ISSUE BRIEF

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HEALTHY NORTH CAROLINA 2030:
A Path Toward Health

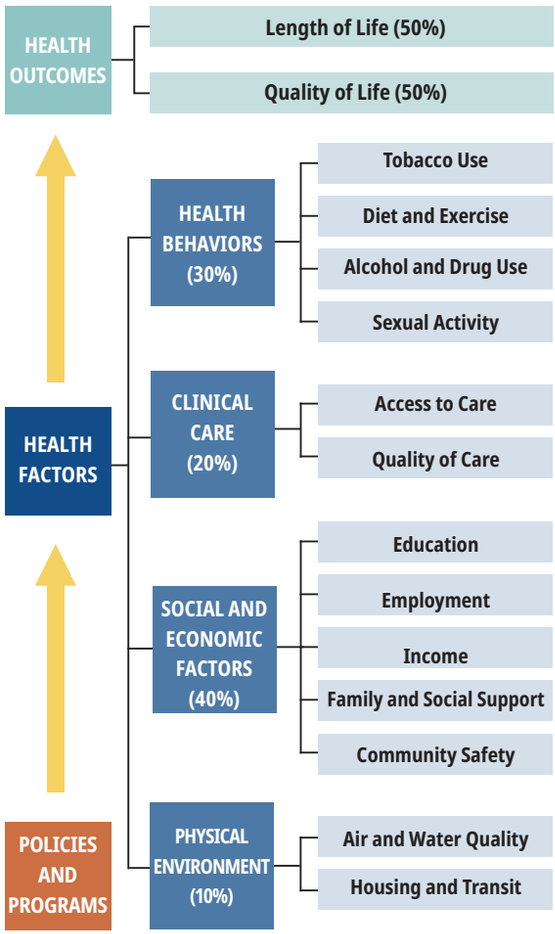
Healthy people and healthy communities are the foundation of a thriving, prosperous state, and improving the health, safety, and well-being of North Carolinians is a core part of the work of state government. In parallel with the national Healthy People initiative run by the United States Department of Health and Human Services, the North Carolina Department of Health and Human Services (NC DHHS) has released Healthy North Carolina (HNC) goals at the beginning of each decade since 1990. HNC is a set of health indicators with 10-year targets designed to guide state efforts to improve health and well-being. Identifying key indicators and targets allows NC DHHS, the Division of Public Health (DPH), local health departments, and other partners across the state to work together toward shared goals.

One of the goals of NC DHHS is to ensure that all North Carolinians have the opportunity for health. Health equity is the opportunity for all people to attain the highest level of personal health regardless of demographic characteristics.[1] Health begins in families and communities, and is largely determined by the social and economic contexts (responsible for 40% of the variation in health outcomes) in which we grow up, live, work, and age; the healthy behaviors (30%) that those contexts make easier or harder[2]; and our physical environments (10%) **(Figure 1)**. Some of the social, economic, behavioral, and environmental factors that affect health include:

- safety of families and communities,
- exposure to environmental contaminants in air, water, and soil,
- quality of housing and education,
- access to transportation and healthy food,
- availability of employment opportunities and a living wage,
- exposure to and use of alcohol, tobacco, and other drugs, and
- opportunities for physical activity.

These factors are called drivers of health (also known as social determinants of health) and they directly affect health outcomes like development of disease and life expectancy. HNC 2030 sets the stage for a focus on health equity and these overall drivers of health outcomes.

