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# EXECUTIVE SUMMARY

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Health is defined as the mental and physical well being that allows one to develop to the fullest potential. Health is a precious resource that also allows for the development of meaningful relationships in families and a full, productive life in our communities. Over the last 100 years the nation's health has greatly improved. However, all Americans have not realized these improvements. There are significant and often dramatic differences in health status by both region and by race and Hispanic origin.

Given the changes in the makeup of the US and state populations, it is imperative that differences in health status and healthcare by race and Hispanic origin be fully examined and improved. Health and healthcare disparities are not only unjust and unacceptable, but also a main focus of national health policy. These inequalities have human, economic, social and developmental costs that impact all residents of the nation now and will continue to do so in the future.

The purpose of the Arkansas Racial and Ethnic Health Disparity Study is to describe the differences in health outcomes by race and ethnicity in Arkansas and the factors that contribute to the observed health and healthcare disparities.

The study was done in two phases. **In phase I**, multiple data sources were identified that contain state-level information about the demographics, socioeconomic status, health behavior status, and the health outcomes of all available racial and ethnic groups. These data, as well as information on healthcare utilization and workforce, were then analyzed and

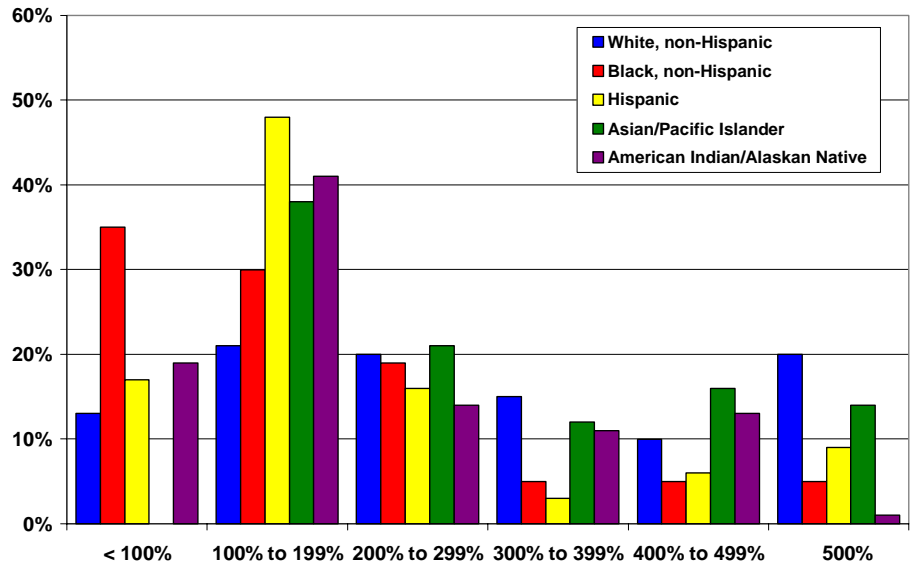
summarized. **In phase II**, a series of 15 focus groups were conducted across the state in minority and majority communities to help provide insight into the factors that contribute to health and healthcare disparities.

## Phase I Findings:

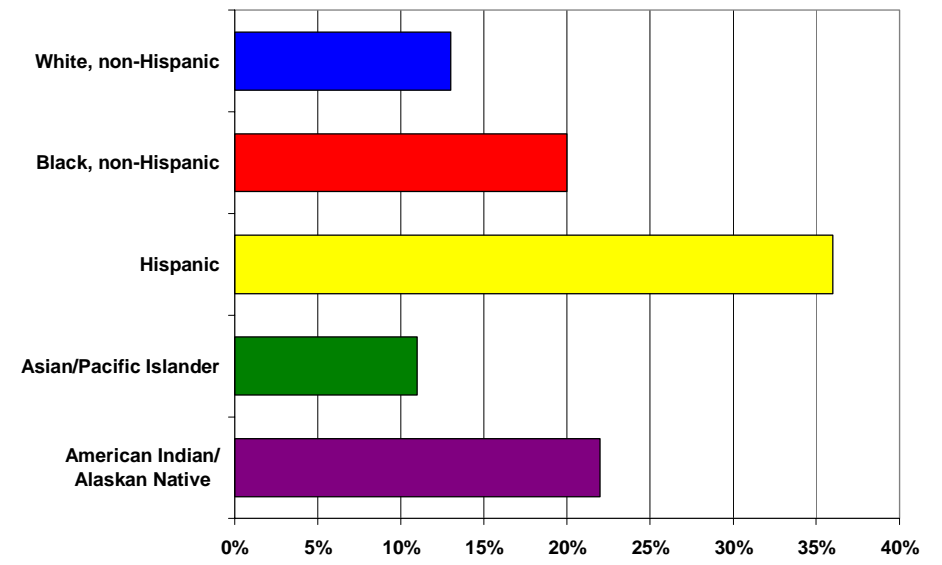
Arkansas has become more diverse over the last ten years. This is largely due to the growth of the Hispanic (greater than 300% growth from 1990-2000) and Asian populations. In fact, the rate of growth for Hispanics is among the fastest in the nation. African Americans make up a larger proportion of people in the state compared to the US and are located mainly in the southeastern half of the state. Asian and Latino populations are spread throughout the state but concentrated along the western border and in the central region. In general, these diverse populations are younger than the White population in the state.

