MISSISSIPPI STATE DEPARTMENT OF HEALTH

Office of Health Disparity Elimination
Office of Health Data & Research

State of the State:

Annual Mississippi Health Disparities and Inequalities Report

570 East Woodrow Wilson Blvd.
P.O. Box 1700
Jackson, MS 39215-1700
(601) 576-7646

October 2015

Acknowledgements

Suggested Citation:

Lamees El-sadek, MHS; Lei Zhang, PhD; Rodolfo Vargas, MS; Tanya Funchess, DHA; Candice Green, MPH, Mississippi Health Disparities and Inequalities Report, the Office of Health Disparity Elimination and the Office of Health Data & Research. Mississippi State Department of Health, Jackson, MS, October 2015.

The Mississippi State Department of Health (MSDH) would like to acknowledge those who contributed their time and effort to the development of this report. Contributors included:

- Mississippi State Department of Health Office of Health Data and Research
- Mississippi State Department of Health Office of Health Disparity Elimination
- Mississippi State Department of Health Office of Health Promotion and Health Equity

For further information about this report please contact:
Tanya Funchess, DHA, MPH, MSM
Mississippi State Department of Health
Office of Health Disparity Elimination
715 S. Pear Orchard Road
Ridgeland, MS 39157
Email: Tanya.Funchess@msdh.ms.gov
Phone: (601) 206-1542

Table of Contents

Foreword

With this publication, we are excited to announce the first annual State of the State: Health Disparities and Inequalities Report. With this new commitment, we hope to enhance transparency and communication with our public and establish standardized measures to assess how far we have traveled and how much further we have to travel as a community.

A chain is only as strong as its weakest link, and the nation's public health leaders recognize this. Every ten years, since 1979, the United States Department of Health and Human Services issues a national set of objectives to promote health and prevent disease. The culmination of this is called *Healthy People*, a program of goals that is the product of diverse individual and organizational input. One of *Healthy People 2000's* two overarching goals was to reduce health disparities.[1] *Healthy People 2010* raised this standard and called the nation's medical and community leaders to outright "eliminate health disparities."[2] Healthy People 2020 further expanded upon the goal for health disparity elimination to direct the nation to achieve "health equity, eliminate disparities, and improve the health of all groups."[3]

Our Office of Health Disparity Elimination (OHDE) is committed to a similar vision for all Mississippians, and we're motivated because we realize the pain felt by our communities. We understand that, on average, Mississippians live sicker and die earlier than our national counterparts. At an average life span expectancy of 75.8 years, Mississippians die 3.1 years earlier than the national average.[4] We also understand that disparities exist *within* our state—subpopulations such as rural black women and babies suffering worse than other groups within the state. An individual cannot alter how s/he was born, but a village can intervene in "social inheritance," the preventable and avoidable determinants that cause some populations to suffer worse health outcomes than others.

The OHDE is committed to the long-term vision of eliminating health disparities within Mississippi, and we understand such a lofty goal is impossible to accomplish unless we walk hand-in-hand with our communities. It is this need to understand the problem and brainstorm interventions by all stakeholders that the OHDE is issuing its *First Annual Mississippi's Health Disparities Report*. This report presents descriptive analysis for a wide range of health outcomes and risk factors. We know that lack of data is a barrier to both 1) identifying the problems at hand and 2) designing programs, interventions, research studies, and policy reforms to respond to health disparities and prevent new illnesses from arising. Public health measures to remove barriers to health equity can be incorporated at all levels, and it is the hope of the OHDE that the data presented below motivates community and faith leaders, medical and health practitioners, researchers, academicians, employers, and policymakers to address the public health burden of health inequality.

The report's specific goals are to 1) inform and provide transparent data to the public, 2) call to action individuals, health practitioners, organizations, and communities to health-related change, 3) provide data to support programmatic efforts, and 4) encourage public health research to strengthen the science and policies affecting Mississippian health.

The OHDE is glad to provide any additional data analysis and programmatic support—within our capacity—that aims to both seat and serve more communities at the table. Our contact information is found at the end of this report, and we are truly excited to working alongside you to ensure a more equitable and healthier Mississippi for *all*.

Sincerely,

Tanya T. Funchess

Tanya T. Funchess, DHA, MPH, MSM
Office Director, Health Disparity Elimination
715 S. Pear Orchard Road
Ridgeland, MS 39157
Post Office Box 1700
Jackson, MS 39215-1700
Phone 601-206-1542
Fax 601-957-6781

Glossary[1]

Age-Adjusted: method that allows statisticians to compare populations of normal distribution. For example, a state with a particularly elderly population would present a greater number of illnesses, so age-adjusted health outcomes allow statisticians to standardize such differences.[5]

Frequency: the amount or number of occurrences of an attribute or health outcome within a population.[6]

Health Disparity: a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. [7]

Health Equity: attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.[8]

Incidence: a measure of the frequency with which new cases of illness, injury, or other health condition occur, expressed explicitly per a time frame. Incidence rate is calculated as the number of new cases over a specified period divided either by the average population (usually mid-period) or by the cumulative person-time the population was at risk. [9]

Prevalence: the number or proportion of cases or attributes among a given population. [10]

Proportion: a ratio in which the numerator is included in the denominator; the ratio of a part to the whole, expressed as a "decimal fraction" (e.g., 0 2), a fraction (1/5), or a percentage (20%).[11]

Rate: an expression of the relative frequency with which an event occurs among a defined population per unit of time, calculated as the number of new cases or deaths during a specified period divided by either person-time or the average population. [12]

Respondent Size: number of individuals who respond to a survey item or question.

Response Bias: cognitive bias where the respondent answers a question not true to self-opinion, but in the manner s/he believes pleasing to the interviewer.

[1] Glossary terms align with the Centers for Disease Control and Prevention published terminology.

Social Determinants of Health- the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.[13]

Mission and Vision of the Office of Health Disparity Elimination

By year 2043, the United States Census Bureau predicts ethnic minorities will be the new majority in the country as well as in the state of Mississippi.[14] In 2013, racial minorities already comprised 42.4% of Mississippi, whereas the national average was 37.0%.[15] This means that without intervention, and even if rates of sickness do not increase, the State of Mississippi will only become sicker by virtue of a growing minority population that is disproportionately impacted by unfavorable and preventable social determinants of health.

It is the Office of Health Disparity Elimination's mission to protect the health of all Mississippians, because poor health is not only damaging to our families' physical well-being; poor health is damaging to the entire state's economic well-being. A state with a majority population that is unhealthy can cripple its workforce and exhaust its safety nets. For these reasons, addressing our current health disparities and proactively preempting new illnesses is imperative.

The ***mission*** of the Office of Health Disparity Elimination is "*to identify health inequities and their root causes and to promote evidence-based solutions to create a more equitable system*." The OHDE has established four pillars on which to direct our work. These pillars are to collect and disseminate strong data, provide cultural and linguistic services, support access to care, and disseminate and support education and awareness. These pillars align with the goals established by the federal Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities.

The ***vision*** of the Office of Health Disparity Elimination is to work "*Together Toward Health Equity for All Mississippi Residents*. "The OHDE understands strong partnerships can engender better results than any single entity could engender and that is why, at the ***core*** of our work, explicitly stated in our vision, the Office of Health Disparity Elimination realizes the need to work alongside our communities. A community is comprised of numerous, diverse entities with different assets to contribute and different needs to be addressed.

In a February 21, 1998 radio address to the nation, then-President Williams Jefferson Clinton remarked, "Americans are living longer and are in better health than ever before. But we must not be blind to the alarming fact that too many Americans do not share in the fruits of our progress, and nowhere are the divisions of race and ethnicity more sharply drawn than in the health of our people…no matter what the reason, racial and ethnic disparities in health are unacceptable in a country that values equality and equal opportunity for all. And that is why we must act now with a comprehensive initiative that focuses on health care and prevention for racial and ethnic minorities."[16]

16 years later, this message is still relevant: comprehensively and together, we must address our health disparities, at all levels.

Introduction to Health Disparities

The Social Determinants of Health

It is widely understood a person's health is influenced by biology and genetics, but there is much more to the story. The social determinants of health are pivotal to an individual and community's well-being and impact well-being just as much, if not more, as genetic inheritance.

According to the World Health Organization, social determinants of health are "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels."[17] In other words, where and how our citizens live, work, play, and learn directly impacts health.

Examples of social determinants of health include quality of education, food security, job opportunities, living wages, health insurance, public safety, workplace safety, safe and affordable housing, clean water and air, public transportation access, residential segregation, concentrated poverty, exposure to crime and violence, mass media exposure, geographic distribution of providers, social capital, social norms, intentional and unconscious bias, perceptions of discrimination, emerging technologies, and cultural and linguistic competency among health care providers.

Health Disparity and Health Equity

Differences in access and exposure to these social determinants are a large contributor to differences in health outcomes between populations. Differences in social determinants between populations can lead to a burden of illness, suffering, disability, and premature death that is often avoidable.

Healthy People 2020 defines a *health disparity* as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." [8]

Healthy People 2020 defines *health equity* as "the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[9]

Executive Summary: Data Report Highlights and Limitations

The following health outcomes are presented according to the most recent data available to the Mississippi State Department of Health Office of Health Disparity Elimination and Office of Health Data and Research. These data are pulled from several data sources including the Mississippi Behavioral Risk Factor Surveillance System (BRFSS). For a list of the survey questions used, please go to http://www.cdc.gov/brfss/. Other data used come from the Mississippi State Department of Health Vital Records, Mississippi State Department of Health STD/HIV Surveillance, and the University Of Mississippi Medical Center Cancer Registry.

Every health outcome was analyzed by race-ethnicity, gender, education, and income, if data was available. Further analysis into Mississippi's health disparities can include geographic region, age, and sexual orientation.

Data Limitations

BRFSS data limitations include potential response bias on survey items such as self-reported weight and dental visit frequency. Race-ethnicity is self-labeled, so this categorical cultural relativity may also skew data representation.

Another data limitation comes in the form of respondent size. Several survey items received small respondent sizes (<50), and this is indicated in the graphs. Potentially, also due to small sample sizes in data collection, the Hispanic population was not consistently represented in all analyses.

Also of note is that the "other" race-ethnicity-category was significantly represented in several of the health outcomes. Since it is not transparent whether "other" respondents are multiracial or of non-represented ethnic background, lack of consistency in data representation prevented this race-ethnicity category from being included in the report summary. However, they are represented in several of the charts, where data was available. Existence of this "other" categorization should be kept in mind as practitioners design surveys, collect data, and better represent the population in which we live.

A limitation of databases such as with the Mississippi STD/HIV surveillance system and the Cancer Registry is that the represented data is only for diagnosed and reported cases. There likely are a significant number of Mississippians with illnesses that are silenced and undiagnosed as a result of socioeconomic circumstances, miseducation, among other potential reasons.

All mortality data were age-adjusted and unless indicated, all data represents an adult of population of 18 years of age or older.

Executive Summary: Health Disparity Outcomes

The data included in the below executive summary are statistically significant:

Summary of Health Disparities by Race-ethnicity

Black Population

Among Blacks, Whites, and Hispanics, Mississippi's black population had the highest mortality rate due to: hypertension, stroke, diabetes, renal disease, HIV/AIDS, cancer, and homicide. Blacks also had the highest infant mortality rate.

This population also had the higher prevalence of: coronary heart disease, hypertension, obesity, diabetes, current childhood asthma, HIV, and permanent teeth extractions.

Mississippi's black population also had the highest: HIV/AIDS incidence, invasive cancer incidence, and teenage birth rate.

Furthermore, Mississippi's black population ranked lowest in prevalence of: adults who have visited a dentist within the past year. Mississippi's black population also ranked lowest in prevalence of: adults age 65 or older who have received the influenza vaccination within the past year or who have ever received the pneumonia vaccination, Mississippi's black population is also the most uninsured.

White Population

Among Mississippi's Black, White, and Hispanics, Mississippi's whites had the higher prevalence of: coronary heart disease and high cholesterol. This population also had the highest mortality rate due to unintentional injury and suicide.

Hispanic Population

Among Blacks, Whites, and Hispanics, Mississippi's Hispanic population ranked lowest in prevalence of those reporting any amount of exercise over the past month.

Summary of Health Disparities by Gender

Women

Compared to Mississippi's adult men, adult Mississippi women had the higher prevalence of: obesity and current asthma.

Compared to Mississippi's adult men, a lower prevalence of adult Mississippi women reported any exercise over the past month.

Men

Compared to Mississippi's adult women, adult Mississippi men had higher mortality rates due to: heart disease, hypertension, stroke, diabetes, renal disease, HIV/AIDS, cancer, unintentional injury, homicide, and suicide.

This population also had a significantly higher prevalence of: myocardial infarctions, overweight individuals, HIV, and current smokers. This population also demonstrated a higher incidence of HIV/AIDS and invasive cancer.

In comparison to Mississippi women, Mississippi's men also made fewer visits to the dentist in the past year.

Summary of Health Disparities by Education

Those with no high school education had the highest prevalence of: coronary heart disease, hypertension, stroke, myocardial infarction, high cholesterol, diabetes, current asthma, lifetime asthma, permanent teeth extractions, and current smokers.

Those without a high school diploma also ranked lowest in prevalence of: individuals reporting any amount of exercise over the past month, individuals visiting a dentist in the past year for any reason, and individuals covered by any form of health care.

Summary of Health Disparities by Annual Household Income

Those earning less than $15,000 in annual household income had the highest prevalence of: coronary heart disease, hypertension, stroke, myocardial infarction, high cholesterol, obesity, diabetes, current asthma, lifetime asthma, those having any permanent teeth extracted, and current smokers.

Those in this income bracket also ranked lowest in prevalence of: those reporting any amount of exercise over the past month, adults age 65+ who received an influenza shot within the past year, those visiting a dentist within the past year for any reason, and those with any form of health care coverage.

Conditions of Illness

I. Cardiovascular Disease

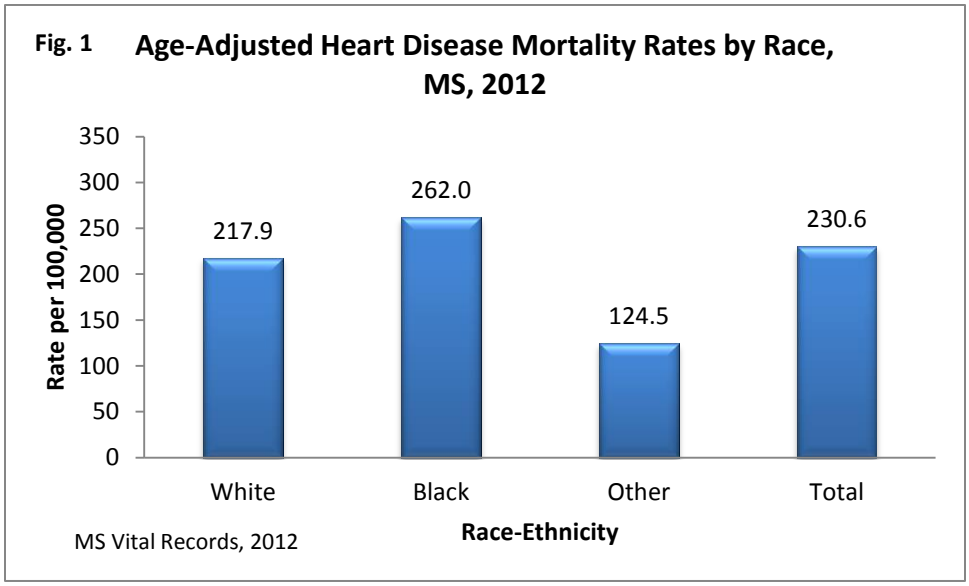

Figure 1: The mortality rate for heart disease, by race-ethnicity, is the highest among black Mississippians at 262.0 deaths per 100,000 population.

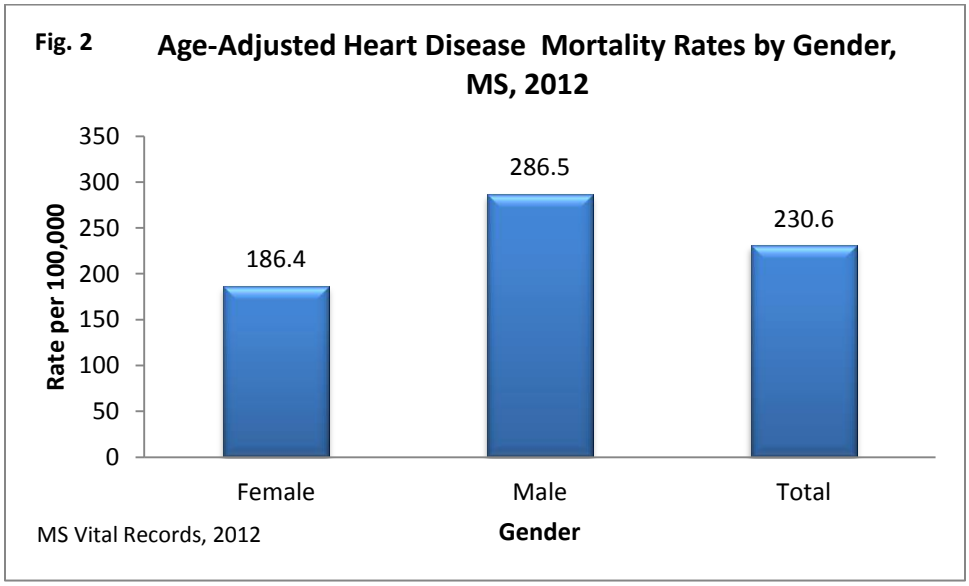

Figure 2: The mortality rate for heart disease, by gender, is the highest among male Mississippians at 286.5 deaths per 100,000 population.

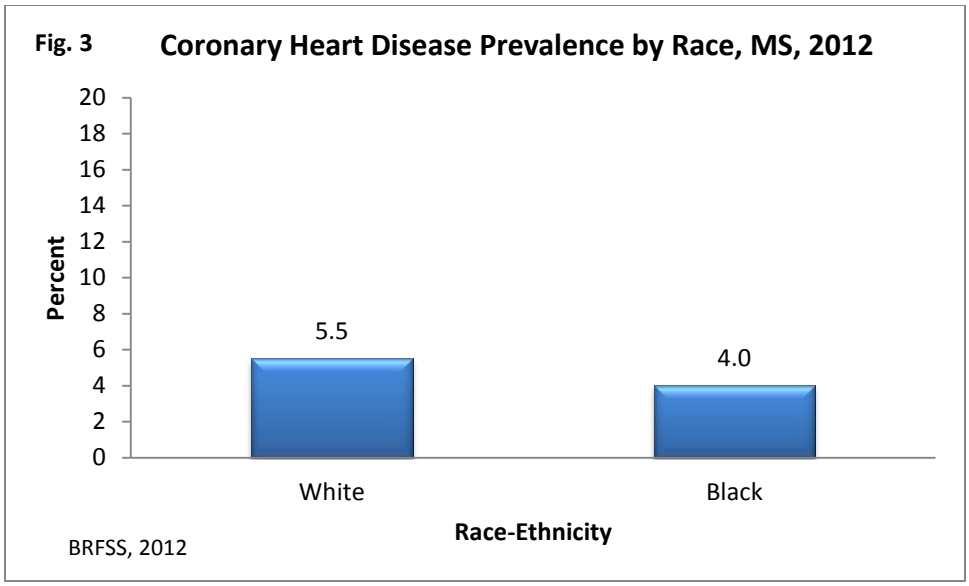

Figure 3: Coronary heart disease prevalence among white adult Mississippians (5.5%) is significantly higher than coronary heart disease prevalence among black adult Mississippians (4.0%).

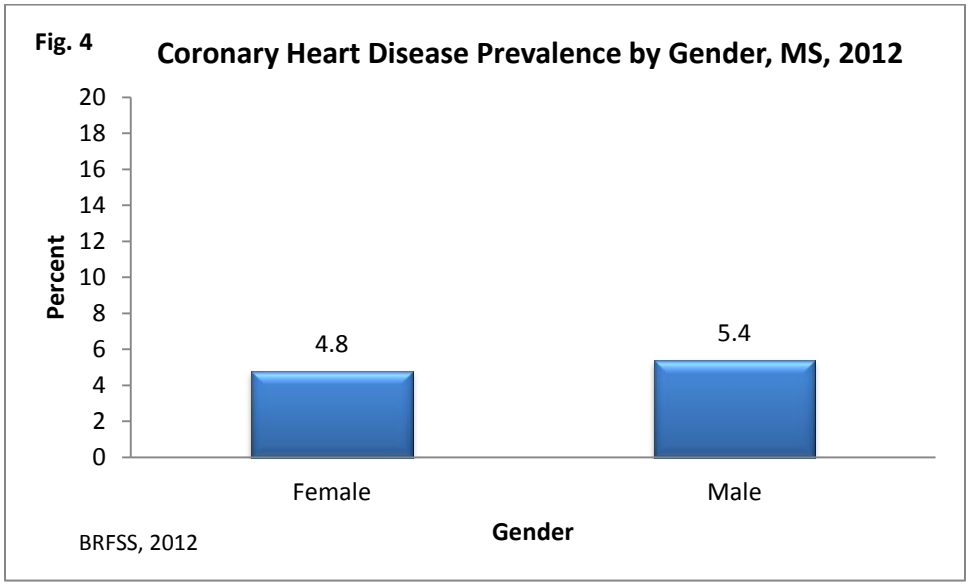

Figure 4: Coronary heart disease affects 5.4% of males and 4.8% of female adults. It cannot be concluded there is a statistically significant difference between the proportion of females and the proportion of males with coronary heart disease.

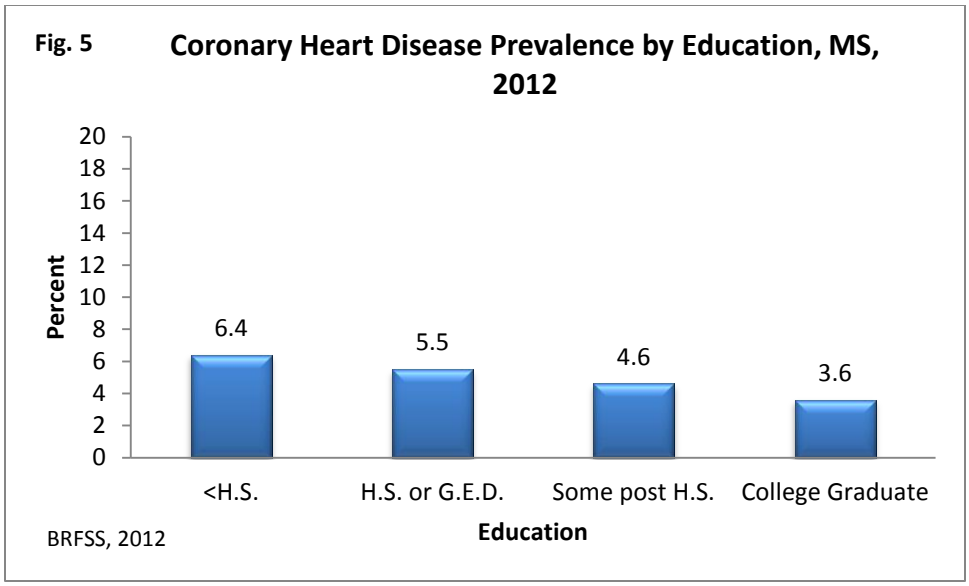

Figure 5: There is a significantly lower prevalence of coronary heart disease prevalence among college graduates versus those with no high school education. Coronary heart disease affects 6.4% of Mississippian adults with no high school education. This rate steadily decreases as level of attained education increases. 3.6% of Mississippians with a college degree report coronary heart disease.

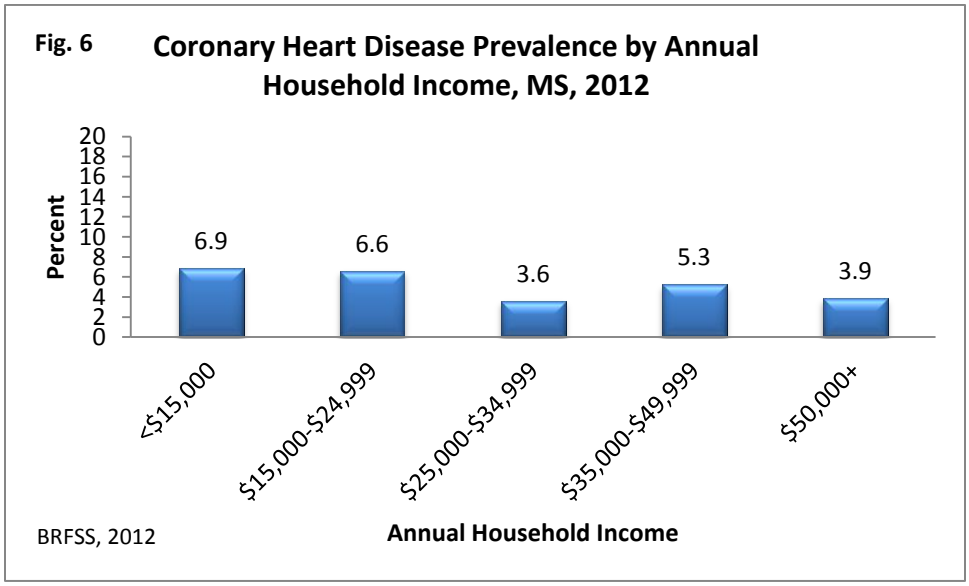

Figure 6: There is a significantly lower prevalence of coronary heart disease prevalence among annual household incomes earning $50,000 or more in comparison to those earning less than $15,000. Coronary heart disease prevalence, by annual household income, is highest among Mississippian adults earning less than $15,000.

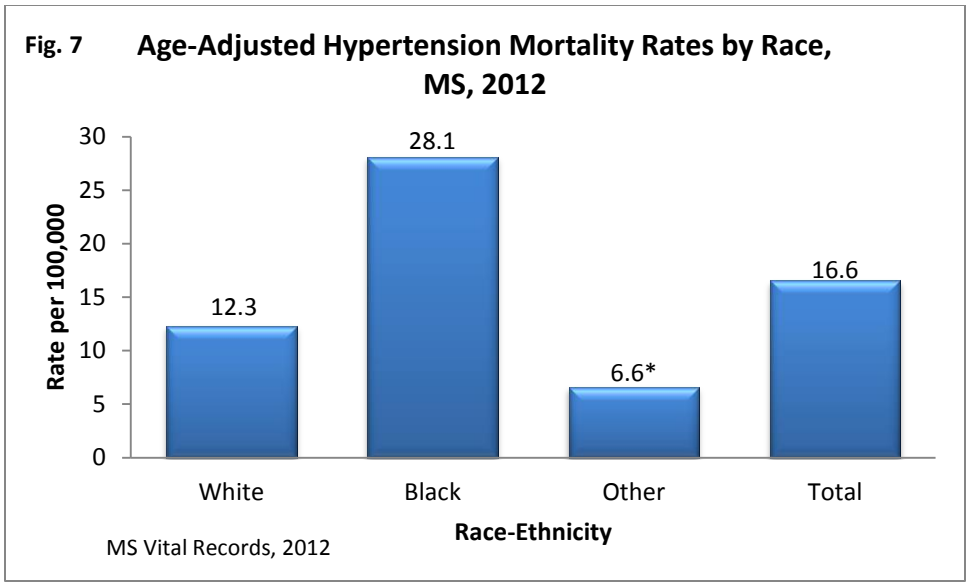

Figure 7: Hypertension mortality, by race-ethnicity, is highest among black Mississippians at 28.1 deaths per 100,000 population.

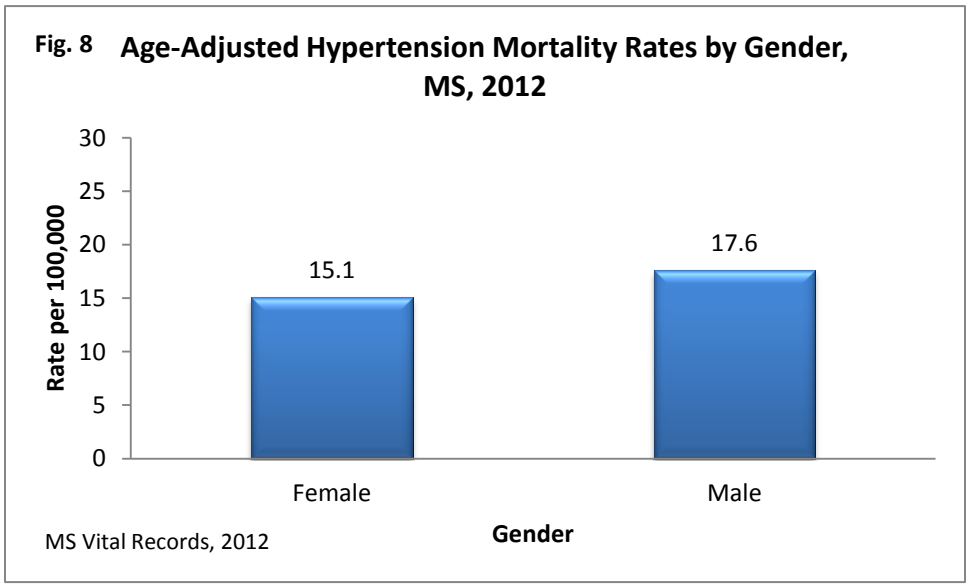

Figure 8: Hypertension mortality, by gender, is highest among male Mississippians at 17.6 deaths per 100,000 population.

