



# HEALTH OUTCOMES IN MINNESOTA: MOVING FROM HEALTH DISPARITIES TO HEALTH EQUITY IMPROVING

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# Public Health

“Public health is what we, as a society, do collectively to assure the conditions in which (all) people can be healthy.”

Institute of Medicine (1988), Future of Public Health

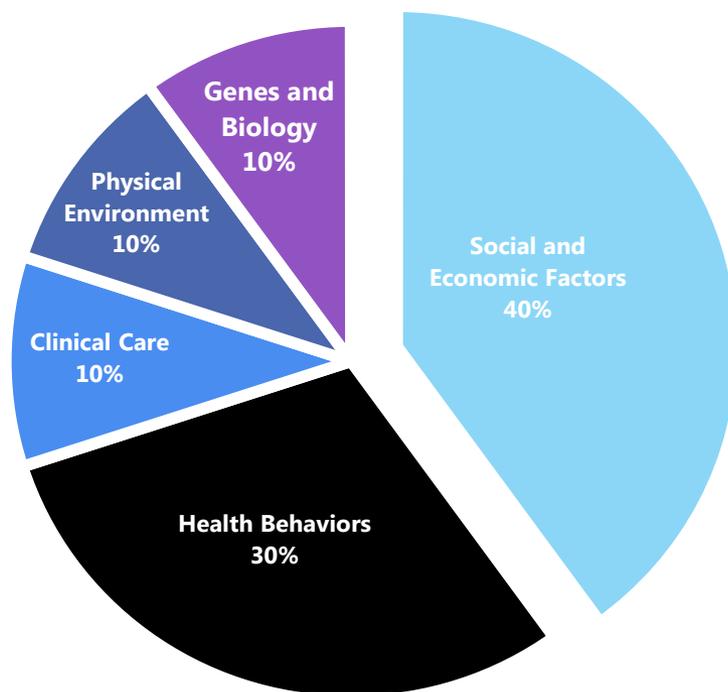
# What is Health?

From WHO 1948 and Ottawa Charter for Health 1986

*"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the objective of living."*

# Consider What Creates Health

## Determinants of Health



### Necessary conditions for health (WHO)

- Peace
- Shelter
- Education
- Food
- Income
- Stable eco-system
- Sustainable resources
- Mobility
- Health Care
- Social justice and equity

Determinants of Health Model based on frameworks developed by: Tarlov AR. *Ann N Y Acad Sci* 1999; 896: 281-93; and Kindig D, Asada Y, Booske B. *JAMA* 2008; 299(17): 2081-2083.

World Health Organization. Ottawa charter for health promotion. International Conference on Health Promotion: The Move Towards a New Public Health, November 17-21, 1986 Ottawa, Ontario, Canada, 1986. Accessed July 12, 2002 at <<http://www.who.int/hpr/archive/docs/ottawa.html>>.

