Health Equity in Context

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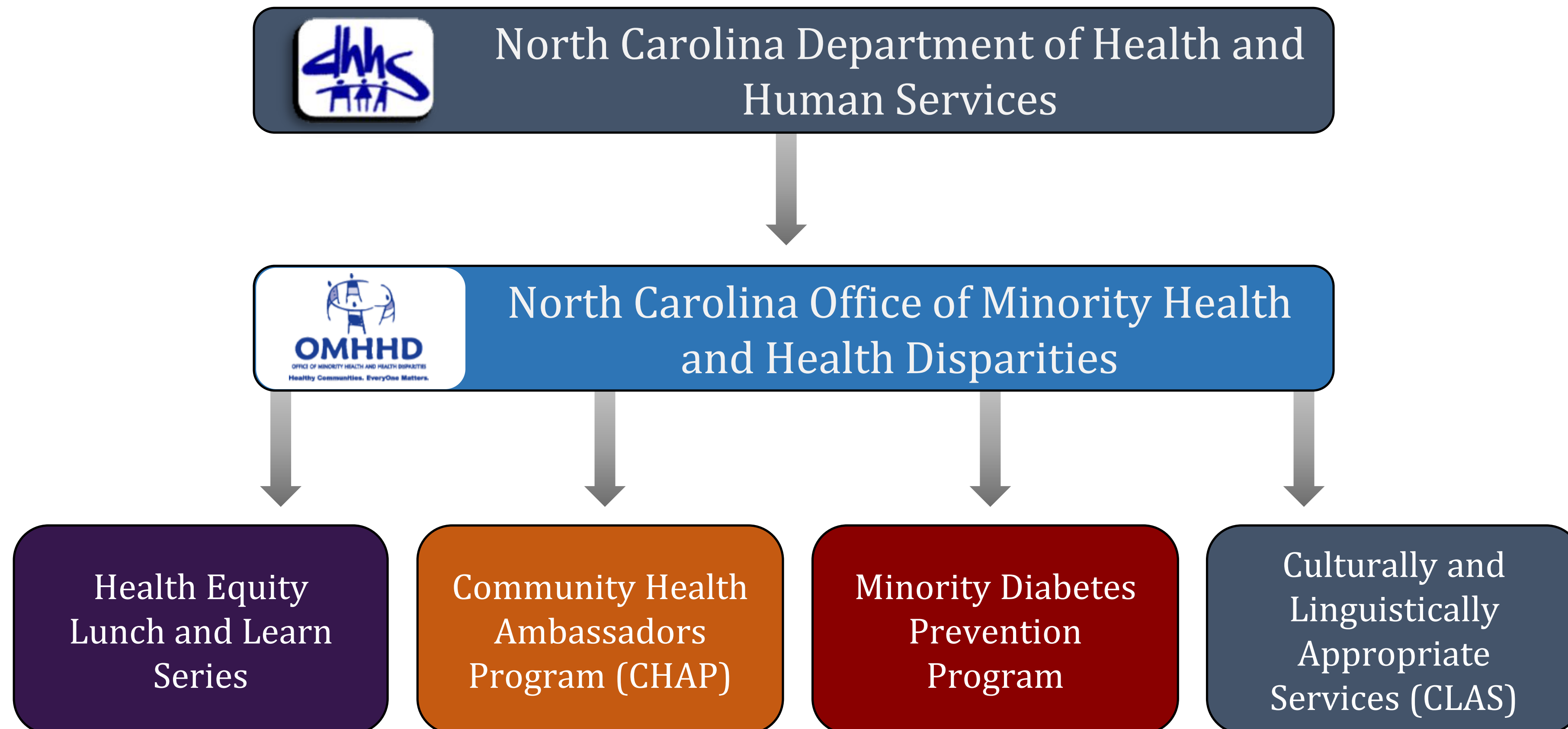
Office of Minority Health and Health Disparities

Organization



Source: www.ncminorityhealth.org

Minority Health Advisory Council

"To advance the elimination of health and health care disparities among racial/ethnic minorities and underserved populations through health equity advocacy."

Mandate:
The Council has the following duties and responsibilities to serve racial/ethnic minority communities:

- Advise and make recommendations to the Governor and Secretary of Health and Human Services
- Identify limitations associated with existing laws, regulations, programs, and services
- Examine the financing and access to health services
- Identify and review health promotion and disease prevention strategies
- Support policies and legislation to improve accessibility and delivery of health services

Source: NC MHAC

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"To advance the elimination of health and health care disparities among racial/ethnic minorities and underserved populations through health equity advocacy."

Subject: Minority Health Advisory Council 2017 Annual Report
Minority Health Advisory Council Members
NC Office of Minority Health and Health Disparities

August 3, 2017

Dear Governor Cooper,

This report contains a summary of health statistics and recommendations to improve population health outcomes among underserved populations for fiscal year 2017-18. The report is divided into two sections. Section I is an Executive Summary of findings and general recommendations resulting from the review of health outcomes and quality of life among racial and ethnic minority populations throughout North Carolina. Section II is a detailed report of specific recommendations for each of the suggested targeted areas of improvement.

Section I: Executive Summary

Diversity is one of North Carolina's (NC) greatest assets. The spirit and creativity of North Carolinians continue to power culture, innovation, and leadership in local, national, and global stages. Regrettably, health outcomes and quality of life among North Carolinians remains inequitable. Racial and ethnic minority populations throughout North Carolina are disproportionately burdened by diabetes, cancer, and inadequate access to reproductive health services and education. The NC Minority Health Advisory Council (MHAC) and the NC Office of Minority Health and Health Disparities (OMHHD) present a summary of health statistics and recommendations to improve population health outcomes among underserved populations for fiscal year 2017-18.

MHAC recommends prioritizing health conditions that: (1) have a significant social and economic burden on all North Carolinians by reducing the quality of life and increasing healthcare expenditures; (2) disproportionally affect racial and ethnic minority populations (i.e., Black/African Americans, American Indians, and Hispanic/Latinx); and (3) can be improved with appropriate resource allocation, screening, and/or education. We therefore recommend that the following conditions be targeted for improvement:

- Prediabetes and Diabetes
- Colon and Prostate Cancers
- Infant Mortality

Reducing health disparities among racial and ethnic minority populations in the state will increase quality of life for all North Carolinians and reduce the economic burden of poor health on families and healthcare systems. MHAC is committed to providing continuous guidance to ensure that all North Carolinians have the opportunity to live healthy lives. We look forward to working with your office to continue improving the health of communities throughout the state and stand ready to assist you in your efforts to address our general recommendations to:

(1) Increase access to healthcare screenings and services;
(2) Increase health education programs across the state; and
(3) Increase awareness of racial and ethnic health disparities and the social and financial burden they place on the entire NC population.

Respectfully Yours,

Leon G. Coleman, Jr, MD, PhD
Chair, Minority Health Advisory Council

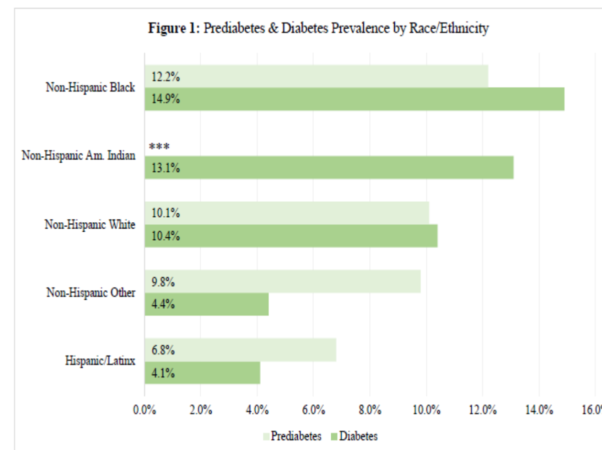
Background Information

Prediabetes & Diabetes

Approximately 2.5 million North Carolinians have prediabetes. Without health-improving lifestyle changes, 15% to 30% of those with prediabetes will develop type 2 diabetes within five years. One in three adults in NC has been diagnosed with diabetes, while an estimated 280,000 adults unknowingly live with the condition.[1]

According to the most recent data from the NC Behavioral Risk Factor Surveillance System (BRFSS), the Hispanic/Latinx population has the lowest prevalence of prediabetes and diabetes in NC (**Figure 1**); non-Hispanic Blacks experience the highest prevalence of each (43.3% greater prevalence of diabetes and 20.8% greater prevalence of prediabetes compared to non-Hispanic Whites). American Indians also experience a relatively high prevalence of diabetes compared to non-Hispanic Whites (26.0% greater prevalence).