*Denotes < 20 events. Due to a small number of events, these rates are unstable and should be interpreted with caution.

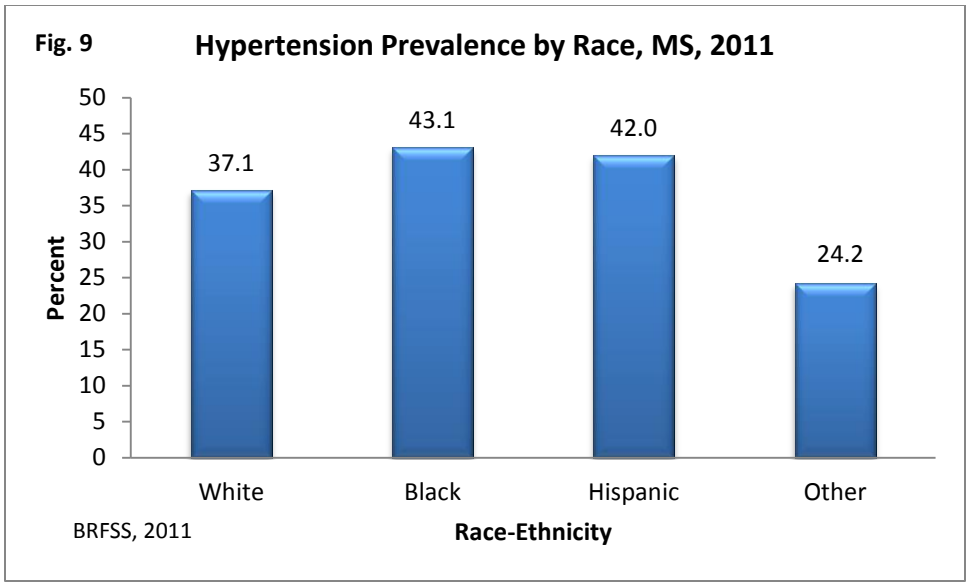

Figure 9: Hypertension prevalence, by race-ethnicity, is significantly higher among black adult Mississippians (43.1%) versus among white Mississippians (37.1%).

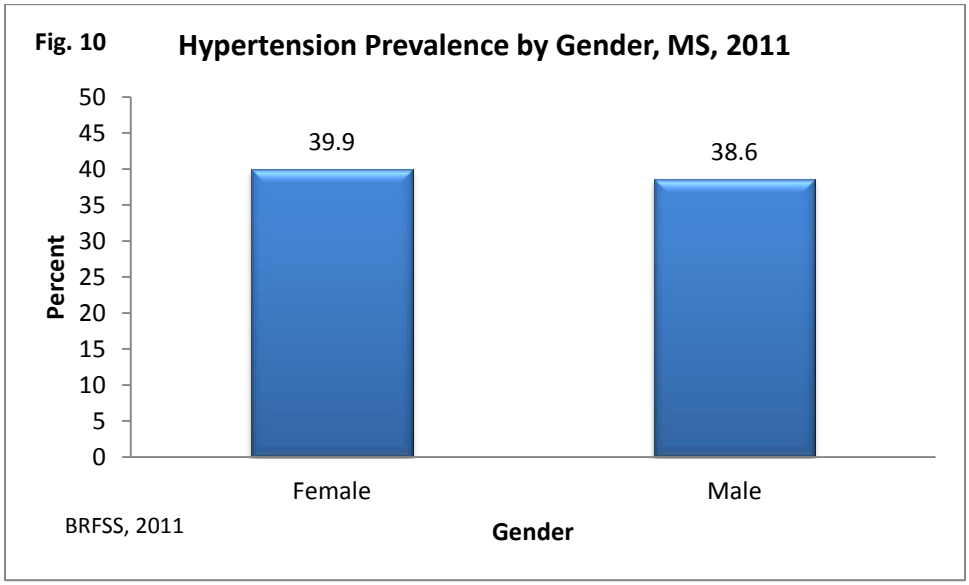

Figure 10: 39.9% of Mississippi's adult females and 38.6% of adult males have been diagnosed with hypertension. It cannot be concluded there is a significantly different prevalence between the proportion of females and the proportion of males with hypertension.

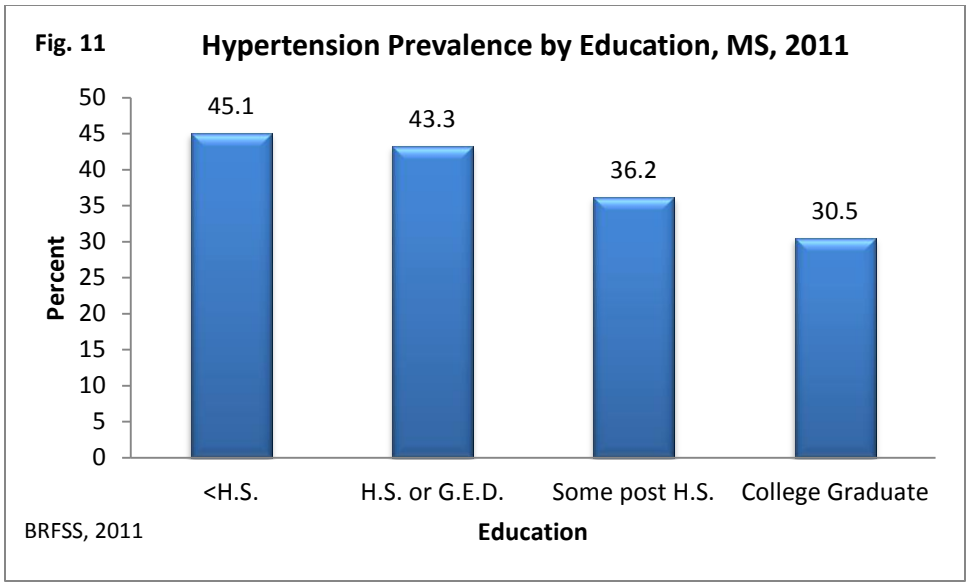

Figure 11: Hypertension prevalence, by education level, is significantly higher (45.1%) among adult Mississippians with no high school education versus among college graduates (30.5%). Hypertension prevalence decreases as level of attained education increases.

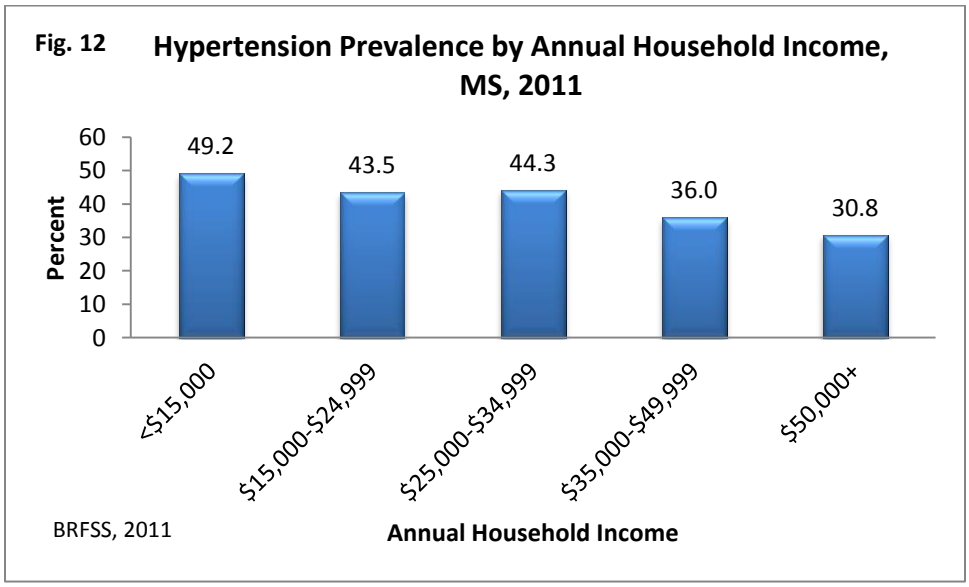

Figure 12: Hypertension prevalence, by annual household income, is significantly higher (49.2%) among Mississippians earning an annual household income less than $15,000 versus those earning $50,000 or more (30.8%).

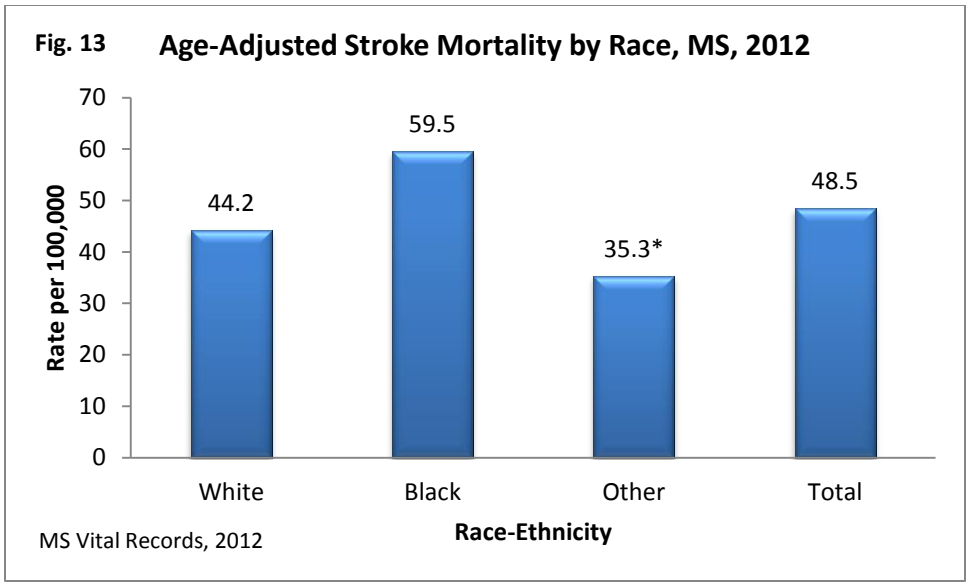

Figure 13: The stroke mortality rate, by race-ethnicity, is highest among black Mississippians at 59.5 deaths per 100,000 population.

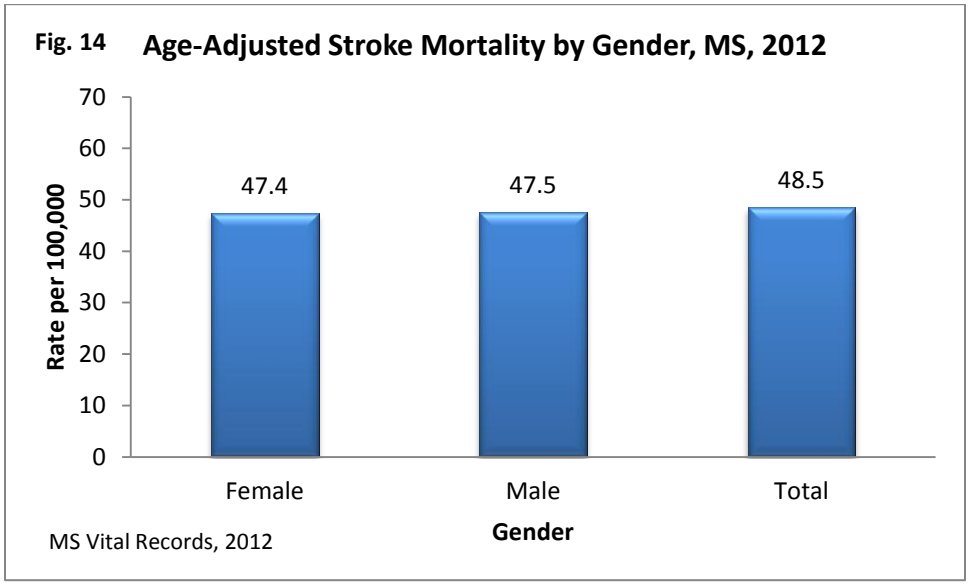

Figure 14: The stroke mortality rate among male Mississippians is 47.5 deaths per 100,000 population.

*Denotes < 20 events. Due to a small number of events, these rates are unstable and should be interpreted with caution.

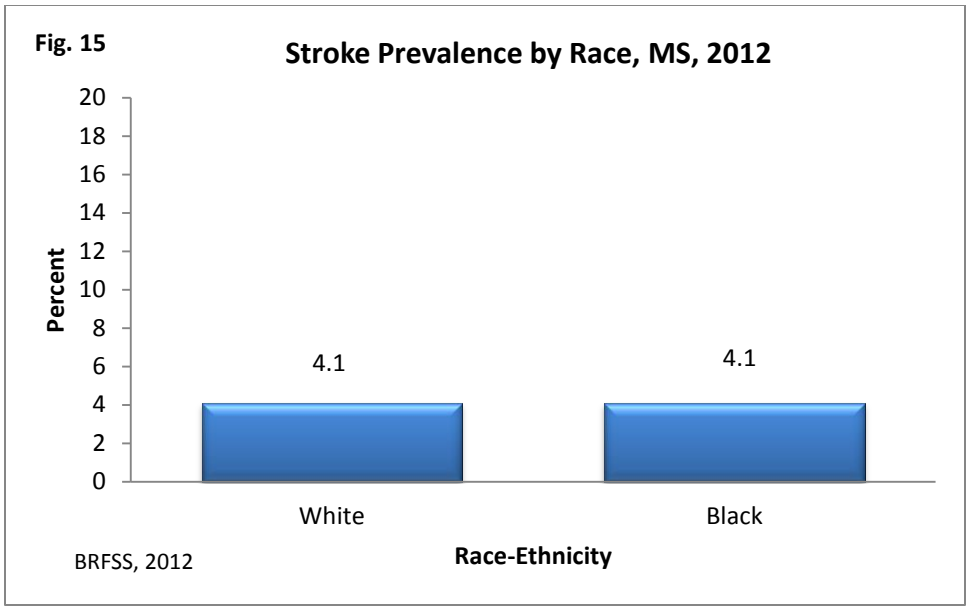

Figure 15: 4.1% of both white and black adult Mississippians have had a stroke at some point in their lifetime. It cannot be concluded there is a significantly different prevalence between the proportion of whites versus the proportion of blacks who have ever had a stroke.

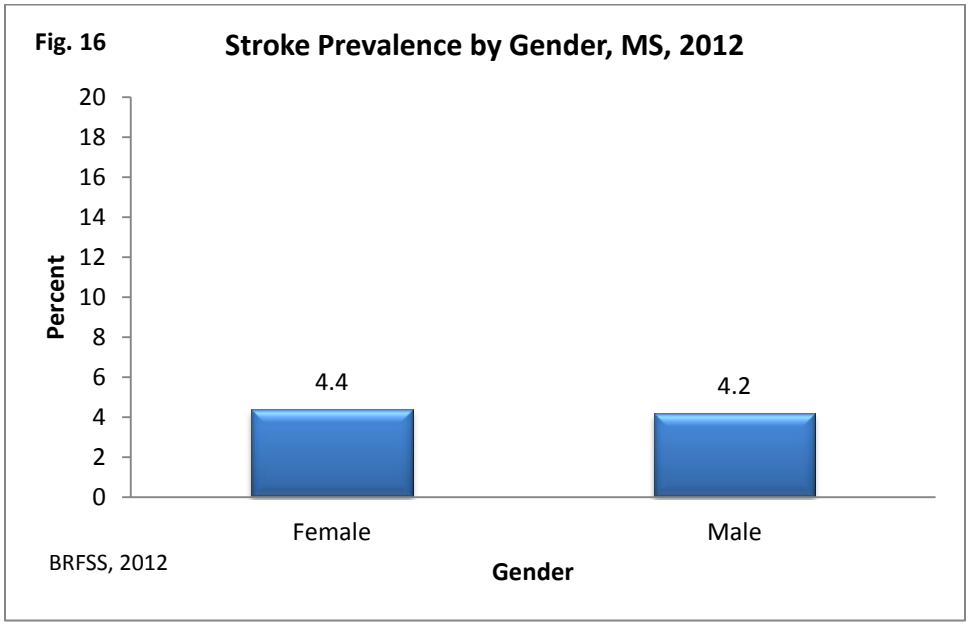

Figure 16: 4.4% of adult Mississippi females and 4.2% of males have had a stroke at some point in their lifetime. It cannot be concluded there is a significant difference between the proportion of females and the proportion of males who have ever had a stroke.

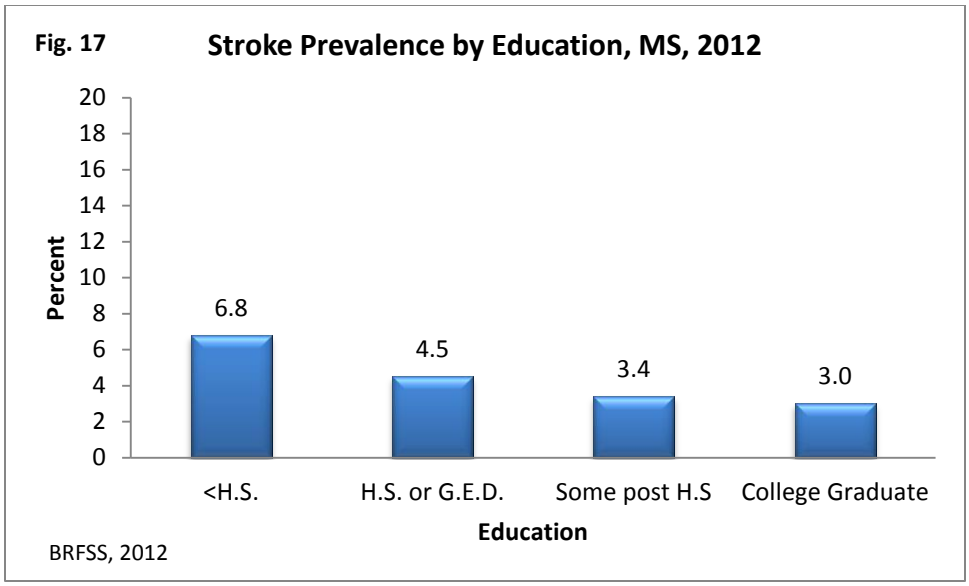

Figure 17: Stroke prevalence, by education level, is significantly higher among Mississippi adults with no high school education (6.8%) versus college graduates (3.0%).

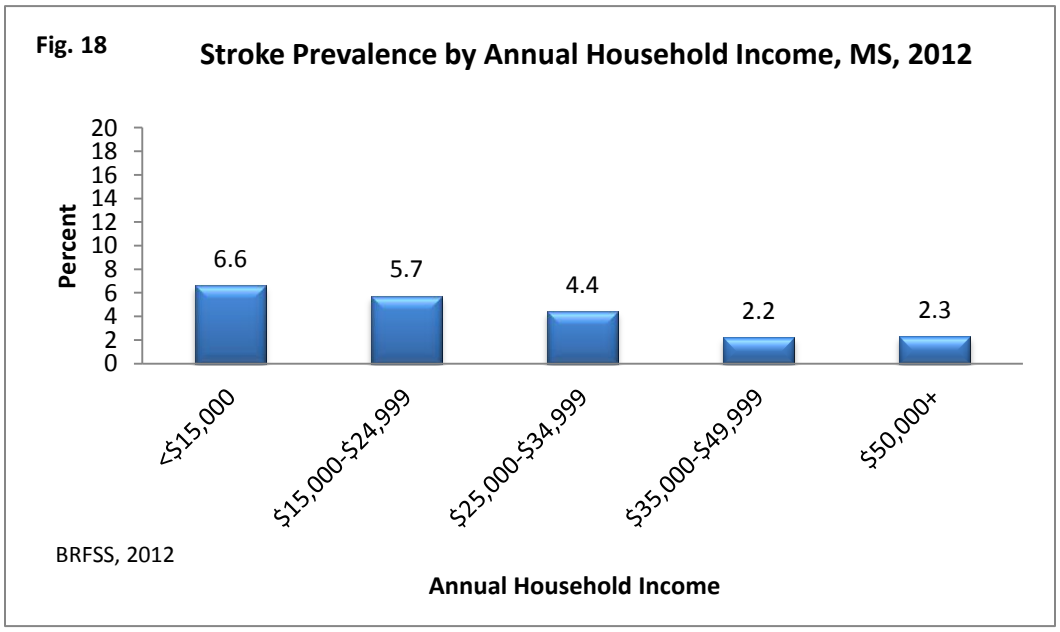

Figure 18: Stroke prevalence, by annual household income, is significantly higher among Mississippi adults who earn less than $15,000 (6.6%) versus those who earn $50,000 or more in annual household income.

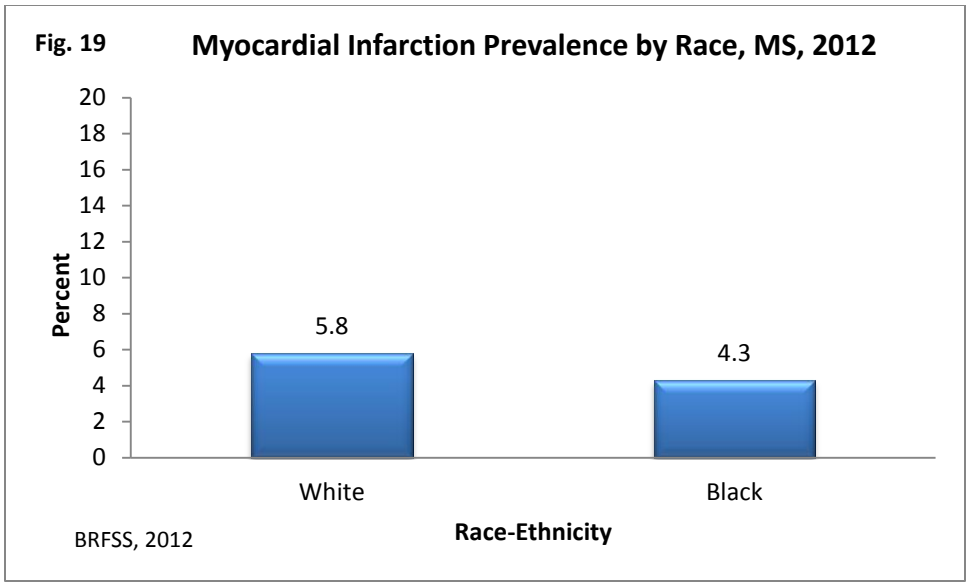

Figure 19: 5.8% of white and 4.3% of black adult Mississippians have had a myocardial infarction at some point in their life. It cannot be concluded there is a significant difference between the proportion of whites and the proportion of blacks who have ever had a myocardial infarction.

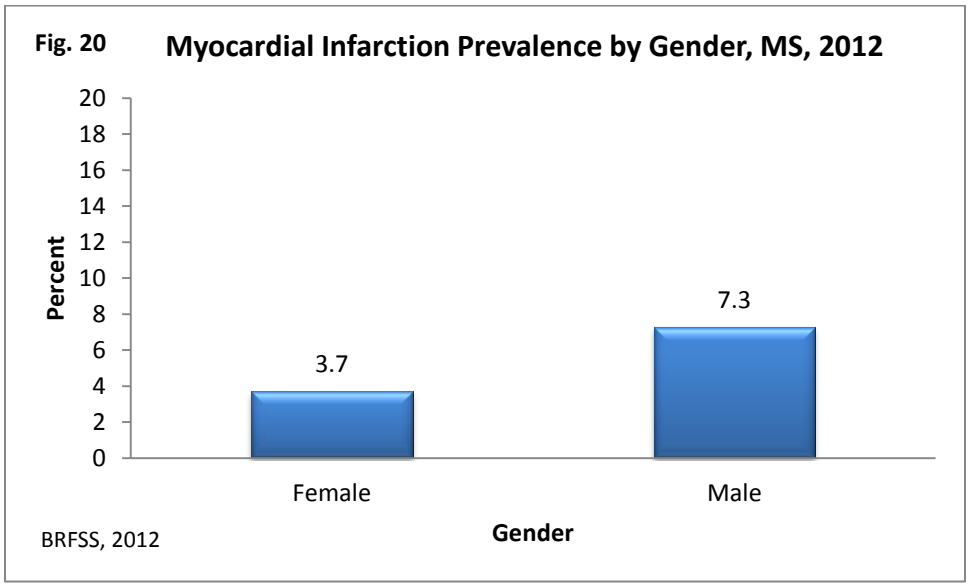

Figure 20: Male adults have a significantly higher prevalence (7.3%) of myocardial infarctions in comparison to females (3.7%).

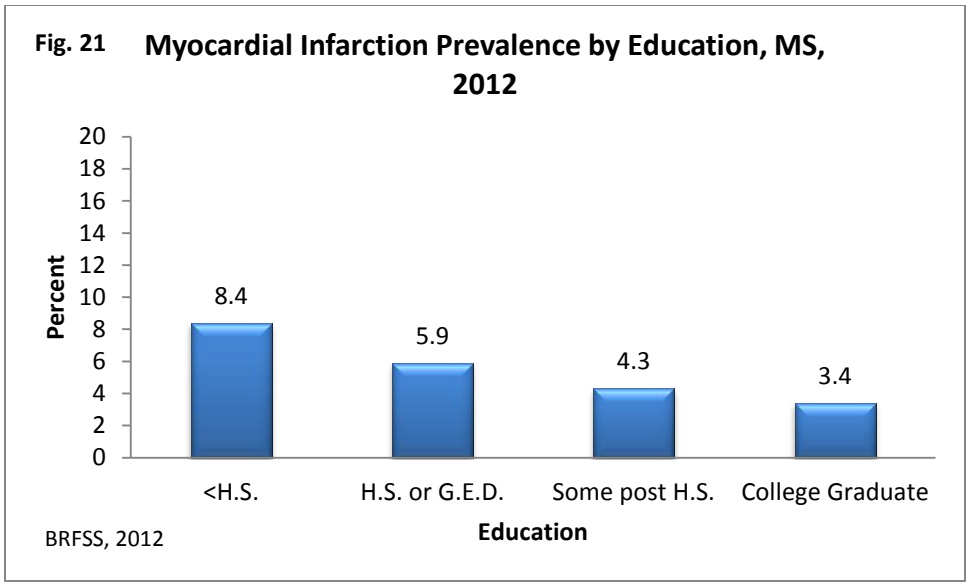

Figure 21: Among adult Mississippians, there is a significantly higher prevalence of myocardial infarctions among those with no high school education (8.4%) versus among college graduates (3.4%). This prevalence steadily decreases as attained level of education increases.

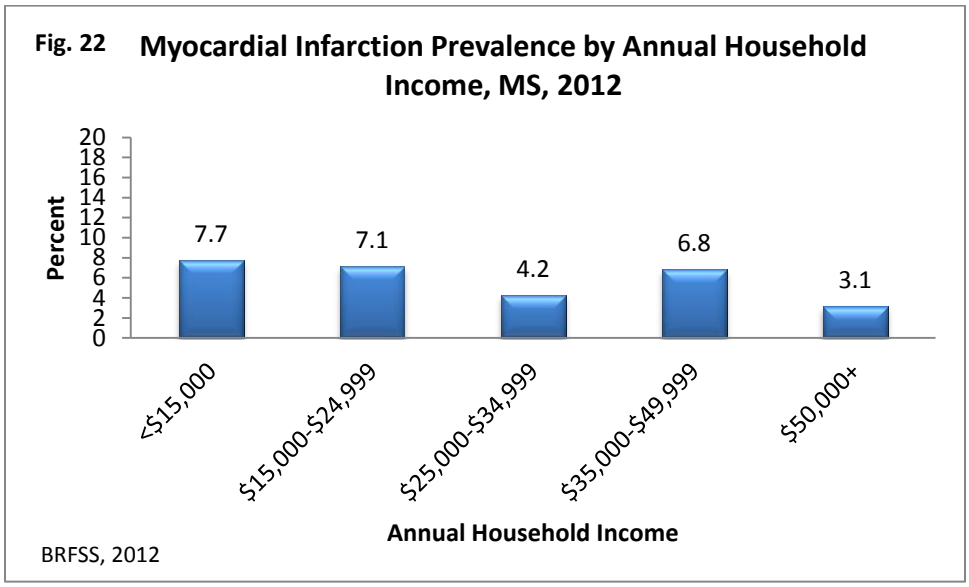

Figure 22: Among adult Mississippians, there is a significantly higher prevalence of myocardial infarctions among those earning less than $15,000 (7.7%) versus those earning $50,000 or more (3.1%).