# In Minnesota, overall, we are doing well!

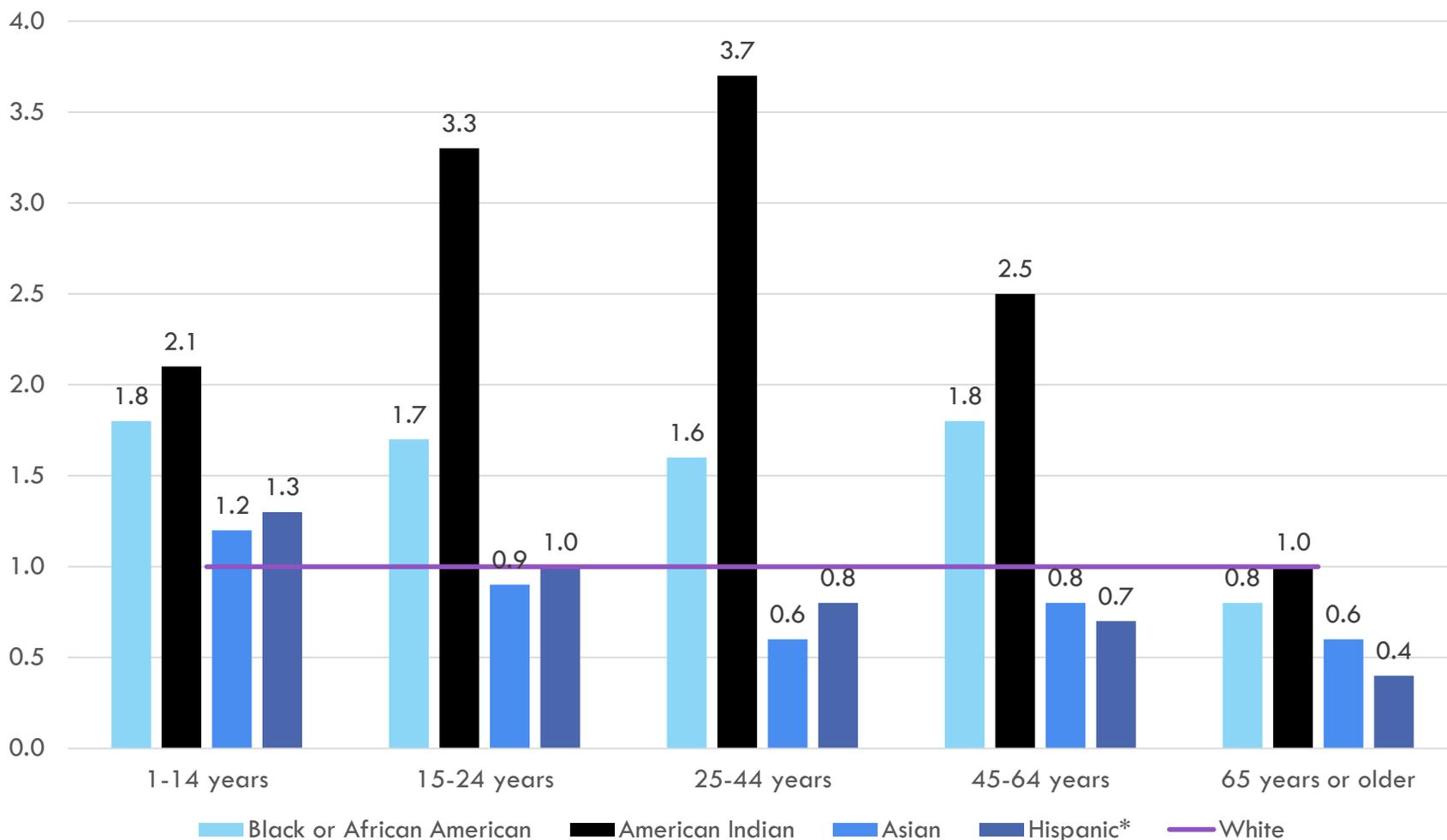
- Minnesota is one of the healthiest states (ranked #6)
- Lowest infant mortality rate (2<sup>nd</sup> highest in life expectancy at birth)
- Highest rated health of seniors (6<sup>th</sup> highest in life expectancy after age 65)
- Best Healthcare System in U.S. (ranked #1)

# Health Disparities and Health Inequity

**Health Disparity:** A population-based difference in health outcomes.

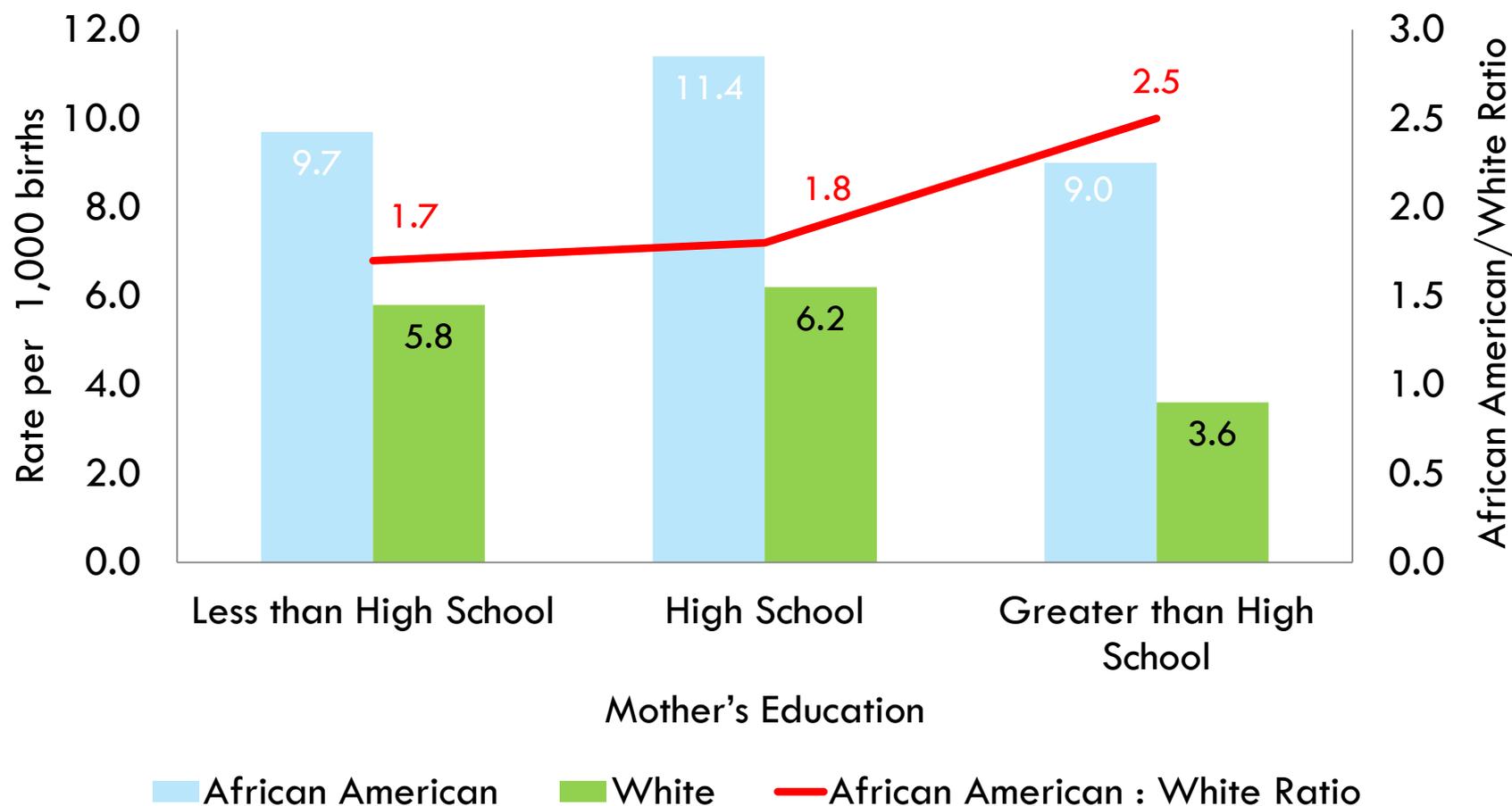
**Health Inequity:** A health disparity base in inequitable, socially-determined circumstances.