Figure 1: Prediabetes & Diabetes Prevalence by Race/Ethnicity



Source: NC Department of Health & Human Services, State Center for Health Statistics; Behavioral Risk Factor Surveillance System (BRFSS), 2015
***Estimate was suppressed because it did not meet statistical reliability standards

Source: NC MHAC Report

Key Terms and Definitions

Health equity is the opportunity for everyone to have good health.

Health inequities are the unfair differences that prevent everyone from the opportunity to have good health.

Health disparities are the measureable differences or gaps seen in one group's health status in relation to another or other group(s).

Social determinants of health are social factors that greatly influence the health and quality of life in neighborhoods and communities

Source: www.ncminorityhealth.org

Key Terms and Definitions

Food deserts are areas with low access to supermarkets and/or large grocery stores.

Food swamps are areas with little to no access to healthy food options.

Health in all policies is an approach to improving health by incorporating health considerations into decision-making across sectors and policy areas.

Health equity in all policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.

Person of color is someone who is not white or of European parentage.

Source: www.ncminorityhealth.org

Equality is a good thing, but...

Equality ≠ Equity

Equality refers to equal inputs, though the outcomes can still be unequal.

EQUALITY VERSUS EQUITY

In the first image, it is assumed that everyone will benefit from the same supports. They are being treated equally.

In the second image, individuals are given different supports to make it possible for them to have equal access to the game. They are being treated equitably.

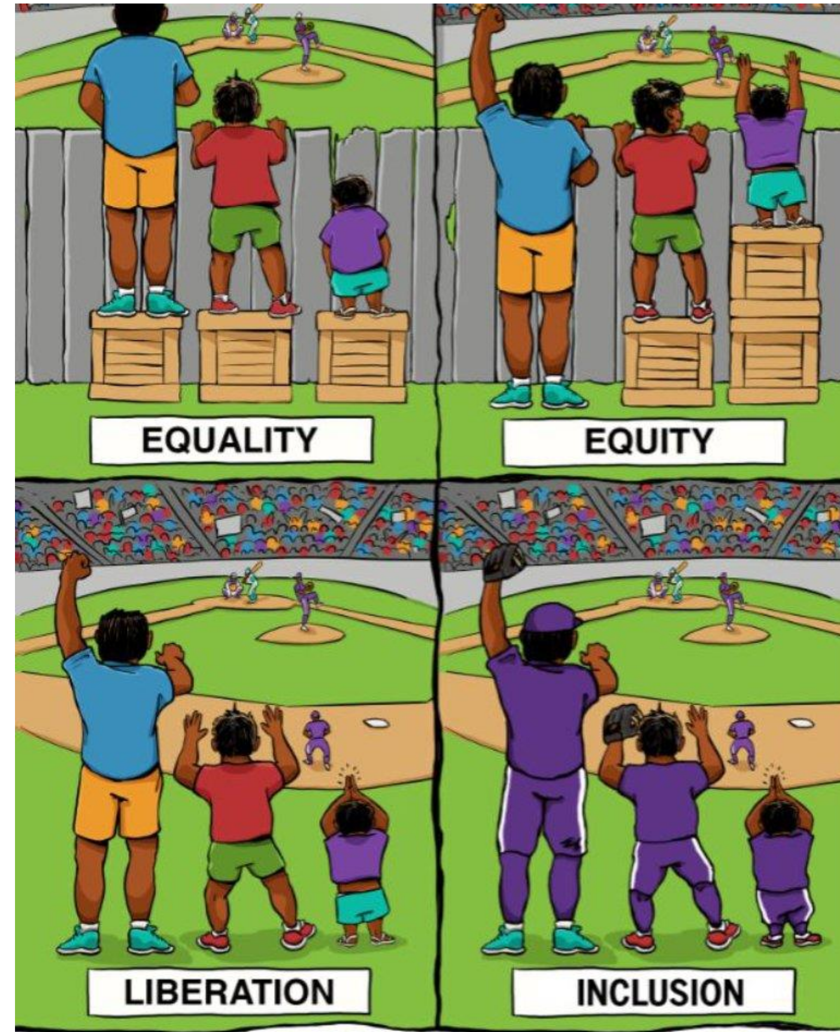
In the third image, all three can see the game without any supports or accommodations because the cause of the inequity was addressed. The systemic barrier has been removed.

With equity, inputs may need to be different to achieve equal outcomes.

Equality refers to inputs, equity to outcomes.

Advancing Equity Inclusion

The Hidden Fences of Health Equity



Inclusion means involvement in the process

The 4th Box

What Influences Health Equity?

- Where we live, learn, work and play has a tremendous impact on health.
- Social factors such as housing, education, income and employment greatly influence the health and quality of life in neighborhoods and communities.

Source: www.cdc.gov/socialdeterminants/

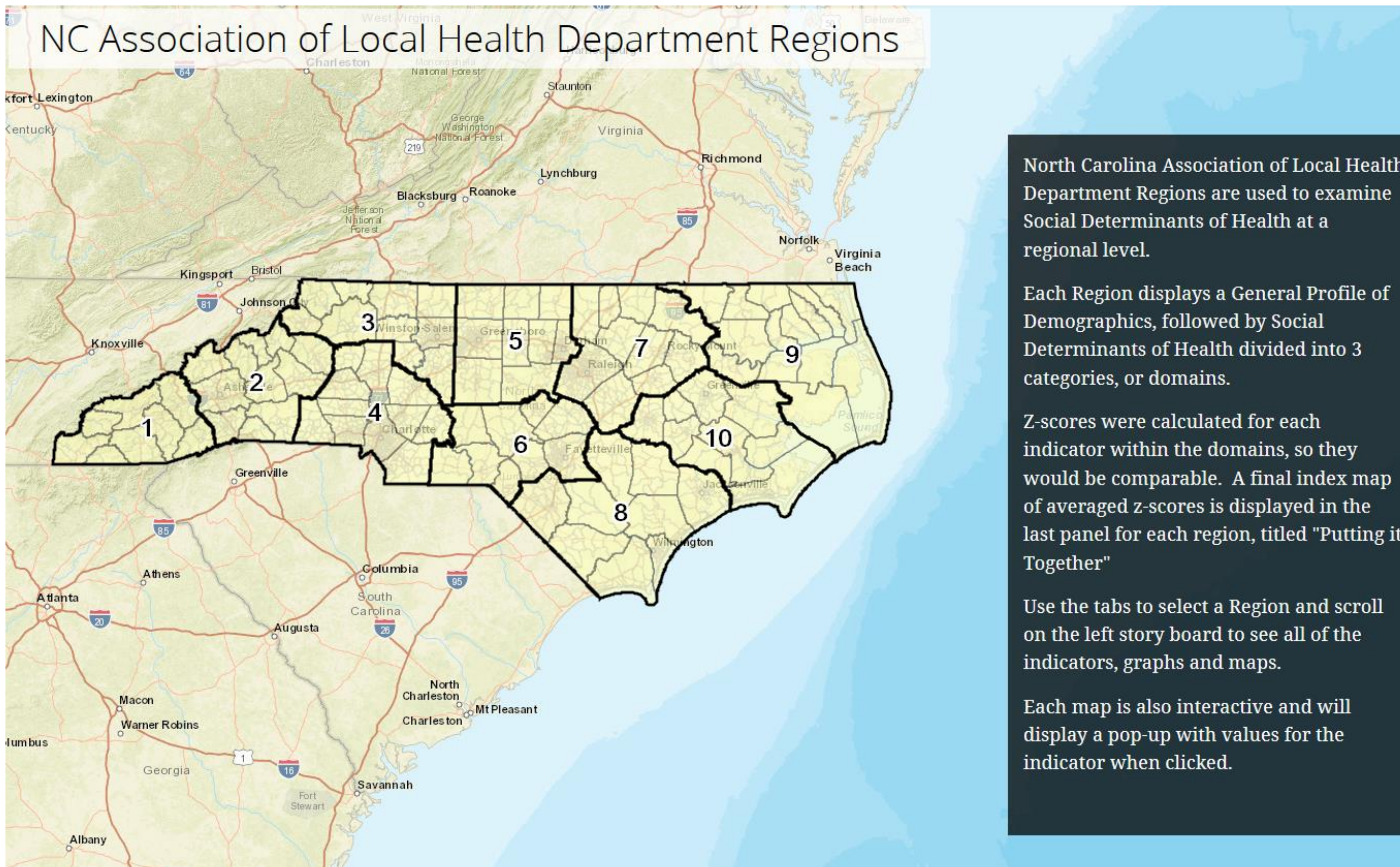
North Carolina Social Determinants of Health by Regions

