

**North Carolina Institute of Medicine  
Task Force on Prevention  
April 24, 2009  
Meeting Minutes  
Socioeconomic Factors**



*Chairs:* Steve Cline, DDS, MPH

*Task Force Members/Steering Committee Members:*

Tom Bacon, Ronnie Bell, Paula Collins, Leah Devlin, Calvin Ellison, Sherman James, Polly Johnson, William Lawrence, Meg Molloy, Bob Parker, Barbara Pullen-Smith, Bill Pully, Kelly Ransdell, George Reed, Vandana Shah, Bill Smith, Lisa Ward, Joyce Young, Jennifer MacDougall, Ruth Petersen, Marcus Plescia, Carol Runyan, Meka Sales

*Interested Persons and Speakers:* Willona Akingbade, John Dervin, Dee Dee Downie, Carol Ford, Pam Highsmith, Lynn Hoggard, Jennifer Houlihan, Wilhelmine Miller, Don Nail, John Stokes, Rebecca Reeve, Sharon Rhyne, Bill Rowe, Valerie Russell, Jessica Schorr Saxe, Maria Spaulding, Nicole Standberry, Walker Wilson

*NCIOM Staff and Interns:* Pam Silberman, Mark Holmes, Jennifer Hastings, Berkeley Yorkery, Thalia Shirley Fuller, Kimberly Alexander-Bratcher, Jesse Lichstein, Christine Nielsen

**Beyond Health Care: The Intersection of Socioeconomic Factors and Health**

*Wilhelmine Miller, MS, PhD, Associate Director, RWJF Commission to Build a Healthier America; Associate Research Professor, Department of Health Policy, The George Washington School of Public Health and Health Services*

More than \$2 trillion is spent each year on health care; however, various measurements of the health status of Americans lag behind those of other industrialized countries. For example, the infant mortality rate in the US is three times as high as the world's best infant mortality rate. In 1980, the US ranking for this indicator was 18<sup>th</sup>, which by 2002, had slipped to 25<sup>th</sup>. Life expectancy in the US has slipped from 14<sup>th</sup> best (1980) to 23<sup>rd</sup> (2003). Now, life expectancy in the US is 4-5 years below that of Japan and Iceland. Life expectancy is dependent on race, income, education, and where individuals live.

To address health, the RWJF Commission felt that it needed to tack in a new direction and expand the dialogue on health to non-medical factors such as social factors. The Commission is led by Mark McClellan and Alice Rivlin and is composed of a diverse group of individuals with expertise ranging from academia to foundation leadership. The two main objectives of the Commission were to raise awareness and identify areas for action at the local, state, and national level. *Overcoming Obstacles to Health*, released by the RWJF in February 2008, served as the baseline for the Commission's work. Insights from the report are that America is not reaching its health potential, we need to take a different course of action because what we have been doing is not working, and the time to act is now. General findings published in the report include the following:

- As years of education increase so does longevity. The life expectancy of college graduates is at least five years longer than that of those who do not finish high school. For example, consider tobacco use is a known health risk behavior and that education disparities have been seen in smoking rates since the mid 1970s. This gap appears to have grown between the most educated and the least educated. Three times as many high school drop-outs smoke than college graduates.
- As income increases so does longevity. The life expectancy of men and women in the highest income bracket is 6.5 years longer than that of poor men and women (<200% of FPG).

- A child's health is impacted by its parents' income level. Poor or fair health is seven times as likely among children in poor families as children in the highest income families.
- Chronic illness that impairs activity is more likely to affect individuals who are poor (1 in 3) versus those in the highest-income group (<1 in 10). It was noted that even middle-class Americans are less healthy than Americans with more advantages. This is a trend that has held steady since the late 1990s.
- Income is linked to health even when controlling for race or ethnicity, and racial and ethnic disparities exist regardless of income.
- Of all racial and ethnic groups, blacks have the highest age-adjusted mortality rate. There are increased rates of certain chronic disease among certain racial and ethnic groups.

One in five US children lives below the federal poverty line. This is a greater proportion than most other affluent countries. Compared to whites, blacks and Hispanics are more likely to experience poverty. The Children's Health Fund predicts that the number of children in poverty will rise from 12-13 million to 17 million by the end of this year. Education provides more income advantage to whites than it does to blacks and Hispanics. Compared to whites, these two groups have less accumulated wealth. This disparity is greatest at the highest income level. Wealth is most predictive of economic stability. Owning a home is less likely among minority households than among whites. Social disadvantage and health disadvantage accumulate throughout life and create additional barriers.

Due to the general lack of success with getting people to change their behaviors and that more medical care has not equaled better health, the Commission decided to look at what influences health-related behaviors, how conditions that influence health-related behaviors be changed, and what other factors influence health. The Commission looked at non-medical pathways to improve health and focused its investigation on field research/investigations, literature reviews, and site visits.