# Mortality Disparity Ratios by Race/Ethnicity and Age in Minnesota, 2007 – 2011



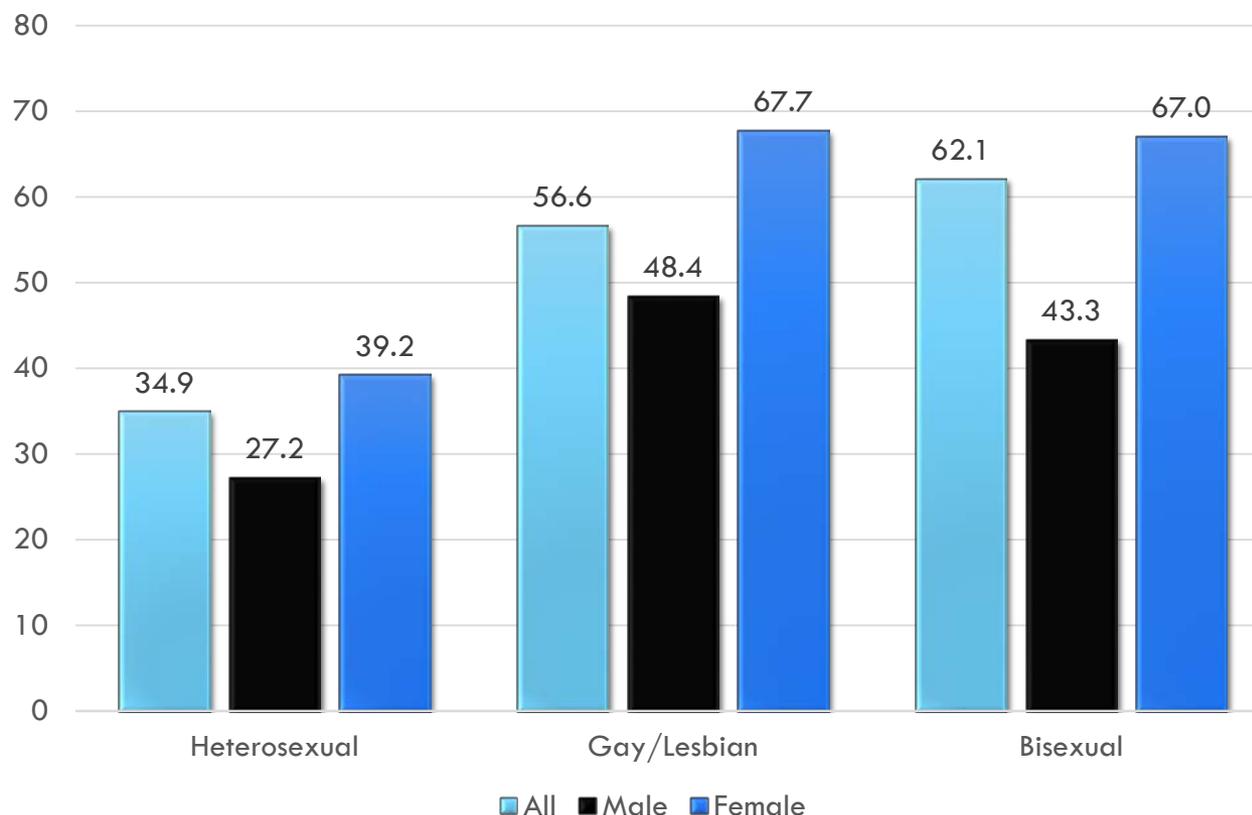
\*Hispanic may be any race.

