically at women's health and women's health care needs? Women's specific needs deserve attention for two major reasons: 1) women differ physiologically from men; and 2) women's socio-economic status differs from men.

Today I want to give you a brief overview of what these two basic differences mean for women's health and women's health care. These differences, coupled with the lack of input women have had in developing policy to address these differences, provide ample reason for the existence of the Campaign for Women's Health and IWPR's decision to participate in it.

Women's physiological differences mean that some illnesses or conditions affecting health are uniquely women's and others affect women disproportionately. Among conditions affecting women uniquely, of course, are those related to reproduction: menstruation, pregnancy, child birth, and menopause; and diseases such as ovarian and uterine cancer. Since most women spend 90 percent of their reproductive lives attempting to postpone or avoid having children, and since unintended pregnancies occur, access to safe and effective contraception including abortion is a critical health care need for women. Women also experience unnecessarily high rates of Caesarian section in child birth and of hysterectomy.

Among those diseases and conditions affecting women disproportionately are breast cancer; osteoporosis; diabetes; lupus; gall bladder disease; depression; and death and injury from domestic violence, rape, and assault. National data for 1988 show homicide as one of the top five causes of death for both black and white women aged 15-34.

Several other women's health issues deserve attention. According to the Center for Disease Control, the incidence of AIDS is now growing faster among women than any other demographic group. In 1988, AIDS was already the fourth largest cause of death of black women aged 25-34 nationally, and the seventh largest cause of death among black women aged 15-24; among white women aged 25-44, it was the ninth largest cause of death.

The lack of drug and alcohol treatment programs for women generally, and especially for those who are the sole support of children (because no child care is available), is a serious health problem for many women.

Smoking is a growing problem for young women. While the rate of smoking is falling among adults, and especially among males, it is actually increasing among young women. Cigarette companies exploit young women's concern about their appearance and seek to associate smoking with slimness and even with healthy sports activities. Smoking not only shortens life through its connection to heart disease, lung, and other cancers, but also is implicated in reduced fertility and higher numbers of low birth-weight babies. And, as a result of the increase in smoking by women that occurred between 1935 and 1966, lung cancer deaths among women increased 600 percent between 1950 and 1980 and are still increasing. Among white women the number of lung cancer deaths surpassed the number of breast cancer deaths in 1986.

Finally, heart disease remains the largest cause of death for women overall, accounting for 28 percent of women's deaths. Yet, because the risk of heart disease among men is well known to be higher, heart disease is often not thought to be a health problem for women. Their symptoms are frequently neither recognized nor treated. Among the older population, where women outnumber men, more women die of heart disease than do men.

The causes of mortality and mortality rates differ markedly by gender, race, and age. Race-based differences among women are especially striking. For example, for heart disease, stroke, and maternal mortality, between the ages of 25 and 55, death rates of black women are three to four times higher than for white women (for women over 35, maternal mortality for black women is 7 times greater than for white women). Overall, women of color have shorter life expectancies than white women (by about five years). They also have higher incidences of chronic illnesses such as diabetes, hypertension, cardiovascular disease, and some cancers. The vast majority of the greater health risks that minority women experience are due, not to race-

and ethnicity-based genetic susceptibilities (of which there are a few), but to long term economic disadvantage and persistent discrimination, which limit their ability to obtain quality health care.

Clearly research and treatment must be sensitive to these differences in the severity of various illnesses and conditions, and public and private resources must be equitably allocated, without discrimination based on gender, race, ethnicity, or age.

Because of the work of the Congressional Caucus on Women's Issues and the Society for the Advancement of Women's Health Research, we are now well aware of the lack of research on women's health needs. Women's specific diseases are understudied, women are not included as patients in clinical trials for conditions experienced by both women and men, and, for many common conditions, little is known about the way illness or medicines may affect women differently.

It is my view that the failure of health research to address women's health needs is primarily a failure of policy--and of a policy process in which policy as usual is policy that omits women's concerns. Would breast cancer be the killer of women it is today if research funds had been allocated differently these past several decades? I think not. The incidence of breast cancer is now rising and we do not know why.

The Campaign for Women's Health is aimed at fixing this failure of policy, so that the economic and social disadvantages women have traditionally faced will not result in their getting inadequate health care.