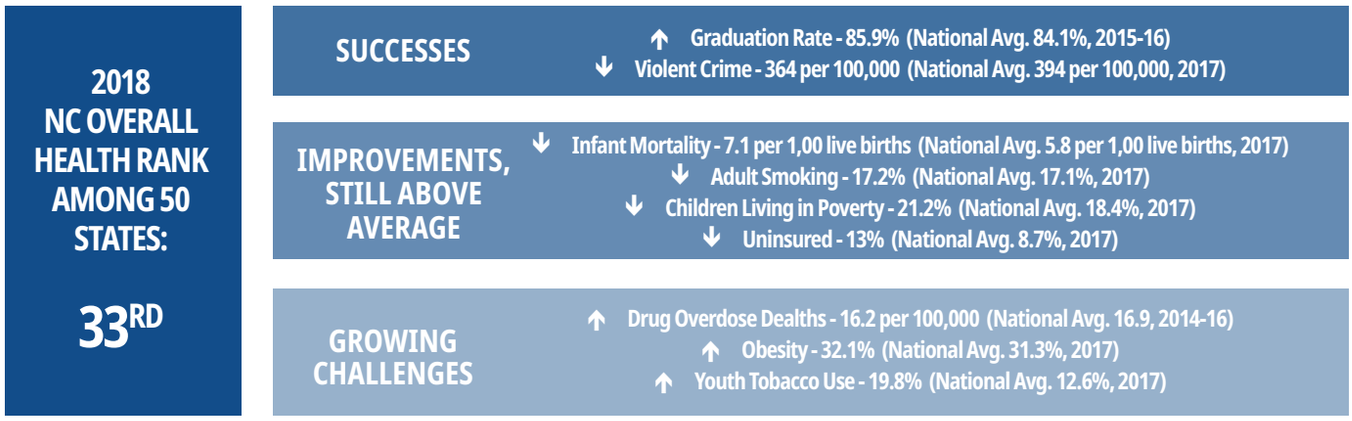
FIGURE 1. POPULATION HEALTH MODEL



Source: County Health Rankings & Roadmaps, County Health Rankings Model. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

[1] *https://www.ncdhhs.gov/about/dhhs-mission-vision-values-and-goals/mission-vision*

FIGURE 2. HEALTH STATUS SUCCESSES AND CHALLENGES IN NORTH CAROLINA



Source: America's Health Rankings (https://www.americashealthrankings.org/explore/annual); Kaiser Family Foundation State Health Facts (https://www.kff.org/other/state-indicator/nonelderly-0-)64/?currentTimeframe=0&selectedDistributions=uninsured&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D,%22states%22:%7B%22all%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Uninsured%22,%22sort%22:%22asc%22%7D; NC DHHS NC Tobacco Prevention and Control Branch analysis of Youth Tobacco Survey

Note: Data presented in this graphic are the most recent available to compare to national average.

Over the past decade, North Carolina's overall health ranking has improved from a low of 37th in 2014 to a high of 31st in 2015 and is now 33rd as of 2018 (ranking of 1st as best and 50th as worst), according to America's Health Rankings. The improvement in ranking is a result of successes in several areas. However, there are some growing challenges in the state that have prevented North Carolina from rising higher. **See Figure 2** for examples of these successes and challenges. In addition to the slow improvement in overall health in the state, stark disparities exist, particularly between different racial and ethnic groups. The HNC 2030 group seriously considered disparities and health equity in the selection of health indicators. When available, data on disparities across race/ethnicity, sex, and poverty status are presented in the final report for each indicator.

THE HNC 2030 TASK FORCE

The HNC 2030 process from January-August 2019 integrated input from a Task Force, four work groups (Social & Economic Factors, Physical Environment, Health Behaviors, and Clinical Care), and communities across the state through a series of eight Community Input Sessions. Funding was provided by the Blue Cross and Blue Shield of North Carolina Foundation, The Duke Endowment, and the Kate B. Reynolds Charitable Trust. Participants considered several priorities during the HNC 2030 process. Because the HNC 2030 indicators represent issues across many sectors of society, it is important that they be understandable to a broad audience. Each indicator is measurable using existing data sources. The group had a preference for data measured at least every three years to allow for monitoring between now and 2030. When possible, there was also a preference for data available at the county level to allow for local goal setting and local action as well as comparisons within the state. In addition, the Task Force tried to align with statewide health improvement plans and measure sets when possible, including the Early Childhood Action Plan, the Opioid Action Plan, the Perinatal Strategic Plan, and the Medicaid Transformation Quality Strategy. The Task Force and work groups prioritized health equity by selecting indicators related to health disparities within the state.

Overall, 21 health indicators were chosen across the topics of Social & Economic Factors, Physical Environment, Health Behaviors, Clinical Care, and Health Outcomes **(Table 1)**.