# Infant Mortality Rates by Race and Education of Mother, Minnesota 2005-2009



Source: MDH, MCHS Linked Infant Death/Birth File

# Any Mental Health Condition Diagnosis – Lifetime All Students by Sexual Identity and Gender



# Stroke Mortality

Race/Ethnicity	Number	Disparity Ratio
African American	235	1.3
American Indian	63	1.0
Asian	186	1.3
Hispanic	90	0.9
White	9,618	1.0

# These examples are only the tip of the health disparities iceberg



# How did we get here? Why should we care?

- Disparities are not simply because of lack of access to health care or to poor individual choices.
- Disparities are mostly the result of policy decisions that systematically disadvantage some populations over others.
- Especially, LGBTQ, low income people, and rural communities, and populations of color and American Indians

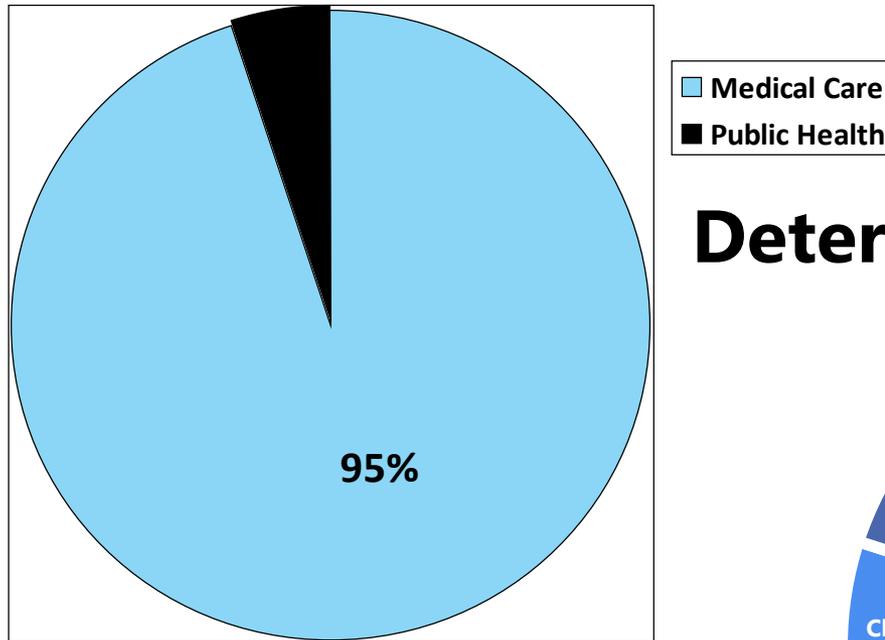
# Populations of Color as a Proportion of Minnesota's Total Population: 1990-2010

Race\Ethnicity	In 1990	In 2000	In 2010	Percent of Growth of Population
African American	2.2	3.5	5.2	189
American Indian	1.1	1.1	1.1	22.1
Asian/Pacific Islander	1.8	2.9	4.1	177.8
Hispanic	1.2	2.9	4.7	364.4
White	94.4	89.4	85.3	9.5