Ironically, despite the lack of attention paid to women's health needs, women have one major health advantage compared to men: they live longer, currently about 7 years longer than men. We don't actually know whether this is primarily a physiological advantage or one based on social factors. For example, in the past women were much less likely than men to smoke, and because of spending fewer years in the labor force than men, they were less likely to be exposed to occupational and industrial health hazards. Both these reasons for women's longer lives are eroding. Whatever the source, however, their longevity means that women also have

greater needs for long term care, compared to men. There are twice as many women as men in nursing homes.

As an economist it is the social and economic differences between women and men that especially interest me. They also strike me as more important than the physiological differences. As feminists have long maintained, gender-based biological differences need not be as important as they appear to be.

It can't really be male genitalia that results in men's higher pay. It's not the physical factor that causes the social factor. It's the social factor that causes the physical factor to have so much salience. It is our failure to do anything about the socio-economic differences between women and men that makes the physiological differences between them seem so important. Simply put, women have less money and power than men. They have fewer resources with which to purchase health care and they and their needs are left out of the policy debate: they are less active as participants, they are less visible as potential beneficiaries.

Their illnesses and health conditions may be perceived as less serious, perhaps because women are often perceived as less economically valuable members of society. They receive differential treatment in the same or similar circumstances, treatment that may jeopardize their health and safety. For example, older women are more likely to be treated with psychotropic drugs (23 percent versus 14 percent for older men), and more likely to suffer from falling and hip injuries, perhaps linked to their higher rate of medication. Older women with heart disease are also less likely to have their condition diagnosed and treated; even when diagnosed, they are less likely to have bypass surgery for conditions that would normally signal such surgery in men.

A classic example of inadequate public and private policy is the way in which individuals typically get access to health insurance. There is much criticism now of the employer-based system that has evolved in the United States. That system is especially inadequate for women. When the system first began to be developed after World War II, it was assumed that most

women in need of health care would be either wives or daughters and would be covered as the family members of male workers.

Women's lives have changed, however. They now marry later, establishing households of their own; they no longer move directly from their parents' home to their new home with their husband. Divorce has increased and more women are raising children on their own, not only because of divorce, but also, because more women are having children outside marriage. Women, of course, are also working more outside the home, but many of the jobs in which they work are among the least likely to provide health insurance as a fringe benefit. Women more often work at low wage jobs, part-time jobs, temporary jobs, and jobs in the retail and service industries. Only the public sector and FIRE (the finance, insurance and real estate industries), which are also industries where many women work, have reasonably good rates of employer-provided health insurance (see the accompanying table).

The low-wage jobs many women (about half) work in are also shorter-lived than higher-wage jobs; they tend to disappear for one reason or another. Because women are also more likely to leave work for family-related reasons than are men, women are more likely to experience loss of employment-based health. While, as the result of recent COBRA regulations, some women may now be able to participate in group plans after leaving employment, the full cost of participation falls on them. Many women work for employers not covered by COBRA, others do not know of their COBRA rights, and yet others cannot afford to exercise their rights. When they do exercise their rights they may not be able to afford to pay for their children's insurance.

For the most part, women's jobs simply do not have male-style fringe benefits. A system of access to health care based on private insurance obtained through employment fails to assure access for women. Women are increasingly dependent on their own employment, rather than a husband's or father's job, for that access. As a matter of fact, the "system" never worked for many women or for the many men who also occupied substandard jobs. Minorities have been

PROPORTION OF WORKERS WITH EMPLOYER PROVIDED HEALTH INSURANCE AND PERCENTAGE OF WOMEN WORKERS BY INDUSTRY

	Percent Covered		Percent of Employment in Industry by Women	
	All Workers	Low Wage Workers	All Workers	Low Wage Workers
Agriculture, Forestry, Fishing	59.8%	31.9%	15.5%	63.8%
Manufacturing	86.0%	60.1%	33.8%	62.2%
Transportation & Communication	85.4%	42.3%	24.6%	40.4%
Wholesale	79.3%	47.3%	26.7%	40.4%
Retail	50.3%	29.1%	51.6%	63.3%
Finance, Insurance, & Real Estate (FIRE)	74.2%	48.6%	62.9%	76.4%
Business Services	52.4%	26.3%	38.0%	38.1%
Personal Services	31.5%	24.5%	78.2%	85.1%
Entertainment, etc.	55.1%	35.4%	34.8%	38.3%
Professional & Related Services	67.7%	45.2%	68.1%	80.6%
Public Administration	83.6%	60.5%	37.5%	56.3%
All Industries	70.2%	40.3%	45.0%	63.8%

*Low-wage workers are those who earned $5.30 per hour or less in 1984 for at least seven months and 500 hours during the year.