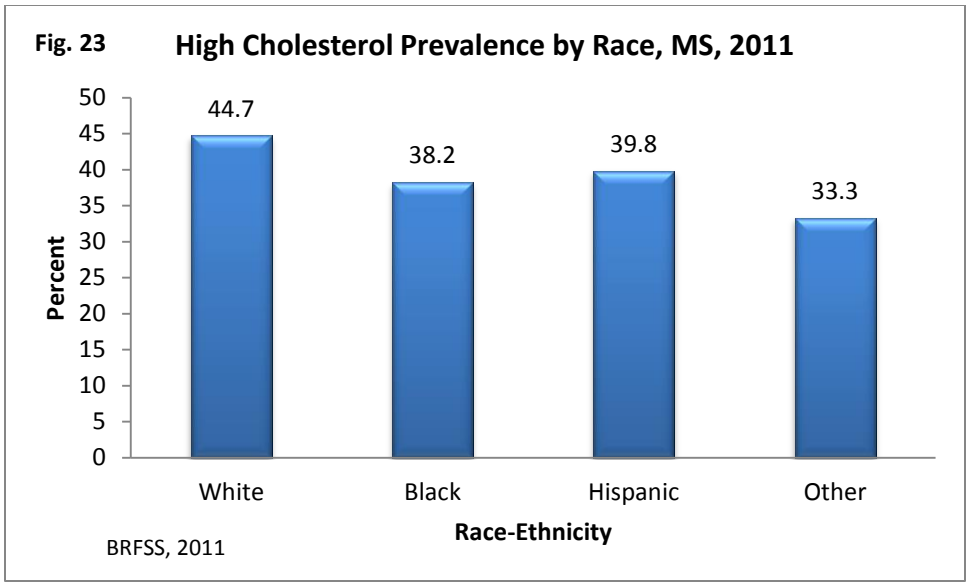

Figure 23: By race-ethnicity, white adult Mississippians have a significantly higher prevalence (44.7%) of high cholesterol in comparison to the black population (38.2%).

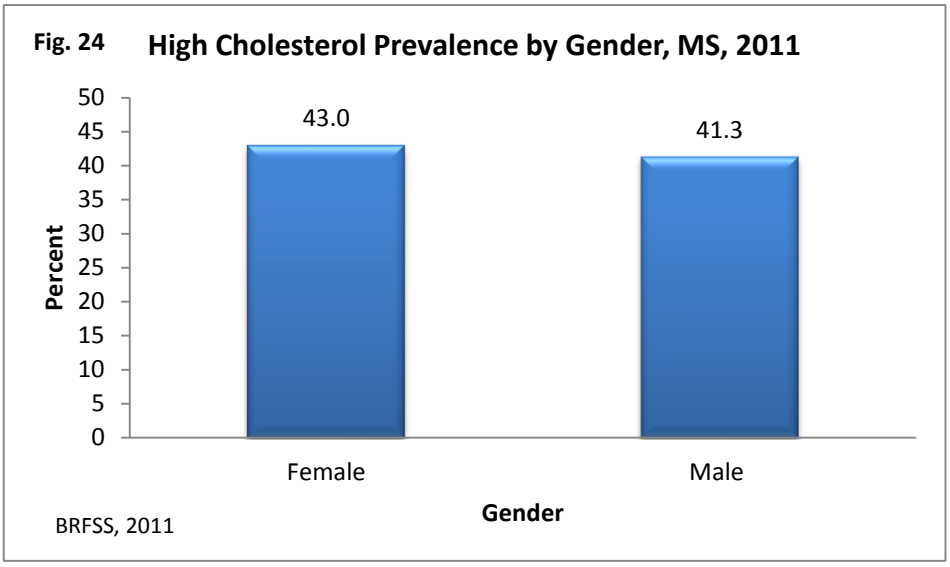

Figure 24: By gender, adult female Mississippians have the higher prevalence (43.0%) of high cholesterol. It cannot be concluded there is a significant difference between the proportion of females and the proportion of males who have high cholesterol.

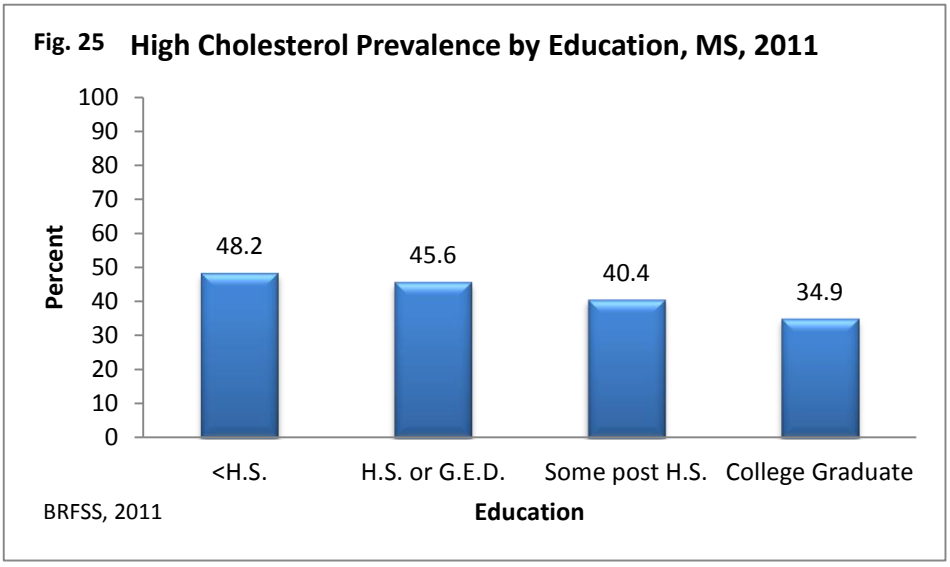

Figure 25: By education level, adult Mississippians with no high school education have a significantly higher prevalence (48.2%) of high cholesterol to college graduates, who have the lowest prevalence (34.9%).

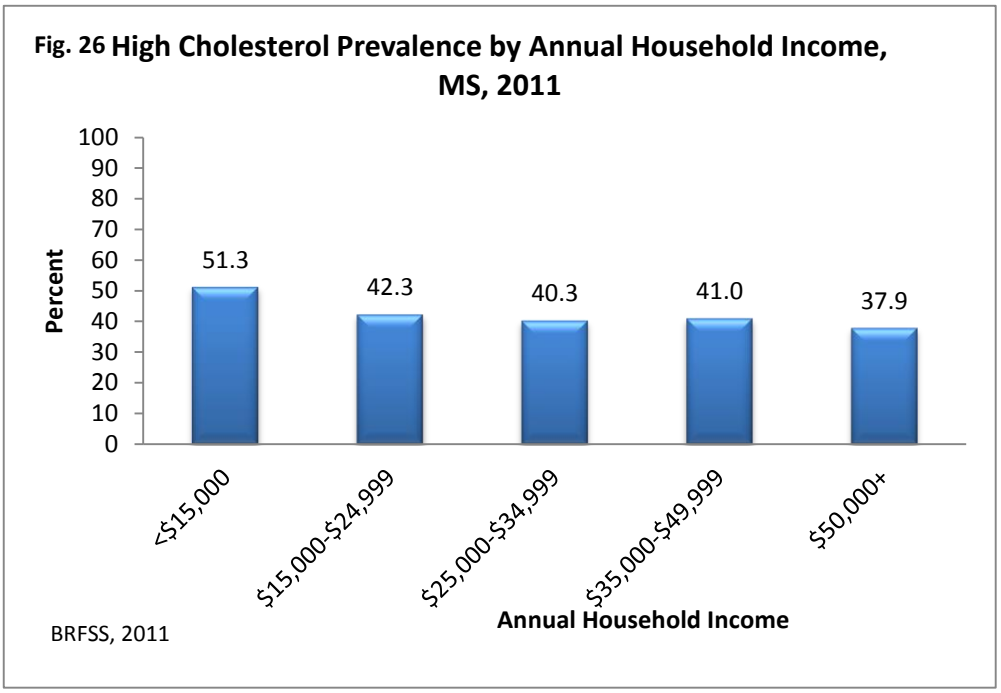

Figure 26: High cholesterol prevalence, by annual household income, is significantly higher among adult Mississippians earning less than $15,000 (51.3%) in comparison to those earning $50,000 or more (37.9%).

I. Overweight/ObesityEpidemic

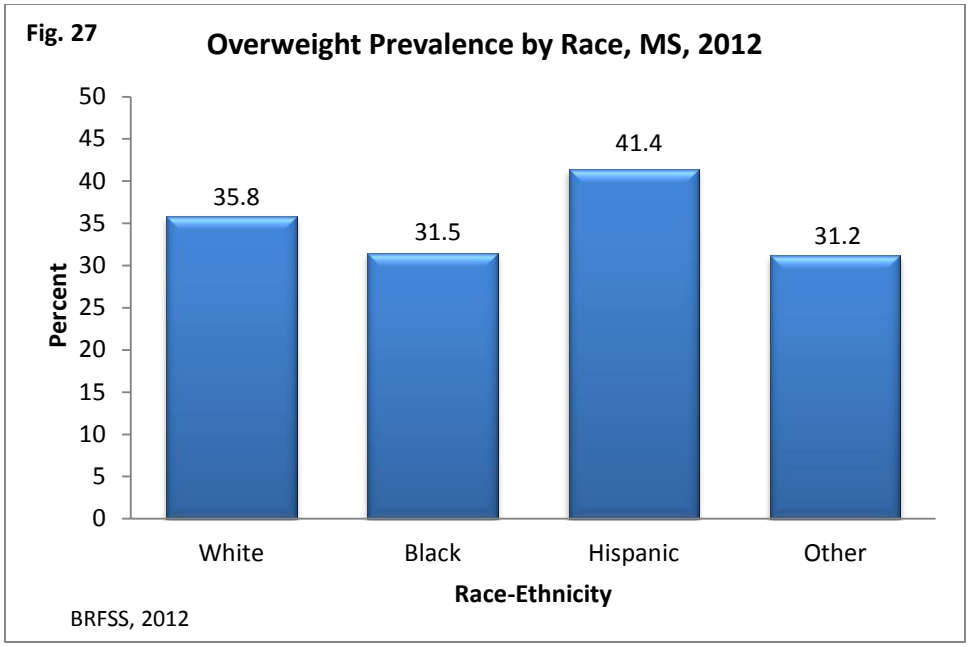

Figure 27: Among adult Mississippians, 35.8% of whites and 31.5% of blacks are overweight. It cannot be concluded there is a significantly higher overweight prevalence among any racial-ethnic group.

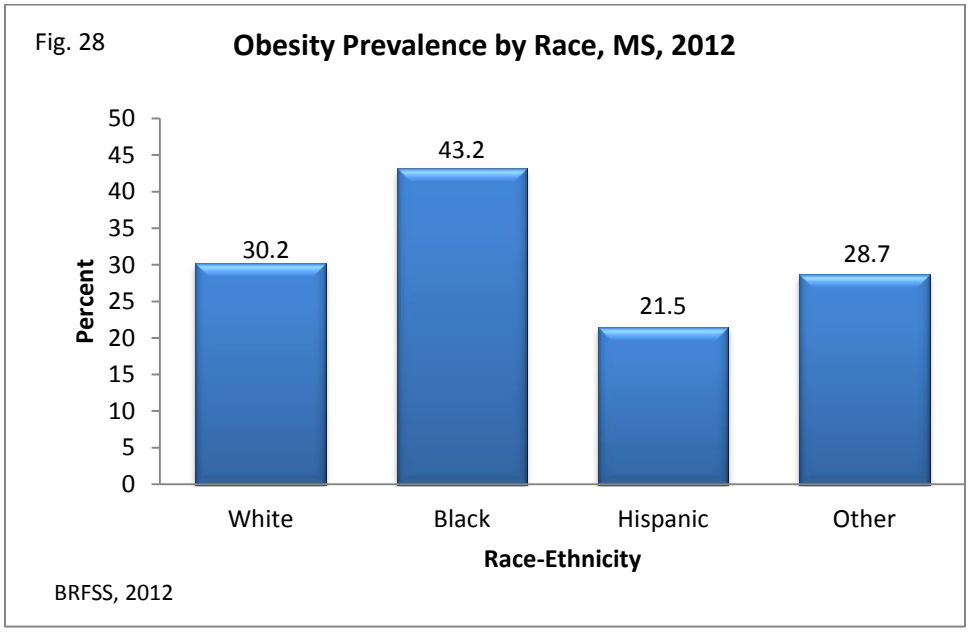

Figure 28: The obesity prevalence for blacks is significantly higher than whites and Hispanics.

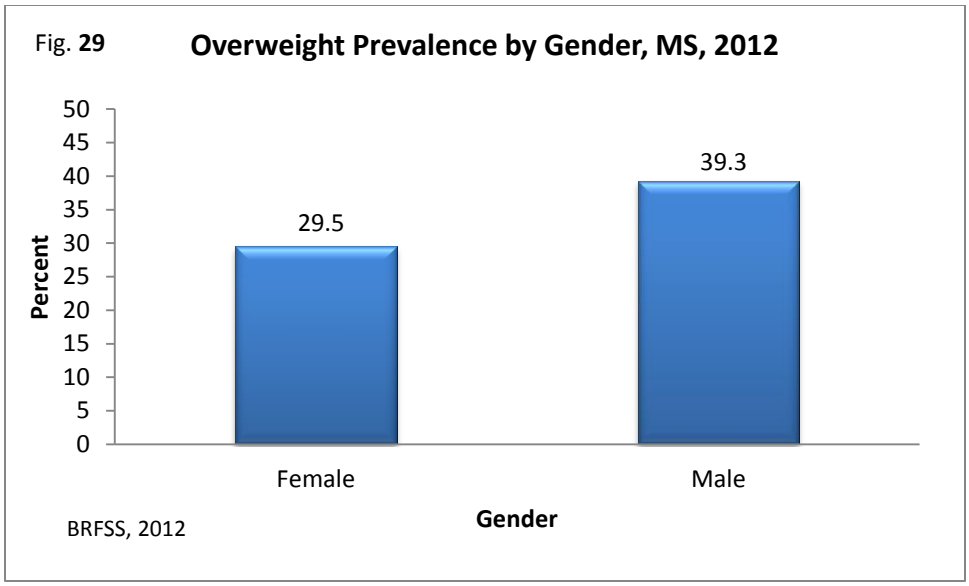

Figure 29: Among adult Mississippians, males have a significantly higher overweight prevalence (39.3%) to females (29.5%).

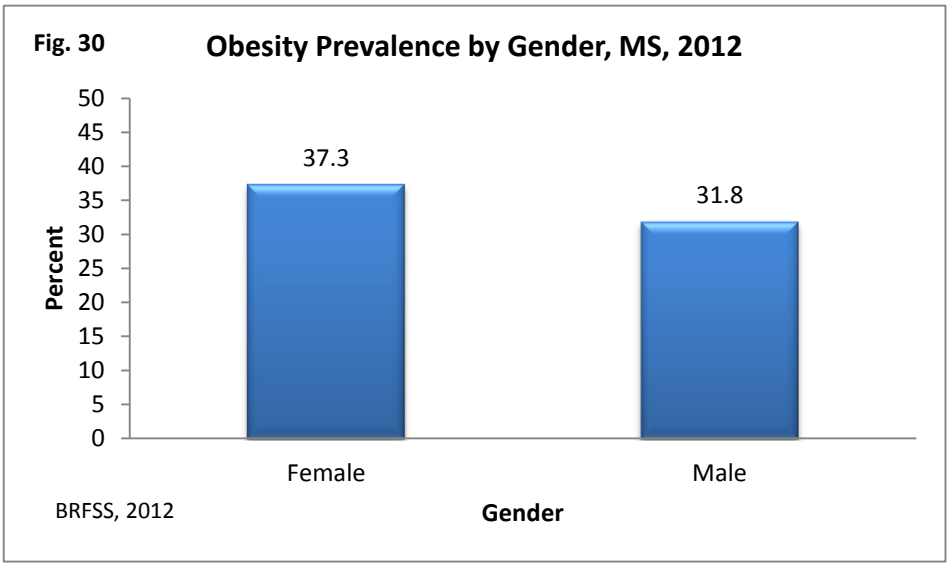

Figure 30: Among adult Mississippians, females have a significantly higher obesity prevalence (37.3%) to males (31.8%).

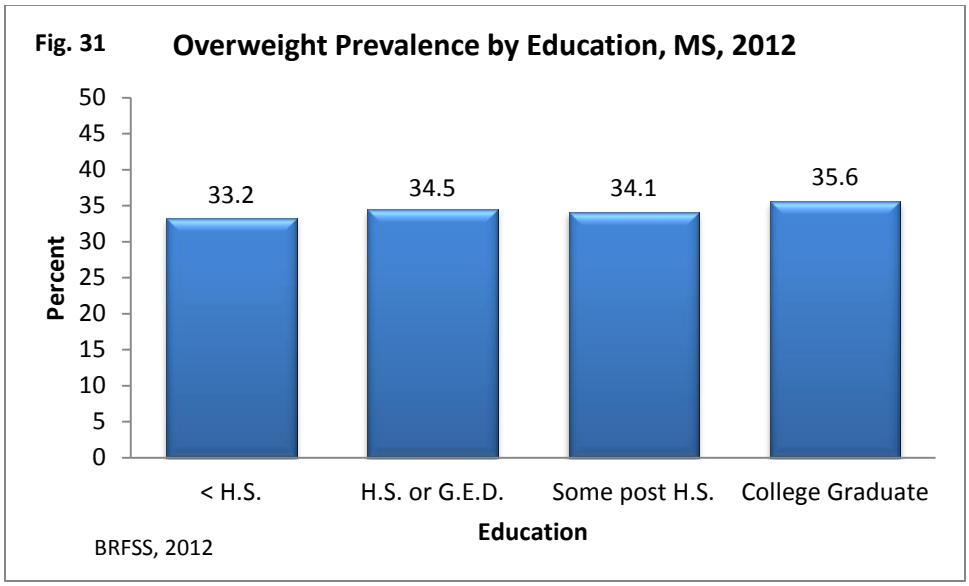

Figure 31: The highest overweight prevalence (35.6%), by education level, is among Mississippi adults with a college degree. The lowest overweight prevalence (33.2%) is among Mississippi adults with no high school education. It cannot be concluded that any education group has a significantly different overweight prevalence.

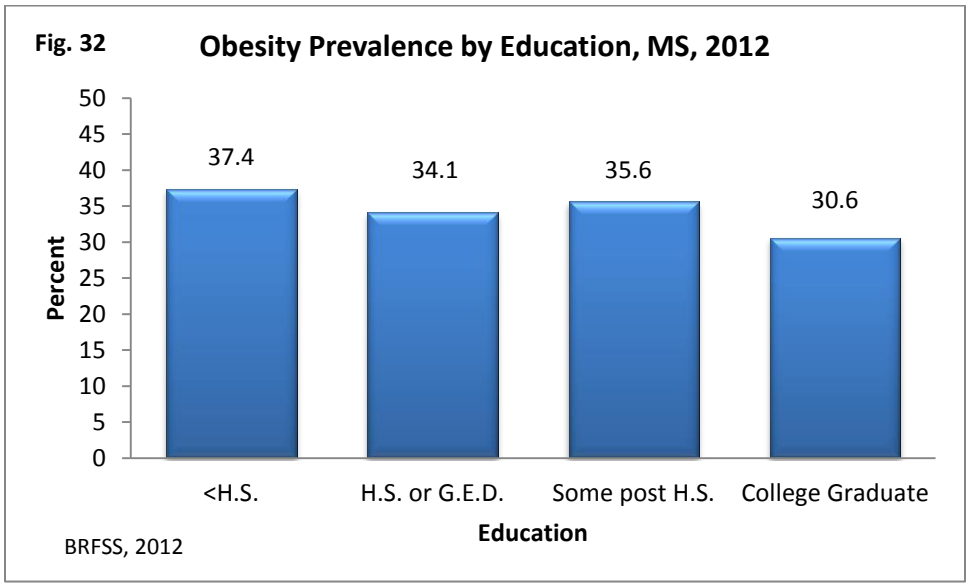

Figure 32: By education level, obesity prevalence is highest (37.4%) among Mississippi adults with no high school education, and it is lowest (30.6%) among those with a college degree. It cannot be concluded that any education group has significantly different obesity prevalence.

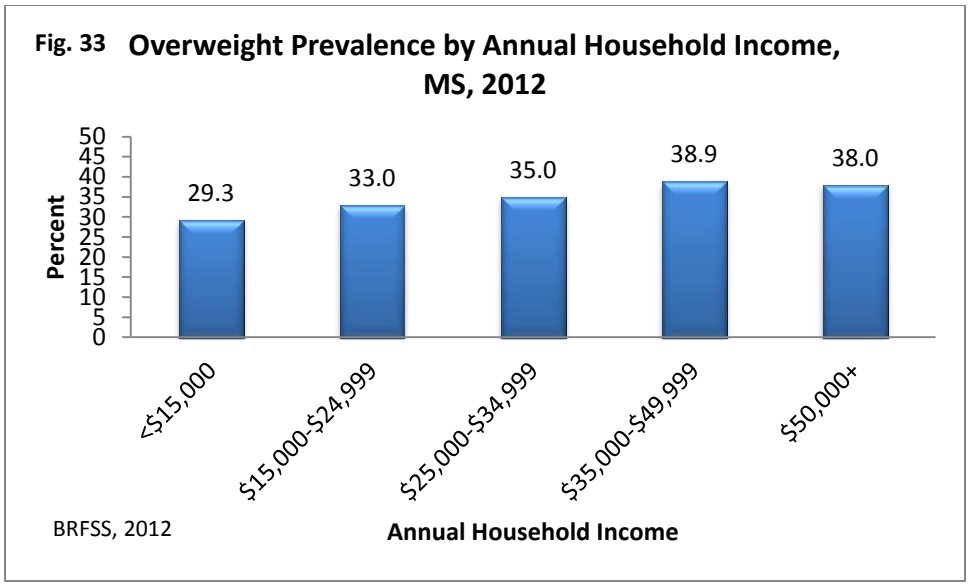

Figure 33: Among all income brackets, the groups who earns $35,000 or more are significantly more overweight than those in the lowest annual household income group (29.3%).

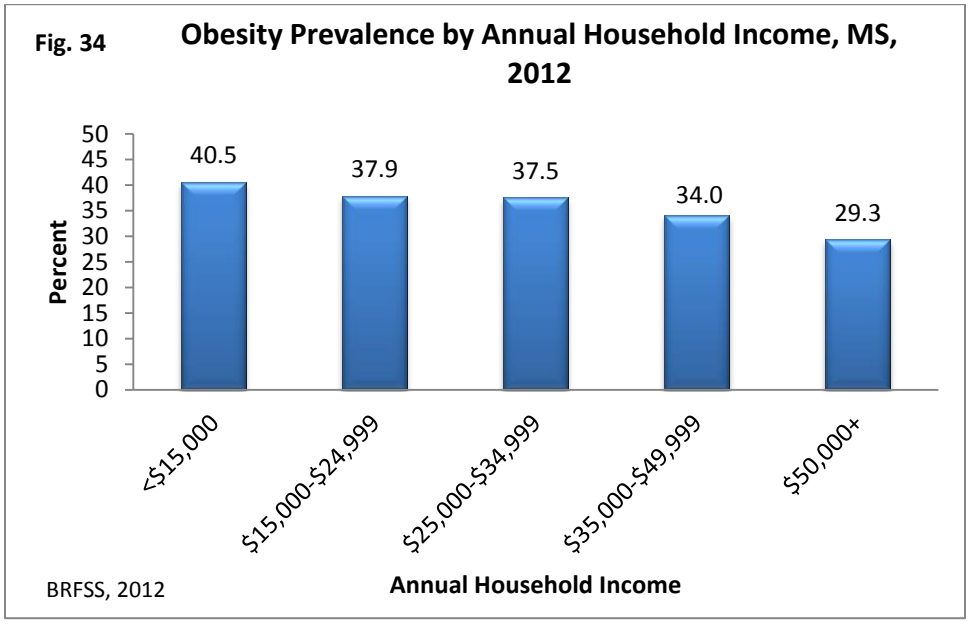

Figure 34: Mississippians earning less than $15,000 in annual household income are significantly more obese (40.5%) than Mississippians earning $50,000 or more (29.3%).

II. Diabetes

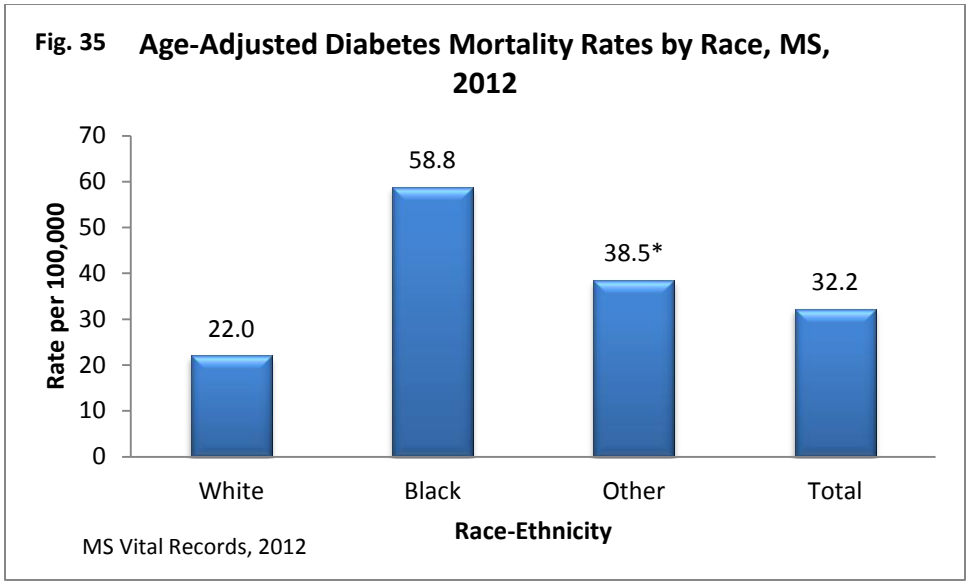

Figure 35: Among adult Mississippians, diabetes mortality by race-ethnicity is highest among blacks at 58.8 deaths per 100,000 population. The diabetes mortality rate is lowest for white Mississippians at 22.0 deaths per 100,000 population.

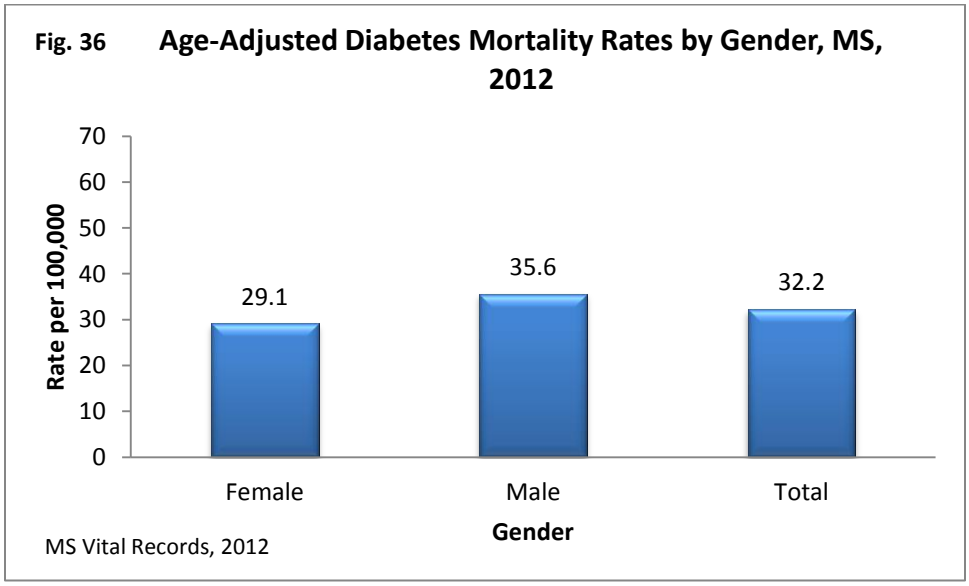

Figure 36: Among Mississippians, diabetes mortality by gender is highest among males at 35.6 deaths per 100,000 population. The diabetes mortality rate is lowest for females at 29.1 deaths per 100,000 population.

*Denotes < 20 events. Due to a small number of events, these rates are unstable and should be interpreted with caution.

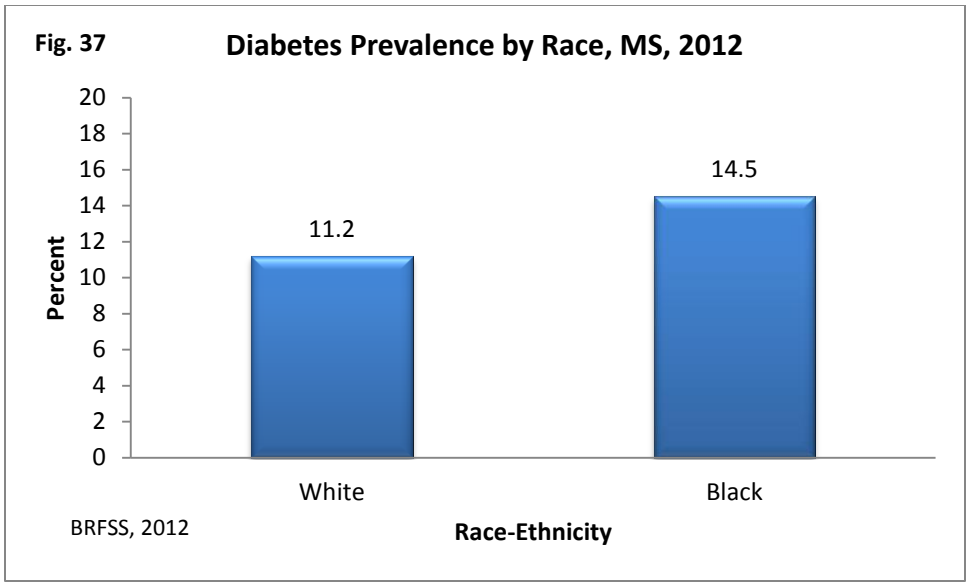

Figure 37: Among adult Mississippians, blacks have a significantly higher diabetes prevalence (14.5%) than whites (11.2%).