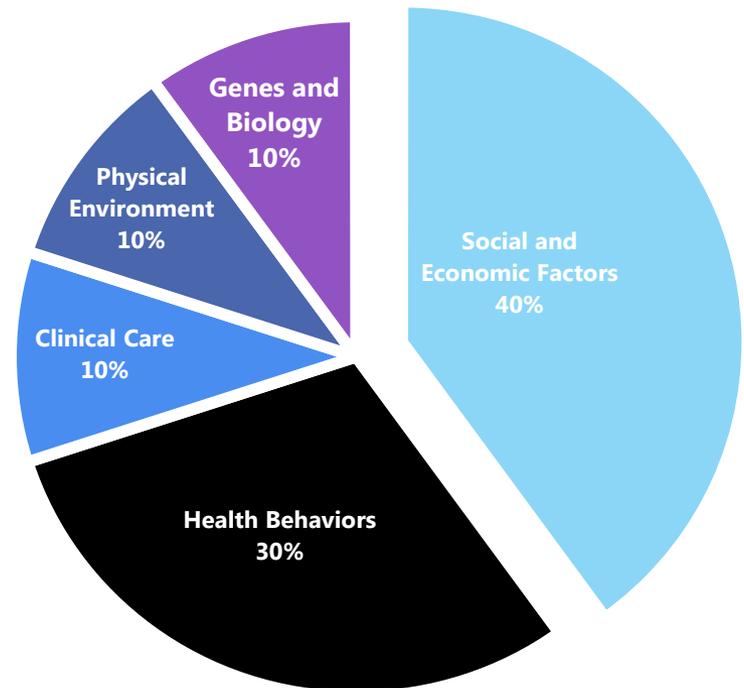
# Economic Burden of Health Disparities

According to a study conducted by the *Joint Center for Political and Economic Studies*, the estimated costs of health disparities and premature death in the United States were estimated to be **\$1.24 trillion**.

# How our healthcare money is spent



## Determinants of Health

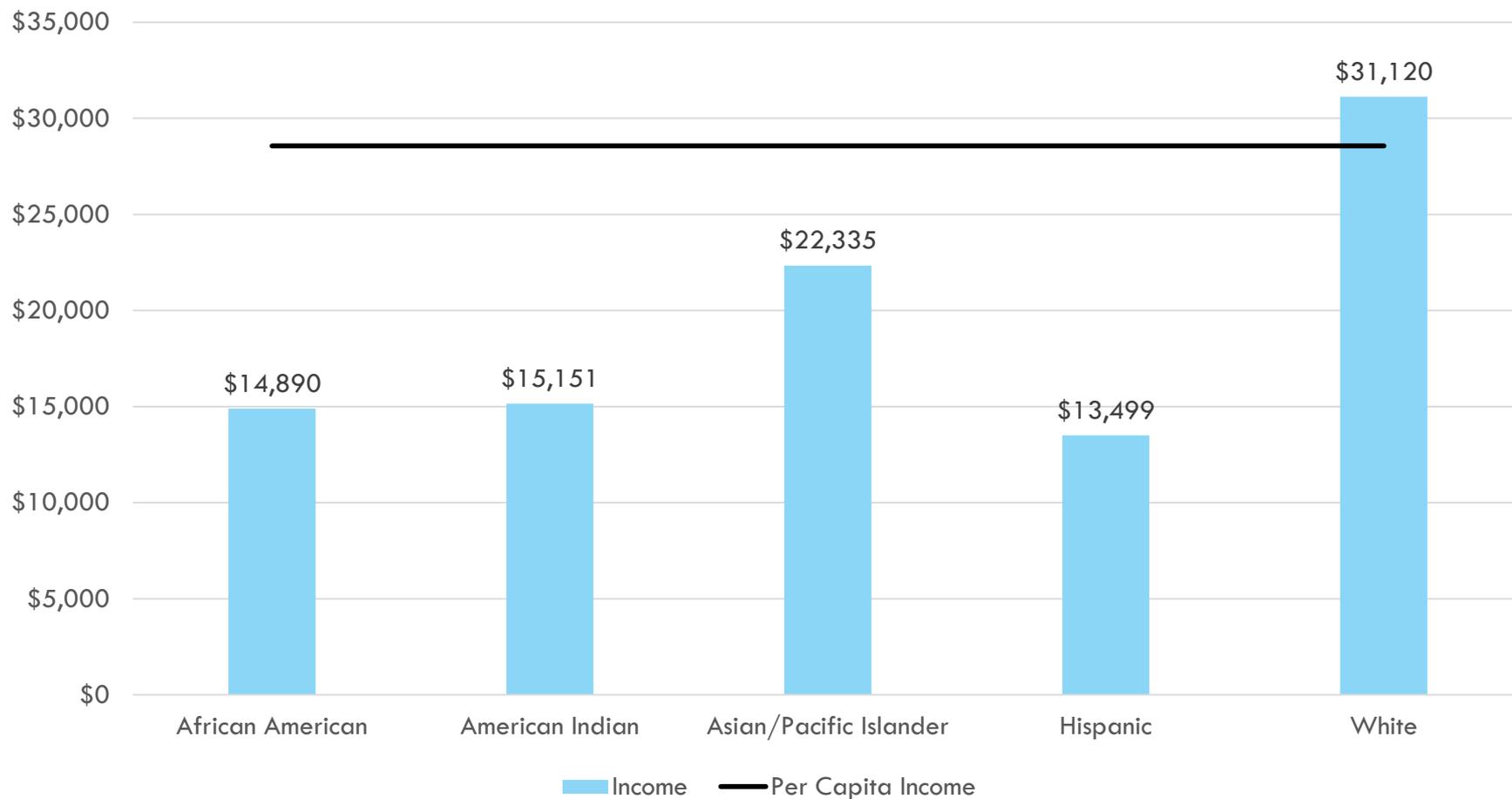


# Structural Inequity: Housing

- 75% of white population in Minnesota owns their own home, compared to:
- 21% of African Americans
- 45% of Hispanic/Latinos
- 47% of American Indians
- 54% Asian Pacific Islanders