Source: IWPR tabulations of the 1984 Survey of Income and Program Participation, U.S. Bureau of the Census.

disproportionately denied access to health care by this same system, a system which leaves much too much to chance.

Recent research by IWPR illustrates some of the weaknesses of the present system of employer-provided coverage. Using the Consumer Expenditure Survey from the Bureau of Labor Statistics to examine differences in coverage by family type, we found that during the 1980's, employer-provided health insurance declined for most types of consumer units (generally households), particularly those with children. As can be seen in the accompanying table, there was a 3 percent drop in the proportion of married couples with children who had health insurance through their employers, but the drop was largest for single mothers at 10 percent, and also quite substantial for single fathers (8 percent). Younger workers, those more likely to have children under 18, have been especially hard hit by the deteriorating set of jobs available, jobs that pay low wages and offer few benefits. Also, many employers are cutting back on health insurance costs, particularly by reducing their subsidies of the premiums for dependents.

During the same period, 1980-87, the Consumer Expenditure Survey data show that the proportion of families, again especially families with children, having any kind of coverage for their dependents has fallen for all but one family type. For married couples with children, the drop is 5 percent, for single mothers 11 percent, and for single fathers 12 percent. By 1987, fully 50 percent of single mothers had no health insurance that covered their children. Thus despite the fact that Medicaid serves many single mother families (Medicaid serves twice as many women as men), the children of single mothers are about twice as likely not to be covered by health insurance as the children of husband-wife families. Clearly, access through voluntary employer fringe benefits no longer works to provide insurance for families and children, particularly for families headed by single parents, the overwhelming majority of whom are women.

Women bear a disproportionate share of poverty; their poverty both limits their access to health care and reduces the quality of the care they receive. Medicaid reimbursement rates

CHANGE IN HEALTH INSURANCE FOR FAMILIES, 1980-87

Percentage of Consumer Units with Employer Provided Coverage, Fully or Partially Paid			
Family Type	1980	1987	Change, 1980-87
Husband & Wife: No Minor Children	66.1%	66.4%	0.3%
Husband & Wife: Children < 18 years old	71.5%	68.3%	-3.2%
Other Husband/Wife	64.2%	65.4%	1.2%
Single Mother: Children < 18 years old	61.1%	51.2%	-9.9%
Single Father: Children < 18 years old	66.8%	58.7%	-8.1%
Single Adult	50.4%	50.6%	0.2%
Other Family Type	62.4%	61.6%	-0.6%

Percentage of Consumer Units With Any Dependent Coverage			
Family Type	1980	1987	Change, 1980-87
Husband & Wife: No Minor Children	73.6%	70.3%	-3.3%
Husband & Wife: Children < 18 years old	82.8%	77.5%	-5.3%
Other Husband/Wife	74.8%	75.6%	0.8%
Single Mother: Children < 18 years old	61.0%	49.7%	-11.3%
Single Father: Children < 18 years old	74.8%	62.6%	-12.2%
Single Adult	11.2%	1.3%	-9.9%
Other Family Type	28.5%	24.2%	-4.3%

Source: Calculated by IWPR from unpublished data provided by the Bureau of Labor Statistics, U.S. Department of Labor, from the 1980 and 1987 Consumer Expenditure Surveys

are so low that many doctors refuse to serve Medicaid patients; numerous studies have documented that poor patients and uninsured patients receive lower quality health care. For example, use of obstetrical and gynecological services is lower for Medicaid patients than for others. Yet Medicaid does provide some care; the noninsured poor fare even worse. To give just one example of the impact of low socio-economic status on health, uterine cancer (including cervical cancer), the incidence of which has been slowly decreasing, is more prevalent among the poor. Yet a simple test, the Pap smear can detect this cancer; fully 90 percent of the deaths from cervical cancer could be prevented if women had more regular pap smears.

Two socio-economic factors in addition to women's greater responsibilities for families and their disproportionate representation in the secondary labor market and consequent poverty are important in assessing public policy proposals affecting health care: the added risks women face as the dominant health care providers, both in their own homes and in paid jobs, and the health risks associated with employment in typically female occupations.