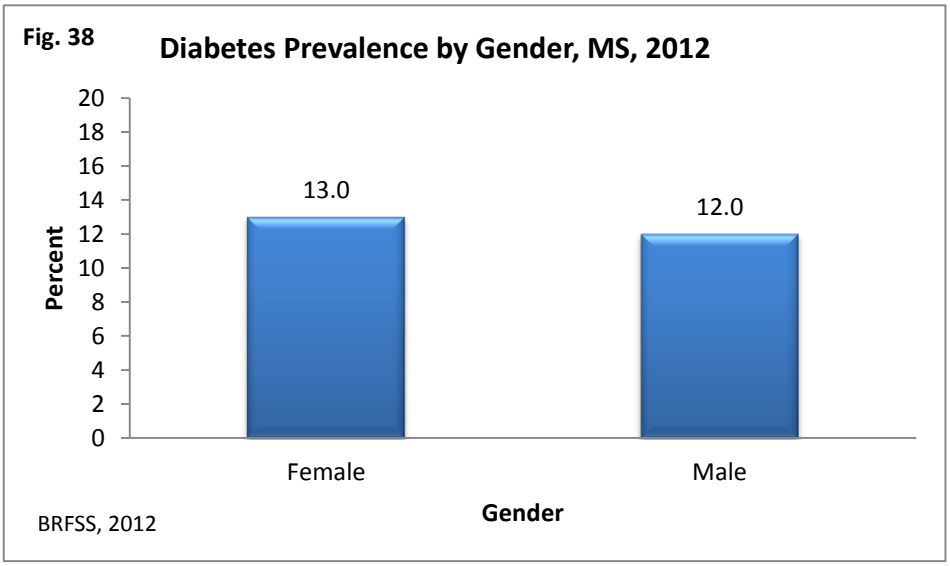

Figure 38: Among adult Mississippians, 13.0% of females and 12.0% of males have been diagnosed with diabetes mellitus. It cannot be concluded there is a significant diabetes prevalence difference between the two genders.

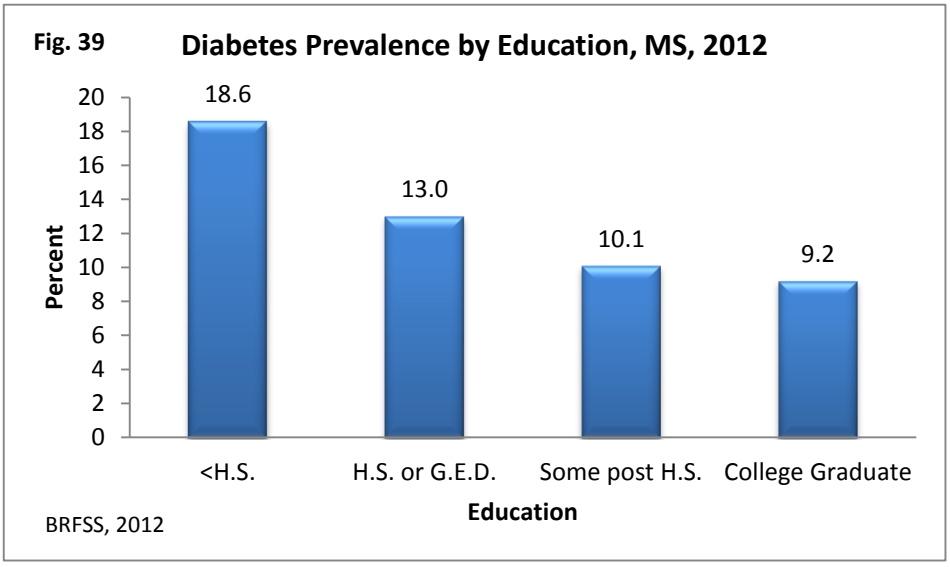

Figure 39: Among adult Mississippians, those with no high school education have a significantly higher diabetes prevalence (18.6%) than college graduates (9.2%). In general, diabetes prevalence decreases as education level increases.

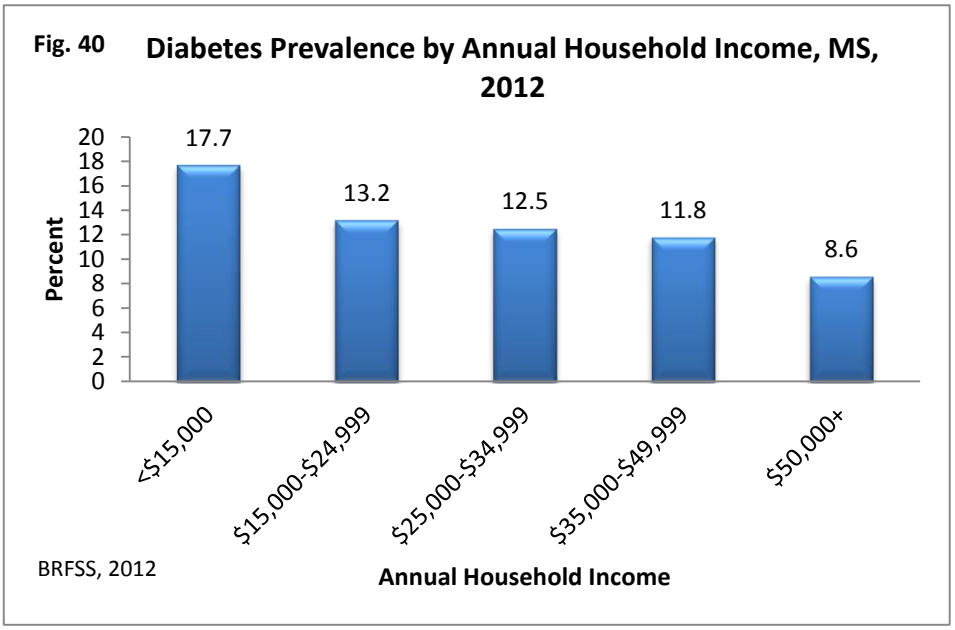

Figure 40: Among adult Mississippians, by income, those earning less than $15,000 in annual household income have a significantly higher diabetes mellitus prevalence (17.7%) than those earning $50,000 or more in annual household income (8.6%). In general, diabetes prevalence decreases as annual household income increases.

III. Renal Disease

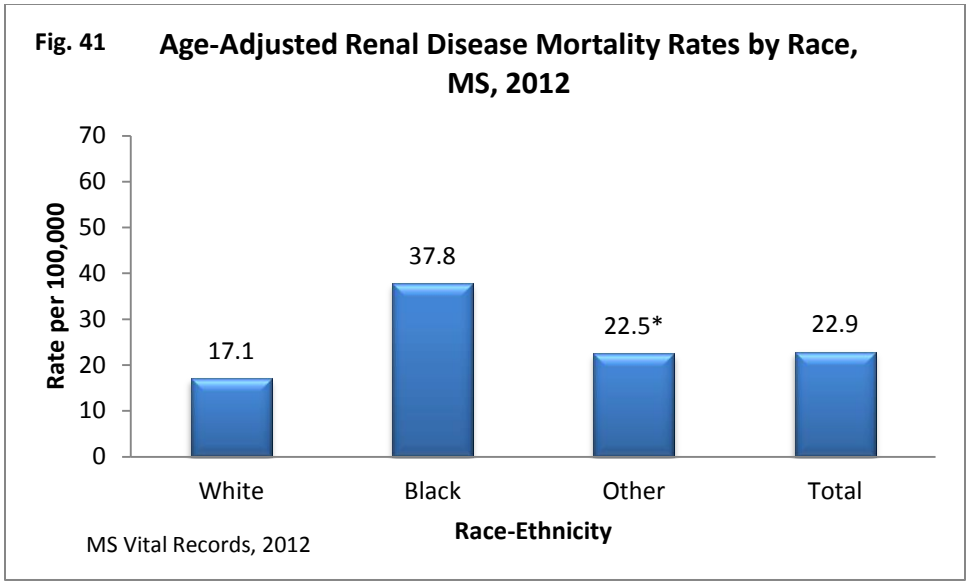

Figure 41: Among Mississippians, renal disease mortality by race-ethnicity is highest among blacks at 37.8 deaths per 100,000 population, and renal disease mortality is lowest among whites at 17.1 deaths per 100,000 population.

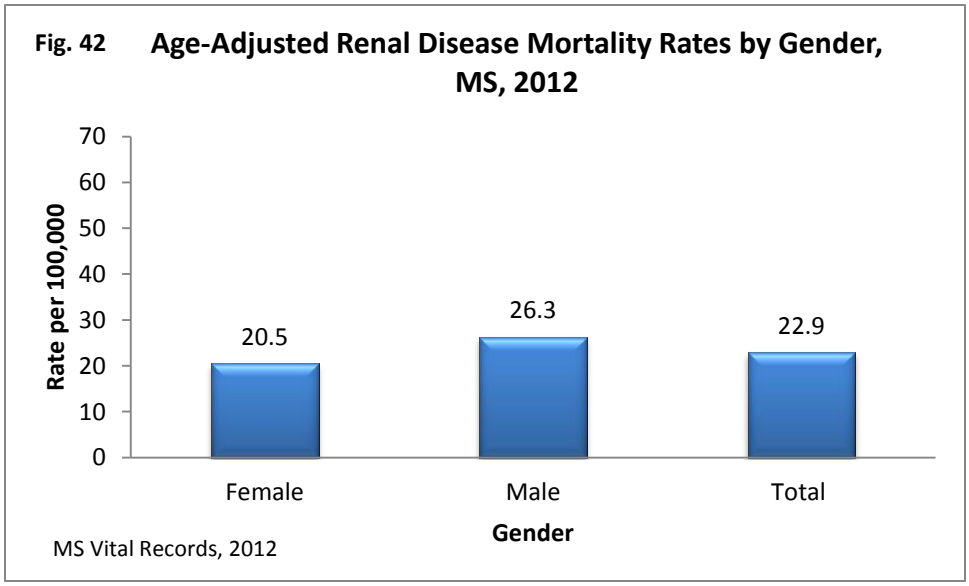

Figure 42: Among Mississippians, 26.3 male deaths and 20.5 female deaths per 100,000 population were attributed to renal disease.

*Denotes < 20 events. Due to a small number of events, these rates are unstable and should be interpreted with caution.

IV. Asthma

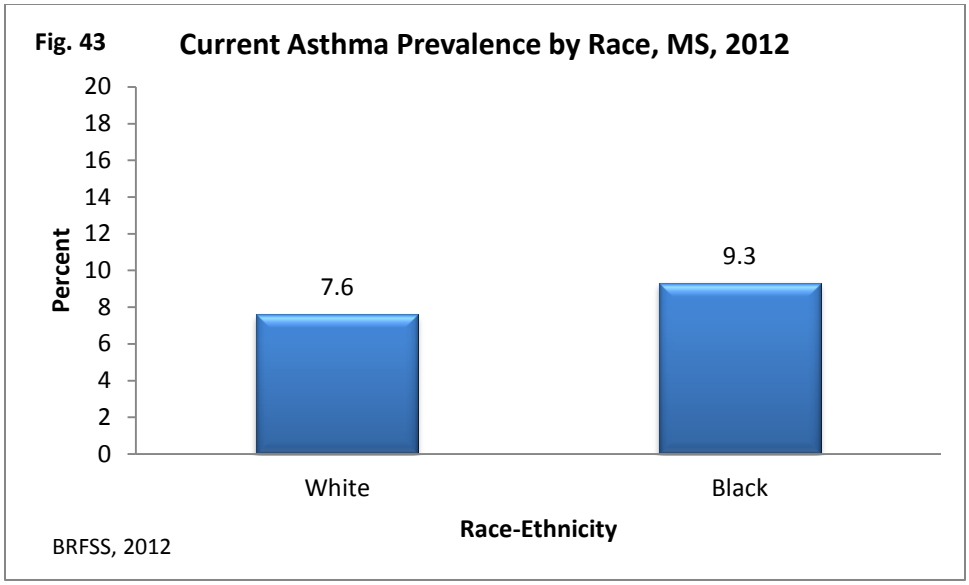

Figure 43: Among adult Mississippians, 9.3% of blacks and 7.6% of whites currently have asthma. It cannot be concluded there is a significantly different prevalence between the proportion of whites and the proportion of blacks who currently have asthma.

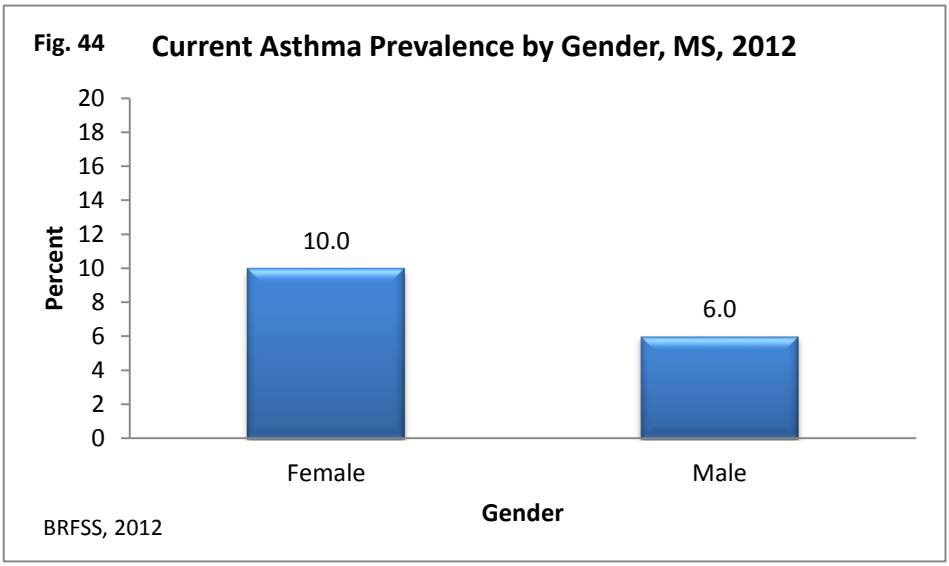

Figure 44: Among adult Mississippians, females currently have a significantly higher asthma prevalence (10.0%) than males (6.0%).

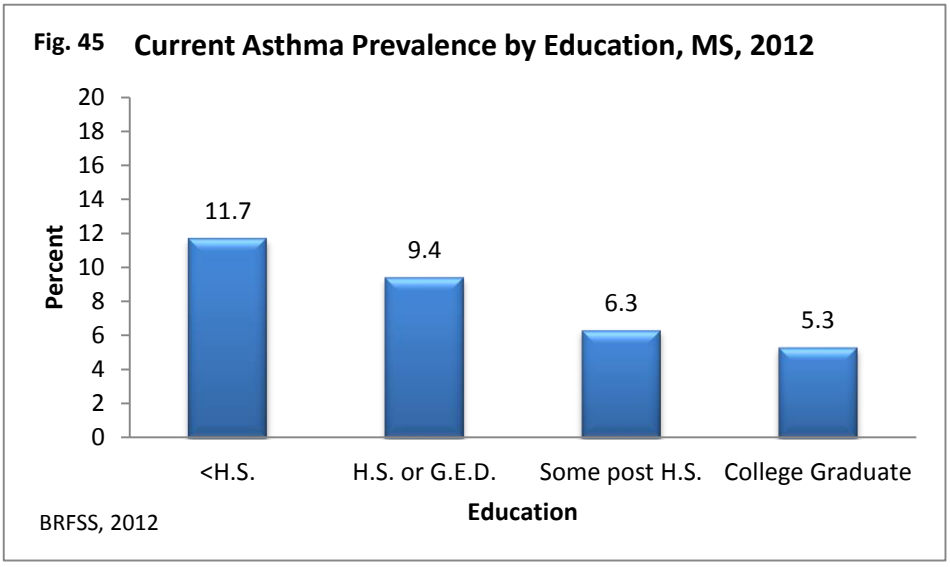

Figure 45: Among adult Mississippians, by education, those with no high school education have significantly higher current asthma prevalence (11.7%) in comparison to college graduates (5.3%). This prevalence decreases as the level of education attained increases.

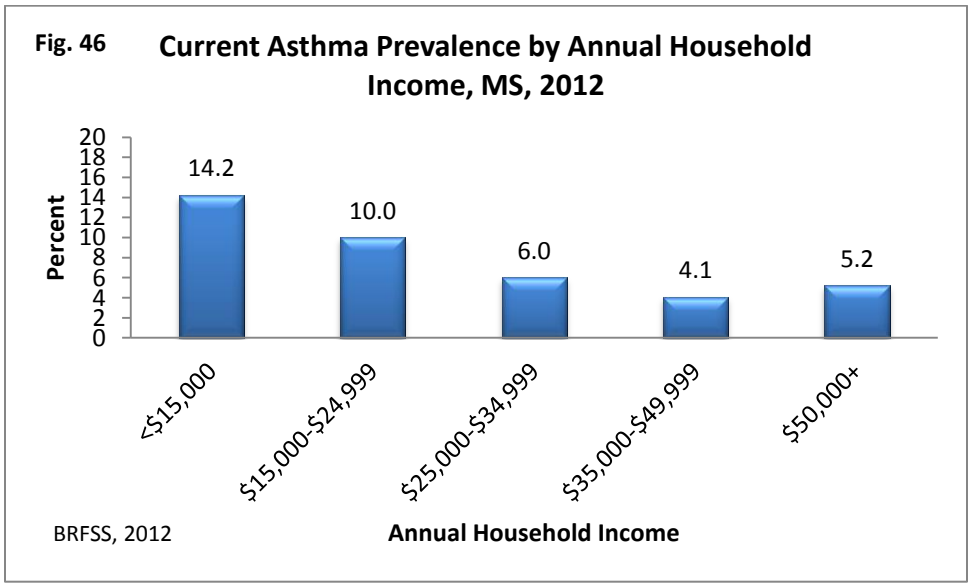

Figure 46: Among adult Mississippians, by income, those who earn less than $15,000 in annual household income have a significantly higher current asthma prevalence (14.2%) in comparison to those who earn $50,000 or more in annual household income (5.2%).

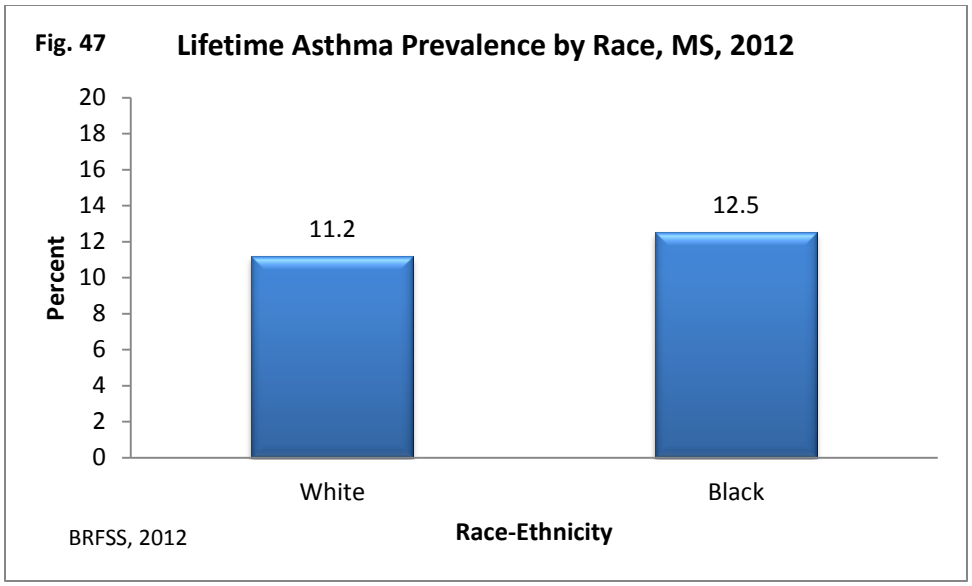

Figure 47: Among adult Mississippians, 12.5% of blacks and 11.2% of whites have had asthma at some point in their lifetime. It cannot be concluded there is a significant difference between the proportion of whites and the proportion of blacks who have ever had asthma.

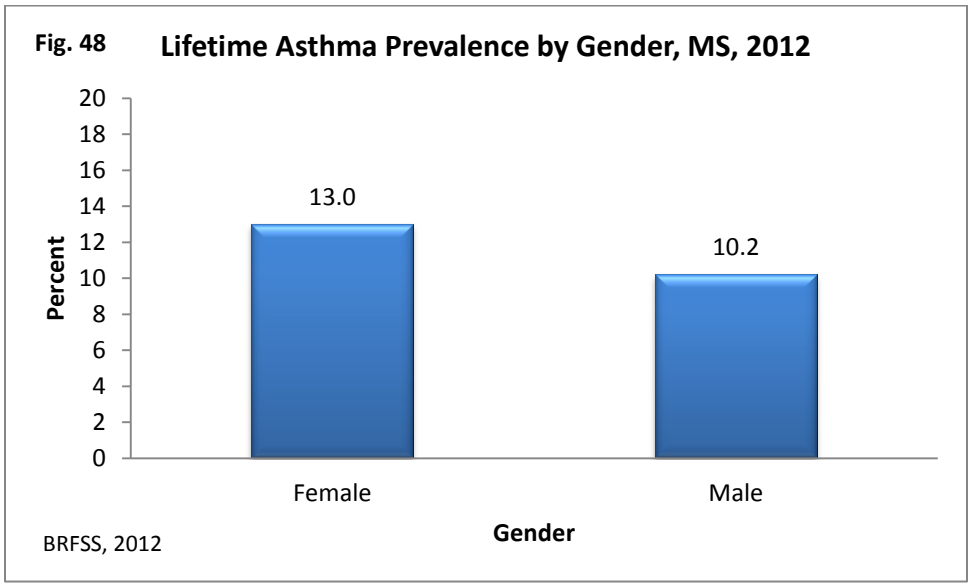

Figure 48: Among adult Mississippians, 13.0% of females and 10.2% of males have had asthma at some point in their lifetime. It cannot be concluded there is a significant difference between the proportion of females and the proportion of males who have ever had asthma.

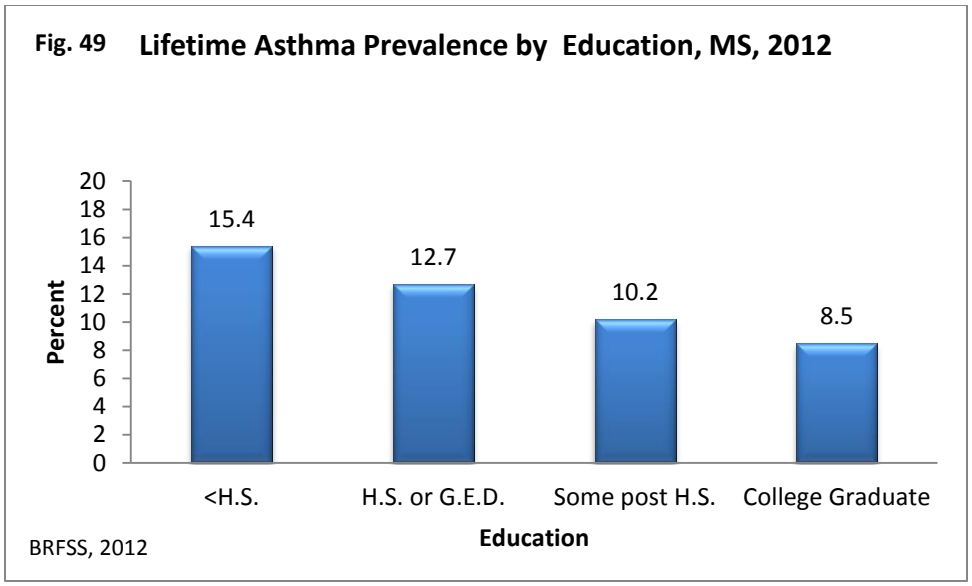

Figure 49: Among adult Mississippians, by education level, the prevalence of those who have had asthma at some point in their lifetime is significantly lower among college graduates (8.5%) than those with no high school education (15.4%). Lifetime asthma prevalence steadily decreases as level of attained education increases.

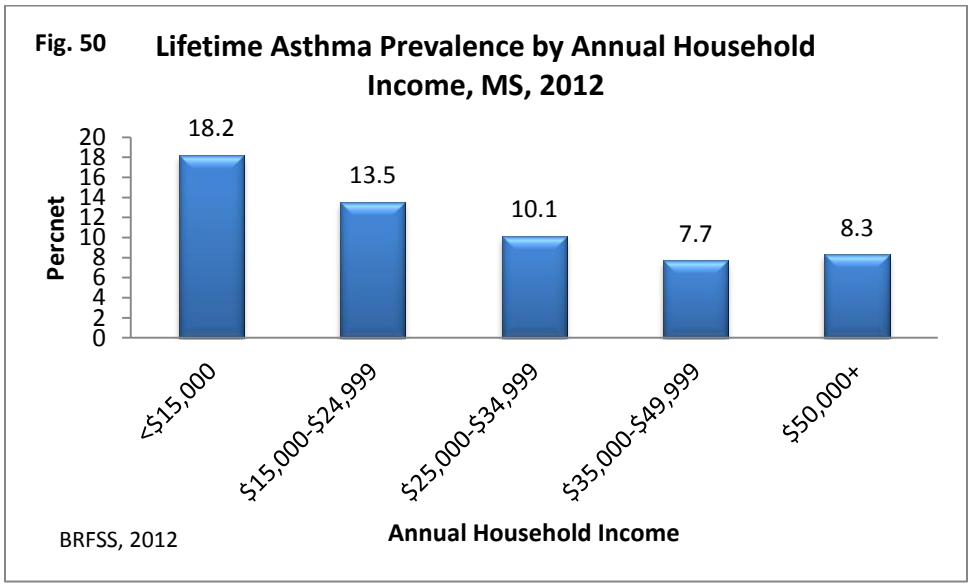

Figure 50: Among adult Mississippians, those earning less than $15,000 in annual household income have a significantly higher prevalence (18.2%) of ever having asthma at some point in their lifetime in comparison to those earning $50,000 or more (8.3%).

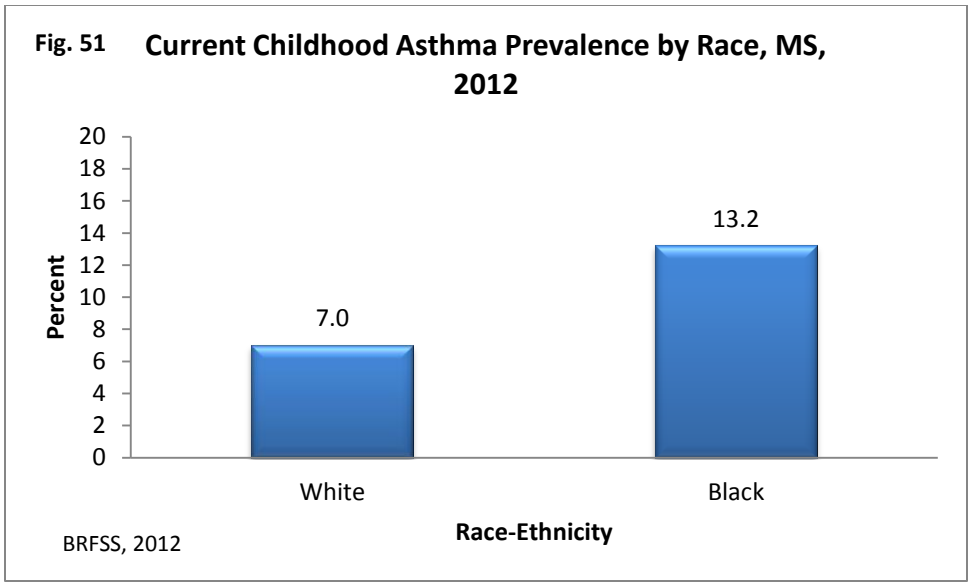

Figure 51: Among Mississippians, ages 17 and below, by race-ethnicity, 13.2% of black children currently have asthma. This is a significantly higher proportion to the 7.0% of white children who currently have asthma.