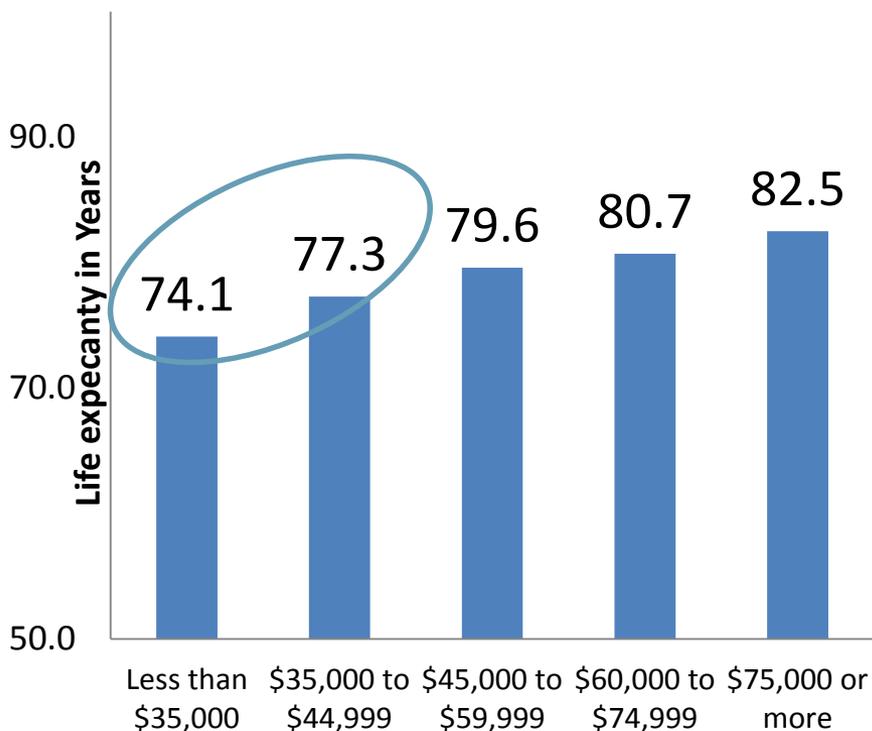
Source: Advancing Health Equity Report 2014