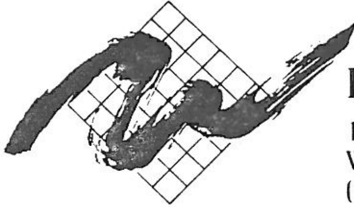
With respect to the former, women bear the brunt of at-home patient care, an especially large burden when the medical system encourages early discharge; in fact, early discharge presumes the availability of a caring adult. In paid health care, women are over 90 percent of the providers in long-term care settings; they earn low wages and often have no pensions or health insurance. Any proposals for improved long-term care must recognize the dire need for better working conditions for the women workers who provide the care.

With respect to the latter factor, occupational health and safety, some predominantly women's occupations are more dangerous than commonly thought (clerical work, for example, has been found to involve a very high level of stress). Yet, because the working conditions in stereotypically female jobs are thought to be less severe than those in typically male jobs, the health risks associated with women's occupations have been understudied. Because women are increasing their years of paid employment over their life times, occupational health risks can be expected to play an even larger role in women's overall health needs in the future. Also, we

need to realize that sexual harassment on the job causes serious health problems, including work absences, for many women.

I hope I have persuaded you that, because of women's physical differences and their different socio-economic status and roles, women's health care needs differ from men's. Paying attention to men's health care needs will not automatically meet women's needs. Women's needs must receive a greater share of the public and private resources devoted to health care and health research than is currently the case. Federal dollars, in health research, Medicaid, Medicare, and other health programs, must be more equitably allocated so that women's health needs are met. The Campaign for Women's Health will be watching and working toward that end. And over the months and years to come, as the Congress debates how best to reform the nation's health care system, the Campaign for Women's Health will be actively seeking to ensure that women's needs are met in any and all reform proposals. We welcome the initiatives taken by the Congress to date and we look forward to working with you as you address these issues.

Thank you.



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WOMEN'S HEALTH IN THE UNITED STATES
TABLES ON CAUSES OF MORTALITY
BY GENDER, RACE, AND AGE

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For a Briefing for Congressional Staff

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DIFFERENCES IN DEATH RATES FOR SELECTED CAUSES FOR BLACK AND WHITE WOMEN OF ALL AGES (AGE ADJUSTED)

Causes of Death	White Deaths per 100,000	Black Deaths per 100,000	Ratio of Black to White Rates
Heart Disease	114.2	118.1	1.6
Cancer	110.1	131.2	1.2
Breast	23.0	27.0	1.2
Lung	24.8	24.6	1.0
Stroke & Related	25.5	46.6	1.8
Maternal Causes	5.6	19.8	3.5
Homicide	2.8	12.7	4.5
AIDS	0.7	6.2	8.9
Suicide	5.1	2.4	0.5

Source: National Center for Health Statistics, Health United States 1990, U.S. Department of Health and Human Services, 1991, pps. 85-101 (DHHS Pub. No. [PHS] 91-1232)

DIFFERENCES IN DEATH RATES FOR SELECTED CAUSES FOR BLACK AND WHITE WOMEN BY AGE

Causes of Death	White Deaths per 100,000	Black Deaths per 100,000	Ratio of Black to White Rates
Women Aged 15-24			
AIDS	0.3	1.7	5.7
Maternal Causes	0.4	1.8	4.5
Homicide	3.9	17.4	4.5
Women Aged 25-44			
AIDS	1.5	15.4	10.3
Homicide	3.9	20.9	5.4
Pneumonia & Influenza	1.4	5.7	4.1
Women Aged 45-64			
Kidney Disease	3.9	17.1	4.4
Blood Poisoning	4.2	13.1	3.1
Diabetes	14.8	44.5	3.0
Women Aged 65 and Over			
Kidney Disease	49.8	109.7	2.2
Diabetes	92.5	196.8	2.1
Blood Poisoning	52.2	97.1	1.9

Source: Unpublished data from the National Center for Health Statistics, U.S. Department of Health and Human Services

LEADING CAUSES OF DEATH FOR ADULTS BY RACE AND SEX FOR AGES 15-24

Top Ten Causes of Death for White Women, Ages 15-24, 1988		
Cause of Death	Number	Deaths per 100,000
1. Accidents	3,742	24.8
2. Suicide	690	4.6
3. Cancer	627	4.2
4. Homicide	589	3.9
5. Heart Diseases	255	1.7
6. Congenital Anomalies	183	1.2
7. Stroke & Related	91	0.6
8. Pneumonia & Influenza	84	0.6
9. Maternal Causes	56	0.4
10. Pulmonary Diseases	51	0.3