Social factors such as income, employment, health insurance status and English speaking ability have an impact on health. In Arkansas as in the US, African Americans and Hispanics are more likely to live in poverty, be unemployed, have lower educational attainment and lack health insurance. Hispanics are by far the group most likely to be without health insurance. Additionally, significant proportions of Asians and Hispanics have limited English-speaking ability. The inability of a healthcare provider to communicate with a consumer has a potentially devastating impact on healthcare access and the health outcomes that result from poor access.

**Federal Poverty Levels by Race and Hispanic Origin, 1999-2001**

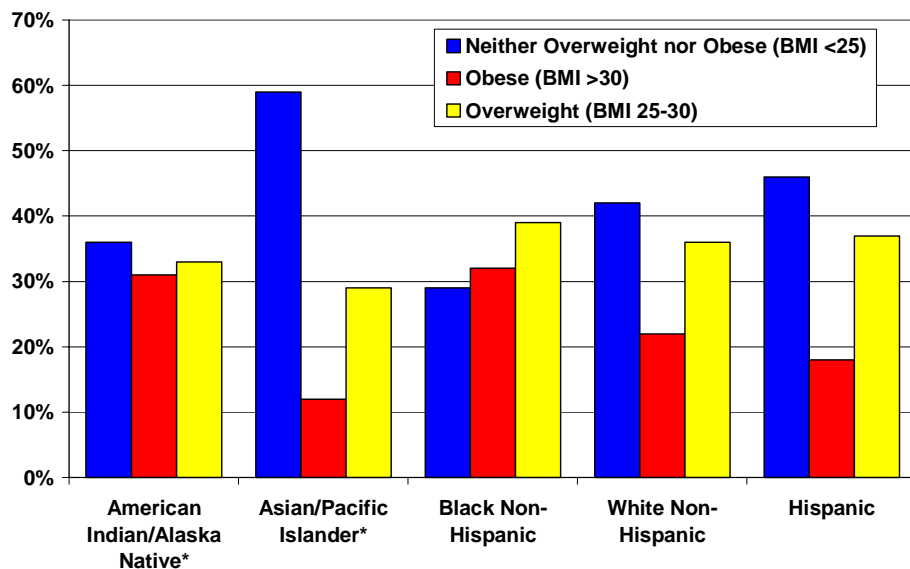


**Lack of Health Insurance by Race and Hispanic Origin, 1999-2001**

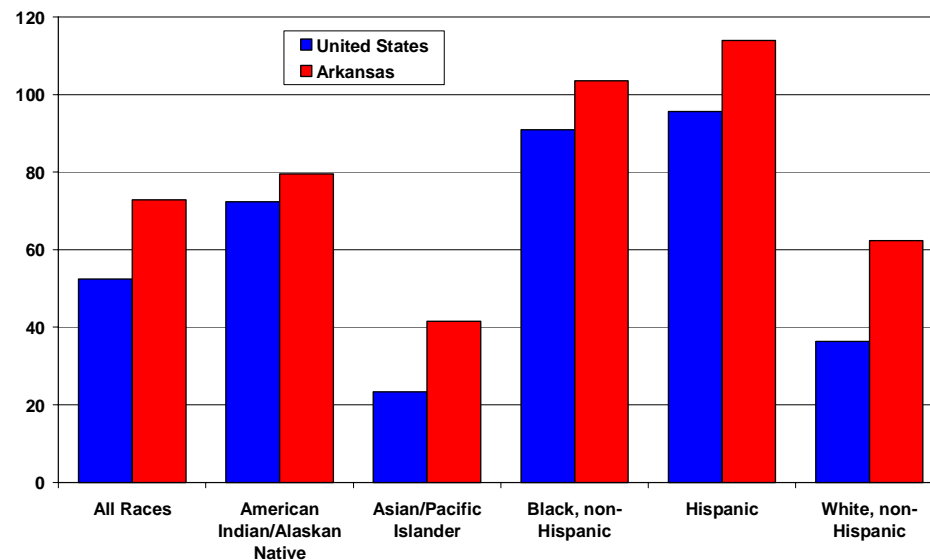


Health behaviors, such as smoking, physical inactivity, eating habits and teen pregnancy have a major impact on individual and population health. Although most Arkansans rate their health as excellent, very good or good, many