# Per capita Income in Minnesota: 2010

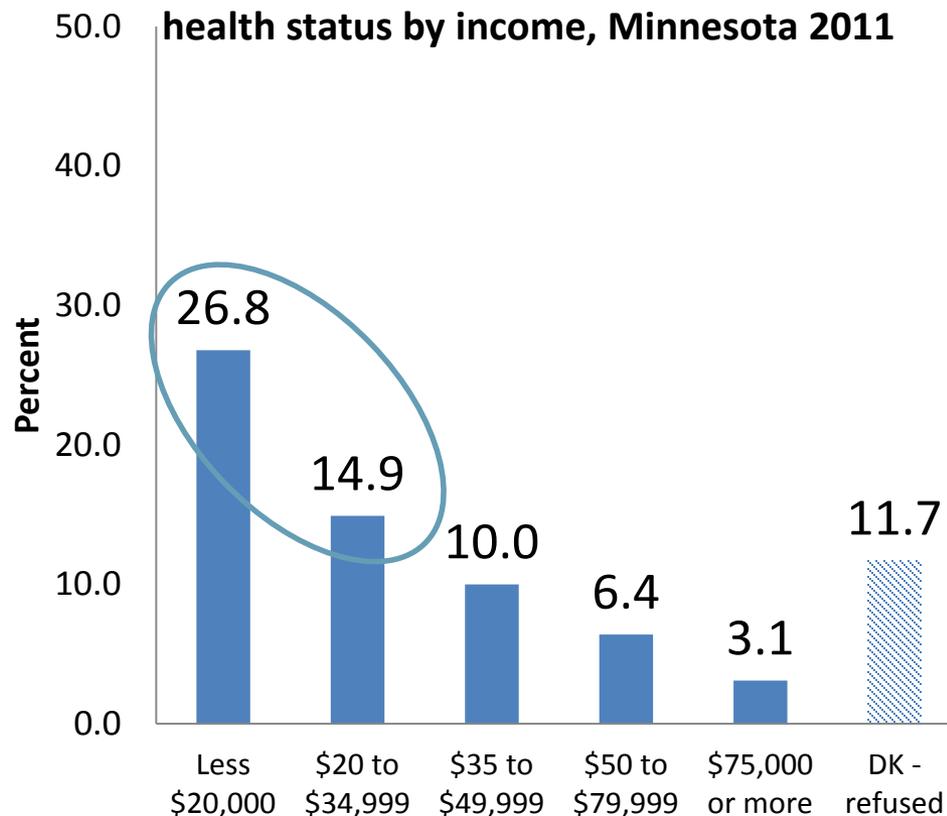


# White Paper: Income and Health

Life expectancy by median household income group of ZIP codes, Twin Cities 1998-2002



Adults 18-64 reporting "fair" or "poor" health status by income, Minnesota 2011



Source: The unequal distribution of health in the Twin Cities, [Wilder Research](http://www.wilderresearch.org), www.wilderresearch.org, Analyses were conducted by Wilder Research using 1998-2002 mortality data from the Minnesota Department of Health and data from the U.S. Census Bureau (population, median household income, and poverty rate by ZIP code

Source: 2011 Behavioral Risk Factor Surveillance System

## Conditions that create opportunities for health

- Home ownership
- Parks & trails
- Grocery stores
- Financial institutions
- Better performing schools
- Good transportation options and infrastructure
- Sufficient healthy housing
- Social inclusion
- IT connectivity
- Safe and clean drinking water

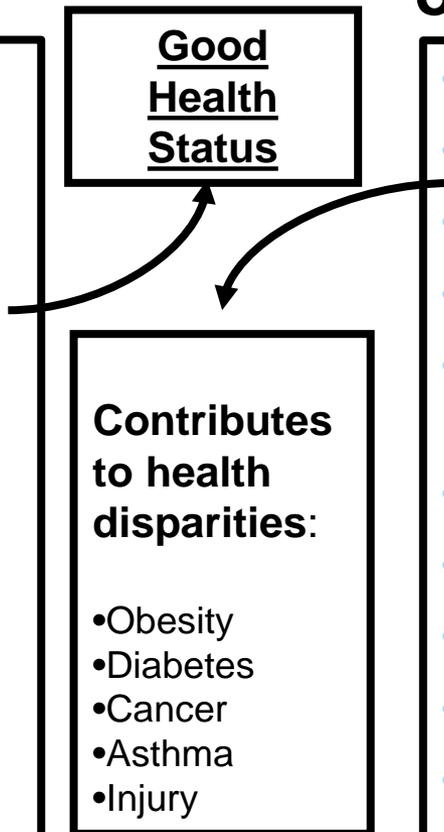
Good Health Status

**Contributes to health disparities:**

- Obesity
- Diabetes
- Cancer
- Asthma
- Injury

## Conditions that limit opportunities for health

- Poor and limited housing stock
- Rental housing/foreclosure
- Unsafe/limited parks
- Fast food restaurants
- Payday lenders and no credible financial institution
- Poor performing schools
- Few transportation options
- Social exclusion
- Limited IT connections
- Contaminated drinking water



# What are the Implications for the Task Force?

- Continue investments in efforts that currently are working to address health disparities.
- Consider investments that can advance health equity
  - A Health in All Policies approach
  - Strengthen the collection and analysis of data to advance health equity.
  - Strengthen communities capacity to create their own health futures