Top Ten Causes of Death for Black Women, Ages 15-24, 1988		
Cause of Death	Number	Deaths per 100,000
1. Homicide	485	17.4
2. Accidents	417	15.0
3. Cancer	136	4.9
4. Heart Diseases	122	4.4
5. Suicide	71	2.6
6. Maternal Causes	50	1.8
7. AIDS	48	1.7
8. Anemias	33	1.2
9. Pneumonia & Influenza	33	1.2
10. Stroke & Related	30	1.1

Top Ten Causes of Death for White Men, Ages 15-24, 1988		
Cause of Death	Number	Deaths per 100,000
1. Accidents	12,147	78.5
2. Suicide	3,618	23.9
3. Homicide	1,784	11.5
4. Cancer	916	5.9
5. Heart Diseases	479	3.1
6. AIDS	282	1.8
7. Congenital Anomalies	210	1.4
8. Stroke & Related	116	0.7
9. Pneumonia & Influenza	99	0.6
10. Diabetes	50	0.3

Top Ten Causes of Death for Black Men, Ages 15-24, 1988		
Cause of Death	Number	Deaths per 100,000
1. Homicide	2,762	101.8
2. Accidents	1,592	58.7
3. Suicide	394	14.5
4. Heart Diseases	214	7.9
5. Cancer	169	6.2
6. AIDS	161	5.9
7. Congenital Anomalies	49	1.8
8. Pulmonary Diseases	44	1.6
9. Pneumonia & Influenza	42	1.5
10. Anemias	34	1.3

Source: Unpublished data from the National Center for Health Statistics, U.S. Department of Health and Human Services

LEADING CAUSES OF DEATH FOR ADULTS BY RACE AND SEX FOR AGES 25-44

Top Ten Causes of Death for White Women, Ages 25-44, 1988		
Cause of Death	Number	Deaths per 100,000
1. Cancer	9,076	27.3
2. Accidents	5,015	15.1
3. Heart Diseases	2,597	7.8
4. Suicide	2,219	6.7
5. Homicide	1,293	3.9
6. Stroke & Related	978	2.9
7. Liver Diseases & Cirrhosis	819	2.5
8. Diabetes	591	1.8
9. AIDS	514	1.5
10. Pneumonia & Influenza	480	1.4

Top Ten Causes of Death for Black Women, Ages 25-44, 1988		
Cause of Death	Number	Deaths per 100,000
1. Cancer	1,985	39.9
2. Heart Diseases	1,436	28.8
3. Accidents	1,080	21.7
4. Homicide	1,042	20.9
5. AIDS	768	15.4
6. Stroke & Related	539	10.8
7. Liver Diseases & Cirrhosis	431	8.7
8. Pneumonia & Influenza	285	5.7
9. Diabetes	217	4.4
10. Suicide	183	3.7

Top Ten Causes of Death for White Men, Ages 25-44, 1988		
Cause of Death	Number	Deaths per 100,000
1. Accidents	17,887	53.3
2. Heart Diseases	8,660	25.8
3. Suicide	8,375	25.0
4. Cancer	7,686	22.9
5. AIDS	7,614	22.7
6. Homicide	4,007	11.9
7. Liver Diseases & Cirrhosis	2,384	7.1
8. Stroke & Related	1,153	3.4
9. Diabetes	925	2.8
10. Pneumonia & Influenza	875	2.6

Top Ten Causes of Death for Black Men, Ages 25-44, 1988		
Cause of Death	Number	Deaths per 100,000
1. Homicide	4,202	97.0
2. Accidents	3,471	80.1
3. AIDS	3,224	74.4
4. Heart Diseases	2,677	61.8
5. Cancer	1,543	35.6
6. Suicide	859	19.8
7. Liver Diseases & Cirrhosis	833	19.2
8. Stroke & Related	624	14.4
9. Pneumonia & Influenza	528	12.2
10. Diabetes	293	6.8

Source: Unpublished data from the National Center for Health Statistics, U.S. Department of Health and Human Services

LEADING CAUSES OF DEATH FOR ADULTS BY RACE AND SEX FOR AGES 45-64

Top Ten Causes of Death for White Women, Ages 45-64, 1988

Cause of Death	Number	Deaths per 100,000
1. Cancer	53,526	259.0
2. Heart Diseases	27,241	131.8
3. Stroke & Related	5,195	25.1
4. Pulmonary Diseases	4,922	23.8
5. Accidents	3,678	17.8
6. Diabetes	3,056	14.8
7. Liver Diseases & Cirrhosis	2,894	14.0
8. Suicide	1,707	8.3
9. Pneumonia & Influenza	1,667	8.1
10. Blood Poisoning	871	4.2