Recommendation areas from the Commission are as follows

- Accessing Healthy Foods
  - Fund and design WIC and SNAP (Food Stamps) programs to meet the needs of hungry families for nutritious food.
  - Create public-private partnerships to open and sustain full-service grocery stores in communities without access to healthful foods.
- Starting Early
  - Feed children only healthy foods in schools.
  - Require all schools (K-12) to include time for all children to be physically active every day.
  - Ensure that all children have high-quality early developmental support (child care, education and other services).
- Creating Healthy Communities
  - Become a smoke-free nation.
  - Create "healthy community" demonstrations to evaluate the effects of a full complement of health-promoting policies and programs.
  - Develop a "health impact" rating for housing and infrastructure projects that reflects the projected effects on community health and provides incentives for projects that earn the rating.
  - Integrate safety and wellness into every aspect of community life.
- Measuring Progress, Building In Accountability
  - Ensure that decision-makers in all sectors have the evidence they need to build health into public and private policies and practices.

(Recommendations excerpted from *Beyond Health Care: New Directions to a Healthier America*. More detail and information is available at <http://www.commissiononhealth.org>.)

## **Improving Population Health and Reducing Health Disparities in North Carolina**

*Sherman James, PhD, Duke University*

Dr. James discussed two intervention approaches to address health disparities: public policies and community-based participatory research (CBPR). These approaches can complement each other.

North Carolina's population is 9.1 million with approximately 65% white, 22% black/African American, and 7% Hispanic. Eight percent of North Carolina households speak a language other than English. Compared to all other races and ethnicities, Hispanics have the lowest rate of death per 100,000 for diabetes, heart disease, and cancer (data from 2003-2007); whereas blacks have the highest.

Care needs to be taken when designing and implementing interventions to improve the public's health because disparities can be inadvertently increased. Public health interventions that are designed to have effects independent of "motivation, resources, or action of individuals" are less likely to increase health disparities. Examples of these types of interventions include water fluoridation, seat belt use, mandatory desegregation of hospitals, increased tobacco taxes, and nutrition and physical activity standards in schools. The last two examples, current recommendations from the Prevention Task Force, would benefit low-income North Carolinians and improve overall population health in the state.

When public health improvement efforts "depend on individual motivation plus adequate economic resources," disadvantaged communities need tailored interventions to change social norms. CBPR is a tailored intervention and can be an effective way to reach hard-to-reach groups. This type of intervention is a long-term process that enables a focusing on the problem in the local context and builds on the community's strengths and resources. Resource-sharing and a commitment to sustainability are paramount. In addition, the community should have a major voice. Limitations to CBPR include that it attracts and retains only those who are highly motivated and that is labor-intensive. However, it is responsive to the needs of individuals and has good potential for sustainability since it can be built into existing social networks.

CBPR strategies are best at changing community/social norms and individual health behaviors, while public policy interventions are best at addressing structural barriers to health.

Dr. James shared a CBPR project occurring in Durham County to improve blood glucose control among African Americans through diet and exercise. The goal of the project is to work with individuals to make sustainable improvements.

## **Poverty in North Carolina**

*Heather Hunt, JD, Assistant Director, UNC Center on Poverty, Work and Opportunity*

Ms. Hunt shared several statistics regarding poverty and unemployment in North Carolina.

- The 2007 poverty rate in North Carolina was 14.8% compared to the US poverty rate of 13.3%.
- Of the 100 counties in the state, 77 have poverty rates higher than the national average. Poverty rates are over 20% in 21 counties (Robeson's is the highest at 29% and Union's is the lowest at 8%).

- Nearly 20% of North Carolinians are below 125% of the federal poverty line, and about 6% are below 50% of the poverty line. One in five (20%) North Carolina children is poor versus 18.3% of US children.
- The state unemployment rate was 10.8% in March (versus 8.5% nationally), which is twice what it was one year ago. Nineteen counties have unemployment rates of 15%.
- Nearly 40% of North Carolina residents with a high school degree or less are considered poor, while over half are “near-poor,” or at 125% of poverty.
- Manufacturing is essential to many rural counties; however, many of these jobs are disappearing. The North Carolina Employment Security Commission estimates that 2,000 furniture jobs are lost per year and 3,000 jobs per year are lost in the textile industry. The economy is now stagnant in many counties, which is an indicator of poverty.

Ms. Hunt offered the following recommendations for the Task Force to consider:

1. Increasing the state Earned Income Tax Credit (Governor Perdue would like to bring it up to 6.5% from 5% of the federal earned income tax credit.)
2. Focus on K-12 education, worker re-training, and access to college
3. Reevaluate how the state encourages corporations to locate to North Carolina and try to direct moves into areas of the state that need jobs most
4. Focus on small business and entrepreneurship

### **Housing Issues in North Carolina and Public Policy Recommendations**

*Bill Rowe, JD, General Counsel and Director of Advocacy, NC Justice Center*

Housing is central to the health and well-being of individuals and communities. It is a lynch pin, a key to helping people out of poverty. There are 3.5 million housing units in the state. Nearly 70% are owner-occupied; 31% are renter-occupied. A shift in the percent of owner-occupied to renter-occupied is predicted. There are many consumer-protection measures in place in North Carolina that have helped to weather the current economic downturn.