have chronic diseases and few engage in activities such as exercise and the consumption of fruits and vegetables that promote health. Furthermore, nearly 3 of 4 African Americans and over half of Whites and Hispanics report they are overweight or obese. Against a backdrop of teen birth rates that are higher than national figures, Hispanic and African American teens have much higher birth rates than their White peers.

### Overweight or Obese, 1999–2001

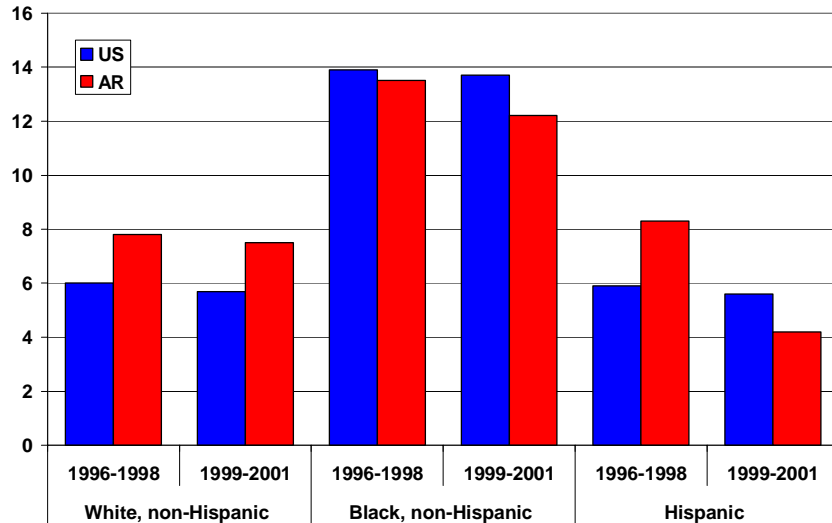


### Birth Rate per 1,000 Females Aged 15–19 Years, 1996–1998

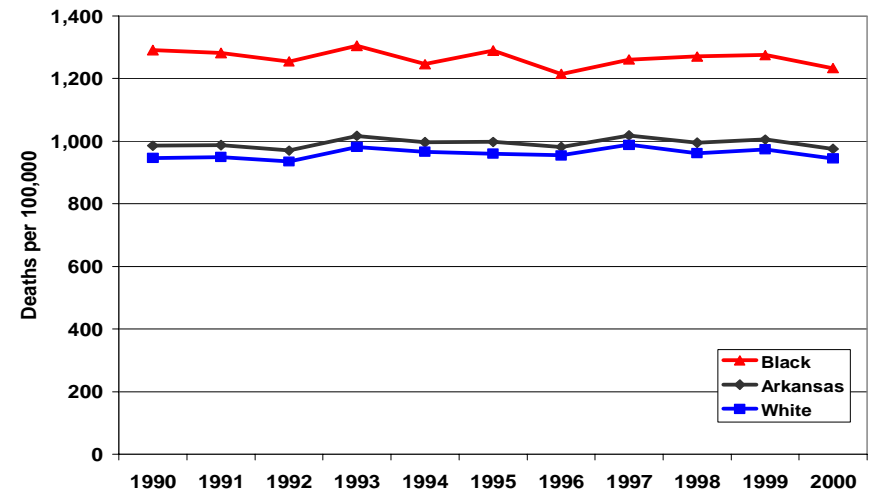


Arkansans die at a higher rate than other Americans. The state mortality rate for 2001 is 11% higher than the national rate. Minority mortality data is limited to the African American population. From 1990-2000 a significant difference in mortality between African Americans and Whites is persistent. Overall, the mortality rate for African Americans is 31% higher than for Whites. In terms of infant mortality, African American infants have a 63% higher mortality rate than White infants.