About | Region 1 | Region 2 | Region 3 | Region 4 | Region 5 | Region 6 | Region 7 | Region 8 | Region 9 | Region 10

Overview

Social Determinants of Health

Source: NC SDOH Maps



Source: NC SDOH Maps

A story on health influences

Local Health Departments Region 1

The conditions in which people live, work, play, and worship are known as **Social Determinants of Health**. (Healthy People 2020) These conditions can have influence on a wide range of health and quality of life outcomes.

Social Determinants of Health

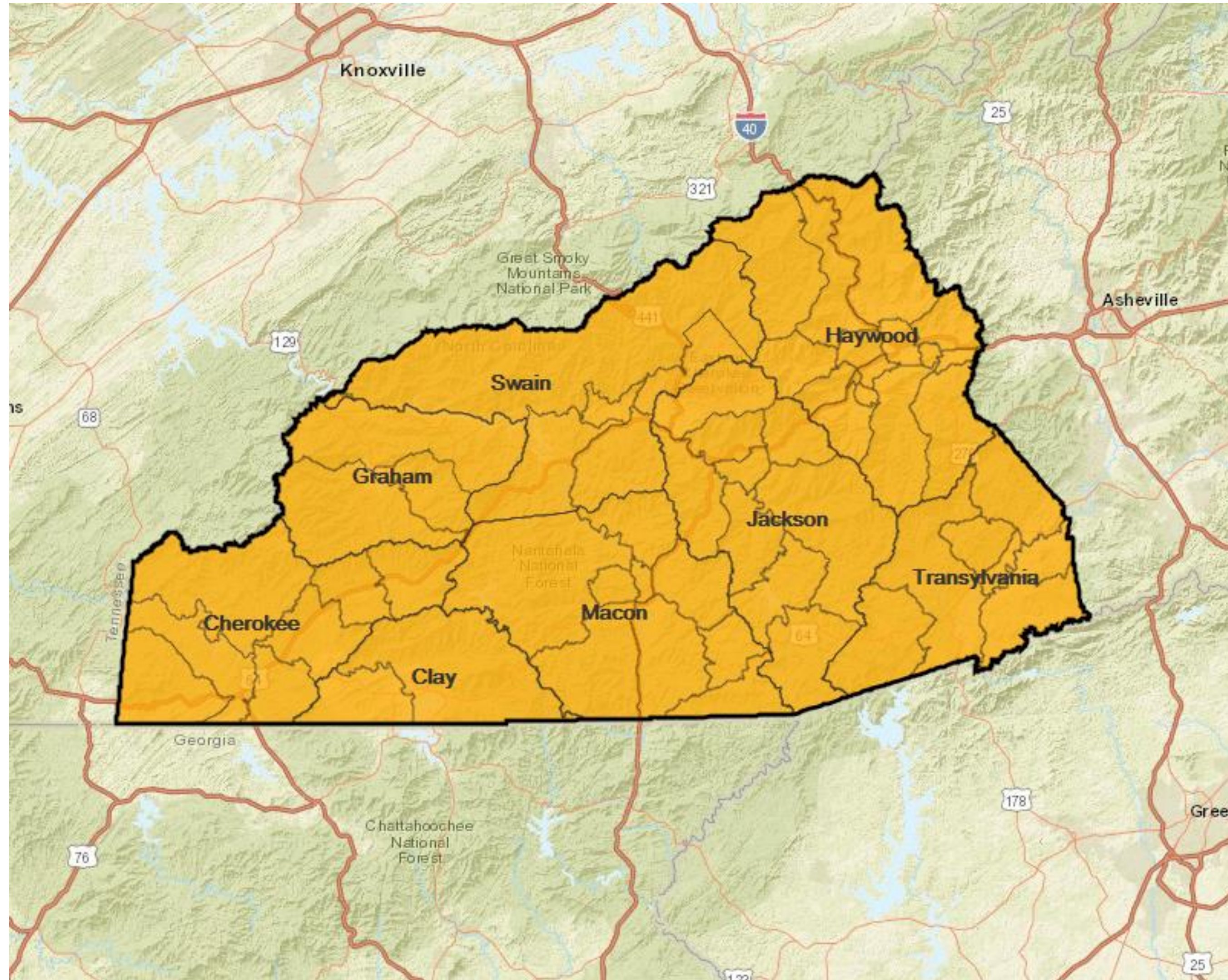
Source: NC SDOH Maps

Social Determinants of Health

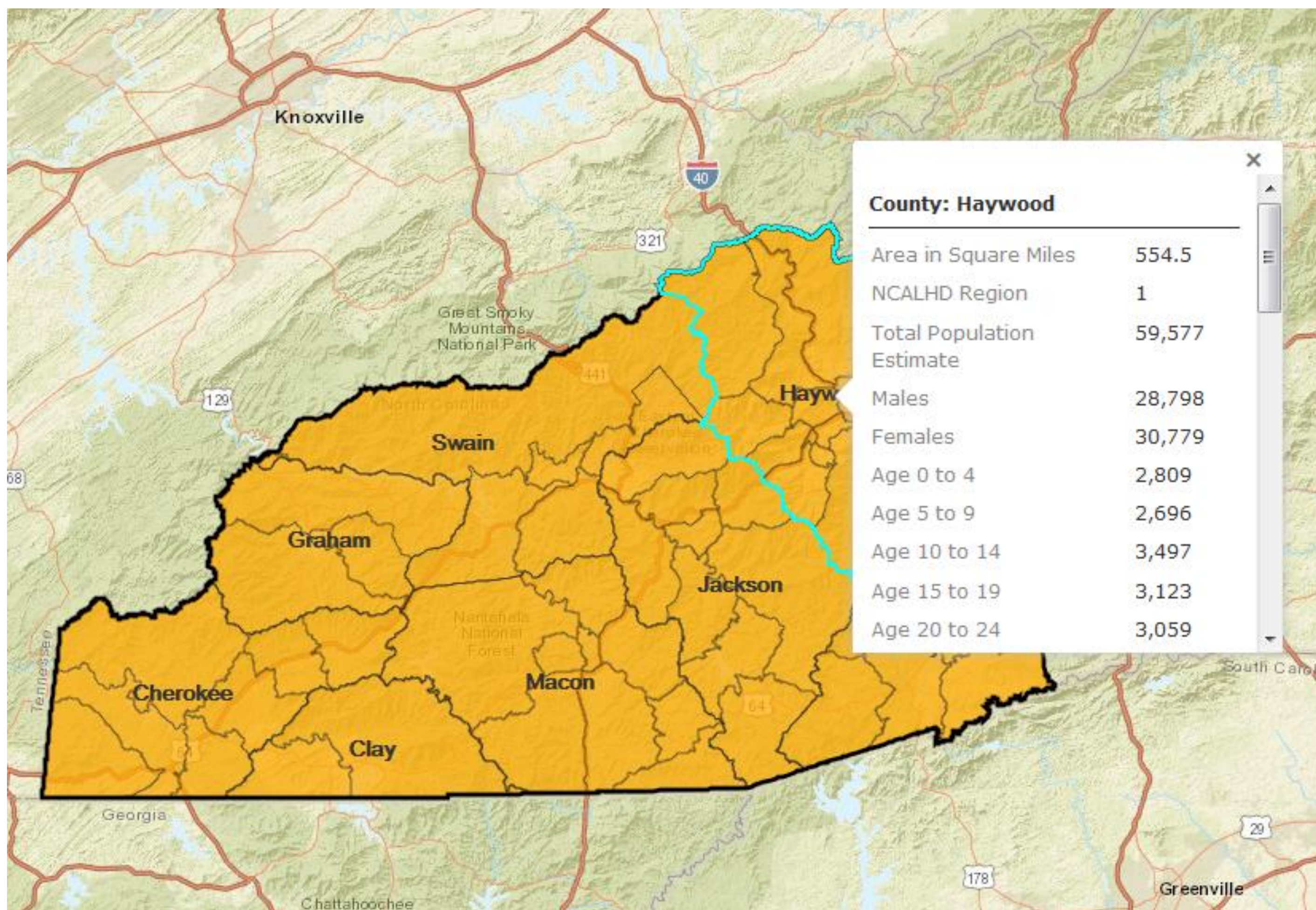
This story map displays a set of indicators along with an overall index to help understand the geographic disparities in the social determinants of health. These data are tabulated at the U.S. Census Tract level and are from the *U.S. Census American Community Survey* 2016 *5-year estimates (2012-2016)*. The data on food access is from the USDA Food and Nutrition Service, (Update 2015 based on 2010 Census).

