



**NORTH CAROLINA CENTER FOR
PUBLIC POLICY RESEARCH INC.**

NEWS RELEASE

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STUDY SPOTLIGHTS PROBLEMS IN MINORITY HEALTH, CALLS FOR STATE ACTION

The rates of death and illness for minorities greatly exceed those for whites in nearly every area in which the state keeps data, according to a year-long study released today by the N.C. Center for Public Policy Research. The Center recommends a broad-based intervention to address these disproportionate illness and death rates of minorities.

"North Carolina minorities have higher rates of illness, they die younger from everything from diabetes to AIDS, and they are less likely to get the preventive care they need to live a long and healthy life," says Mike McLaughlin, editor of the Center's journal, North Carolina Insight. "The difference in overall health status between whites and minorities is startling."

How wide is that health gap? Statistics comparing African American and white death rates from various causes from the State Center for Health and Environmental Statistics show the following:

Stroke. Average mortality rate 79.9 for African Americans. White mortality rate 67.3. African-American rate 19 percent higher.

Chronic Liver Disease and Cirrhosis. Average African-American mortality rate 13.9. Average white mortality rate 9.9. African-American mortality rate 40 percent higher.

Diabetes. Average mortality rate 33 per 100,000 for African-Americans. White mortality rate 17.3 per 100,000. African-American rate 91 percent higher.

Infant mortality. African-American rate 15.7 per 1,000 live births in 1992. White rate 7.2 per 1,000 live births. African-American rate more than twice as high.

Acquired Immune Deficiency Syndrome (AIDS). Average African-American mortality rate 16.8. Average white mortality rate 3.5. African-American mortality rate 380 percent higher.

Heart disease and cancer also kill African Americans in far disproportionate numbers when the data are adjusted to account for age differences in the population. Indeed, the mortality rate of African American males suffering from prostate cancer is among the highest of any state in the nation.

Minorities also suffer disproportionately from *higher disease rates*. Consider these examples:

--African-Americans are more than five times more likely to be infected with AIDS than whites.

--African-Americans are more than twice as likely as whites to be affected with hepatitis B.

For Native Americans, motor vehicle accidents are a major killer, claiming lives at nearly twice the rate of whites. Homicide rates also are double the rate of whites, and deaths by diabetes mellitus are somewhat higher.

Hispanic expectant mothers are less likely to seek prenatal care than whites and most other subgroups of the population. Nationally, they are much less likely to be insured than whites, which also leads to a lack of preventive health care.

The gap in health outcomes between whites and minorities has led public health officials to call for a greater focus on the health of minorities. "[T]he reality is, health differences between whites and minorities are not getting any better," says Barbara Pullen-Smith, director of the Office of Minority Health in the N.C. Department of Environment, Health, and Natural Resources.

The Center's study, published today in the latest edition of *North Carolina Insight*, included four major research components: an analysis of data on illness and death kept by the State Center for Health and Environmental Statistics (CHES); a review of immunization records for children ages 2 and under at nine local health departments; and a survey of all 86 local health directors to determine barriers to serving minorities at the local level. The Center also examined existing programs addressing minority health problems to glean lessons for attacking the health gap.

In a review of 4,194 immunization records, the Center found that a little more than half (54.1 percent) of minority youth who get their shots at the local health department were up to date, compared to almost two-thirds (66.4 percent) of whites. The Department of Environment, Health, and Natural Resources' goal is to have 90 percent of all children ages 2-and-under up to date on their immunizations by the year 2000.

Immunization rates also suggest how likely citizens are to seek preventive health services such as well-child care. Immunizations are considered among the most cost effective of all health interventions. For example, each dollar spent on immunization against measles, mumps, and rubella saves an estimated \$16.30 in later costs, according to the federal Centers for Disease Control.

Immunization shots are free to patients at local health departments and available for a nominal administration fee at private clinics. "Health departments need to market this service more effectively to minority communities and make sure they check the immunization status of children who come into clinics for other reasons," says McLaughlin. "They also need to do a better job of following up with parents who fail to get their children's shots on time."