While rents are higher in metropolitan areas, 2009 fair market rents range from \$539 for a zero-bedroom to \$1,016 for a four-bedroom. Of North Carolina households, an estimated 1.1 million have a housing problem such as housing is unaffordable (cost is greater than 30% of household income), inadequate kitchen inadequate plumbing, and overcrowding.

Cost is the single largest burden to housing. Eighteen percent of households (more than 624,000) in the state spend 30 to 49% of their income on housing costs; 13% (more than 460,000) pay at least 50% of their income for housing. Compared to owners, renters are disproportionately affected as the most cost burdened, and the majority of burden falls on renters making less than \$35,000 per year.

Eviction from housing has spiraling effect. For example, bad credit disables someone from getting a lease and therefore from having stable housing. Often people have to live in unsafe neighborhoods and/or unsafe conditions because they have lower rents. A high housing cost burden means that people have a hard time making ends meet and cannot afford other needs such as medications, utilities, and food. In March 2009, utility companies in the state cut the power supply to approximately 30,000 customers. Low wealth communities do not have access to city services. Annexation can help these communities.

Mr. Rowe offered the following recommendations for the Task Force to consider:

1. Increase investment in the NC Housing Trust Fund, which is a flexible housing resource in the state that provides a range of financing from homeless shelters to home ownership. The Trust Fund reaches people with extremely low incomes.
2. Support HB 1050 which is a fund to help low-income people live in homes that are energy efficient.

### **The Relationship Between Poverty and Educational Outcomes**

*Rebecca Garland, EdD, Chief Academic Officer, North Carolina Department of Public Instruction*

Dr. Garland presented the percentage of economically disadvantaged students and non-economically disadvantaged students passing end-of-grade tests (EOGs). (These percentages were derived from overlaying test scores with free and reduced lunch data.) In grades 3-8, the percent of economically disadvantaged students passing EOGs was substantially less than non-economically disadvantaged students (in 2006-07: 48.5% versus 77.2%; in 2007-08: 33.3% versus 66.9%). This also held true among high school youth for EOGs (53.6% versus 76%). These comparisons show that there is a correlation between economic disadvantage and student test performance. Graduation rates among the economically disadvantaged are 59.2% versus the all students graduation rate of 70.3%. (Note that free and reduced lunch is not as good as an indicator at this level because high school students in need do not always sign up for free and reduced lunch. Forty percent of high school students are economically disadvantaged. Students do not want to be labeled as economically disadvantaged.) The drop-out rate is calculated annually, so a student who drops out in the 11<sup>th</sup> and 12<sup>th</sup> grades will be counted twice. Interestingly, the economically disadvantaged and the all student five-year cohort graduation rates are very close (70.2% and 71.8%). More time helps to bring the graduation rate up of economically disadvantaged students because it allows for more intervention. Data from Charlotte-Mecklenburg County Schools show that a school's math average and reading average are correlated with the percent of students on free and reduced lunch. Case examples of this were shown for elementary, middle, and high schools.

SAT performance is also correlated with family income. Test scores consistently rise as family income rises. Poverty is linked to many factors that explain this correlation including:

1. Parents have less discretionary time to spend with kids
2. Parents' educational attainment reflects their desire for their children to be educated
3. Children who are poor are more likely to spend time watching TV and gaming
4. Parents' literacy level
5. Parents who did not do well in school may have mistrust in school
6. Students do not see a long-term vision of how education could help them

There are promising interventions to help economically disadvantaged students perform better academically, such as the following:

1. One-course of study options
2. Learn and earn early colleges allow students to be in high school and college at the same time (this allows students to concurrently earn a diploma and associate's degree)
3. Redesign of schools (large campuses do not easily foster extra support)
4. Career technical programs help students get certifications

5. Drop-out prevention and recovery programs
6. Evening schools help pregnant girls and students who need to work to support families stay in school
7. NC Virtual Public School for students who need to stay at home

Efforts to create equity include supplemental funding for disadvantaged students, federal money through Title 1 (Federal Disadvantaged Students), Title 2 (Federal Teacher Quality), Title 3 (Federal English Second Language), federal migrant funding, and federal homeless funding.

Dr. Garland offered the following recommendations for the Task Force to consider:

1. Permanently fund district and school improvement/transformation (a coaching model that works with leadership to build capacity at the state level and local level. This is designed to help schools meet state proficiency standards)
2. Expand partnerships programs between community colleges and high schools
3. Continue to explore and implement customized options and programs to meet students' needs
4. Find ways to engage students in learning, such as technology infusion in K-12
5. Commit resources to ensure appropriate time is allotted for students as some simply students need more time