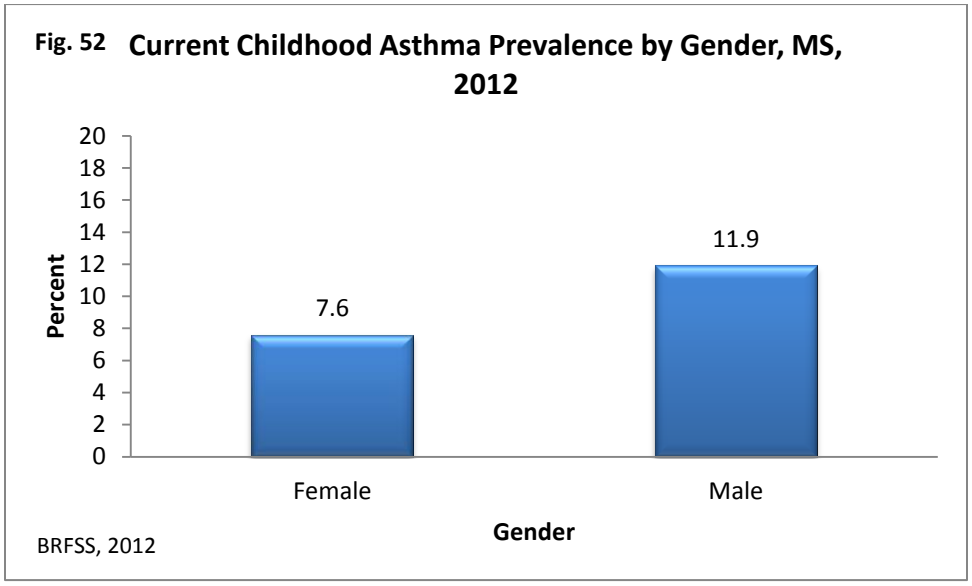

Figure 52: Among Mississippians, ages 17 and below, by gender, 11.9% of male children and 7.6% of female children currently have asthma. It cannot be concluded there is a significant difference between the proportion of girls and the proportion of boys who currently have asthma.

V. HIV/AIDS

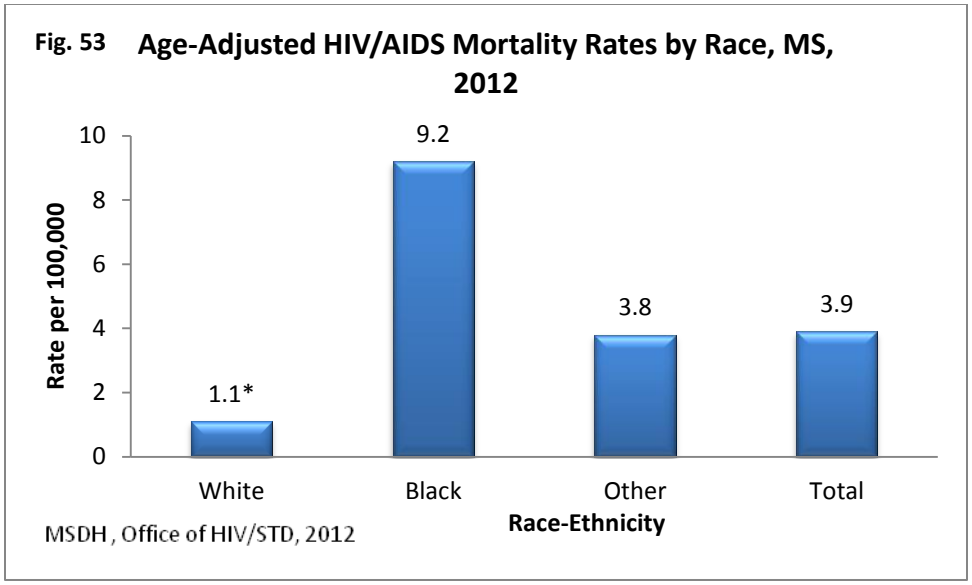

Figure 53: The age-adjusted HIV/AIDS mortality rate, by race-ethnicity, is 9.2 deaths per 100,000 blacks compared to 1.1* deaths per 100,000 whites.

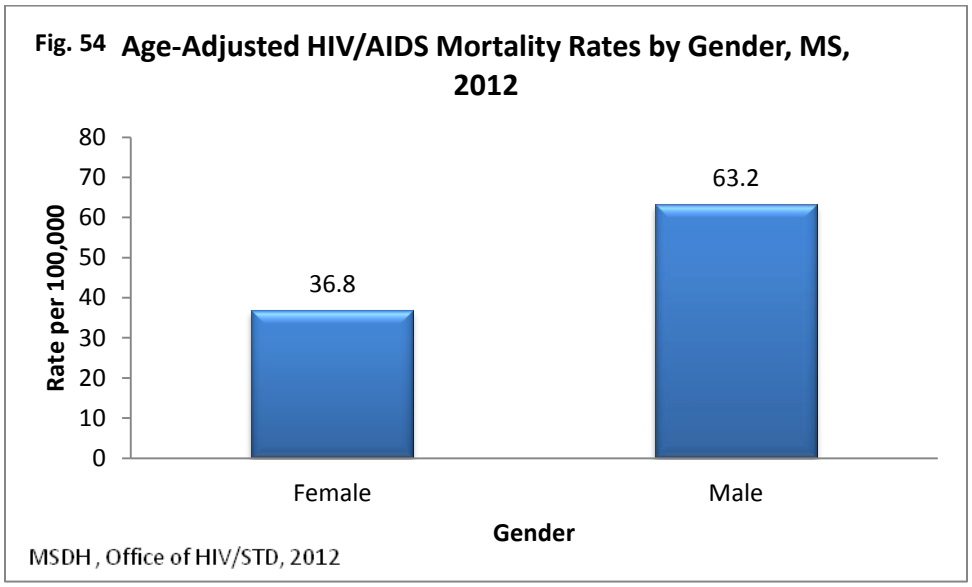

Figure 54: The age-adjusted HIV/AIDS mortality rate, by gender, is 63.2 deaths per 100,000 males compared to 36.8 deaths per 100,000 females.

*Denotes < 20 events. Due to a small number of events, these rates are unstable and should be interpreted with caution.

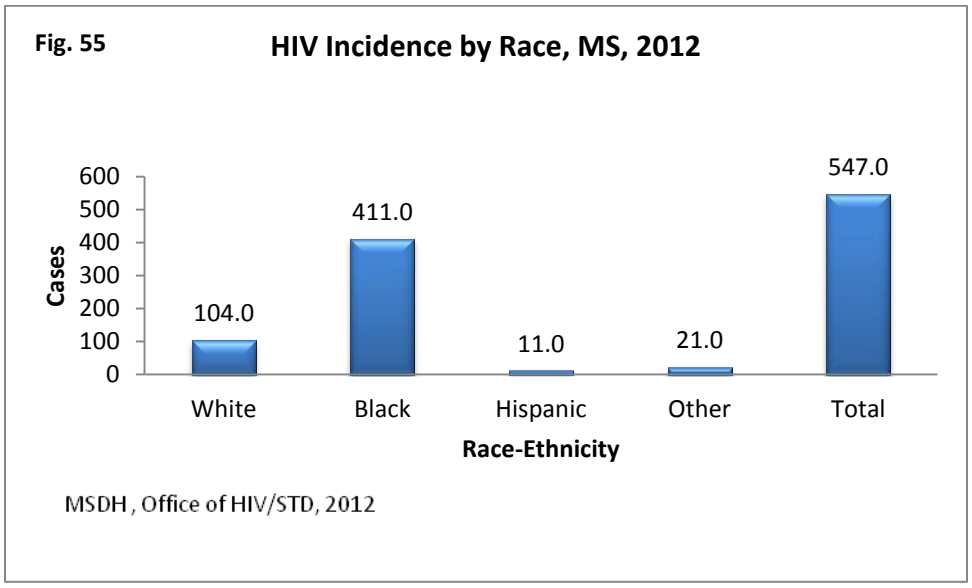

Figure 55: Among Mississippians in year 2012, there were 411.0 new HIV cases among blacks and 104.0 new HIV cases among whites.

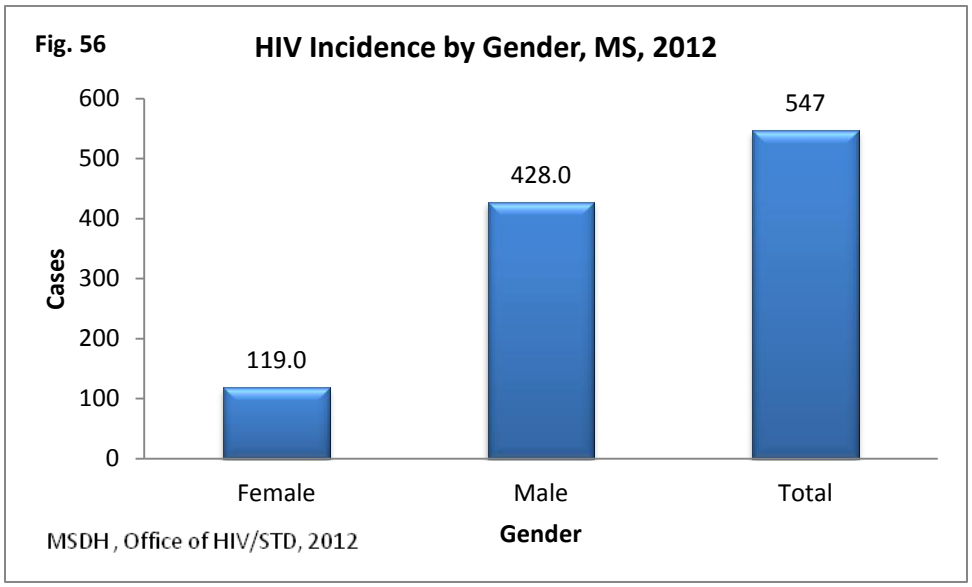

Figure 56: Among Mississippians, in year 2012, there were 428.0 new HIV cases among males compared to 119.0 new HIV cases among females.

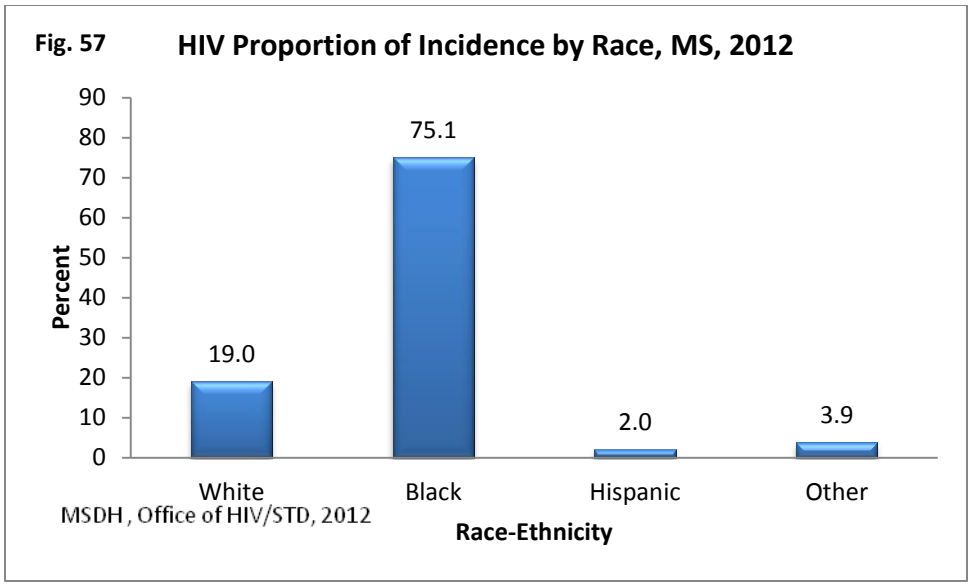

Figure 57: Among Mississippians in year 2012, blacks accounted for 75.1% of new HIV cases, while whites accounted for 19.0% of new HIV cases.

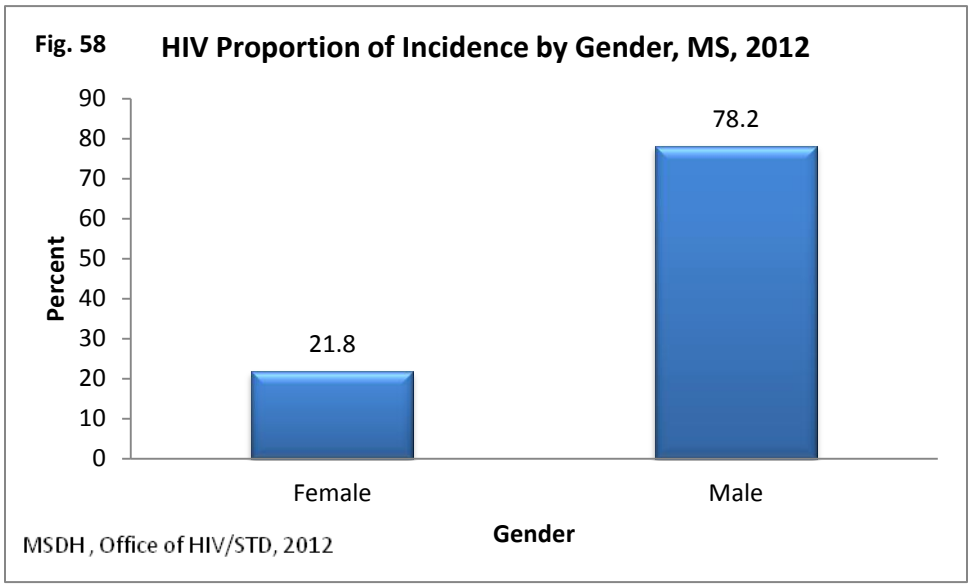

Figure 58: Among Mississippians in year 2012, males accounted for 78.2% of new HIV cases, while females accounted for 21.8% of new HIV cases.

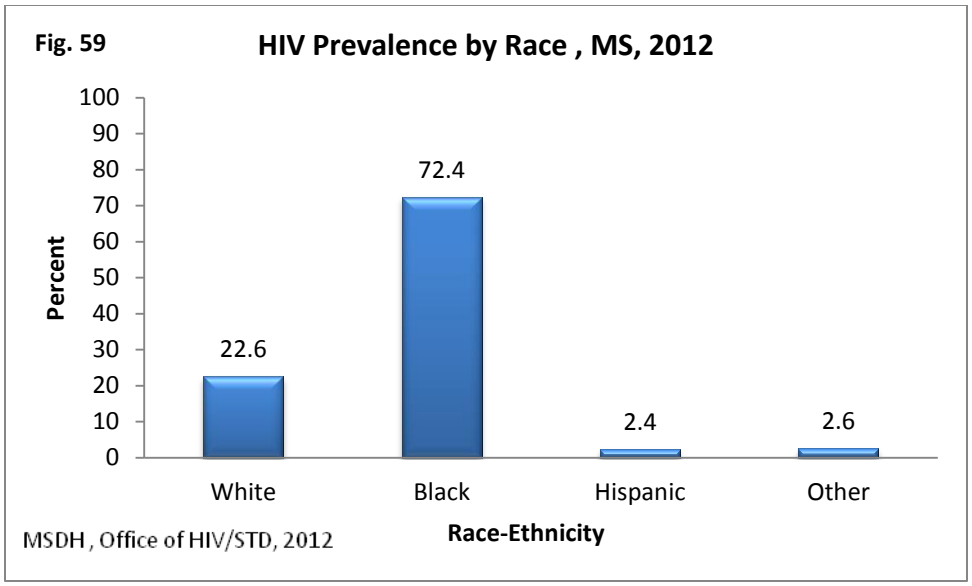

Figure 59: Of Mississippians living with HIV, 72.4% are black, 22.6% are white, 2.6% are "other," and 2.4% are Hispanic.

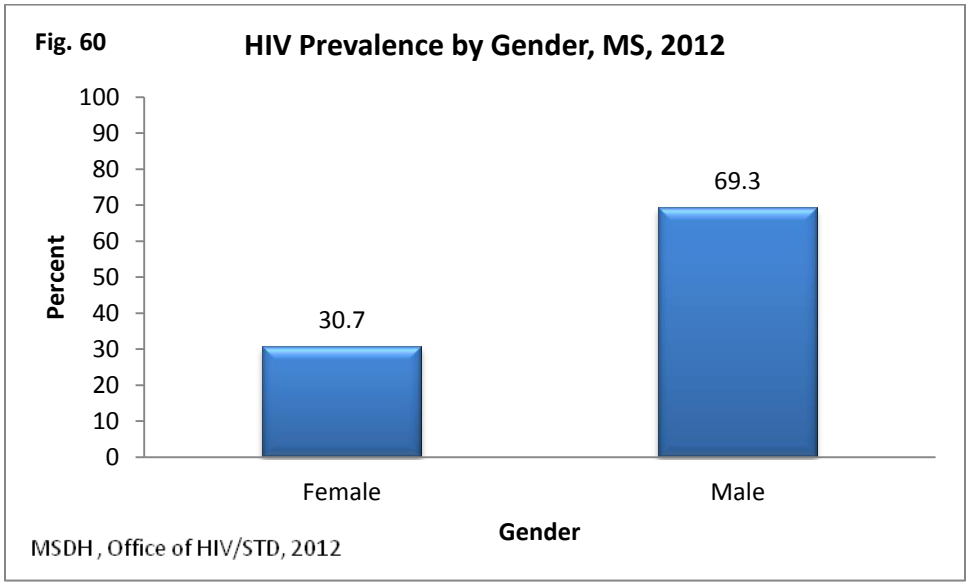

Figure 60: Of Mississippians living with HIV, 69.3% are male and 30.7% are female.

VI. Cancer

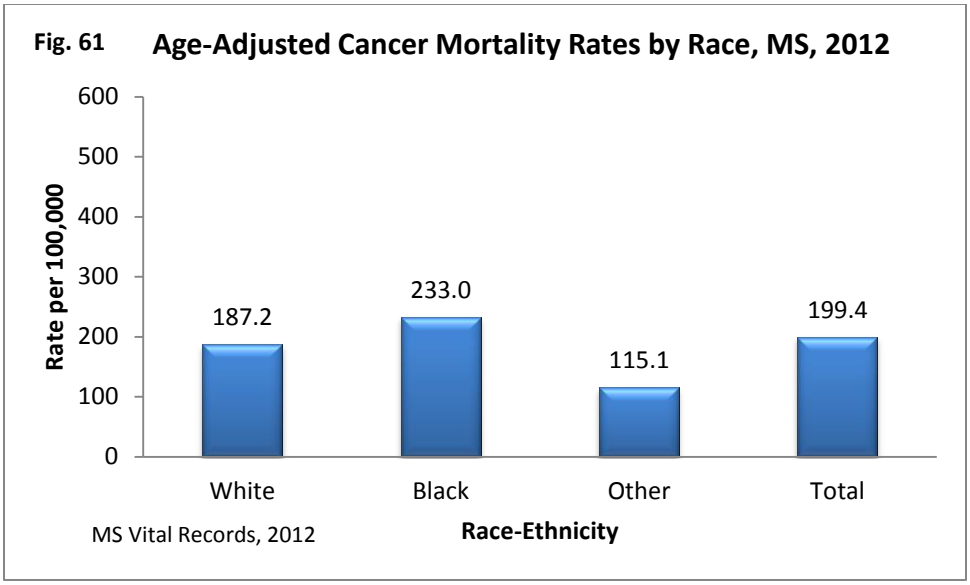

Figure 61: By race-ethnicity, the age-adjusted cancer mortality rate is 233.0 deaths among black Mississippians and 187.2 deaths among white Mississippians, per 100,000 population.

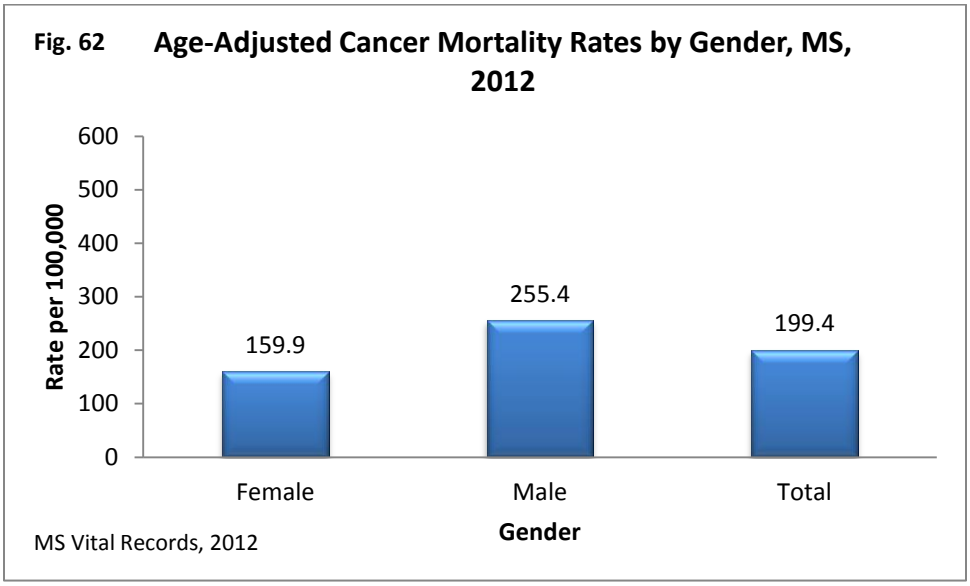

Figure 62: By gender, the age-adjusted cancer mortality rate among all Mississippians is 255.4 male deaths and 159.9 female deaths per 100,000 population.

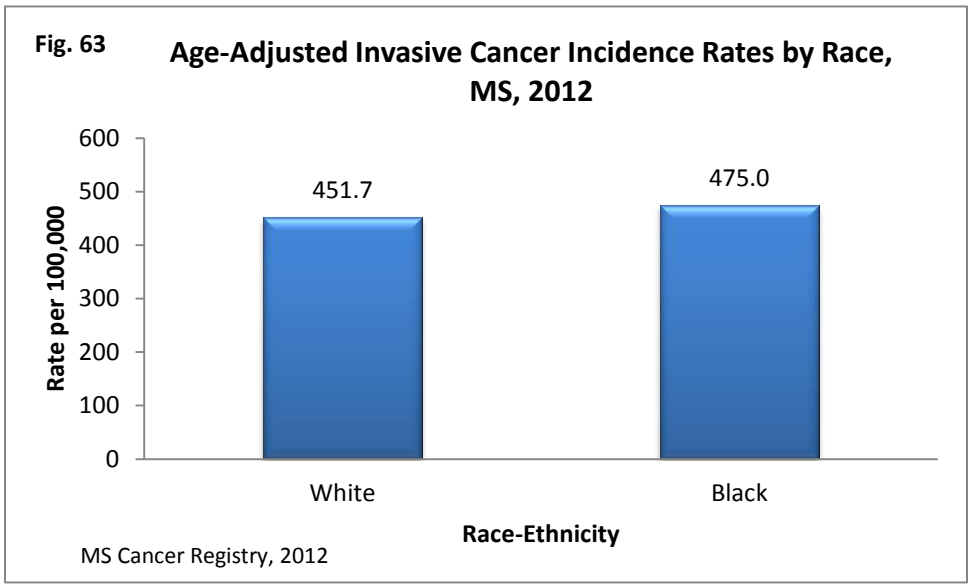

Figure 63: By race-ethnicity, in 2012, among all Mississippians, invasive cancer affected 475.0 black and 451.7 white individuals per 100,000 population.

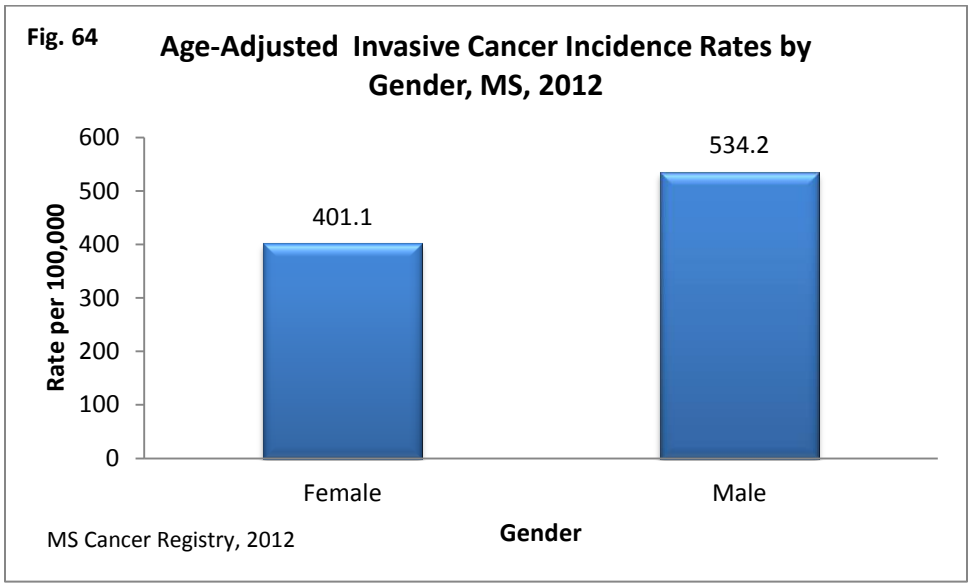

Figure 64: By gender, in 2012, among all Mississippians, invasive cancer affected 534.2 males and 401.1 females per 100,000 population.

VII. Infant Mortality

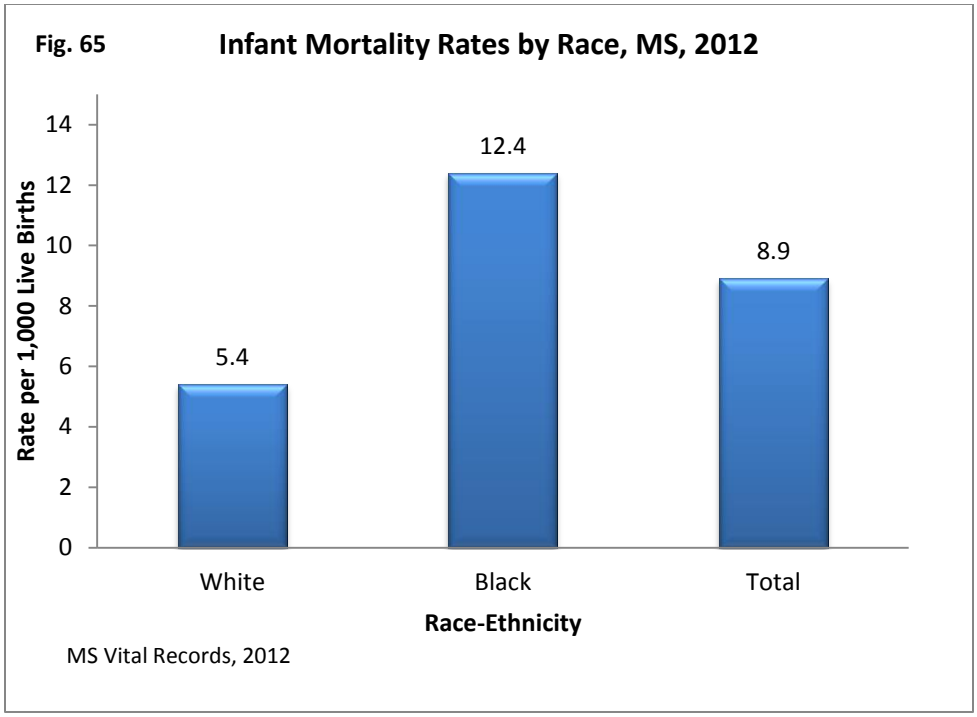

Figure 65: Among Mississippi infants 0-1 year of age, there were 8.9 infant deaths per 1,000 live births. The mortality rate for black infants was more than twice as high as white infants.

VIII. Teenage Pregnancy

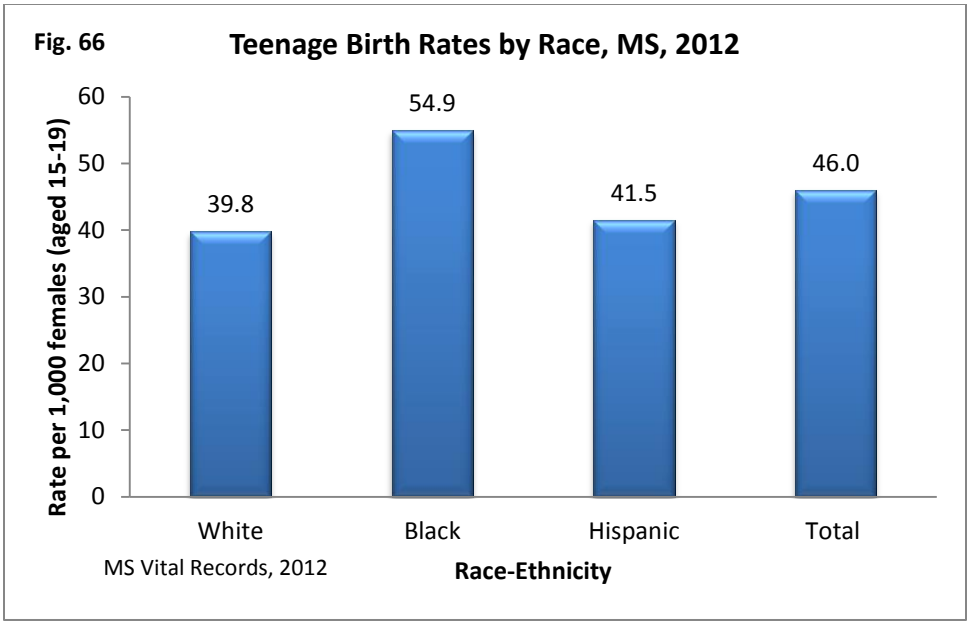

Figure 66: Per 1,000 Mississippi females, ages 15 to 19, blacks had 54.9 live births, Hispanics had 41.5 live births, and whites had 39.8 live births.