Local health directors surveyed by the Center identified access to existing services as a larger barrier to adequate health care for minorities than lack of services. In fact, access to health services was singled out by health directors as the most significant health issue for minorities at the local level.

Access issues included the lack of health insurance, inadequate or non-existent transportation services, clinics open too few or inconvenient hours, the language barrier for Spanish-speaking clients, and lack of knowledge regarding both the availability and importance of preventive health services.

A key policy question that emerged from the Center's research was whether the state should make a special effort to target minorities for health services. Nearly two-thirds (61.1 percent) of local health directors surveyed on this question answered yes.

But some local health directors thought that minorities should not be given special attention, arguing that all health services should be for all people. "Health department services should focus on a broad spectrum of populations," commented one local health director who responded to the Center's survey. A caller to "Open Net," a television show aired by the N.C. Agency for Public Telecommunications, agreed in even stronger language: "I wouldn't like to have to separate and exclude groups from attention and public services because of race. It's not working, I don't like it, it's not fair, and it's biased."

But Ron Levine, the state health director, believes the state *should* address differences in health outcomes between racial and ethnic groups. "It's absolutely defensible to spend our energies and resources on addressing the health gap," says Levine. "You do that not by bringing the health status of others down, but by bringing the status of minorities up."

Based on its research, the Center offers six recommendations for addressing the health gap and improving minority use of health services with the aim of producing a healthier North Carolina. These recommendations call for legislative or executive branch action to:

- (1) Attack the health gap between whites and minorities through a \$750,000 legislative appropriation in the 1996-97 fiscal year to develop local community-based preventive health programs. Minorities

in North Carolina have far higher rates of death and illness than whites. The Center found strong evidence that the health of minorities can be improved through preventive health programs. This approach should be used to target counties with sizable minority populations and large discrepancies in health outcomes.

(2) Fight infant mortality through expansion of maternal outreach workers to all 100 counties and an appropriation of \$550,000 to allow maternal outreach workers to work with families until children reach age 3. The legislature already has taken some steps toward addressing the race gap in the state's infant mortality rate, appropriating \$750,000 in 1994 to pay for community-based programs for minorities in up to 15 counties.

(3) Help close the immunization gap between minority and white children through a \$500,000 annual appropriation to fund immunization outreach workers in 20 high-minority, low-wealth counties. In a review of nine local health departments, the Center found that minorities are more likely to be behind on their immunization shots than whites. Special marketing, outreach, and follow-up efforts are needed to close this gap.

(4) Prevent the further spread of AIDS in minority communities and treat those already infected through annual appropriations of \$500,000 for prevention and \$500,000 for treatment. AIDS kills African Americans at a rate nearly five times that of whites.

(5) Encourage local health departments to involve both minority staff and minority-community members in planning for health services, and make services more accessible to minorities. Well over a third (37.5 percent) of local health directors who responded to the Center's survey said they do not involve minorities in a process for planning services that is mandated in the state contract with local health departments. And only 36 of 86 local health departments indicated they do more than the minimum required to make clinics accessible by opening on nights and weekends.

(6) Improve local health department communications with Hispanics through \$250,000 in annual matching funds to hire additional bilingual staff at the local level. The Center's survey of local health directors indicates Hispanics represent only about 4.6 percent of health department clientele, yet at some departments, the percentage is much higher. This appropriation would allow local health departments with large Hispanic populations to add interpreter services.

"These recommendations call for an ounce of spending on prevention to obtain a pound of cure through a healthier population," says McLaughlin. "The result could be a ton of savings in treatment costs in the long run."

Estimates of long-term savings from age-appropriate immunization

range from \$3.40 per dollar spent for administering the oral polio vaccine to \$16.30 for the measles, mumps, rubella vaccine. And every dollar spent on maternal care coordination to prevent low birthweight infants results in roughly \$2 in savings on medical care costs.

With the current emphasis on shrinking state government, a new focus on preventive health may be appropriate. Delton Atkinson, director of the State Center for Health and Environmental Statistics, believes that a campaign targeting preventive health and lifestyle changes could have an impact on the disparity in death and illness rates between whites and minorities. "If you look at what's driving some of those rates, it seems to be more lifestyle factors," says Atkinson. "If you could significantly change some of those things, you might see a difference in health outcomes."