While the indicators selected for HNC 2030 are all important for North Carolina's population health status, they are not the only important health indicators for the state. HNC 2030 indicators were selected to represent a broad range of important issues for health in North Carolina and oftentimes represent larger issues. For example, primary care providers per population and health insurance status are indicators of broader health care access issues but are not the only important characteristics of that access.

Along with the selection of health indicators, the HNC 2030 group set targets for change. The group reviewed data across several years, any sub-population data available, forecasted values for North Carolina based on historical data, comparisons to other states and among counties within North Carolina, and any relevant targets for health indicators used at the national level (i.e., Healthy People 2030). The group also discussed the potential for movement in each indicator, what is currently being done at community and state levels, what political will and public interest exist to create change, and whether there is funding for the work needed to create change. In some cases, the targets chosen by the group are ambitious. While reaching the selected targets by 2030 is the goal, turning the trend and making improvements toward the goal by 2030 will be considered a success.

NEXT STEPS

The NC DHHS, DPH, and local health departments will remain at the forefront of HNC 2030 efforts; however, they cannot achieve these goals alone. HNC 2030 should be more than goals for public health; it should be goals for the whole state. The inclusion of factors traditionally outside the sphere of public health (e.g., education, employment, housing) means that achieving the HNC 2030 goals will require engaging partners across multiple sectors to improve population health and drive health equity over the next decade.

As the new decade begins, the NC DHHS and DPH will be developing a population health improvement strategy and resources to be used at the local level. The broader view of the drivers of health and well-being with attention to health disparities is an exciting step toward making North Carolina a place for everyone to live a healthy life.

TABLE 1.
HEALTHY NORTH CAROLINA 2030 HEALTH INDICATORS AND DATA (TOTAL NC POPULATION, 2030 TARGET, AND DATA BY RACE/ETHNICITY, SEX, AND POVERTY LEVEL)