IX. Injury and Violence

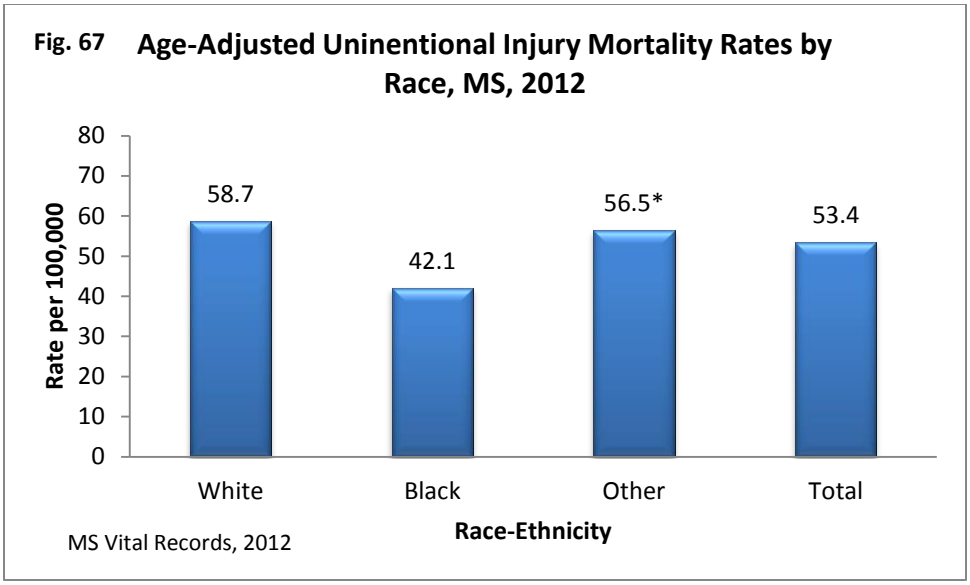

Figure 67: The age-adjusted unintentional injury mortality rate, by race-ethnicity, is 58.7 deaths per 100,000 population. This is compared to blacks, who have an age-adjusted unintentional injury mortality rate of 42.1 deaths per 100,000 population.

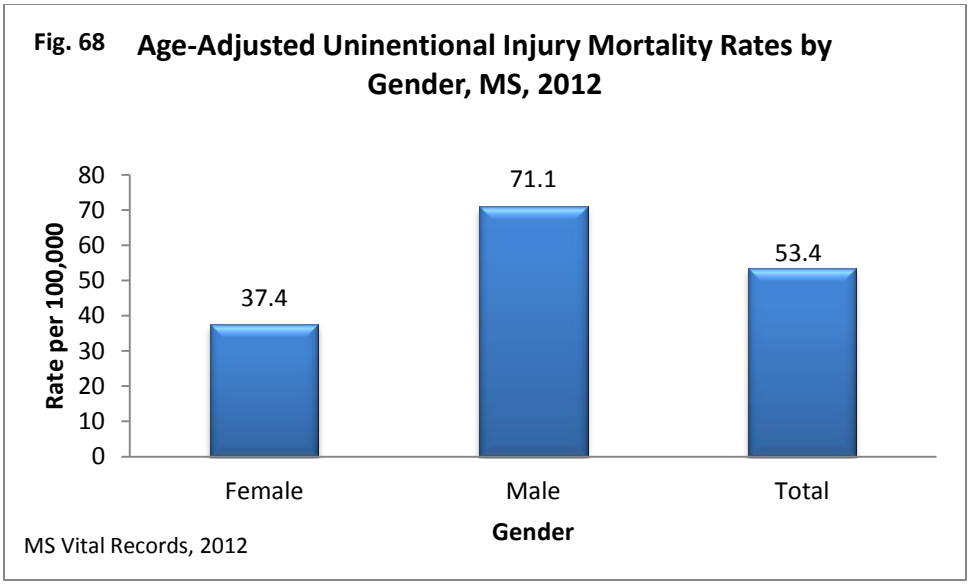

Figure 68: The age-adjusted unintentional injury mortality rate, by gender, for male Mississippians is 71.1 deaths per 100,000 population. For females, the mortality rate is 37.4 deaths per 100,000 population.

*Denotes < 20 events. Due to a small number of events, these rates are unstable and should be interpreted with caution.

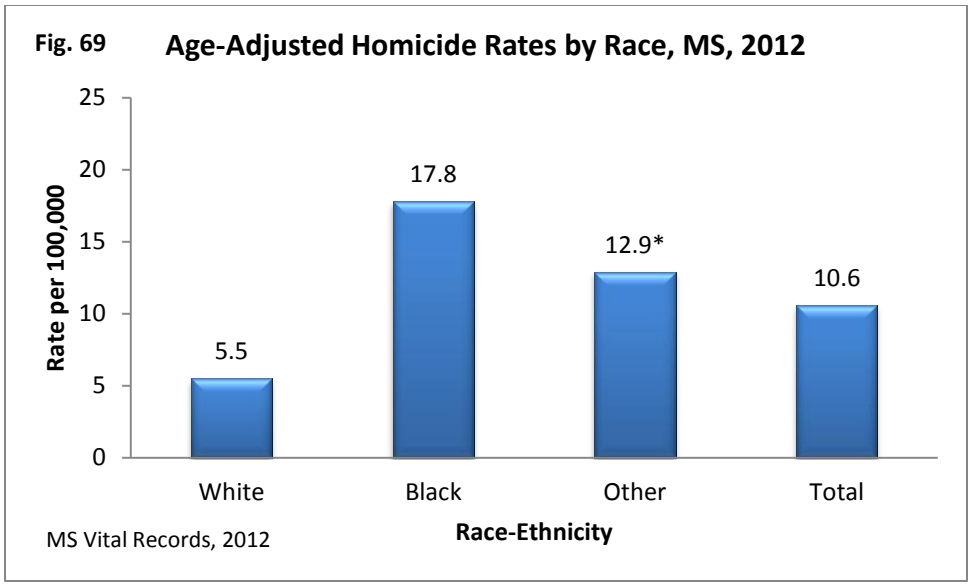

Figure 69: The age-adjusted homicide rate, by race-ethnicity, is highest for black Mississippians at 17.8 deaths per 100,000 population.

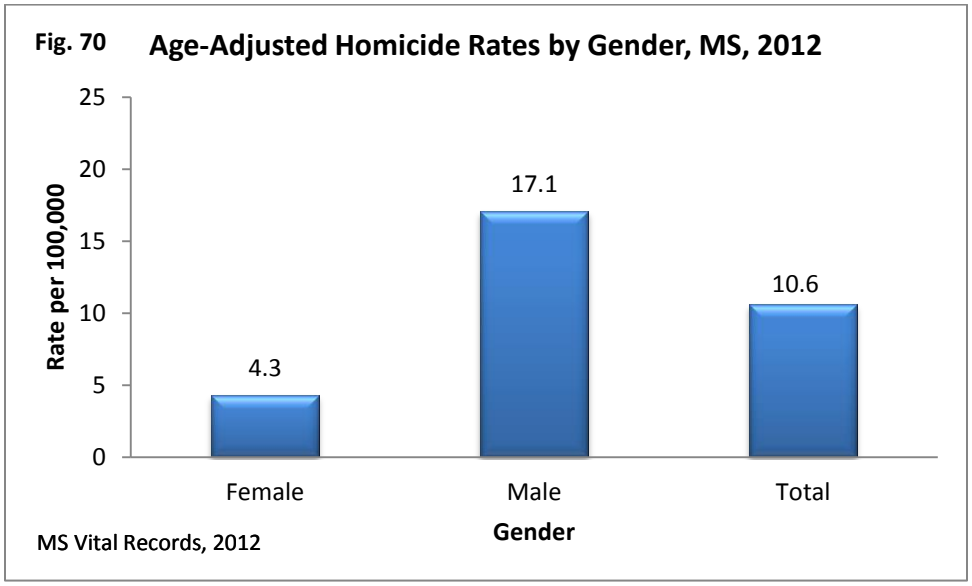

Figure 70: The age-adjusted homicide rate, by gender, is highest for male Mississippians at 17.1 deaths per 100,000 population, as compared to 4.3 female deaths per 100,000 population.

*Denotes < 20 events. Due to a small number of events, these rates are unstable and should be interpreted with caution.

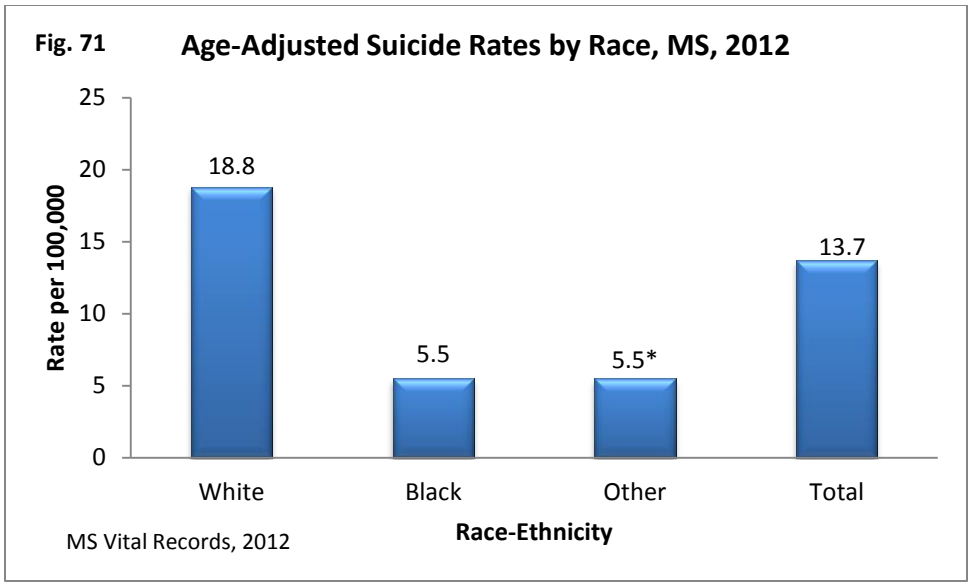

Figure 71: The age-adjusted suicide rate, by race-ethnicity, is highest among white Mississippians at 18.8 deaths per 100,000 population compared to 5.5 black deaths per 100,000 population.

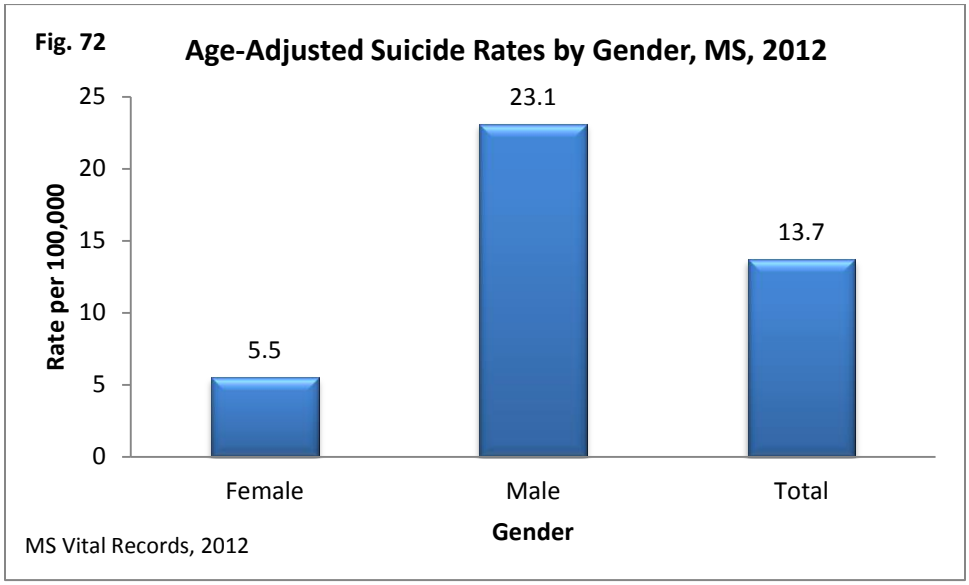

Figure 72: The age-adjusted suicide rate, by gender, is highest among male Mississippians at 23.1 deaths per 100,000 population compared to 5.5 female deaths per 100,000 population.

*Denotes < 20 events. Due to a small number of events, these rates are unstable and should be interpreted with caution.

B. Risk Factors of Illness

I. Exercise

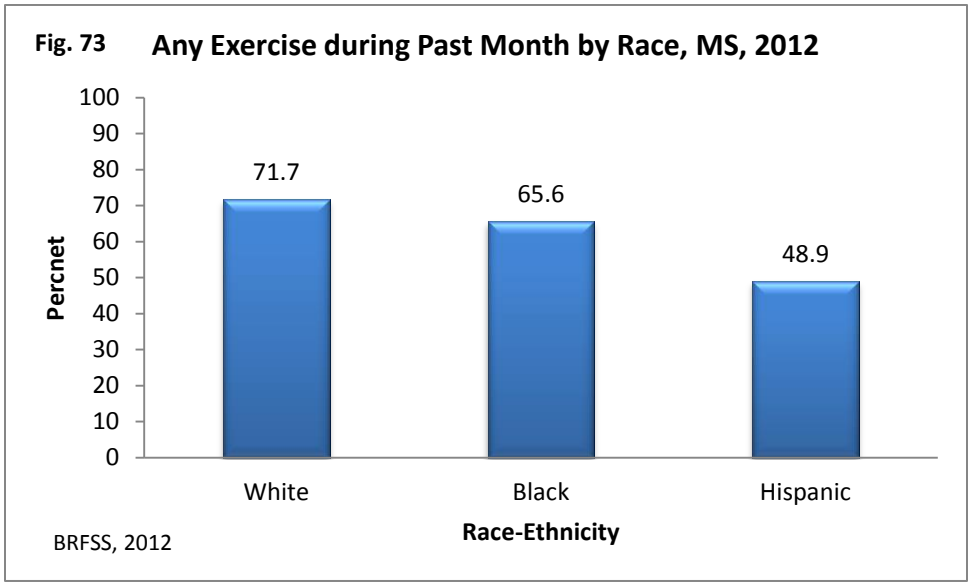

Figure 73: Of adult Mississippians, by race-ethnicity, the prevalence of Hispanics who exercised in the past month (48.9%) was significantly lower than the group with the largest proportion exercising, the white population (71.7%).

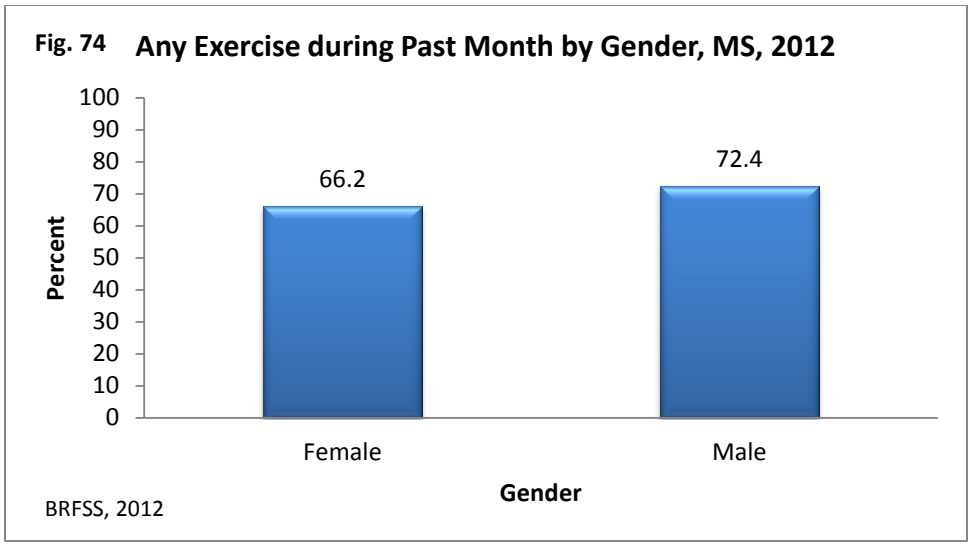

Figure 74: Of adult Mississippians, by gender, the proportion of males who exercised any during the past month (72.4%) is significantly higher than females (66.2%).

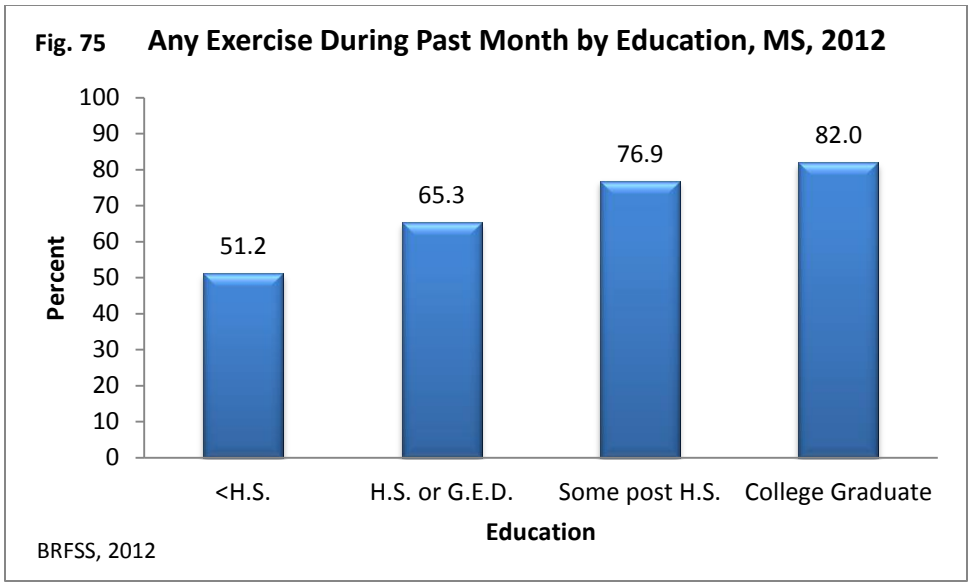

Figure 75: Of adult Mississippians, by education level, 51.2% of those with no high school education reported any exercise over the past month, significantly lower than the 82.0% prevalence of college graduates who reported exercising during the past month. Self-reported prevalence of exercise steadily increases with level of attained education.

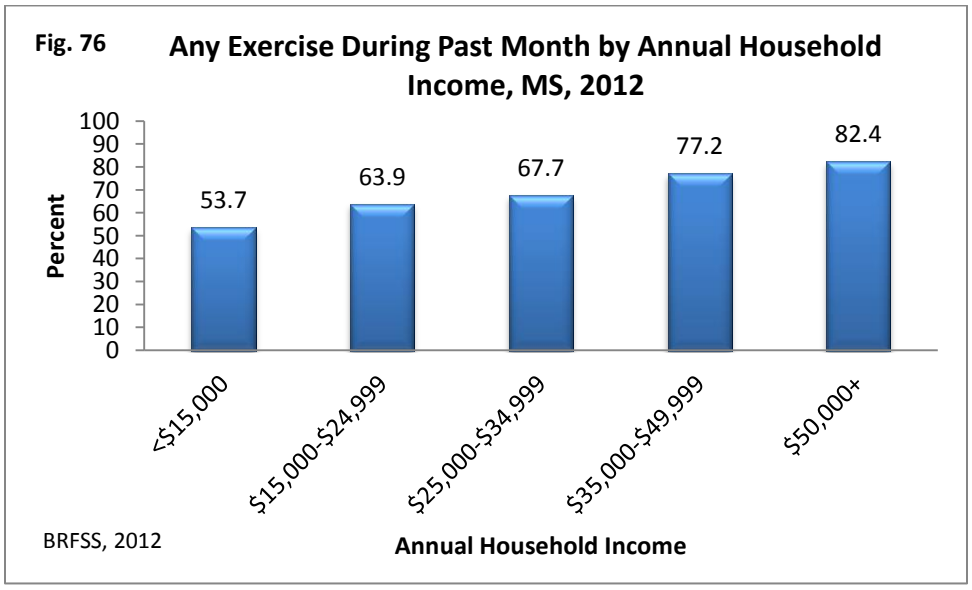

Figure 76: Of adult Mississippians, by income, 53.7% of those earning less than $15,000 in annual household income report any exercise over the past month, significantly lower than the 82.4% prevalence of college graduates reporting to have engaged in exercise. The proportion of those who exercised any over the past month steadily increases as annual household income increases.

II. Immunizations

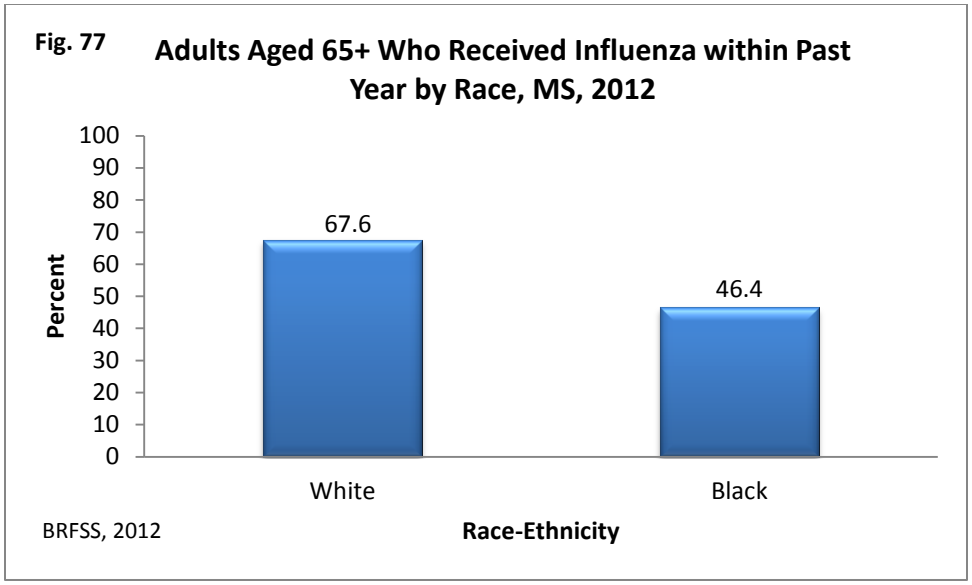

Figure 77: Of Mississippians, ages 65 and above, the 67.6% prevalence of whites who reported receiving influenza shots within the past year was significantly higher than among blacks (46.4%).

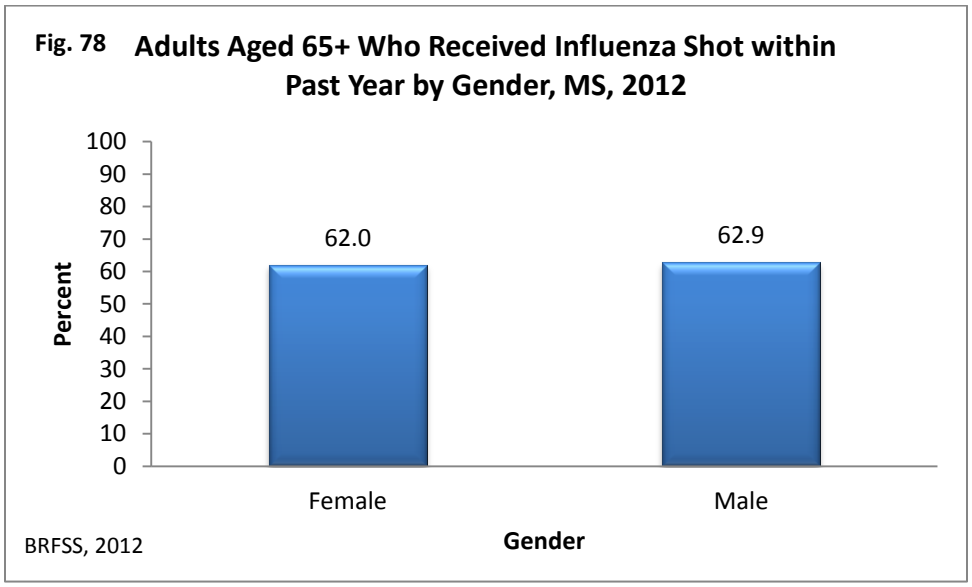

Figure 78: Of Mississippians, ages 65 and above, 62.9% of males and 62.0% of females reported receiving an influenza shot within the past year.

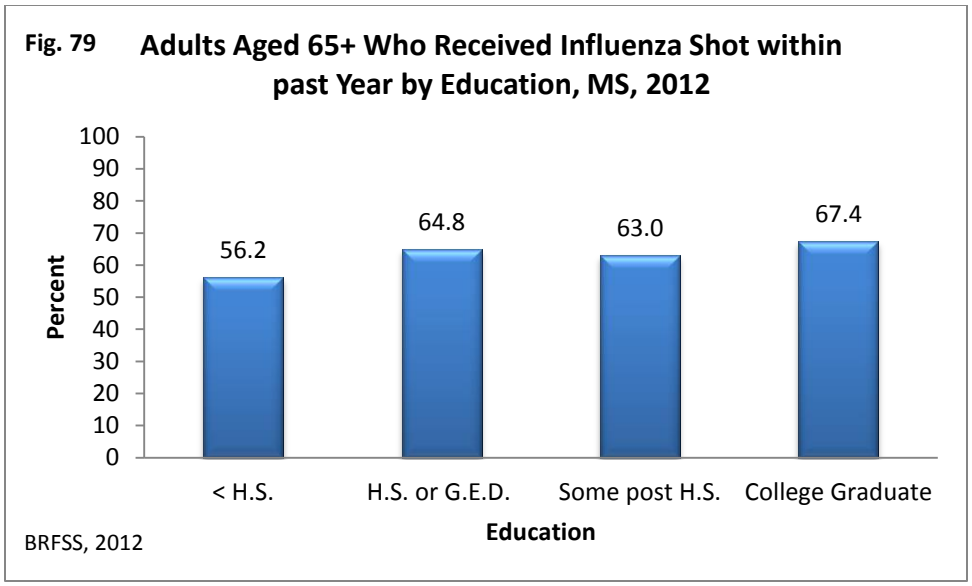

Figure 79: Of Mississippians, ages 65 and above, the 67.4% prevalence of college graduates receiving an influenza shot within the past year was significantly higher than the 56.2% prevalence among adults ages 65+ with no high school education.

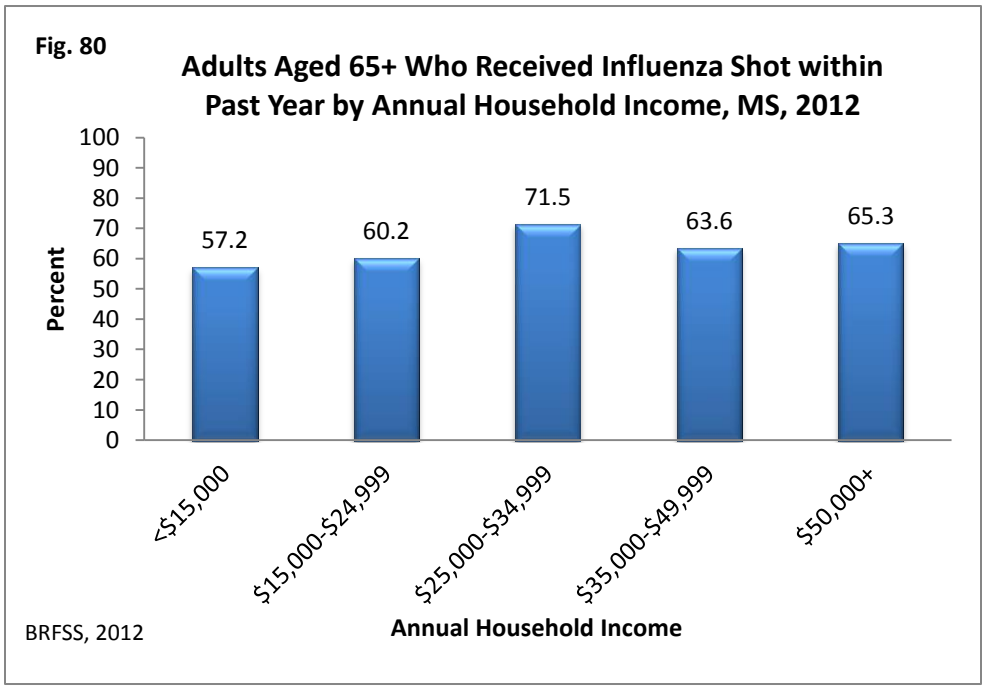

Figure 80: Of Mississippians, ages 65 and above, 71.5% of those earning between $25,000 to $34,999 had reported receiving the influenza shot within the past year, significantly higher than the income group earning less than $15,000 in annual household income.

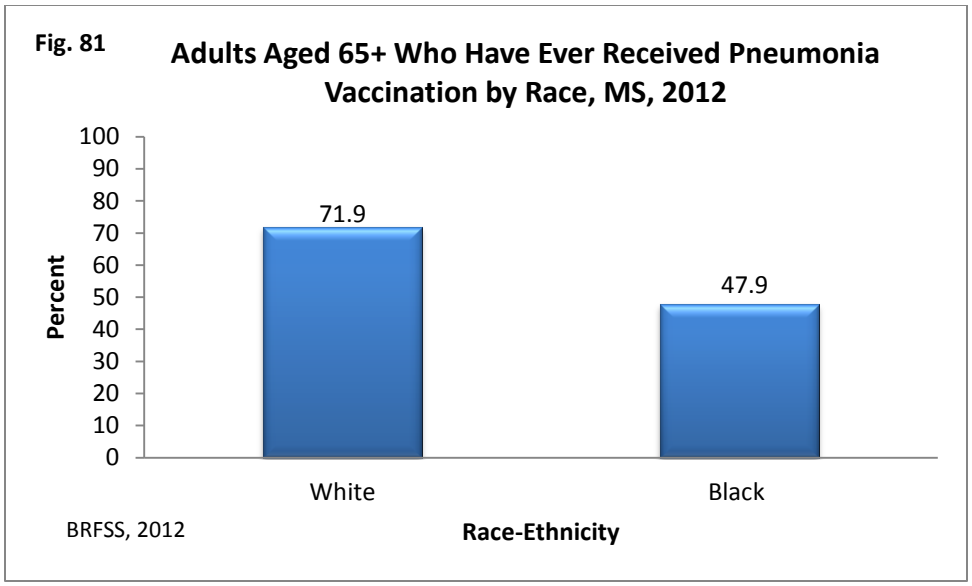

Figure 81: Of Mississippians, ages 65 and above, a significantly higher prevalence of whites (71.9%) received the pneumonia vaccination in comparison to blacks (47.9%).