The N.C. Center for Public Policy Research is an independent, nonpartisan, nonprofit corporation created to study public policy issues facing North Carolina and evaluate state government programs. The Center's research on issues affecting the health of minority citizens in North Carolina was funded through a project grant from Glaxo Inc., a pharmaceutical research company with U.S. headquarters at Research Triangle Park. The Center receives general operating support from the Z. Smith Reynolds and Mary Reynolds Babcock Foundations, 156 corporate contributors, and 927 individual and organizational members.

In addition to publishing *North Carolina Insight* magazine, the Center recently completed studies on how the University of North Carolina system evaluates and rewards teaching performance and how the states regulate pesticides. It recently published *Article II: A Guide to the 1995-96 N.C. Legislature*, as well as rankings of the effectiveness of all 170 legislators, and *The 50 Most Influential Lobbyists in the N.C. General Assembly*.

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Copies of the issue of *Insight* magazine containing the Center's research on issues affecting the health of minority citizens in North Carolina can be obtained from the Center for \$14.75, including tax, postage and handling. To order, call (919) 832-2839, fax to (919) 832-2847, or write the N.C. Center for Public Policy Research, P.O. Box 430, Raleigh, N.C. 27602.

Table 12. The Cost of Prevention Versus the Cost of Cure

Each Dollar Spent for These Preventive Measures	Equals These Dollars Saved in Treatment Costs
For measles, mumps, rubella vaccine	\$16.30
For diphtheria, tetanus, pertussis vaccine	6.20
For oral polio vaccine	3.40
For maternal care coordination to prevent low birthweight infants	2.02

Sources: Paul A. Buescher, *et al.*, "an Evaluation of Maternity Care Coordination on Medicaid Birth Outcomes in North Carolina," *American Journal of Public Health*, Vol. 81, No. 12, (December 1991), pp. 1626-1627; for immunizations, Centers for Disease Control, Atlanta, Ga.

Table 1. U.S. and N.C. Age-Adjusted Mortality Rates for Heart Disease and Cancer, by Race, 1991*

Mortality Rates per 100,000	White Male		White Female		Minority Male		Minority Female	
	U.S.	N.C.	U.S.	N.C.	U.S.	N.C.	U.S.	N.C.
Heart Disease	196.1	204.8	100.7	99.5	234.0	275.1	143.1	153.2
Cancer	159.5	159.4	111.2	104.2	207.4	241.0	121.2	114.9
Stroke	26.9	32.7	22.8	26.8	48.2	65.9	36.9	47.3

* Deaths per 100,000 population using 10-year age groups and U.S. 1940 population as standard for direct age adjustment.

Source: "North Carolina Center for Health Statistics Pocket Guide—1993," State Center for Health and Environmental Statistics, N.C. Department of Environment, Health, and Natural Resources, December 1994, Table 5.

Table 2. Leading Causes of Death in North Carolina, 1988–1992, Overall and by Race, with Rankings by Race

Cause	Total Deaths	Rate per 100,000	Overall Rank	Native American Deaths	Rate per 100,000	Rank	Asian/Other Deaths	Rate per 100,000	Rank
DISEASES OF THE HEART									
	94,793	284.8	1	666	164.0	1	73	27.4	2
CANCER	66,147	198.8	2	396	97.5	2	112	42.0	1
CEREBRO-VASCULAR DISEASES (STROKE)									
	23,005	69.1	3	121	29.8	4	26	9.7	4
CHRONIC OBSTRUCTIVE PULMONARY DISEASES (LUNG DISEASE)									
	10,737	32.3	4	66	16.2	8	4	—	11
PNEUMONIA AND INFLUENZA									
	9,596	28.8	5	59	14.5	9	6	—	9*
OTHER ACCIDENTS AND ADVERSE EFFECTS									
	7,425	22.3	6	88	21.7	6	20	7.5	6
MOTOR VEHICLE ACCIDENTS									
	7,343	22.1	7	164	40.4	3	29	10.9	3
DIABETES MELLITUS									
	6,901	20.7	8	101	24.9	5	11	—	7
SUICIDE	4,275	12.8	9	38	9.4	10	9	—	8
HOMICIDE/LEGAL INTERVENTION									
	3,748	11.3	10	74	18.2	7	22	8.2	5
CHRONIC LIVER DISEASE AND CIRRHOSIS									
	3,570	10.7	11	36	8.9	11	6	—	9*
NEPHRITIS NEPHROSIS (KIDNEY DISEASE)									
	2,740	8.2	12	25	6.2	12	1	—	13
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)									
	2,134	6.4	13	14	—	13	2	—	12
ALL CAUSES									
	290,582	873.2		2,230	549.0		402	150.7	