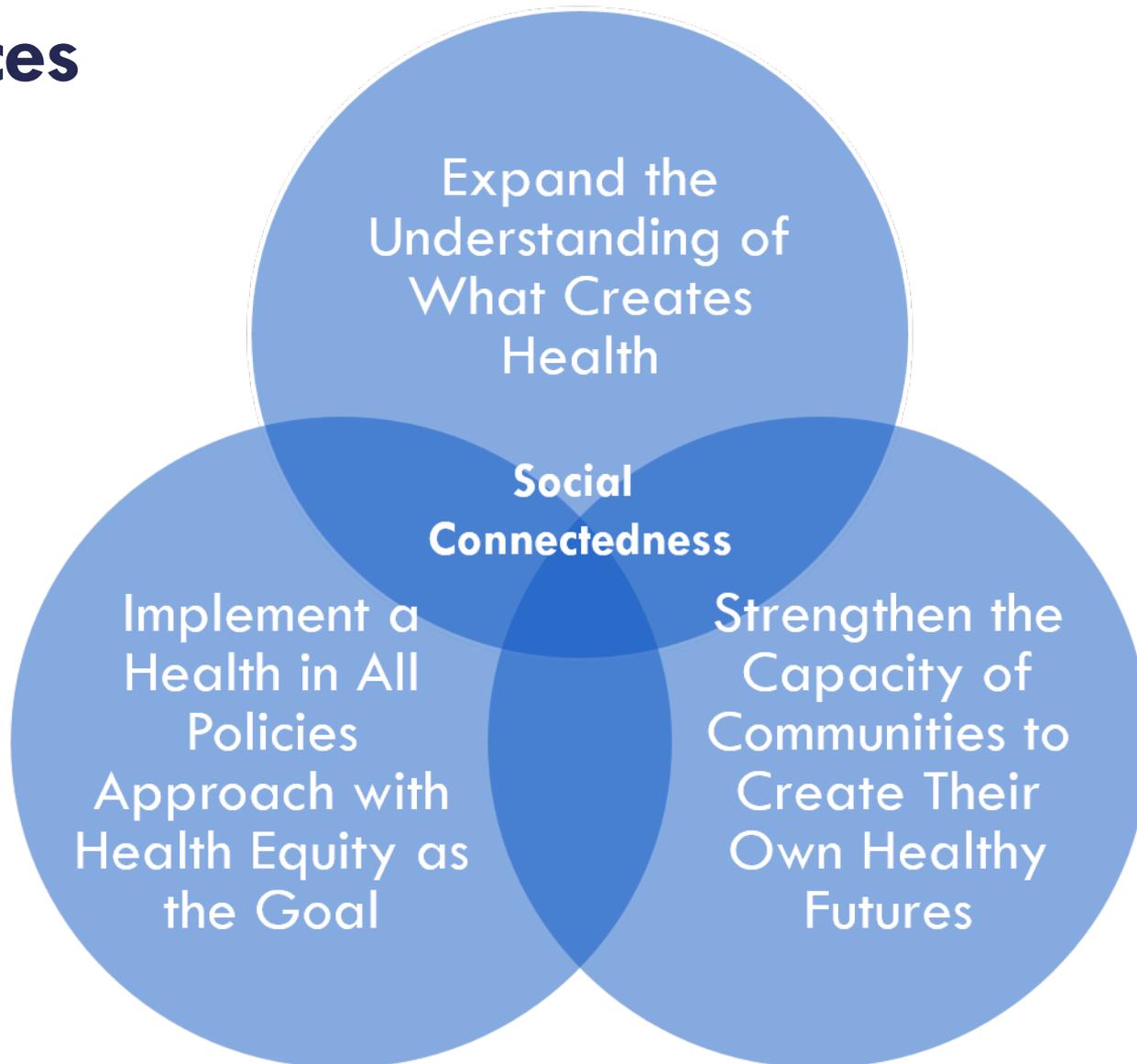
# Continue and Expand current innovative strategies in Health Care

- Universal and stable insurance coverage
- Networks to include
  - Community health centers
  - Behavioral and mental health services
- Services to include:
  - Care coordination
  - Preventive services
  - Home visiting
- Workforce
  - Interpreters
  - Navigators
  - Community Health Workers
- Emphasis on primary care
- Integration with public health and social services
- Individual and community education
- Data collection on race, ethnicity, and language

# Innovative Initiatives

- **State Innovation Model Grant (SIM)**
- **State-wide Health Improvement Program (SHIP)**
- **Essential Community Providers (ECPs)**

# Triple Aim of Health Equity-Essential Practices



# Essential Practices to Advance Health Equity

Purposefully expand the understanding and conversation of what creates health to include the “opportunity for health” (narrative)

Strengthen the capacity of communities to create their own healthy futures. Use public health tools: partnerships, engagement, convening ability, data, reports, education, policy, resources, legislation, “bully pulpit” (people)

Implement a “health in all policies” approach with health equity as the goal to program and policymaking (resources)

# A New Set of Questions for the Task Force

- What do we know about which communities will benefit and which will be left behind by these proposed changes?
- What and whose values, beliefs, and assumptions are guiding or influencing our decisions?
- Will some communities benefit more than others?
- How is the community being involved in this process?

# Implement an 'Health in All Policies' approach with the goal of advancing health equity

- Consider investments to support cross sectoral efforts to improve the conditions for health
- Consider investments to strengthen the collection, analysis and dissemination of health disparities and health equity data

# What are we learning and what are we doing with our work

- This is a rapidly changing field.
- We are constantly learning and evolving.
- MDH is using three essential practices to guide our work to advance Health Equity

**Thank You and please contact us if you want more information.**

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