		TOTAL POPULATION		RACE / ETHNICITY						SEX		FEDERAL POVERTY LEVEL		
HEALTH INDICATOR	**DESIRED RESULT**	**CURRENT (YEAR)**	**2030 TARGET**	**W**	**B/AA**	**H/LX**	**O**	**A/PI**	**AI**	**MALE**	**FEMALE**	**<200%**	**200-399%**	**400%+**
INDIVIDUALS BELOW 200% FPL	Decrease the number of people living in poverty	36.8% (2013-17)	27.0%	30.7%	51.1%	63.6%	46.1%[G]	30.6%	51.5%	34.8%	38.7%	‡	‡	‡
UNEMPLOYMENT	Increase economic security	7.2% (2013-17)	Reduce unemployment disparity ratio between white and other populations to 1.7 or lower	5.7%^	11.7%^	7.1%^	7.3%^ 11.0%^[G]	5.2%^	10.3%^	6.4%	6.7%	‡	‡	‡
SHORT-TERM SUSPENSIONS (PER 10 STUDENTS)	Dismantle structural racism	1.39 (2017-18)	0.80	0.73	3.00	0.88	1.69	0.18[A]	2.46	1.98	0.74	2.09[C]	‡	‡
INCARCERATION RATE (PER 100,000 POPULATION)		341 (2017)	150	203#	915#	209#	‡	‡	488#	649	50	‡	‡	‡
ADVERSE CHILDHOOD EXPERIENCES	Improve child well-being	23.6% (2016-17)	18.0%	17.5%	36.0%	23.2%	37.2%	11.1%	‡	23.8%	23.5%	47.9%	19.9%	8.3%
THIRD GRADE READING PROFICIENCY	Improve third grade reading proficiency	56.8% (2018-19)	80.0%	70.1%	40.8%	42.6%	59.5%[G]	75.6%[A]	44.5%	54.0%	59.8%	42.6%[C]	70.6%[H]	‡
ACCESS TO EXERCISE OPPORTUNITIES	Increase physical activity	73% (2010/18)	92%	DATA NOT AVAILABLE										
LIMITED ACCESS TO HEALTHY FOOD	Improve access to healthy food	7% (2015)	5%											
SEVERE HOUSING PROBLEMS	Improve housing quality	16.1% (2011-15)	14.0%											
DRUG OVERDOSE DEATHS (PER 100,000 POPULATION)	Decrease drug overdose deaths	20.4 (2018)	18.0	26.4	12.9	5.4	4.4	‡	32.6	27.8	13.2	‡	‡	‡
TOBACCO USE	Decrease tobacco use	YOUTH 19.8% (2017)	9.0%	20.6%	17.0%	20.7%	19.0%	‡	‡	23.0%	16.5%	‡	‡	‡
		ADULT 23.8% (2018)	15.0%	25.9%	22.5%	12.2%	17.1%	‡	‡	29.9%	18.5%	32.8%	21.6%	17.2%
EXCESSIVE DRINKING	Decrease excessive drinking	16.0% (2018)	12.0%	17.2%	12.5%	17.8%	13.1%	‡	‡	21.7%	10.8%	14.5%	17.6%	21.2%
SUGAR-SWEETENED BEVERAGE CONSUMPTION	Reduce overweight and obesity	YOUTH 33.6% (2017)	17.0%	36.1%	31.5%	28.9%	24.3%	‡	‡	38.7%	28.3%	‡	‡	‡
		ADULT 34.2% (2017)	20.0%	32.6%	38.7%	37.0%	‡	‡	‡	37.6%	31.0%	41.0%	32.7%	24.1%
HIV DIAGNOSIS (PER 100,000 POPULATION)	Improve sexual health	13.9 (2018)	6.0	4.9	40.8	17.7	‡	4.3	5.9	23.1	5.4	‡	‡	‡
TEEN BIRTH RATE (PER 1,000 POPULATION)		18.7 (2018)	10.0	12.9	24.1	34.3	6.9	‡	38.3	‡	‡	‡	‡	‡
UNINSURED	Decrease the uninsured population	13% (2017)	8%	10%	13%	31%	8%	9%	18%	14%	11%	21%	12%	4%
PRIMARY CARE CLINICIANS (COUNTIES AT OR BELOW 1:1,500 PROVIDERS TO POPULATION)	Increase the primary care workforce	62 (2017)	25% decrease for counties above 1:1,500 providers to population	NOT APPLICABLE										
EARLY PRENATAL CARE	Improve birth outcomes	68.0% (2018)	80.0%	74.8%	60.5%	57.5%	66.0%	‡	54.3%	‡	‡	‡	‡	‡
SUICIDE RATE (PER 100,000 POPULATION)	Improve access and treatment for mental health needs	13.8 (2018)	11.1	17.8	5.7	5.8	7.7	‡	‡	22.4	5.9	‡	‡	‡
INFANT MORTALITY (PER 1,000 BIRTHS)	Decrease infant mortality	6.8 (2018)	6.0	5.0	12.2	4.8	5.0	‡	9.3	8.0	5.5	‡	‡	‡
		Black/white disparity ratio = 2.4	Black/white disparity ratio = 1.5											
LIFE EXPECTANCY (YEARS)	Increase life expectancy	77.6 (2018)	82.0	78.3*	75.5*	‡	87.0*	‡	75.6*	74.8	80.3	‡	‡	‡

Source: See full Healthy North Carolina 2030 report for information on data sources at www.nciom.org.

W = WHITE
B/AA = BLACK/AFRICAN AMERICAN
H/LX = HISPANIC/LATIN(X)
A/PI = ASIAN/PACIFIC ISLANDER
AI = AMERICAN INDIAN
FPL = FEDERAL POVERTY LEVEL
‡ NOT AVAILABLE OR NOT APPLICABLE

* 2016-18 AVERAGE
^ INCLUDES HISPANIC ETHNICITY
# DATA FROM 2015
A - ASIAN ONLY
B - PACIFIC ISLANDER
C - ECONOMICALLY DISADVANTAGED STUDENTS, AS DEFINED BY NC DEPARTMENT OR PUBLIC INSTRUCTION

D - 50%-100% FEDERAL POVERTY LEVEL
E - 101%-150% FEDERAL POVERTY LEVEL
F - 151%-200% FEDERAL POVERTY LEVEL
G - TWO OR MORE RACES
H - STUDENTS WHO ARE NOT ECONOMICALLY DISADVANTAGED, AS DEFINED BY NC DEPARTMENT OF PUBLIC INSTRUCTION

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A copy of the full Healthy North Carolina 2030 report is available on the North Carolina Institute of Medicine website: www.nciom.org

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