* Indicates tie in rankings

Source: Data produced by the State Center for Health and Environmental Statistics, Department of Environment, Health, and Natural Resources. Rates are average number of annual deaths per 100,000 persons, based on a five-year period, 1988–92. Rates based on fewer than 20 deaths may be misleading and were not computed.

Table 2, continued

Cause	African-American Deaths	Rate per 100,000	Rank	White Deaths	Rate per 100,000	Rank
DISEASES OF THE HEART	19,728	268.8	1	74,326	294.2	1
CANCER	14,265	194.4	2	51,374	203.3	2
CEREBROVASCULAR DISEASES (STROKE)	5,846	79.7	3	17,012	67.3	3
CHRONIC OBSTRUCTIVE PULMONARY DISEASES (LUNG DISEASE)	1,253	17.1	9	9,414	37.3	4
PNEUMONIA AND INFLUENZA	1,863	25.4	7	7,668	30.3	5
OTHER ACCIDENTS AND ADVERSE EFFECTS	2,159	29.4	5	5,158	20.4	7
MOTOR VEHICLE ACCIDENTS	1,763	24.0	8	5,387	21.3	6
DIABETES MELLITUS	2,419	33.0	4	4,370	17.3	8
SUICIDE	485	6.6	13	3,743	14.8	9
HOMICIDE/LEGAL INTERVENTION	2,067	28.2	6	1,585	6.3	12
CHRONIC LIVER DISEASE AND CIRRHOSIS	1,019	13.9	11	2,509	9.9	10
NEPHRITIS/NEPHROSIS (KIDNEY DISEASE)	1,007	13.7	12	1,707	6.8	11
AQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)	1,236	16.8	10	882	3.5	13
ALL CAUSES	68,542	933.9		219,408	868.4	

Source: Data produced by the State Center for Health and Environmental Statistics, Department of Environment, Health, and Natural Resources. Rates are average number of annual deaths per 100,000 persons, based on a five-year period, 1988-92. Rates based on fewer than 20 deaths may be misleading and were not computed.

Table 4. Rates of Death from Diabetes in North Carolina, 1988–1992, by Race and by County*