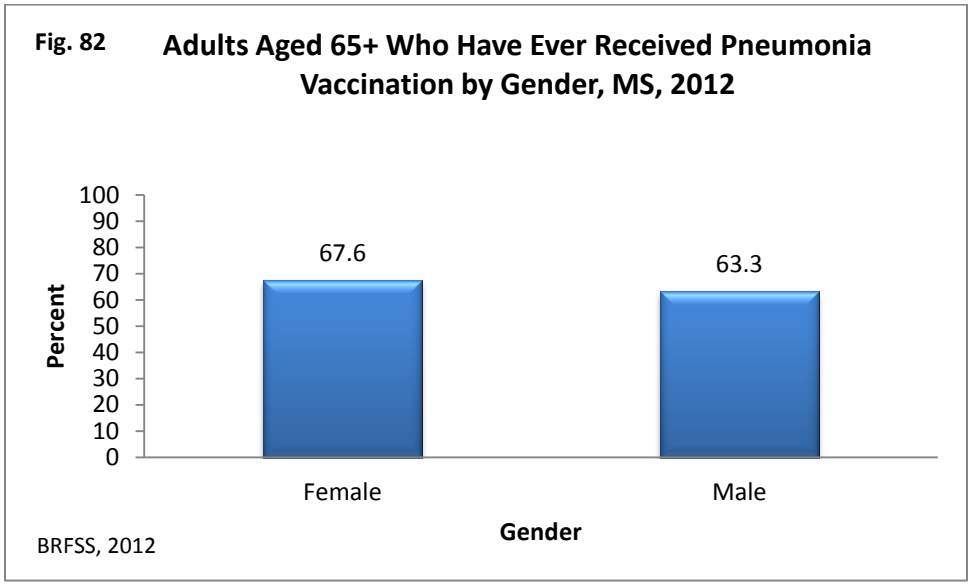

Figure 82: Of Mississippians, ages 65 and above, 67.6% of females compared to 63.3% of males reported ever receiving the Pneumonia vaccination. It cannot be concluded there is a significant difference between the proportion of females and the proportion of males receiving the pneumonia vaccination.

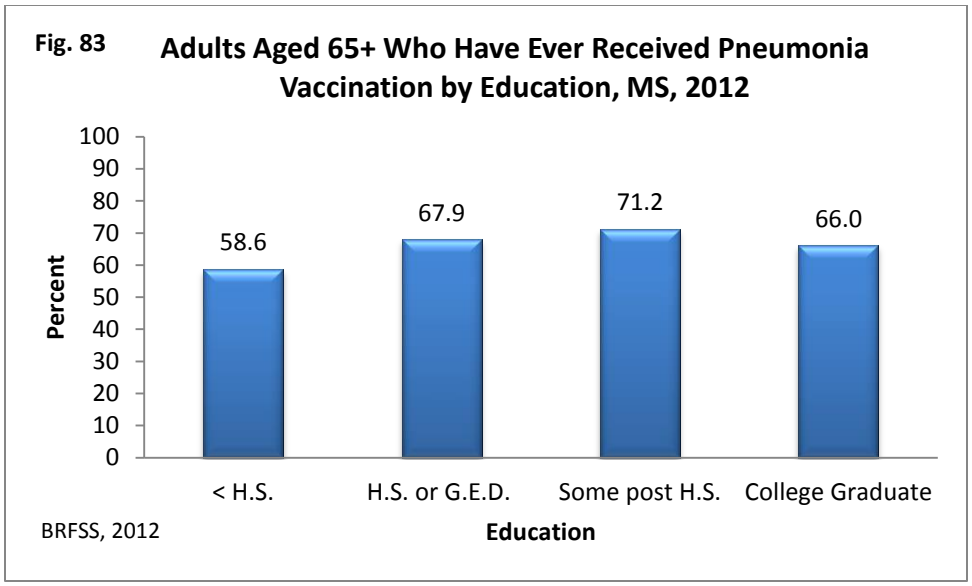

Figure 83: Of Mississippians, ages 65 and above, 58.6% of those with no high school education reported ever receiving a Pneumonia vaccination. It cannot be concluded there is a significant difference between the proportions of groups receiving the pneumonia vaccination according to education level.

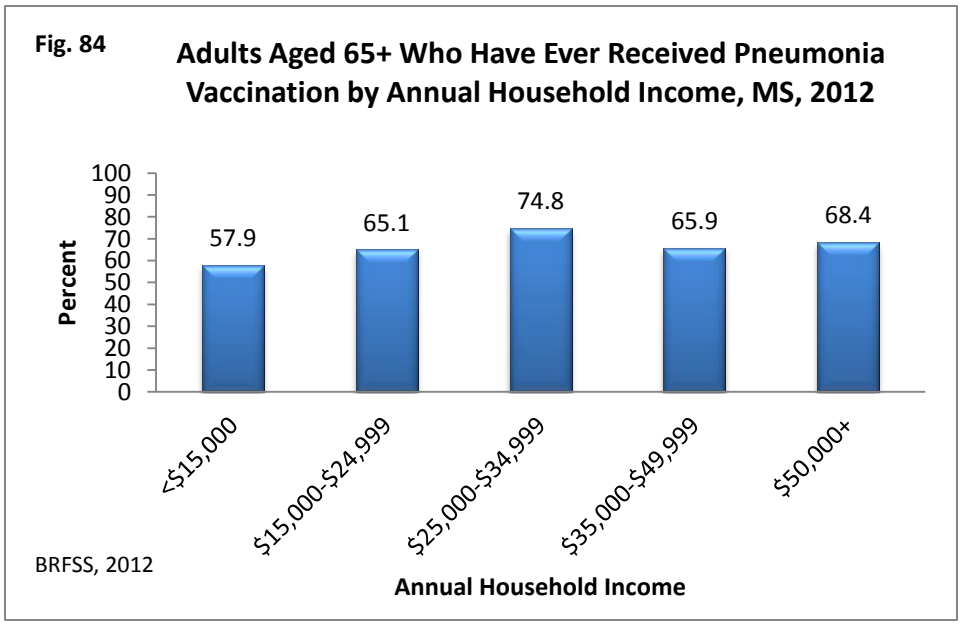

Figure 84: Of Mississippians, ages 65 and above, 57.9% of those earning an annual household income less than $15,000 reported ever receiving the Pneumonia vaccination. It cannot be concluded there is a significantly different prevalence between the proportions of groups receiving the pneumonia vaccination according to annual household income.

III. Oral Health

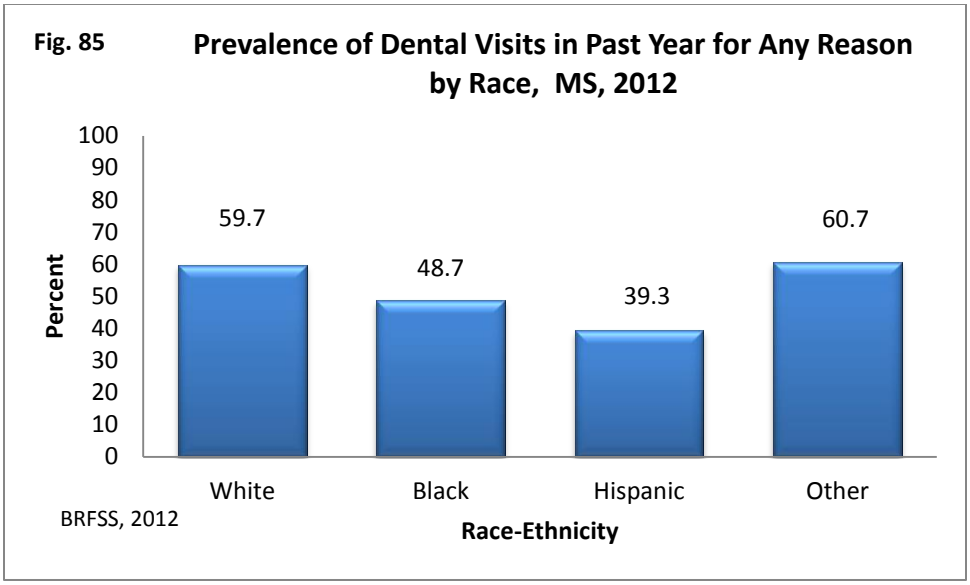

Figure 85: Of adult Mississippians, a significantly higher proportion of whites (59.7%) had a dental visit in the past year for any reason in comparison to blacks (48.7%).

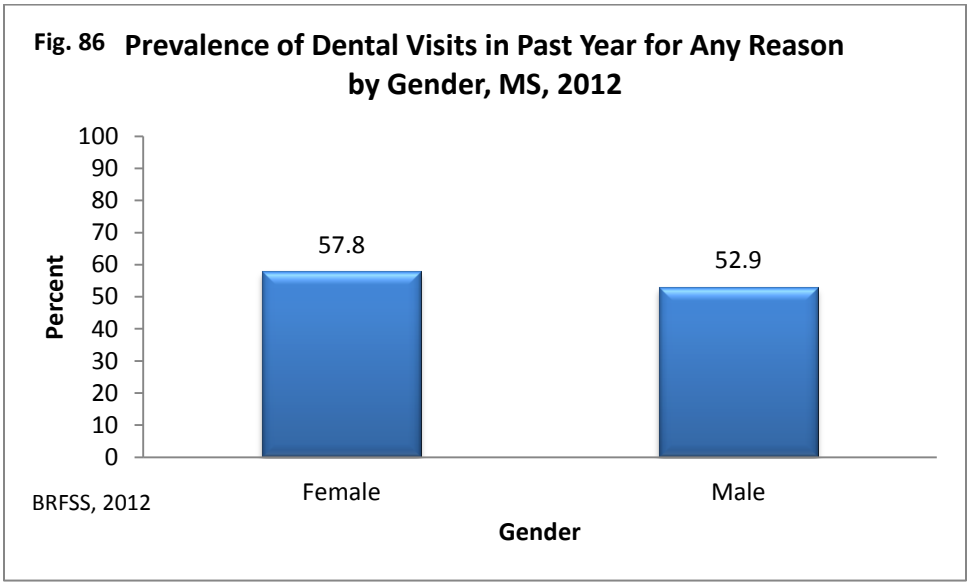

Figure 86: Of adult Mississippians, a significantly higher proportion of females (57.8%) had a dental visit in the past year for any reason in comparison to males (52.9%).

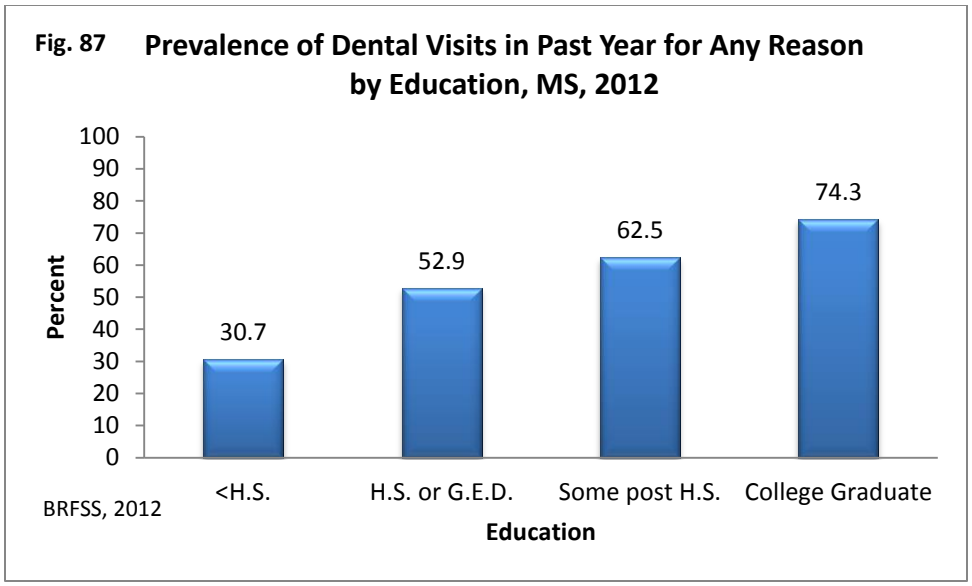

Figure 87: Of adult Mississippians, a significantly lower prevalence of those with no high school education (30.7%) visited the dentist within the past year for any reason in comparison to college graduates (74.3%). The prevalence of individuals who reported visiting a dentist over the past year steadily increases with level of attained education.

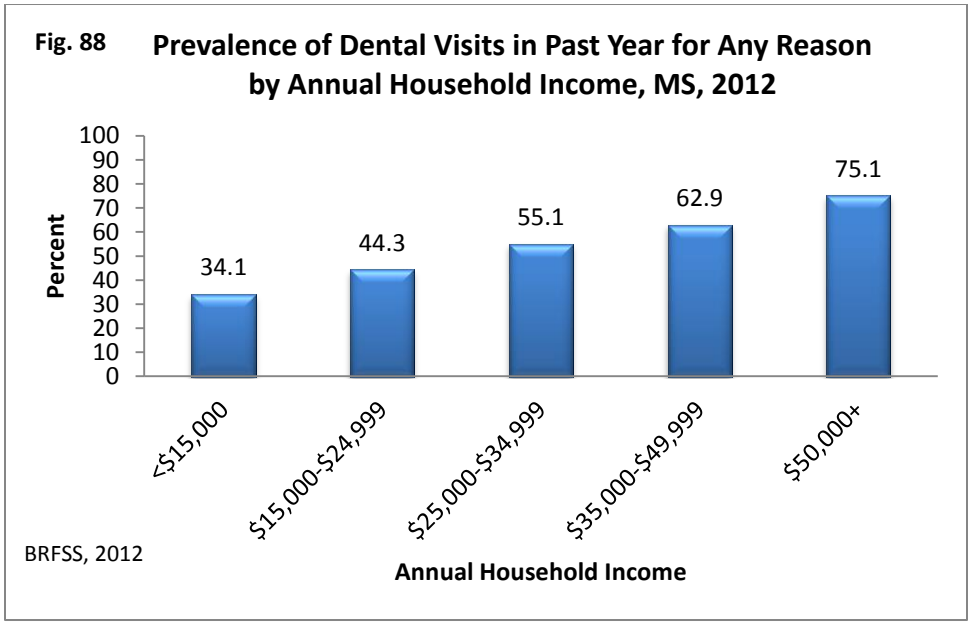

Figure 88: Of adult Mississippians, a significantly lower prevalence of those earning less than $15,000 in annual household income (34.1%) visited the dentist within the past year for any reason in comparison to those earning $50,000 or more (75.1%). The prevalence of individuals who reported visiting a dentist over the past year steadily increases with increased annual household income.

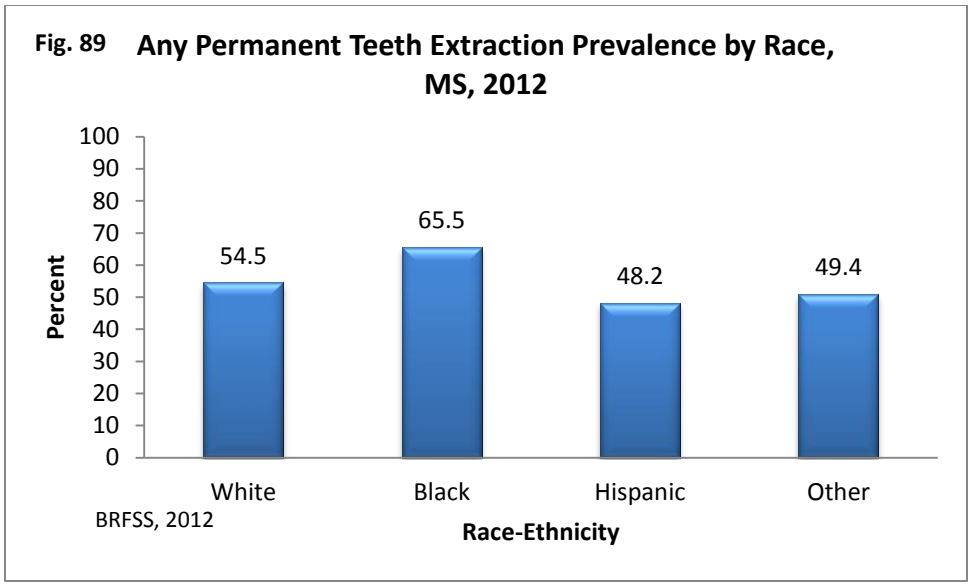

Figure 89: Of adult Mississippians, a significantly higher prevalence (65.5%) of blacks have ever received a permanent teeth extraction in comparison to Hispanics (48.2%).

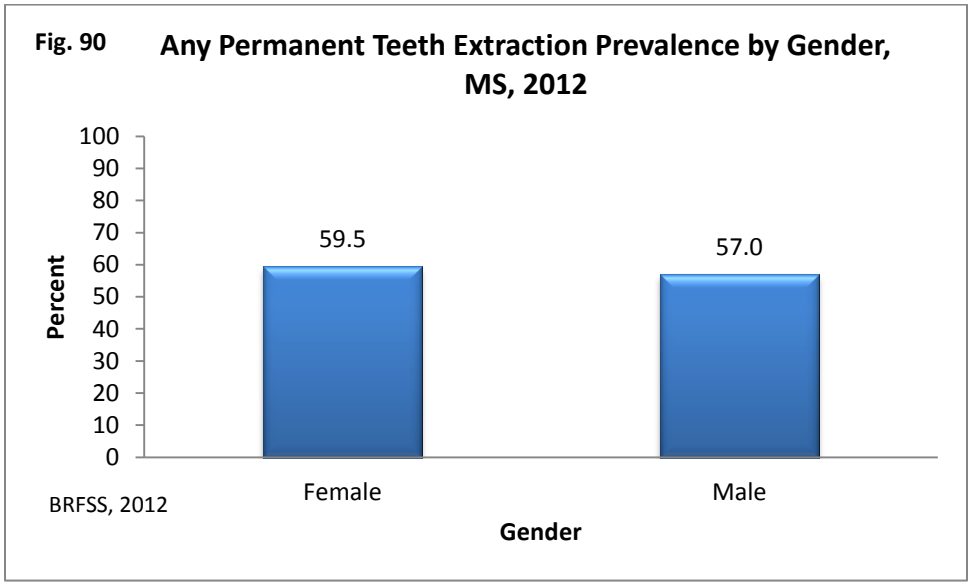

Figure 90: Of adult Mississippians, 59.5% of females and 57.0% of males reported ever having any permanent teeth extracted. It cannot be concluded there is a significantly different prevalence in permanent teeth extractions according to gender.

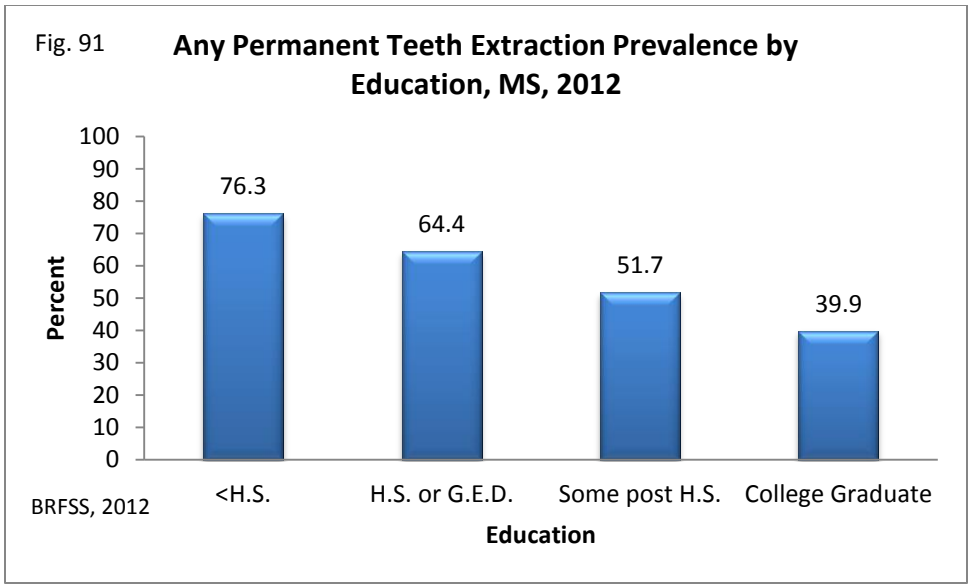

Figure 91: Of adult Mississippians, a significantly higher prevalence of those with no high school education (76.3%) has had any permanent teeth extractions in comparison to college graduates (39.9%). The prevalence of individuals who report ever having permanent teeth extractions steadily decreases with level of attained education.

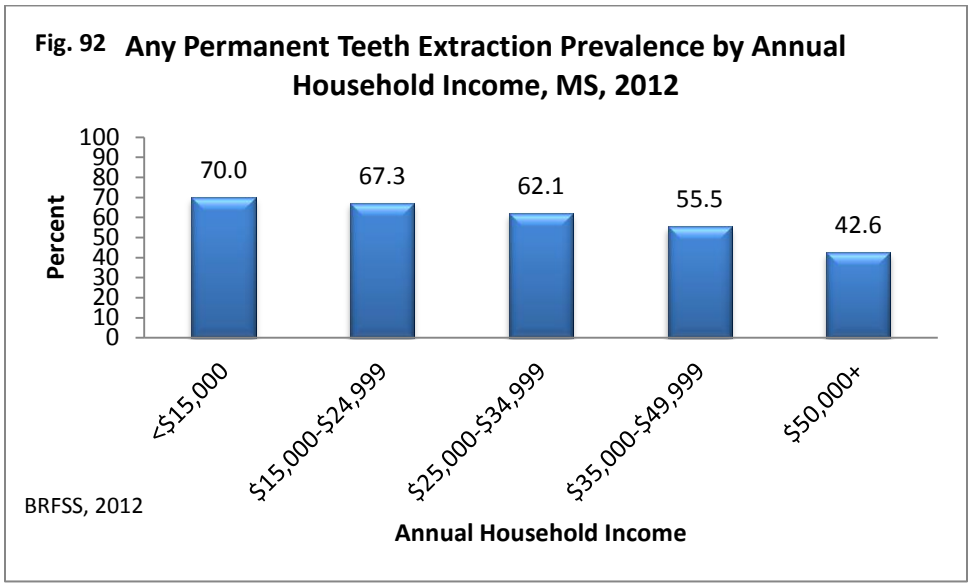

Figure 92: Of adult Mississippians, a significantly higher prevalence of those earning less than $15,000 in annual household income (70.0%) has had any permanent teeth extractions in comparison to those earning $50,000 or more (42.6%). The prevalence of individuals who report ever having permanent teeth extractions steadily decreases with increased annual household income.

IV. Tobacco

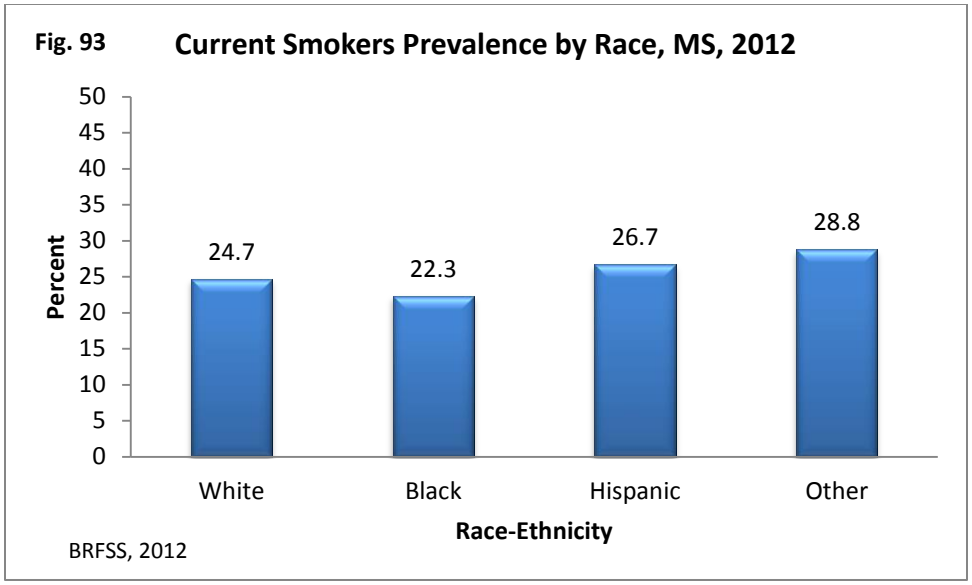

Figure 93: Of adult Mississippians, by race-ethnicity, smoking prevalence is highest (26.7%) among Hispanics and lowest (22.3%) among blacks. It cannot be concluded there is a significantly different prevalence of current smokers according to race-ethnicity.

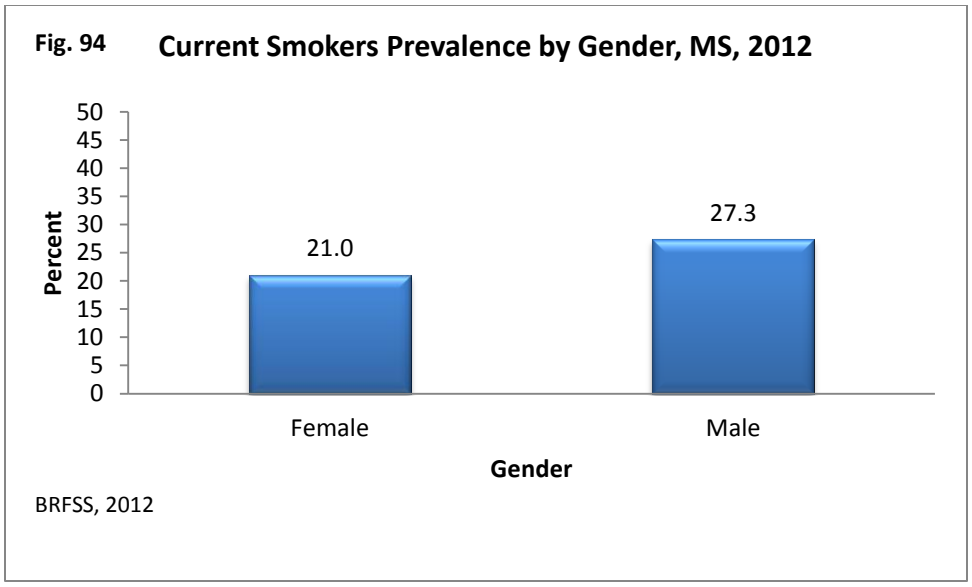

Figure 94: Of adult Mississippians, a significantly higher proportion of males (27.3%) are current smokers in comparison to females (21.0%).

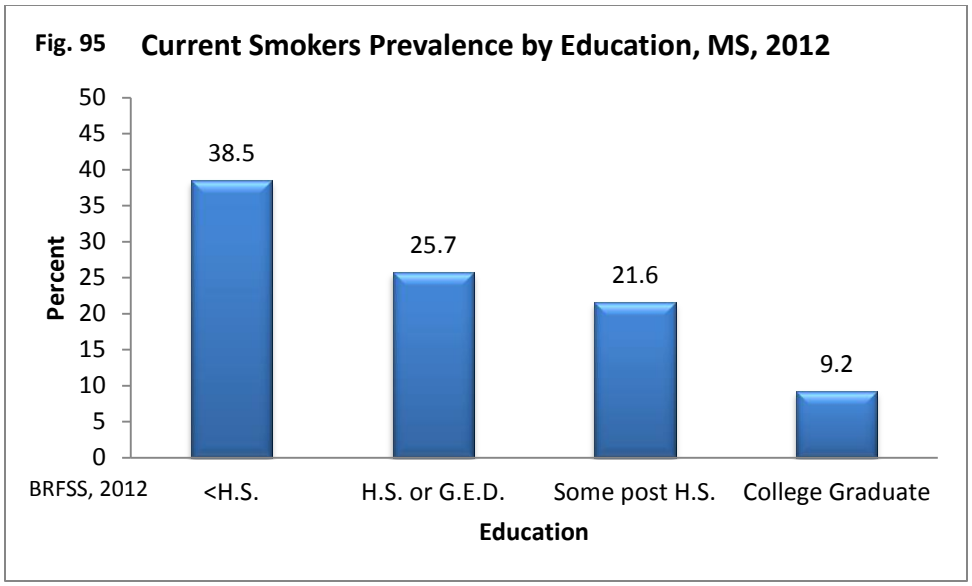

Figure 95: Of adult Mississippians, a significantly higher prevalence of those with no high school education (38.5%) are current smokers in comparison to college graduates (9.2%). The prevalence of current smokers steadily decreases as education level increases.