**Infant Mortality Rates per 1,000 Live Births by Race and Hispanic Origin**



**Arkansas All Cause Mortality by Race 1990-2000**



For specific diseases, there is widespread disparity in mortality between African Americans and Whites (Table 1). Most of these differences were statistically significant, that is unlikely to occur by chance. Only for mortality from lung cancer and motor vehicle accidents was there not a statistically significant difference between Whites and African Americans. Worse still, for mortality from diseases such as colorectal cancer, breast cancer, prostate cancer, diabetes and HIV/AIDS the disparities are increasing.

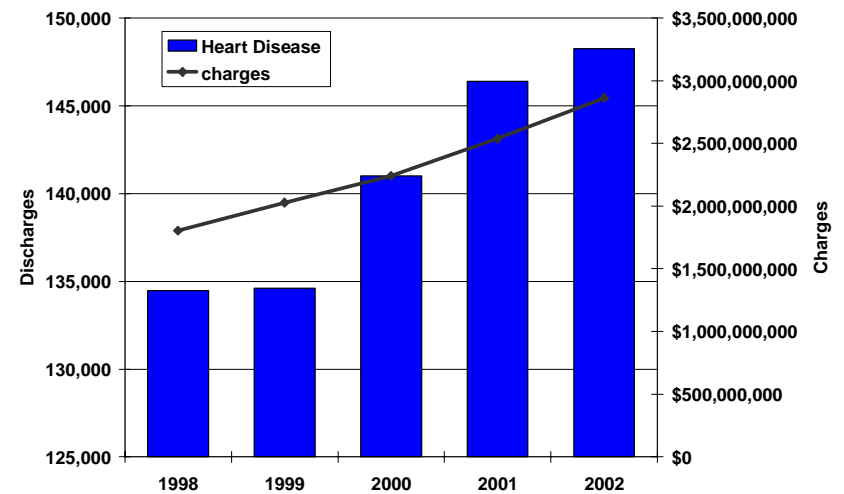
**TABLE 1. Arkansas Racial Health Disparity**

	Black/White Disparity
<b>Infant Mortality</b>	+63%
<b>Heart Disease</b>	+25%
<b>Ischemic heart disease</b>	+21%
<b>Lung Cancer</b>	+1%
<b>Colorectal Cancer</b>	+46%
<b>Breast Cancer</b>	+43%
<b>Cervical Cancer</b>	+136%
<b>Prostate Cancer</b>	+143%
<b>Stroke</b>	+45%
<b>All Accidents</b>	+19%
<b>Motor Vehicle Accidents</b>	+2%
<b>Diabetes</b>	+152%
<b>Asthma</b>	+194%
<b>HIV/AIDS</b>	+242%
<b>Homicide</b>	+490%
<b>All Cause Mortality</b>	+31%

The economic impact of diseases that cause the most death in Arkansas, such as heart disease, cancer and stroke, cannot be overstated. For heart disease in general, and for the more specific ischemic heart disease, hospital discharges increased modestly from 1998-2002 but total charges grew by nearly 33% to over \$3 billion. It is clear from these data that even minor improvements in disease burden, treatment and prevention would have a significant positive economic impact. Hospital charges for unintentional injuries, asthma and all cancers, all conditions that