County	White Deaths	Rate per 100,000	African-American Deaths	Rate per 100,000
ALAMANCE	139	32.1	49	46.9
ALEXANDER	12	—	3	—
ALLEGHANY	5	—	—	—
ANSON	10	—	17	—
ASHE	19	—	2	—
AVERY	10	—	—	—
BEAUFORT	43	29.6	47	70.9
BERTIE	16	—	23	36.6
BLADEN	15	—	33	58.4
BRUNSWICK	30	14.3	16	—
BUNCOMBE	134	16.8	33	45.8
BURKE	83	23.7	9	—
CABARRUS	69	16.1	16	—
CALDWELL	87	26.0	12	—
CAMDEN	6	—	1	—
CARTERET	44	18.4	11	—
CASWELL	14	—	18	—
CATAWBA	94	17.6	20	37.1
CHATHAM	42	28.1	13	—
CHEROKEE	20	20.4	—	—
CHOWAN	3	—	11	—
CLAY	3	—	—	—
CLEVELAND	78	23.4	31	34.8
COLUMBUS	33	19.9	33	43.0
CRAVEN	20	6.7	31	29.1
CUMBERLAND	110	12.5	84	18.9
CURRITUCK	12	—	4	—
DARE	15	—	—	—
DAVIDSON	87	15.2	19	—
DAVIE	23	18.1	4	—
DUPLIN	22	16.5	36	53.4
DURHAM	80	14.5	101	29.8
EDGECOMBE	32	25.6	40	24.8
FORSYTH	180	18.2	147	44.2
FRANKLIN	23	19.4	29	44.6
GASTON	129	17.0	33	28.9
GATES	2	—	5	—
GRAHAM	6	—	—	—
GRANVILLE	12	—	32	42.5
GREENE	9	—	6	—
GUILFORD	214	17.1	108	23.5
HALIFAX	38	29.1	42	30.2
HARNETT	52	20.0	26	33.6
HAYWOOD	57	24.5	3	—
HENDERSON	36	10.8	5	—
HERTFORD	13	—	15	—
HOKE	5	—	15	—
HYDE	3	—	7	—
IREDELL	51	13.0	26	34.6
JACKSON	22	18.5	—	—
JOHNSTON	63	18.8	23	31.3
JONES	3	—	10	—

—continues

Table 4, continued

County	White Deaths	Rate per 100,000	African-American Deaths	Rate per 100,000
LEE	32	20.2	23	48.4
LENOIR	40	23.1	41	36.1
LINCOLN	30	13.1	6	—
MACON	34	29.4	—	—
MADISON	24	28.5	—	—
MARTIN	23	32.9	29	51.1
MCDOWELL	36	21.2	3	—
MECKLENBURG	273	14.9	189	28.0
MITCHELL	18	—	—	—
MONTGOMERY	19	—	8	—
MOORE	27	11.3	17	—
NASH	51	19.7	39	32.4
NEW HANOVER	84	17.5	50	41.0
NORTHAMPTON	7	—	27	43.6
ONslow	30	5.3	15	—
ORANGE	45	11.7	23	30.8
PAMLICO	5	—	5	—
PASQUOTANK	25	25.8	11	—
PENDER	14	—	16	—
PERQUIMANS	6	—	4	—
PERSON	15	—	10	—
PITT	59	16.5	86	47.6
POLK	22	32.8	5	—
RANDOLPH	79	15.9	16	—
RICHMOND	45	29.0	28	43.1
ROBESON	67	35.1	37	28.1
ROCKINGHAM	74	21.7	34	38.7
ROWAN	85	18.5	31	34.7
RUTHERFORD	52	20.7	14	—
SAMPSON	34	22.0	30	37.7
SCOTLAND	16	—	25	40.8
STANLY	71	31.2	12	—
STOKES	24	13.7	2	—
SURRY	56	19.0	6	—
SWAIN	8	—	—	—
TRANSYLVANIA	20	16.4	3	—
TYRRELL	3	—	4	—
UNION	59	16.7	22	32.5
VANCE	33	31.1	20	22.8
WAKE	167	10.1	142	31.7
WARREN	4	—	11	—
WASHINGTON	5	—	5	—
WATAUGA	15	—	—	—
WAYNE	63	18.0	53	31.2
WILKES	48	16.9	4	—
WILSON	49	24.0	63	50.3
YADKIN	21	14.3	1	—
YANCEY	25	32.6	—	—
NORTH CAROLINA	4,370	17.3	2,419	33.0

* *Source:* State Center for Health and Environmental Statistics, Department of Environment, Health, and Natural Resources. Rates are average annual number of deaths per 100,000 persons, based on a five-year period, 1988–92. The Native-American and Asians/Others categories are omitted from this table because the number of deaths at the county level is too small to produce meaningful statistics. Rates based on fewer than 20 deaths may be misleading and were not computed.

all over the nation,” says Meriwether. “It’s more prevalent among people who live in poverty. It’s more prevalent among people who live in crowded conditions.” (See Table 5 below for a breakdown of AIDS and Tuberculosis disease rates, by race.)