Top Ten Causes of Death for Black Women, Ages 45-64, 1988

Cause of Death	Number	Deaths per 100,000
1. Cancer	8.084	313.1
2. Heart Diseases	7,884	305.3
3. Stroke & Related	1,844	71.4
4. Diabetes	1,149	44.5
5. Liver Diseases & Cirrhosis	633	24.5
6. Accidents	596	23.1
7. Pulmonary Diseases	578	22.4
8. Kidney Disease	441	17.1
9. Pneumonia & Influenza	423	16.4
10. Blood Poisoning	339	13.1

Top Ten Causes of Death for White Men, Ages 45-64, 1988

Cause of Death	Number	Deaths per 100,000
1. Heart Diseases	70,436	364.4
2. Cancer	61,935	320.5
3. Accidents	8,672	44.9
4. Liver Diseases & Cirrhosis	6,713	34.7
5. Pulmonary Diseases	6,435	33.3
6. Stroke & Related	6,219	32.2
7. Suicide	4,824	25.0
8. Diabetes	3,295	17.0
9. Pneumonia & Influenza	2,747	14.2
10. AIDS	2,277	11.8

Top Ten Causes of Death for Black Men, Ages 45-64, 1988

Cause of Death	Number	Deaths per 100,000
1. Heart Diseases	12,113	573.0
2. Cancer	10,726	507.4
3. Stroke & Related	2,182	103.2
4. Accidents	1,858	87.9
5. Liver Diseases & Cirrhosis	1,228	58.1
6. Pneumonia & Influenza	939	44.4
7. Diabetes	900	42.6
8. Pulmonary Diseases	856	40.5
9. Homicide	800	37.8
10. AIDS	695	32.9

Source: Unpublished data from the National Center for Health Statistics, U.S. Department of Health and Human Services

LEADING CAUSES OF DEATH FOR ADULTS BY RACE AND SEX FOR AGES 65+

Top Ten Causes of Death for White Women, Ages 65+, 1988		
Cause of Death	Number	Deaths per 100,000
1. Heart Diseases	306,409	1,891.9
2. Cancer	136,791	844.6
3. Stroke & Related	73,022	450.9
4. Pneumonia & Influenza	34,818	215.0
5. Pulmonary Diseases	26,541	163.9
6. Diabetes	14,981	92.5
7. Atherosclerosis	12,447	76.9
8. Accidents	12,064	74.5
9. Blood Poisoning	8,448	52.2
10. Kidney Disease	8,068	49.8

Top Ten Causes of Death for Black Women, Ages 65+, 1988		
Cause of Death	Number	Deaths per 100,000
1. Heart Diseases	30,236	2,018.4
2. Cancer	13,312	888.7
3. Stroke & Related	7,924	529.0
4. Diabetes	2,948	196.8
5. Pneumonia & Influenza	2,270	151.5
6. Kidney Disease	1,643	109.7
7. Blood Poisoning	1,454	97.1
8. Accidents	1,090	72.8
9. Pulmonary Diseases	1,046	69.8
10. Atherosclerosis	880	58.7

Top Ten Causes of Death for White Men, Ages 65+, 1988		
Cause of Death	Number	Deaths per 100,000
1. Heart Diseases	261,302	2,353.4
2. Cancer	153,159	1,379.4
3. Stroke & Related	43,110	388.3
4. Pulmonary Diseases	37,971	342.0
5. Pneumonia & Influenza	28,174	253.8
6. Accidents	11,894	107.1
7. Diabetes	9,724	87.6
8. Kidney Disease	7,322	65.9
9. Atherosclerosis	6,969	62.8
10. Blood Poisoning	5,751	51.8

Top Ten Causes of Death for Black Men, Ages 65+, 1988		
Cause of Death	Number	Deaths per 100,000
1. Heart Diseases	24,331	2,428.2
2. Cancer	17,749	1,771.4
3. Stroke & Related	5,228	521.8
4. Pulmonary Diseases	2,520	251.5
5. Pneumonia & Influenza	2,375	237.0
6. Accidents	1,523	152.0
7. Diabetes	1,430	142.7
8. Kidney Disease	1,190	118.8
9. Blood Poisoning	1,050	104.8
10. Atherosclerosis	639	63.8

Source: Unpublished data from the National Center for Health Statistics, U.S. Department of Health and Human Services