This story map is based on work first done at the University of North Carolina Gillings School of Public Health and the Carolinas HealthCare System.

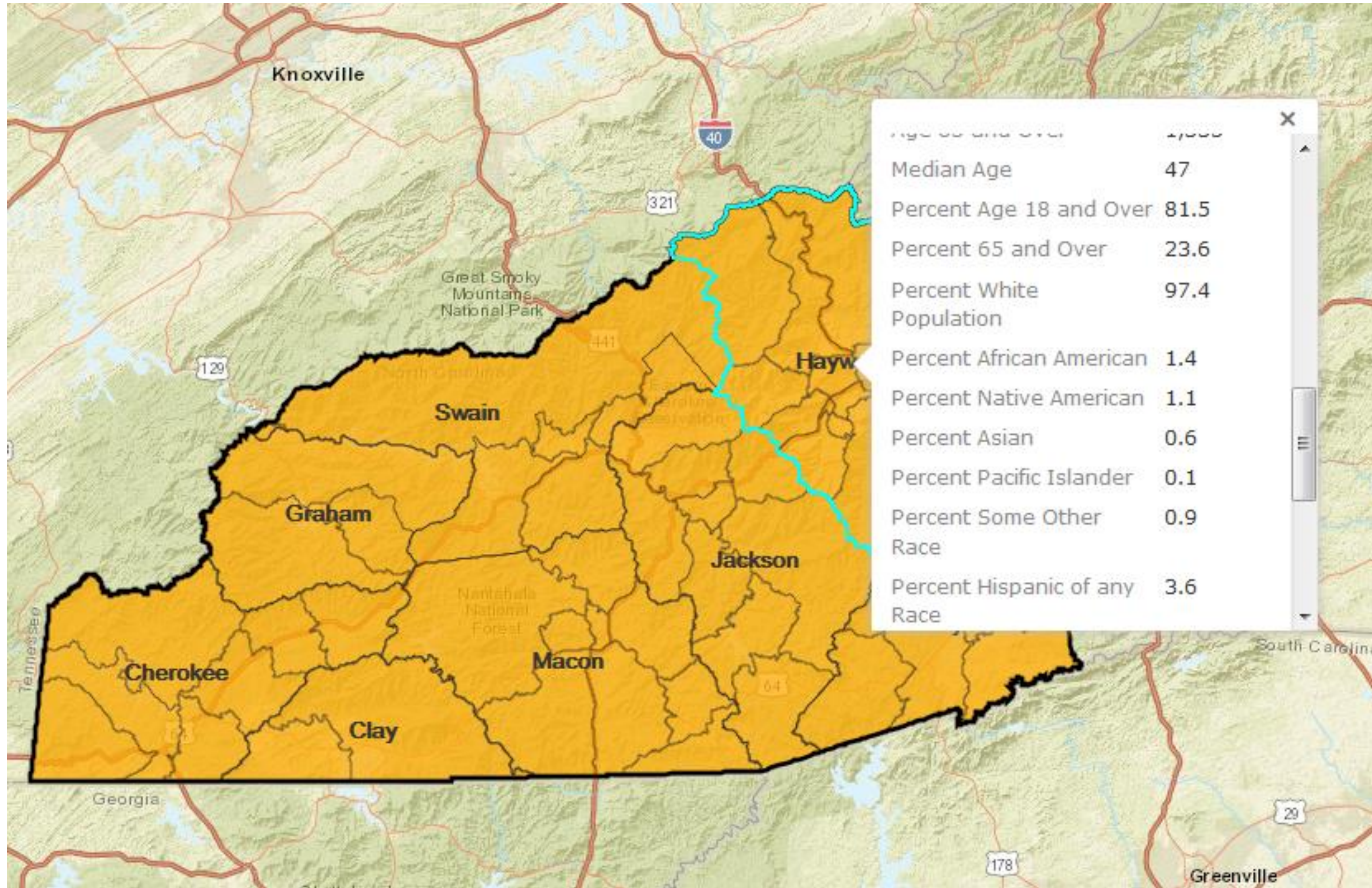
Source: NC SDOH Maps



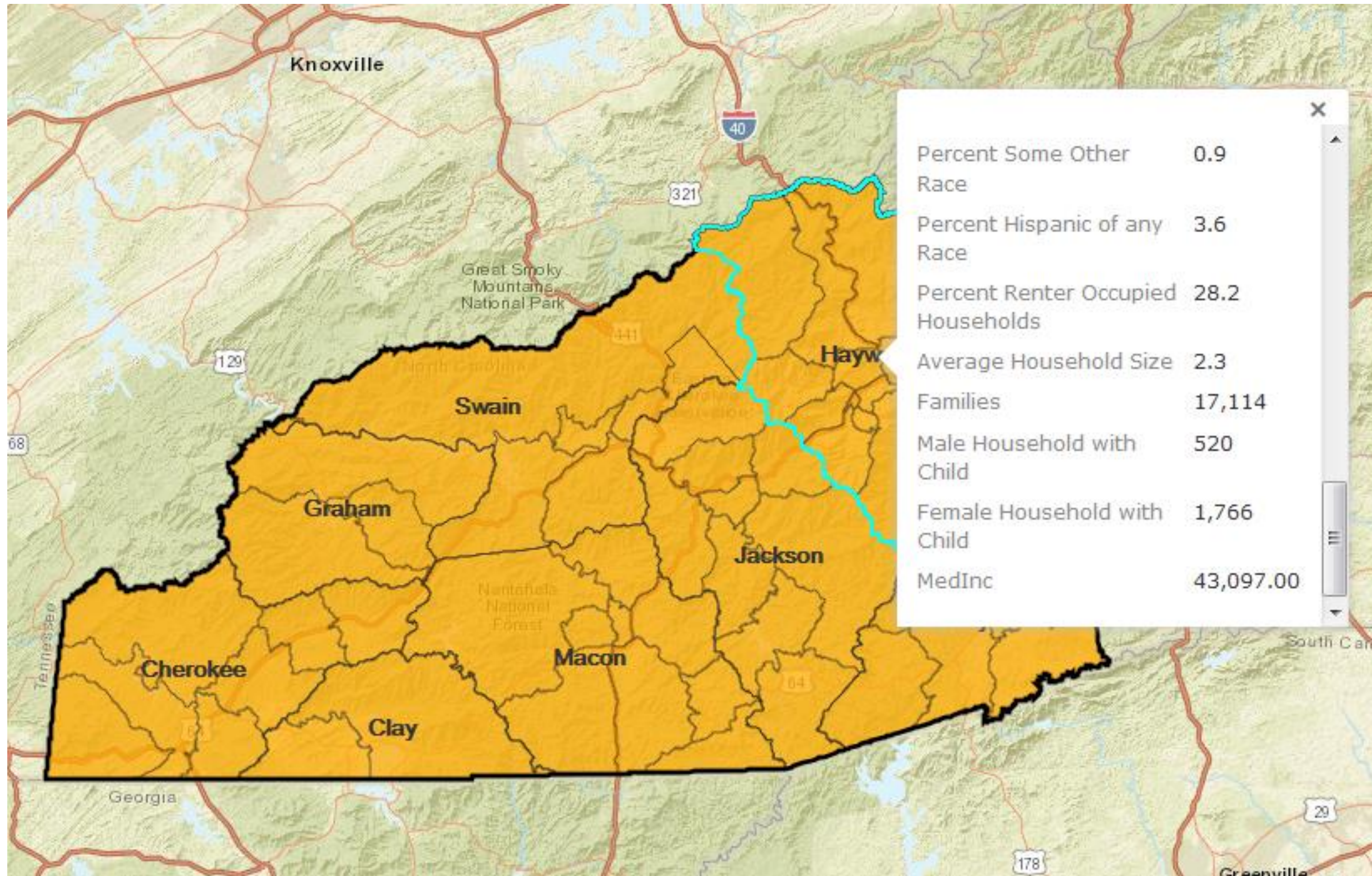
Source: NC SDOH Maps



Source: NC SDOH Maps



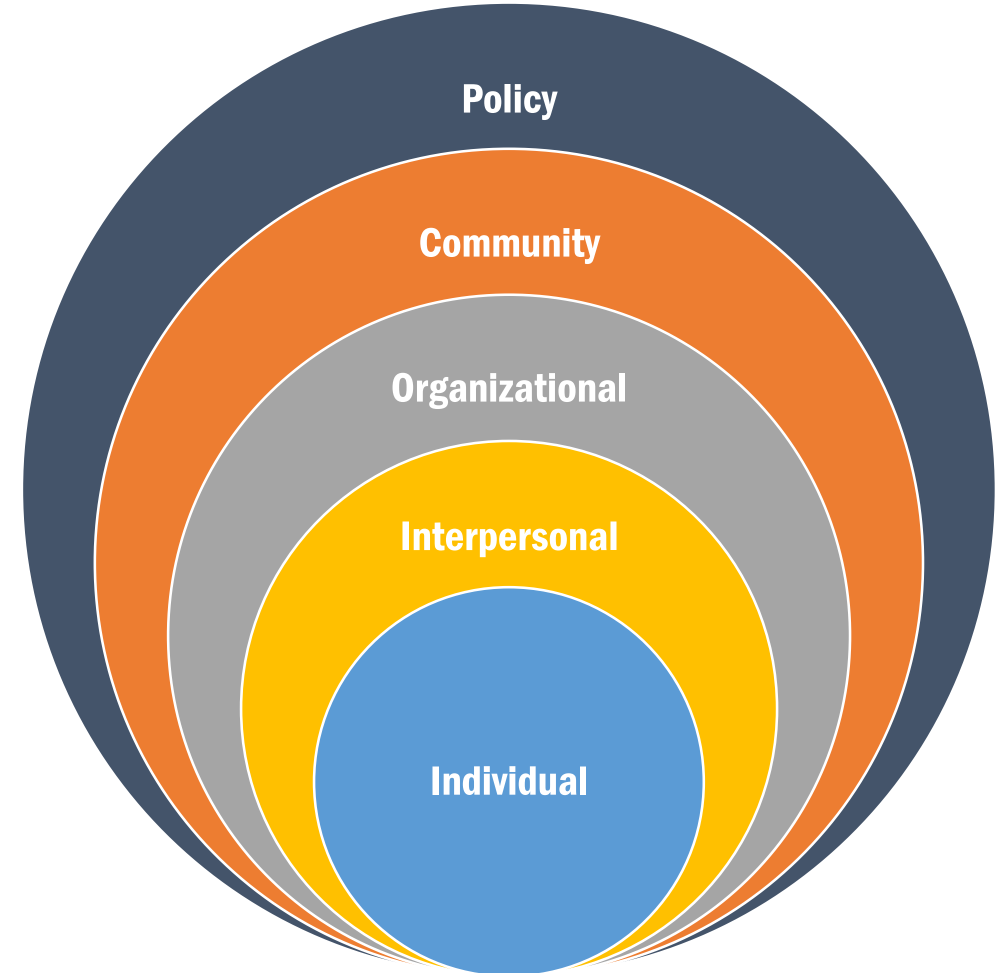
Source: NC SDOH Maps



Source: [NC SDOH Maps]

What Influences Health Equity?

- **Policy**
  National, State, Local Laws, Policies, Regulations
- **Community**
  Relationships among Organizations
- **Organizational**
  Organizations, Social Institutions
- **Interpersonal**
  Family, Friends, Social Networks
- **Individual**
  Genetics, Knowledge, Behavior



Understanding Health Equity:
Barriers

Commonly recorded barriers:

- Access/Opportunity
- Transportation
- Workforce
- Financial
- Education
- Fear/Mistrust
- Myths/Misinformation

Understanding Health Equity:
Barriers

Understanding Community Complexities:

- “Non Compliance”
- “Frequent Flyers”
- “Color-Blind Care”
- Geographic Make-up
- Food Access
- Lack of Plain Language

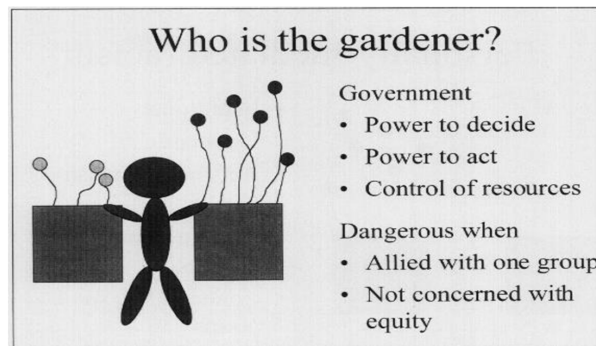
Levels of Racism: A Theoretic Framework and a Gardener's Tale

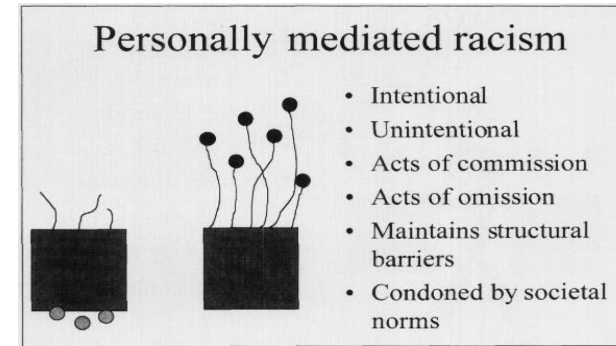
Dr. Jones shares a simple yet remarkably profound allegory that she grew and nurtured to help people come to a place of understanding about the many layers and nuances of institutionalized, personally-mediated, and internalized racism.