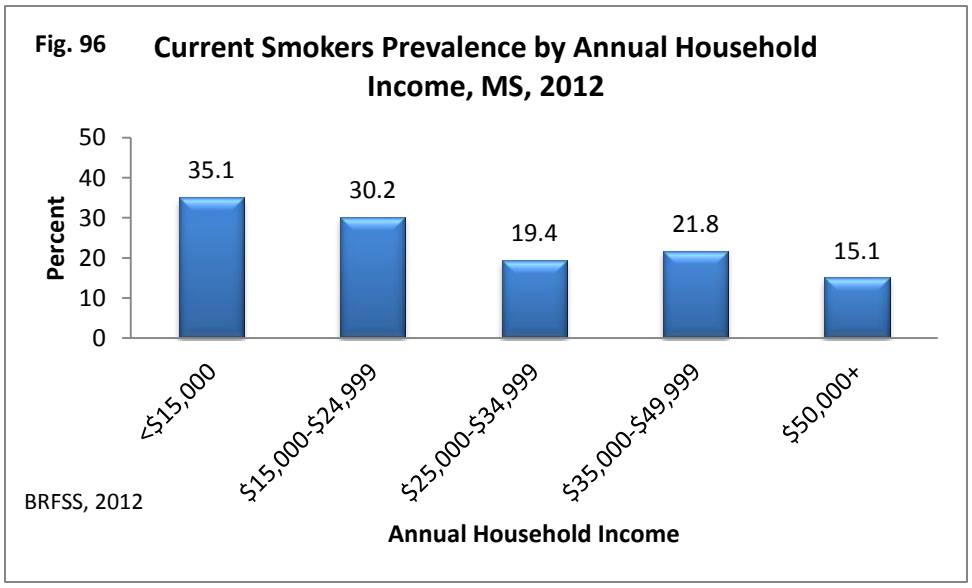

Figure 96: Of adult Mississippians, a significantly higher prevalence of those earning less than $15,000 in annual household income (35.1 %%) are current smokers in comparison to those earning $50,000 or more (15.1%).

C. Access to Care

I. Health Insurance Coverage

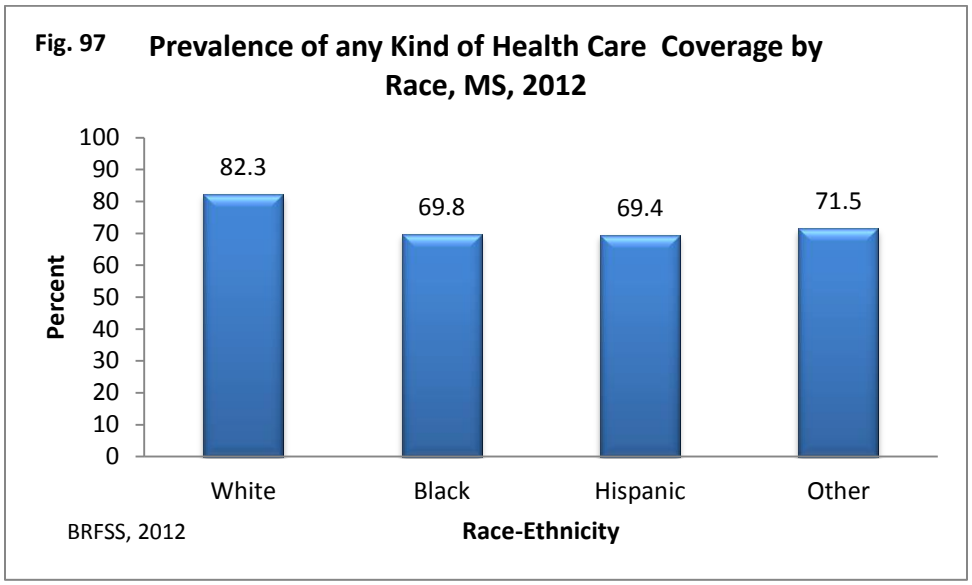

Figure 97: Of adult Mississippians, a significantly higher prevalence of whites (82.3%) is covered by any health care in comparison to blacks (69.8%).

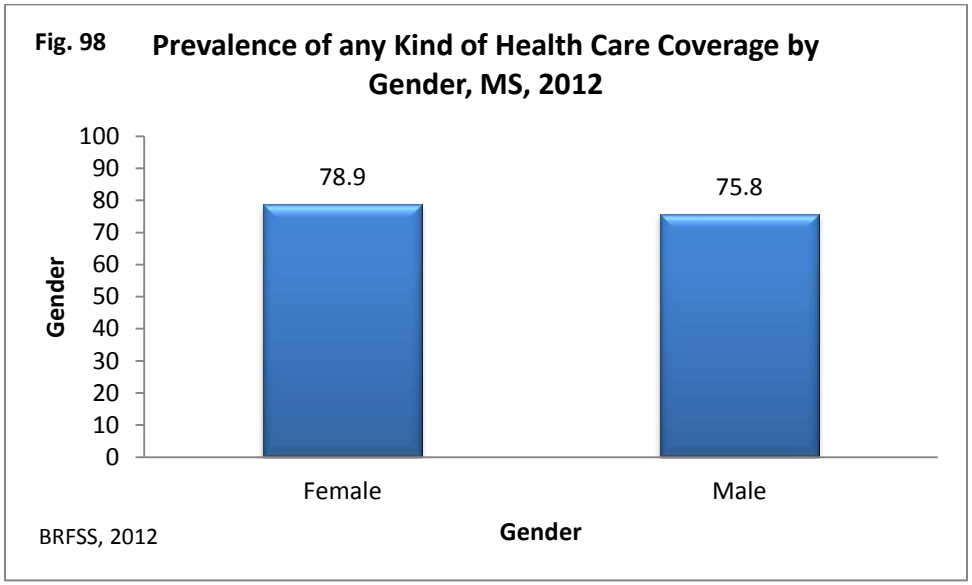

Figure 98: Of adult Mississippians, 78.9% of females and 75.8% of males have any form of health care coverage. It cannot be concluded there is a significantly different prevalence of health care coverage according to gender.

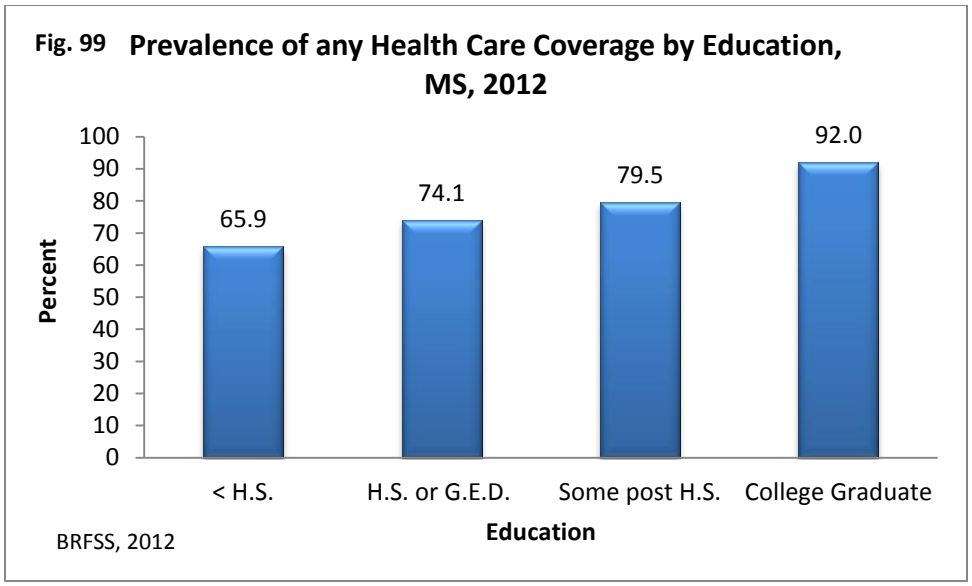

Figure 99: Of adult Mississippians, a significantly higher prevalence of college graduates (92.0%) is covered by health insurance in comparison to those with no high school education (65.9%). The prevalence of insured steadily increases as education level increases.

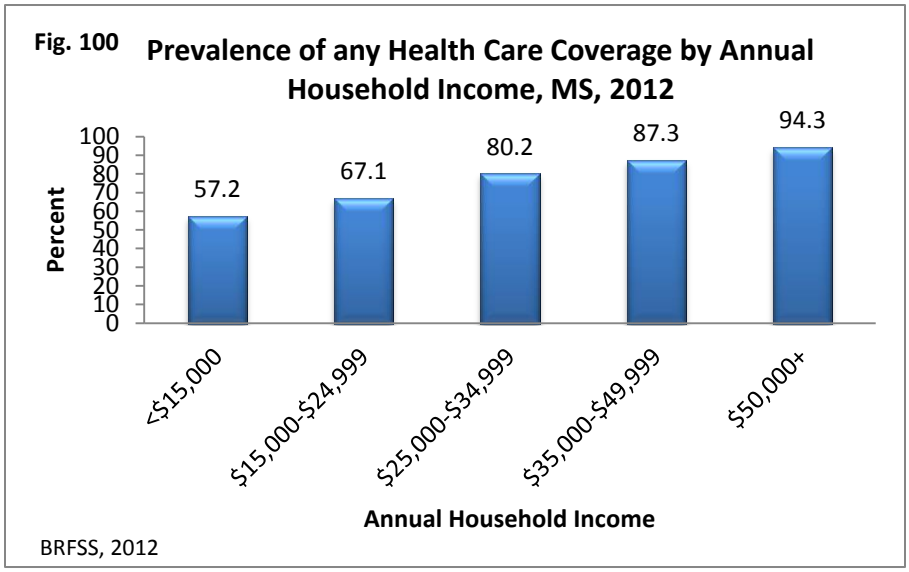

Figure 100: Of adult Mississippians, a significantly lower prevalence of those earning less than $15,000 in annual household income (57.2%%) are covered by a health care in comparison to those earning $50,000 or more (94.3%). This health insured prevalence steadily decreases as annual household income decreases.

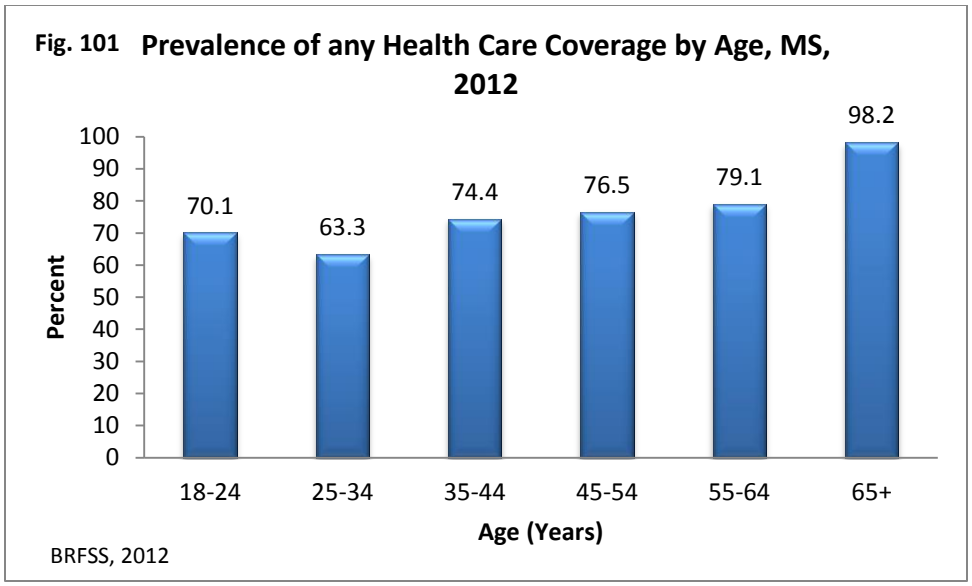

Figure 101: Of adult Mississippians, those who are 65 years of age or older have a significantly higher health care coverage (98.2%) in comparison to the 25-34 age group (63.3%).

Mississippi Disparities by Condition
2012 BRFSS

Condition	(%)	95% CI lower	upper
Coronary Heart Disease			
Race-ethnicity			
Black	**4.0**	3.2	4.8
White	**5.5**	4.8	6.3
Gender			
Women	**4.8**	4.1	5.5
Men	**5.4**	4.5	6.3
Education			
<High School	**6.4**	4.8	7.9
HS or GED	**5.5**	4.5	6.5
Some High School	**4.6**	3.6	5.7
College Graduate	**3.6**	2.7	4.4
Annual Household Income			
<$15,000	**6.9**	5.3	8.5
$15,000-$24,999	**6.6**	5.2	8.1
$25,000-$34,999	**3.6**	2.4	4.8
$35,000-$49,999	**5.3**	3.7	7.0
$50,000+	**3.9**	2.8	5.1
Hypertension			
Race-ethnicity			
Black	**43.1**	40.6	45.7
White	**37.1**	35.5	38.8
Hispanic	**42.0**	30.5	53.4
Gender			
Women	**39.9**	38.2	41.6
Men	**38.6**	36.4	40.7

Condition	%	95% CI lower	95% CI upper
Education			
<High School	**45.1**	41.5	48.6
HS or GED	**43.3**	40.9	45.7
Some High School	**36.2**	33.7	38.6
College Graduate	**30.5**	28.1	32.9
Annual Household Income			
<$15,000	**49.2**	45.8	52.5
$15,000-$24,999	**43.5**	40.2	46.8
$25,000-$34,999	**44.3**	40.1	48.5
$35,000-$49,999	**36.0**	32.3	39.7
$50,000+	**30.8**	28.3	33.3
Ever Had a Stroke			
Race-ethnicity			
Black	**4.1**	3.3	4.9
White	**4.1**	3.5	4.8
Gender			
Women	**4.4**	3.7	5.1
Men	**4.2**	3.4	5.0
Education			
<High School	**6.8**	5.3	8.3
HS or GED	**4.5**	3.6	5.4
Some High School	**3.4**	2.5	4.2
College Graduate	**3.0**	2.2	3.8
Annual Household Income			
<$15,000	**6.6**	5.2	8.1
$15,000-$24,999	**5.7**	4.4	7.1
$25,000-$34,999	**4.4**	2.7	6.0
$35,000-$49,999	**2.2**	1.2	3.2
$50,000+	**2.3**	1.5	3.0
Myocardial Infarctions			
Race-ethnicity			
Black	**4.3**	3.3	5.2
White	**5.8**	5.1	6.6

Condition	%	95% CI lower	95% CI upper
Gender			
Women	**3.7**	3.1	4.3
Men	**7.3**	6.2	8.3
Education			
<High School	**8.4**	6.6	10.1
HS or GED	**5.9**	4.8	7.0
Some High School	**4.3**	3.3	5.2
College Graduate	**3.4**	2.5	4.3
Annual Household Income			
<$15,000	**7.7**	6.0	9.5
$15,000-$24,999	**7.1**	5.6	8.7
$25,000-$34,999	**4.2**	2.8	5.6
$35,000-$49,999	**6.8**	4.8	8.8
$50,000+	**3.1**	2.2	3.9
High Cholesterol			
Race-ethnicity			
Black	**38.2**	35.4	41.1
White	**44.7**	42.8	46.5
Hispanic	**39.8**	26.7	52.9
Gender			
Women	**43.0**	41.2	44.9
Men	**41.3**	38.9	43.8
Education			
<High School	**48.2**	44.1	52.4
HS or GED	**45.6**	42.9	48.3
Some High School	**40.4**	37.6	43.2
College Graduate	**34.9**	32.2	37.6
Annual Household Income			
<$15,000	**51.3**	47.4	55.2
$15,000-$24,999	**42.3**	38.8	45.8
$25,000-$34,999	**40.3**	35.9	44.7
$35,000-$49,999	**41.0**	36.8	45.2
$50,000+	**37.9**	35.1	40.8

Condition	%	95% CI lower	95% CI upper
Overweight Prevalence			
Race-ethnicity			
Black	**31.5**	28.8	34.2
White	**35.8**	33.9	37.8
Hispanic	**41.4**	26.7	56.0
Gender			
Women	**29.5**	27.6	31.3
Men	**39.3**	36.8	41.8
Education			
<High School	**33.2**	29.3	37.1
HS or GED	**34.5**	31.8	37.1
Some High School	**34.1**	31.2	37.1
College Graduate	**35.6**	32.7	38.5
Annual Household Income			
<$15,000	**29.3**	25.5	33.0
$15,000-$24,999	**33.0**	29.5	36.5
$25,000-$34,999	**35.0**	30.3	39.7
$35,000-$49,999	**38.9**	34.2	43.6
$50,000+	**38.0**	35.0	41.0
Obesity Prevalence			
Race-ethnicity			
Black	**43.2**	40.3	46.1
White	**30.2**	28.4	32.1
Hispanic	**21.5**	11.6	31.5
Gender			
Women	**37.3**	35.3	39.4
Men	**31.8**	29.4	34.2
Education			
<High School	**37.4**	33.3	41.5
HS or GED	**34.1**	31.4	36.7
Some High School	**35.6**	32.6	38.5
College Graduate	**30.6**	27.7	33.4

Condition	%	95% CI lower	95% CI upper
Annual Household Income			
<$15,000	**40.5**	36.4	44.6
$15,000-$24,999	**37.9**	34.2	41.6
$25,000-$34,999	**37.5**	32.8	42.3
$35,000-$49,999	**34.0**	29.4	38.5
+50,000+	**29.3**	26.5	32.1
Diabetes			
Race-ethnicity			
Black	**14.5**	12.8	16.1
White	**11.2**	10.2	12.2
Gender			
Women	**13.0**	11.8	14.2
Men	**12.0**	10.6	13.4
Education			
<High School	**18.6**	15.9	21.3
HS or GED	**13.0**	11.4	14.6
Some High School	**10.1**	8.6	11.6
College Graduate	**9.2**	7.7	10.7
Annual Household Income			
<$15,000	**17.7**	15.0	20.4
$15,000-$24,999	**13.2**	11.2	15.2
$25,000-$34,999	**12.5**	9.8	15.1
$35,000-$49,999	**11.8**	9.3	14.3
$50,000+	**8.6**	7.2	10.1
Currently Have Asthma			
Race-ethnicity			
Black	**9.3**	7.7	10.9
White	**7.6**	6.6	8.7
Gender			
Women	**10.0**	8.8	11.3
Men	**6.0**	4.9	7.2

Condition	%	95% CI lower	95% CI upper
Education			
<High School	**11.7**	9.1	14.2
HS or GED	**9.4**	7.8	11.0
Some High School	**6.3**	4.8	7.7
College Graduate	**5.3**	4.1	6.5
Annual Household Income			
<$15,000	**14.2**	11.3	17.0
$15,000-$24,999	**10.0**	8.0	12.1
$25,000-$34,999	**6.0**	3.6	8.3
$35,000-$49,999	**4.1**	2.4	5.9
$50,000+	**5.2**	3.9	6.5
Ever Had Asthma			
Race-ethnicity			
Black	**12.5**	10.7	14.3
White	**11.2**	9.9	12.5
Gender			
Women	**13.0**	11.6	14.4
Men	**10.2**	8.7	11.7
Education			
<High School	**15.4**	12.6	18.2
HS or GED	**12.7**	10.8	14.5
Some High School	**10.2**	8.3	12.1
College Graduate	**8.5**	7.0	10.1
Annual Household Income			
<$15,000	**18.2**	15.0	21.3
$15,000-$24,999	**13.5**	11.1	15.9
$25,000-$34,999	**10.1**	7.0	13.2
$35,000-$49,999	**7.7**	5.1	10.4
$50,000+	**8.3**	6.6	9.9
Current Childhood Asthma			
Race-ethnicity			
Black	**13.2**	10.5	16.0
White	**7.0**	5.1	8.8

Condition	%	95% CI lower	95% CI upper
Gender			
Girls	**7.6**	5.6	9.7
Boys	**11.9**	9.5	14.4
Exercised During Past Month			
Race-ethnicity			
Black	**65.6**	62.9	68.3
White	**71.7**	70.0	73.5
Hispanic	**48.9**	34.7	63.1
Gender			
Women	**66.2**	64.4	68.1
Men	**72.4**	70.1	74.7
Education			
<High School	**51.2**	47.1	55.4
HS or GED	**65.3**	62.7	67.9
Some High School	**76.9**	74.4	79.3
College Graduate	**82.0**	79.9	84.2
Annual Household Income			
<$15,000	**53.7**	49.5	57.8
$15,000-$24,999	**63.9**	60.4	67.4
$25,000-$34,999	**67.7**	63.1	72.3
$35,000-$49,999	**77.2**	73.5	80.9
$50,000+	**82.4**	80.3	84.6
Adults 65+ Receiving Influenza Shots			
Race-ethnicity			
Black	**46.4**	41.1	51.6
White	**67.6**	65.1	70.1
Gender			
Women	**62.0**	59.2	64.7
Men	**62.9**	59.0	66.8

Condition	%	95% CI lower	95% CI upper
Education			
<High School	**56.2**	51.3	61.2
HS or GED	**64.8**	61.0	68.5
Some High School	**63.0**	58.4	67.7
College Graduate	**67.4**	62.9	71.9
Annual Household Income			
<$15,000	**57.2**	51.4	63.0
$15,000-$24,999	**60.2**	55.4	65.0
$25,000-$34,999	**71.5**	65.7	77.3
$35,000-$49,999	**63.6**	56.1	71.0
$50,000+	**65.3**	60.1	70.6
Adults 65+ Receiving Pneumonia Vaccination			
Race-ethnicity			
Black	**47.9**	42.7	53.2
White	**71.9**	69.5	74.3
Gender			
Women	**67.6**	65.0	70.3
Men	**63.3**	59.4	67.3
Education			
<High School	**58.6**	53.6	63.6
HS or GED	**67.9**	64.1	71.8
Some High School	**71.2**	66.9	75.6
College Graduate	**66.0**	61.4	70.6
Annual Household Income			
<$15,000	**57.9**	51.9	63.9
$15,000-$24,999	**65.1**	60.4	69.9
$25,000-$34,999	**74.8**	69.3	80.2
$35,000-$49,999	**65.9**	58.7	73.2
$50,000+	**68.4**	63.1	73.7

Condition	%	95% CI lower	95% CI upper
Visits to Dentist for Any Reason			
Race-ethnicity			
Black	**48.7**	45.8	51.6
White	**59.7**	57.7	61.7
Hispanic	**39.3**	25.8	52.7
Gender			
Women	**57.8**	55.8	59.8
Men	**52.9**	50.3	55.5
Education			34.6
<High School	**30.7**	26.8	55.8
HS or GED	**52.9**	50.1	65.5
Some High School	**62.5**	59.5	76.9
College Graduate	**74.3**	71.7	
Annual Household Income			
<$15,000	**34.1**	30.0	38.2
$15,000-$24,999	**44.3**	40.5	48.0
$25,000-$34,999	**55.1**	50.2	60.0
$35,000-$49,999	**62.9**	58.2	67.6
$50,000+	**75.1**	72.4	77.8
Permanent Teeth Extractions			
Race-ethnicity			
Black	**65.5**	62.6	68.4
White	**54.5**	52.4	56.5
Hispanic	**48.2**	34.0	62.4
Gender			
Women	**59.5**	57.5	61.6
Men	**57.0**	54.3	59.6
Education			
<High School	**76.3**	72.3	80.2
HS or GED	**64.4**	61.5	67.3
Some High School	**51.7**	48.6	54.8
College Graduate	**39.9**	37.1	42.8

Condition	%	95% CI lower	upper
Annual Household Income			
<$15,000	**70.0**	65.9	74.1
$15,000-$24,999	**67.3**	63.5	71.1
$25,000-$34,999	**62.1**	57.1	67.1
$35,000-$49,999	**55.5**	50.5	60.5
$50,000+	**42.6**	39.6	45.5
Current Smokers			
Race-ethnicity			
Black	**22.3**	19.9	24.8
White	**24.7**	22.8	26.6
Hispanic	**26.7**	14.0	39.4
Gender			22.7
Women	**21.0**	19.2	29.7
Men	**27.3**	24.9	
Education			
<High School	**38.5**	34.3	42.7
HS or GED	**25.7**	23.1	28.3
Some High School	**21.6**	19.0	24.2
College Graduate	**9.2**	7.5	10.8
Annual Household Income			
<$15,000	**35.1**	31.0	39.2
$15,000-$24,999	**30.2**	26.6	33.8
$25,000-$34,999	**19.4**	15.8	23.1
$35,000-$49,999	**21.8**	17.3	26.2
$50,000+	**15.0**	12.7	17.4
Health Care Coverage			
Race-ethnicity			
Black	**69.8**	67.0	72.5
White	**82.3**	80.6	84.1
Hispanic	**69.4**	54.8	84.1
Gender			
Women	**78.9**	77.1	80.7
Men	**75.8**	73.3	78.2

	%	95% CI lower	95% CI upper
Education			
<High School	**65.9**	61.7	70.1
HS or GED	**74.1**	71.5	76.7
Some High School	**79.5**	76.8	82.1
College Graduate	**92.0**	90.4	93.6
Annual Household Income			
<$15,000	**57.2**	53.0	61.4
$15,000-$24,999	**67.1**	63.3	70.8
$25,000-$34,999	**80.2**	76.0	84.5
$35,000-$49,999	**87.3**	83.8	90.8
$50,000+	**94.3**	92.7	95.9
Age			
18-24	**70.1**	64.6	75.6
25-34	**63.3**	58.6	68.0
35-44	**74.4**	70.5	78.3
45-54	**76.5**	73.5	79.5
55-64	**79.1**	76.5	81.6
65+	**98.2**	97.5	98.8

References

1. U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020. Section IV. Advisory Committee findings and recommendations. Available at: http://www.healthypeople.gov/hp2020/advisory/PhaseI/sec4.htm#_Toc211942917. Accessed 1/6/10.

2. U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020. Section IV. Advisory Committee findings and recommendations. Available at: http://www.healthypeople.gov/hp2020/advisory/PhaseI/sec4.htm#_Toc211942917. Accessed 1/6/10.

3. U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020. Section IV. Advisory Committee findings and recommendations. Available at: http://www.healthypeople.gov/hp2020/advisory/PhaseI/sec4.htm#_Toc211942917. Accessed 1/6/10.

4. MMWR, 2013. State-Specific Healthy Life Expectancy at Age 65 Years—United States, 2007-2009. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6228a1.htm?s_cid=mm6228a1_

5. National Cancer Institute. SEER*Stat Tutorials: Calculating Age-adjusted Rates. Retrieved from http://seer.cancer.gov/seerstat/tutorials/aarates/definition.html

6. Dicker R, Coronado F, Koo D, Parrish R II, Principles of Epidemiology in Public Health Practice, 3rd edition. 2012. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention (CDC). Office of Workforce and Career Development. Atlanta, GA 303333.

7. U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020. Section IV. Advisory Committee findings and recommendations. Available at: http://www.healthypeople.gov/hp2020/advisory/PhaseI/sec4.htm#_Toc211942917. Accessed 11/30/13.

8. U.S. Department of Health and Human Services, Office of Minority Health. National Partnership for Action to End Health Disparities. The National Plan for Action Draft as of February 17, 2010. Chapter 1: Introduction. Available at: http://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?&lvl=2&lvlid=34

9. Dicker R, Coronado F, Koo D, Parrish R II, Principles of Epidemiology in Public Health Practice, 3rd edition. 2012. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention (CDC). Office of Workforce and Career Development. Atlanta, GA 303333.

10. Dicker R, Coronado F, Koo D, Parrish R II, Principles of Epidemiology in Public Health Practice, 3rd edition. 2012. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention (CDC). Office of Workforce and Career Development. Atlanta, GA 303333.

11. Dicker R, Coronado F, Koo D, Parrish R II, Principles of Epidemiology in Public Health Practice, 3rd edition. 2012. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention (CDC). Office of Workforce and Career Development. Atlanta, GA 303333.

12. Dicker R, Coronado F, Koo D, Parrish R II, Principles of Epidemiology in Public Health Practice, 3rd edition. 2012. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention (CDC). Office of Workforce and Career Development. Atlanta, GA 303333.

13. World Health Organization, 2013. Social Determinants of Health. Retrieved from http://www.who.int/social_determinants/en/

14. U.S. Department of Commerce, 2013. U.S. Census Bureau Projections Show a Slower Growing, Older, More Diverse Nation a Half Century from Now. Retrieved from https://www.census.gov/newsroom/releases/archives/population/cb12-243.html

15. U.S. Department of Commerce. Population Facts, 2012. Retrieved from http://quickfacts.census.gov/qfd/states/28000.html

16. Brooks J, 1998. Clinton Announces Racial and Ethnic Health Disparities Initiative. Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/Clinton%20Announces%20Racial%20and%20Ethnic%20Health%20Disparities%20Initiative.pdf.

17. World Health Organization, 2013. Social Determinants of Health. Retrieved from http://www.who.int/social_determinants/

Any inquiries, please contact Office of Health Disparity Elimination
715 S. Pear Orchard Road
Ridgeland, MS 39157
P.O.Box 1700
(601)206-1542

MISSISSIPPI STATE DEPARTMENT OF HEALTH