Meriwether says improvements in living standards have contributed to a long-term decline in the prevalence of tuberculosis, but the rate of decrease

has slowed. One reason for this, she says, is the rise in the number of people infected with HIV. TB is relatively difficult to catch, Meriwether says, and people with compromised immune systems are more susceptible. Between 1988 and 1992, 2,013 tuberculosis cases were reported among N.C. African Americans compared to 1,034 cases among whites.

—continues on page 20

**Table 5. Communicable Disease Cases and Rates in N.C.,
By Race, 1988–92***

White Cases	Rate per 100,000	African- American Cases	Rate per 100,000	Native- American Cases	Rate per 100,000	Asian/ Other	Rate per 100,000	Total in N.C.	Rate per 100,000
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)									
988	3.9	1488	20.3	1	—	6	—	2483	7.5
HEPATITIS A									
1377	5.4	390	5.3	12	—	15	—	1794	5.4
ACUTE HEPATITIS B									
2200	8.7	1540	21.0	121	29.8	112	42.0	3973	11.9
SALMONELLOSIS									
3746	14.8	1587	21.6	66	16.2	32	12.0	5431	16.3
SHIGELLOSIS									
1690	6.7	1170	15.9	62	15.3	16	—	2938	8.8
BACTERIAL MENINGITIS AND H FLU									
1019	4.0	489	6.7	31	7.6	6	—	1545	4.6
SYPHILIS									
1790	7.1	15295	208.4	95	23.4	47	17.6	17227	51.8
GONORRHEA									
15893	62.9	139275	1897.6	1070	263.4	458	171.7	156696	470.9
CHLAMYDIA AND NON-GONOCOCCAL URETHRITIS									
33808	133.8	76717	1045.3	791	194.7	703	263.5	112019	336.6
TUBERCULOSIS									
1034	4.1	2013	27.4	35	8.6	97	36.4	3179	9.6

* *Source:* Data produced by the State Center for Health and Environmental Statistics, Department of Environment, Health, and Natural Resources. Rates are average number of annual cases per 100,000 persons, based on a five-year period, 1988–92. Rates based on fewer than 20 cases may be misleading and were not computed.

Immunization Index

Percentage of U.S. children fully immunized on entering school in 1991: 97 to 98 percent.

Percentage of N.C. children fully immunized on entering school in 1991: 95 percent.

Percentage of U.S. children not fully immunized at age 2 in 1991: up to 40 percent.

Percentage of N.C. children not fully immunized at age 2 in 1991: 41.3 percent.

Number of countries with higher immunization rates than the U.S. for children under 1 year in 1988-89: 16, including Brazil, Bulgaria, Chile, China, Greece, Hungary, Mexico, North Korea, and Romania.

Number of measles cases in the U.S. in 1983: 1,497.

Number of measles cases in the U.S. in 1990: 27,672.

Source: Gary L. Freed, W. Clayton Bordley and Gordon H. DeFries, "Childhood Immunization Programs," The Milbank Quarterly, Vol. 71, No. 1, 1993, pp. 65 ff.

Table 9. Percentage of Minority Children Up-To-Date on Their Immunizations Compared to Whites in the Nine Counties Surveyed

County	Percent of White Children Up-To-Date*	Percent of Minority Children Up-To-Date	Overall Total
BUNCOMBE	64.3%	65.5%	64.4%
HALIFAX	70.6	54.5	60.7
HERTFORD	41.9	43.0	42.7
JOHNSTON	65.6	56.4	62.1
MECKLENBURG	54.6	55.6	55.2
NEW HANOVER	77.4	64.8	73.2
PENDER	65.4	57.4	61.9
ROBESON	59.9	50.4	52.6
SWAIN	80.2	70.2	79.1
Total	66.4	54.1	60.6

* Children were counted up-to-date if they had received immunization shots on the following schedule: Age 1.5-5 months, first diphtheria, pertussis, tetanus (DPT1), first oral polio (OPV1); age 5-7 months, DPT2, OPV2; age 7-16 months, DPT3, OPV2; over 16 months, DPT4, OPV3, measles, mumps, rubella (MMR1).