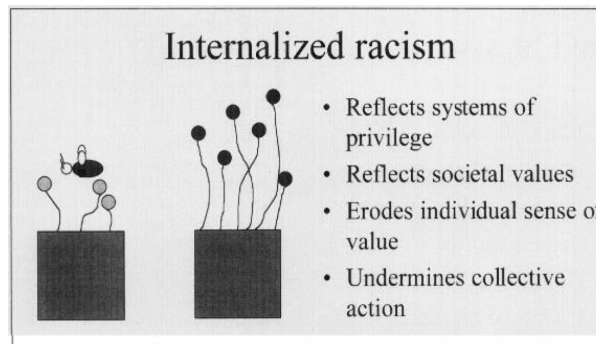
Camara Phyllis Jones, MD, MPH, PhD

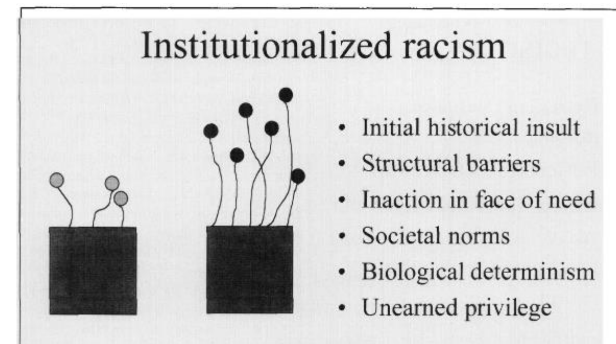
Past-President

American Public Health Association (APHA)









RACIAL AND ETHNIC HEALTH DISPARITIES IN NORTH CAROLINA

NORTH CAROLINA HEALTH EQUITY REPORT 2018

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Minority Health and Health Disparities

Source: NC Health Equity Report 2018

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Source: NC Health Equity Report 2018

UNDERSTANDING HEALTH

There are a few concepts we need to know before we can understand health.

Health equity is the absence of avoidable or remediable differences, allowing for the attainment of optimal health for all people. Health equity is achieved when everyone has the opportunity to attain their full health potential and no one is disadvantaged because of socially determined circumstances. Achieving it requires focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.[1]

Health inequities are unfair health differences closely linked to social, environmental, or economic disadvantages that adversely affect specific groups of people. Inequity involves more than inequality with respect to health determinants and access to resources; it also represents a failure to avoid or overcome inequalities that infringe on fairness and human rights norms. It is important to understand that health inequities are different from health disparities.

Health disparities are measurable differences in health status between people that are related to social or demographic factors such as race, gender, income, or geographic region. While ensuring equality in health and access to resources seems appropriate to mitigate health disparities, it should be noted that equality differs greatly from equity. *Figure 1* demonstrates the differences between these concepts.

Equality, demonstrated in the first image, refers to equal inputs, though the outcomes can still be unequal.

Equity, demonstrated in the second image, refers to inputs that may need to be different to achieve equal outcomes.

In the third image, no support or accommodations are needed because the cause of inequity has been addressed and the systematic barrier has been removed.

Social Determinants of Health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. The five determinant areas that reflect the critical components that influence health outcomes in the state of North Carolina are neighborhood and built environment, economic stability, health

FIGURE 1: EQUALITY VS. EQUITY

Photo adapted by *City for All Women Initiatives* equity and inclusion lens.

Source: NC Health Equity Report 2018

and health care, education, and social and community context. Within those areas, access to healthy foods, primary and other quality health care, and environmental conditions have a significant impact on disease development and prevention. For years, wealth and income have been linked to health. Economic resources protect people from certain daily stressors that, over time, can be particularly damaging to health.

ACCESS TO HEALTHY FOODS

Diet plays a critical role in the incidence and prevalence of chronic diseases. In 2014, 23 percent of North Carolina's total population lived in **food deserts** – areas where residents experienced both a lack of access to supermarkets and healthy food, and high death rates from diet-related disease. The lack of adequate transportation available in low-income, segregated communities exacerbates malnutrition among the poor by hindering access to healthy foods in surrounding grocery stores.

ENVIRONMENTAL CONDITIONS

Racial and ethnic communities are less likely to have access to parks and other physical activity settings compared to white communities. Resource-poor neighborhoods can contribute to chronic and acute daily stress. Stress and other negative emotions have shown to evoke physiological processes that are associated with cardiovascular and liver diseases, obesity, hypertension, and diabetes.[2]

ACCESS TO HEALTH CARE

Residents living in low-income, segregated communities face greater barriers in accessing health services due to a growing shortage of providers. Adding to the problem is the lack of physicians willing and able to work in impoverished neighborhoods. Access to quality health care is an important component of prevention and management. Studies have shown that many low-income individuals do not seek needed medical care due to competing priorities, such as having to pay for food, shelter, or utilities bills.[3] Adults and children from all racial minority and ethnic groups are less likely to have a usual place of care than whites.

Source: NC Health Equity Report 2018

Racial and Ethnic Health Disparities in North Carolina

PURPOSE OF THIS REPORT

Racial and Ethnic Health Disparities in North Carolina Health Equity Report 2018 is a tool that:

- Measures and monitors the state's progress toward eliminating the health status gaps experienced by racial/ethnic minorities;
- Provides current data that can aid community-based organizations, faith-based organizations, tribal governments, local health departments, state agencies, legislators, local businesses, and communities in devising services and outreach plans; and
- Can inform key decision makers about eliminating health disparities through policy reform and system change.

America's Health Rankings a report that analyzes states' health through the lens of clinical care, behaviors, community and environment, policy, and outcomes data, ranks North Carolina 32nd in the nation in overall health status in 2016. Health status is directly impacted by the health status of minorities and other underserved populations.

ABOUT THE DATA

This North Carolina Health Equity Report contains data from various sources. The key indicators used were chosen based on their relevance to health and health disparities and the availability of data. Although data are presented by race/ethnicity to describe health status gaps, race/ ethnicity by itself is not a cause of any health condition or health status. For this 2018 Health Equity Report, all rates presented by race/ethnicity are mutually exclusive categories. Therefore, rates and figures presented here will differ from earlier Report Cards. Note: Some data show percentages, e.g., from the North Carolina Behavioral Risk Factor Surveillance System (BRFSS), while other data show rates per 100,000 population (e.g., mortality data).

The ratios in this report are a measure, within each of the predominant racial/ ethnic groups in North Carolina, divided by that same measure in the White group; each indicates whether a disparity exists and the extent of that difference. The white population is used as a point of comparison because they are the majority population in North Carolina. In this report, the ratios have been categorized by color: red indicates a group fares worse than the referent group, green indicates a group fares better than the referent group, and white indicates no significant difference between the referent and comparison group.

Here is an example.

The 2004—2008 prostate cancer death rate shown for African Americans (59.1) divided by the prostate cancer death rate for whites (21.3) provides a ratio of 2.8 (i.e., 59.1÷21.3=2.8). This ratio indicates that the prostate cancer death rate for African American men was 2.8 times the rate for white men during this time period.

The color coding system provided in this report does not consider trends in the data nor the ranking of North Carolina relative to the United States. Also note that data are not shown in cases where racial/ethnic groups have a small number of reported events or if their rates/ percentages are statistically unstable. The ♦ symbol is used to indicate reliable rates could not be calculated.