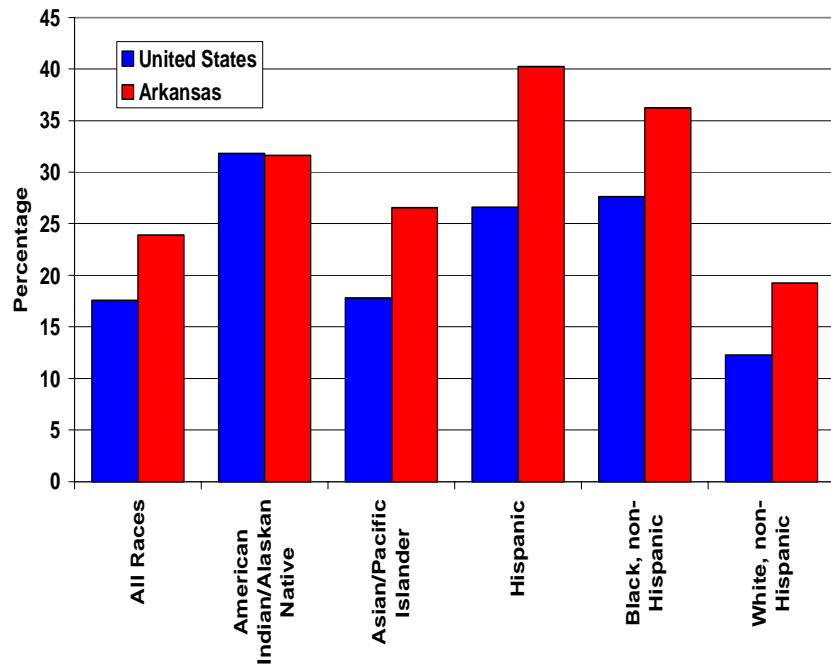
disproportionately kill African Americans, are rising rapidly as well.

**Hospital Cases: Discharges and Charges**



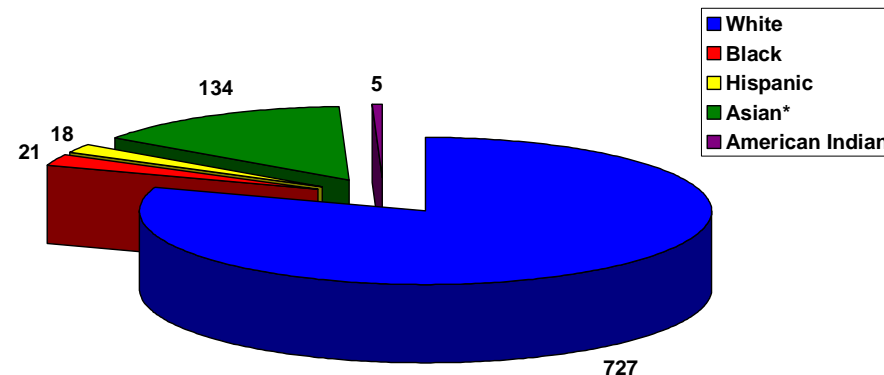
The use of preventive measures such as immunizations and screening tests such as mammograms is an important factor in reducing disease burden. Most Arkansans do not get an annual flu vaccine. Hispanic and African American women are less likely than White women to have a mammogram or receive prenatal care in the first trimester of pregnancy. 1 of 4 Whites and 1 of 3 African Americans have never had blood cholesterol checked.

**Women Not Receiving First Trimester Prenatal Care, 1996–1998**

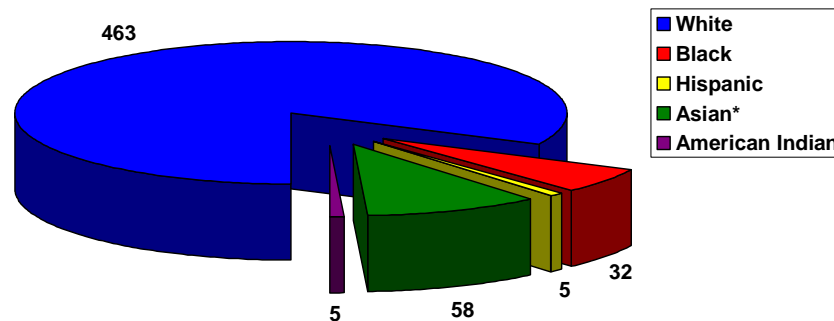


Professionals that make up the healthcare workforce are more plentiful in number and in ratio to the population in Central and Northwest Arkansas. The Southeast Public Health Region has the least healthcare professionals, across all professions except physicians, per population. Given the increasing diversity of the state’s population, an examination of trainees and faculty at the state’s major health professions institution reveals under-representation of minorities across nearly all disciplines.