Source: NC Health Equity Report 2018

HEALTH EQUITY REPORT SUMMARY

Subject	Subcategory	African American	American Indian	Hispanic/Latinx	Other
Social and Economic Well-Being	Income				
	Education				
	Employment				
Maternal/Child Health	Infant Death Rate				
	Late or No Prenatal Care				
Child and Adolescent Health	Death of Children				
	Teen Pregnancy				
	Children without Health Insurance		♦		
Risk Factors	Current Smokers				
	Overweight		♦		
Mortality Rates	Cancer				
	Heart Disease				
Communicable Diseases	HIV Infection				
	Chlamydia				
Violence and Injury	Homicide				
	Suicide				
Access to Health Care	No Health Insurance				
	Could Not See a Doctor		♦		

■ Green indicates a group is faring better than the referent group
■ Red indicates a group is faring worse than the referent group
□ White indicates there is no significant difference between the referent and comparison group
♦ Symbol indicates reliable rates could not be calculated

Source: NC Health Equity Report 2018

DEMOGRAPHICS

2016 Population Estimates [4]	Total		White		African American		American Indian		Hispanic/Latinx		Other	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Total	10,146,788	100.0	6,539,036	64.4	2,243,994	22.1	121,630	1.2	932,221	9.2	309,907	3.1
Gender												
Male	4,932,952	48.6	3,191,245	48.8	1,049,934	46.8	58,386	48.0	484,263	51.9	149,124	48.1
Female	5,213,836	51.4	3,347,791	51.2	1,194,060	53.2	63,344	52.0	447,958	48.1	160,783	51.9
Age Group												
Under 18	2,298,720	22.7	1,258,132	19.2	566,279	25.2	30,420	25.0	363,788	39.0	80,101	25.8
18-64	6,278,603	61.9	4,040,457	61.8	1,419,866	63.1	76,565	62.9	537,146	57.6	207,569	67.0
65 & Over	1,569,465	15.5	1,240,447	19.0	260,849	11.6	14,645	12.0	31,287	3.4	22,237	7.2

In 2016, North Carolina's population was an estimated 10.1 million, with whites constituting the majority population at 6.5 million people (64.4 percent of the total state population). African Americans represent the largest minority group, constituting 22.1 percent of the population, followed by Hispanic/Latinx at 9.2 percent. Data suggest that by 2050 there will be a demographic shift, with racial minorities becoming the majority population.[5]

Source: NC Health Equity Report 2018

SOCIAL AND ECONOMIC WELL-BEING

Subject	Subcategory	Total	White	African American		American Indian		Hispanic/Latinx		Other	
		%/Rate	%/Rate	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio
Education	High School Graduation Rate, 2016-2017[6]	86.5	89.2	83.8	1.1	84.3	1.1	80.5	1.1	93.6	1.0
	Adults 25+ with High School Diploma or GED, 2016[7]	87.3	89.3	84.7	1.1	75.7	1.2	59.5	1.5	87.0	1.0
	Adults 25+ with Bachelor's Degree, 2016[7]	30.4	33.2	20.3	1.6	13.9	2.4	14.8	2.2	57.1	0.6
Employment	Unemployed, 2016[7]	3.8	3.0	6.1	2.0	5.4	1.8	4.4	1.5	3.7	1.2
Income	Median Household Income, 2016[7]	$50,584	$55,656	$36,014	1.5	$38,002	1.5	$39,388	1.4	$80,381	0.7
Poverty Rate	All Ages	15.4	12.0	23.5	2.0	25.5	2.1	27.3	2.3	11.9	1.0
	Children <18 Years, 2016[7]	21.7	15.8	33.8	2.1	33.4	2.1	35.8	2.3	10.9	0.7
	Elderly 65+ Years, 2016[7]	9.4	7.7	16.6	2.2	16.9	2.2	21.4	2.8	6.6	0.9
Housing	Living in a Home They Own, 2016[7]	64.2	71.2	43.9	1.6	63.5	1.1	43.0	1.7	61.1	1.2
Disability Status	Disability, 2016[7]	13.8	14.0	15.4	1.1	16.5	1.2	6.8	0.5	5.1	0.4

- Green indicates a group is faring better than the referent group
- Red indicates a group is faring worse than the referent group
- White indicates there is no significant difference between the referent and comparison group

Many factors can create or limit opportunities for good health. In North Carolina, some communities are resource-rich while others lack the social, economic, and environmental investments needed to support good health. Public health literature suggests that our health is greatly shaped by our everyday environment: where we live, learn, grow, and play.[5] Whether families have access to quality health care, nutritious foods, and neighborhoods with safe outdoor spaces, all impact health. Our socioeconomic status, including our education level, employment, income, and housing, also influence health.

Source: NC Health Equity Report 2018

EDUCATION

In the state of North Carolina, 87.3 percent of adults aged 25 years and older have a high school diploma or GED; 30.4 percent have a bachelor's degree. These proportions for whites are higher than the state average, with 89.3 percent of adults with a high school diploma or GED and 33.2 percent with a bachelor's degree. African Americans, American Indians, and Hispanic/Latinx have comparatively lower proportions of adults with high school diplomas/GEDs (84.7 percent, 75.7 percent, and 59.5 percent, respectively) and bachelor's degrees (20.3 percent, 13.9 percent, and 14.8 percent, respectively). Compared to whites, other races (including Asian/Pacific Islanders) have similar proportions of adults with high school diplomas/GEDs (87.0 percent), but the highest proportion of adults with a bachelor's degree (57.1 percent) in the state.

EMPLOYMENT

The overall rate of unemployment in North Carolina in 3.8. Whites have the lowest rate of unemployment in the state (3.0); rates among African Americans, American Indians, and Hispanic/Latinx exceed that of whites (6.1, 5.4, and 4.4, respectively). The rate of unemployment for other races, including Asian/Pacific Islanders, also exceeds that of whites, but is comparable to the state rate at 3.7.

INCOME

White households report a median income of $55,656 – nearly $20,000 more than African American, American Indian, and Hispanic/Latinx households in the state. Other races, including Asian/Pacific Islanders, report a median household income of $80,381, almost $25,000 more than white households and nearly $30,000 more than the state average.

DISABILITY

Nearly 1 in 7 North Carolinians has a disability. Disabilities are most prevalent among American Indians (16.5 percent), followed by African Americans (15.4 percent), whites (13.8 percent), and Hispanic/Latinx (6.8 percent). Disabilities are least prevalent among other races (5.1 percent).

Source: NC Health Equity Report 2018

ORAL HEALTH

Oral Health, 2016	White		African American		American Indian		Hispanic/Latinx		Other	
	%	CI	%	CI	%	CI	%	CI	%	CI
Adults who have not visited a dentist or dental clinic within the last year, 2016[8]	32	30.3-33.8	44.5	41.1-47.9	43.0	31.4-54.5	51.2	45.9-56.5	♦	♦
Adults who have had any of their permanent teeth removed, 2016[8]	45.5	43.7-47.3	58.5	55.1-61.9	52.3	40.7-63.9	43.6	38.5-48.8	♦	♦
Adults aged 65+ that have had all their natural teeth extracted, 2016[8]	16.7	14.3-19.2	24.6	18.2-31.1	♦	♦	♦	♦	♦	♦

■ Green indicates a group is faring better than the referent group

■ Red indicates a group is faring worse than the referent group

CI indicates confidence interval, or a range of values in which a result is expected to fall.

□ White indicates there is no significant difference between the referent and comparison group

♦ Symbol indicates reliable rates could not be calculated

Dental health and hygiene is an important part of overall health. Poor oral health can lead to diseases and injuries of the skull and face. Public health has been focusing on improving oral health for all by reducing disparities and expanding access to effective prevention programs. Efforts include community water fluoridation, school dental sealant programs, and integrating oral health programs into chronic disease prevention efforts and medical care.

CHILD ORAL HEALTH

In North Carolina, children of minority backgrounds continue to have high rates of tooth decay. Among American Indian and Hispanic children, 55 percent and 52 percent respectively experience tooth decay compared to 30 percent of white children. Untreated tooth decay among children has decreased to 13 percent, half of the national goal. However, 29 percent of American Indian and 23 percent of Asian American children have untreated tooth decay, compared to 13 percent of white children.[9]

ADULT ORAL HEALTH

In 2016, 32 percent of white adults in North Carolina did not visit a dentist or dental clinic. Significantly fewer African Americans (44.5 percent) and Hispanic/Latinx (51.2 percent) did not see a dentist in this timeframe. While African Americans were less likely to have visited a dentist, a greater proportion of this population has had at least one of their permanent teeth removed (58.5 percent). For North Carolinians age 65 and older, 18 percent have had all their natural teeth removed. Of those, 24.6 percent were African Americans, while 16.7 percent were white.

Source: NC Health Equity Report 2018

MATERNAL AND CHILD HEALTH

Maternal/Child Health Indicators	Total	White	African American		American Indian		Hispanic/Latinx		Other	
	%/Rate	%/Rate	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio
Infant Death Rate (per 1,000 live births), 2012-16[10]	7.2	5.4	13.0	2.4	9.0	1.7	5.1	0.9	5.3	1.0
Low Birth Weight (<=2500 grams) Births (%), 2014-16[11]	9.1	7.5	14.1	1.9	12.0	1.6	7.0	0.9	8.6	1.1
Late or No Prenatal Care (%), 2014-16[11]	30.6%	23.9%	39.1%	1.6	35.9%	1.5	41.1%	1.7	32.6%	1.4
Maternal Smoking During Pregnancy (%), 2014-16[11]	9.4%	11.9%	9.0%	0.8	23.1%	1.9	1.7%	0.1	1.6%	0.1

- Green indicates a group is faring better than the referent group
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- White indicates there is no significant difference between the referent and comparison group

Improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system.[12]

INFANT DEATH RATE

North Carolina's total infant death rate is 7.2 per 1,000 live births. Whites (5.4), Hispanic/Latinx (5.1), and other racial minorities, including Asian/Pacific Islanders (5.3), have lower infant death rates than the state average, surpassing the Healthy People 2020 goal of 6.0 per 1,000 live births. American Indians have an infant death rate of 9.0, while the rate among African Americans is 13.0.

LATE OR NO PRENATAL CARE

Nearly 1 in 3 North Carolinians either receives no prenatal care or enters prenatal care after the first trimester of pregnancy. This proportion is even greater among Hispanic/Latinx (41.1 percent), African Americans (39.1 percent), and American Indians (35.9 percent).

MATERNAL SMOKING DURING PREGNANCY

Less than 1 in 10 North Carolinians smokes during pregnancy, though the proportion of whites (11.9 percent) and American Indians (23.1 percent) that do is higher than the state average. Smoking during pregnancy is particularly rare among Hispanic/Latinx (1.7 percent) and other races (1.6 percent).

Source: NC Health Equity Report 2018

HEALTH RISK FACTORS AMONG NORTH CAROLINA ADULTS

Health Risk Factor Among NC Adults, 2016[18]	Total		White		African American		American Indian		Hispanic/Latinx		Other	
	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio
Percent of Adults who are Current Smokers	17.9	16.7-19.2	17.9	16.4-19.5	20.0	17.3-23.0	26.2	17.6-37.1	13.6	10.2-17.8	14.3	10.1-19.8
Percent of Adults who are Overweight	35.0	33.6-36.5	35.0	33.2-36.8	34.7	31.4-38.1	♦	♦	35.1	29.8-40.8	33.7	25.6-42.9
Percent of Adults who are Obese	31.8	30.4-33.3	30.0	28.2-31.7	41.3	37.9-44.9	♦	♦	31.2	26.0-36.9	16.2	11.6-22.0
Percent of Adults Reporting Fair/Poor Health	18.3	17.2-19.5	16.5	15.2-17.9	20.9	18.3-23.7	♦	♦	26.6	22.1-31.5	13.8	8.7-21.2
Percent of Adults Diagnosed with 2+ Chronic Conditions	25.7	24.5-26.9	28.9	27.3-30.5	24.2	21.5-27.1	32.2	23.1-42.9	6.8	4.8-9.6	14.5	10.2-20.0

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According to the World Health Organization, a risk factor is any attribute, characteristic, condition, or behavior that increases the likelihood of developing a disease or injury.[19] Some examples of risk factors include smoking, being underweight or overweight, and reporting poor health.

SMOKERS

In 2012, 20.9 percent of North Carolinians were smokers. That percentage decreased to 17.9 percent in 2016. American Indians have the highest percentage of smokers (26.2 percent), whereas Hispanic/Latinx have the lowest (13.6 percent).

OBESE

The percentage of obese adults in North Carolina has increased from 29.6 percent in 2012, to 31.8 percent in 2016. Significantly more African Americans are considered obese (41.3 percent) compared to whites (30.0 percent), while Hispanic/Latinx are slightly higher at 31.2 percent.

Source: NC Health Equity Report 2018

MORTALITY RATES

Mortality Rates, 2012-2016 [20]		Total	White	African American		American Indian		Hispanic/Latinx		Other	
		Rate	Rate	Rate	Disparity Ratio	Rate	Disparity Ratio	Rate	Disparity Ratio	Rate	Disparity Ratio
Heart Disease		161.3	159.0	187.1	1.2	182.0	1.1	56.6	0.4	76.0	0.5
Stroke		43.1	40.6	56.0	1.4	39.5	1.0	21.7	0.5	36.4	0.9
Diabetes		23.0	18.8	44.0	2.3	45.0	2.4	11.3	0.6	14.3	0.8
Chronic Lower Respiratory Disease		45.6	50.7	27.6	0.5	43.8	0.9	8.6	0.2	12.5	0.2
Kidney Disease		16.4	13.4	31.0	2.3	19.6	1.5	8.2	0.6	10.5	0.8
HIV Disease		2.2	0.8	7.5	9.4	1.6*	♦	1.1	1.4	♦	♦
Cancer	Total	166.5	165.0	190.7	1.2	158.7	1.0	72.9	0.4	104.4	0.6
	Colorectal	14.0	13.3	18.9	1.4	13.1	1.0	5.0	0.4	8.0	0.6
	Lung	47.5	49.1	46.3	0.9	51.2	1.0	13.1	0.3	23.5	0.5
	Breast	20.9	19.4	28.3	1.5	20.2	1.0	9.9	0.5	13.2	0.7
	Prostate	20.1	17.2	39.1	2.3	28.5	1.7	6.8	0.4	6.5	0.4

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* Rates based on fewer than 20 cases may be statistically unstable and should be interpreted with caution. Rates based on fewer than five cases are suppressed in this report.

Chronic diseases and injuries are responsible for approximately two-thirds of all deaths in North Carolina, or about 50,000 deaths each year. Cancer, heart disease, stroke, chronic lung disease, and unintentional injuries make up the top five causes of death in North Carolina. Many deaths in the state are preventable, particularly through alterations in risky behaviors or lifestyles. Among the leading causes of preventable death are tobacco use, unhealthy diet/physical inactivity, and alcohol and drug abuse and misuse.[21]

Source: NC Health Equity Report 2018

Key Terms in Discussing Racial and Ethnic Health Disparities

BRFSS (Behavioral Risk Factor Surveillance System): An ongoing, monthly telephone survey which collects data from randomly selected North Carolina adults in households with telephones.

Data: Information or numbers collected and used to present facts.

Disparity: Health disparities refer to differences in the health of different groups of people — differences that can be prevented. Some diseases and other poor health outcomes unfairly impact groups of people based on their race or ethnicity, religion, income or education, sex or gender, sexual orientation, age, mental health, disability, or where they live. This is because of how our society has viewed or treated each of these groups at one time or another and how resources were given to some groups of people but not to others.

Disparity Ratio: A measure or number for a race or ethnic group compared to the measure of another group.

Food Desert: a low-income census tract where either a substantial number or share of residents has low access to a supermarket or large grocery store

Health Disparities: the measurable differences or gaps seen in one group's health status in relation to another or other group(s).

Health Equity: the opportunity for everyone to have good health.

Health Inequities: the unfair differences that prevent everyone from the opportunity to have good health.

Healthy People 2020: A federal initiative and report that states the goals and objectives needed to improve the health and quality of life for individuals and communities by the year 2020

Mortality Rate: The number of deaths in proportion to a population.

Social Determinates of Health: The social factors such as housing, education, income, and employment that greatly influence the health and quality of life in neighborhoods and communities.

Source: NC Health Equity Report 2018

Contact Information

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