**UAMS College of Medicine Full-Time Faculty with Primary Appointments 2002-2003**



**UAMS College of Medicine Student Enrollment 2002-2003**



*\*Asians are not considered to be under-represented minorities in Medicine by the American Association of Medical Colleges.*

## Phase II Findings:

Group interviews were held in 15 communities around the state to give minority and majority people an opportunity to share their experiences in the search for good health. 149 Arkansans participated in focus groups that were held in each public health region. Group members were of the same race and Latino groups were conducted in Spanish. The conversations from these groups enrich the data on health outcomes, risk factors and utilization and complete the picture of health and healthcare disparities. The themes that emerged from the focus group discussions pointed to a healthcare system that is far from perfect for any individual, but worse so for an individual that is a minority, poor, uninsured, elderly or speaks a language other than English. On top of that, troubling stories were told of how minority individuals face additional obstacles due to skin color, language or preconceptions of caregivers about a minority person.

The following themes emerged from the group interviews:

- **In many minority communities the thermostat or frame of reference for health is set on “sick” as participants have come to view health only in terms of ability to work or carry on basic activities. Many accept chronic illnesses as part of life.**
- **Several socioeconomic factors, most importantly poverty, compete and often overshadow individual and community health.**
- “I was worried, but then I said I'm not going to worry no more. I said because God is going to take care of me.

I said he done brought me this far. For Christmas, we had a good Christmas. We had food. We had roof over our heads, and my son said, ‘Well, mama you don't have to get me nothing’. And that was the most important thing to hear him say that. He said, ‘You don't have to get me anything. The only thing I need from you is love’. When he said that everything was nice.”

- **Personal negative experiences with healthcare providers or institutions and a sense that parts of the system are only motivated by profit have led to a building mistrust and suspicion of the healthcare system.** In one county, there was a clear difference between what a Caucasian and an African American participant thought of the local hospital:
- Caucasian: “And we've got to support it. And the truth of the matter is none of us are trusting doctors all that much. I'm not sure our trust is any higher from Little Rock than here. What I'm suggesting is that we have a false sense of thinking things are better in Little Rock. And so I think we need a PR campaign for our hospital, some stories of our successes out there.”
- African American: “Don't take my dog down there... I said I don't take my dog. We don't know where white folks be going. We don't know what they do, because I haven't been in (local) hospital since 1957. They sewed my head up with some grass. You know, if I had to talk about that incident versus the incidents that I hear about sometimes on a weekly or monthly basis, they just don't have a very good record for caring for Black people I know.”
- **There are many barriers such as poverty, lack of insurance, fear, inability to speak English and a lack of cultural awareness by providers that**

**impede the individual's access to quality healthcare and good health.**

- “Yo creo también es como es uno tratado, como lo tratan a uno cuando va a su doctor. A veces...he llevado personas al doctor y entonces, si no hablan ingles...yo pienso que hay discriminación porque a veces no les hacen las mismas preguntas que a alguien que habla ingles le hacen. (I think it's also how you are treated, how you are treated when you go to your doctor. Sometimes...I've taken people to the doctor and then, if they don't speak English...I think there's discrimination because sometimes they are not asked the same questions that are asked of someone who speaks English.)”
- **The function and dysfunction of the physician-patient relationship is a major factor in driving the behavior of the healthcare consumer.**
- “Do more examinations. What most of us are saying is that as patients they are not being examined. They are asking them by word of mouth, “What is your problem? So you say this is your problem, then I'm going to write you this prescription for what you say is your problem.” And it shouldn't be that way. They should be diagnosed. I should be diagnosed if I go there and say I'm sick.”
- **Minority participants have experienced inequalities in the healthcare system and at times were able to identify that poor treatment was connected to their race or ethnicity. However, race or ethnicity was often difficult to separate from other socioeconomic factors that could impact poor treatment.**
- “Same with my kid, but the only thing she doesn't want to say, this other person, her child was white. I feel like that because there was such an epidemic going around

with this flu, my child was diagnosed saying, ‘Oh, he's got the same thing. He's got the (town) crud,’ and you get cough medicine. A lady I work with took her daughter to the same doctor the same day; she had the flu. She gets an antibiotic. So my concern is when there is an epidemic or something like that with the flu, will the African Americans, will we be left out, you know? Will the medicine be given to the other people and we'll just be left out? And just like with the flu, will we be the last person told? Will we not be served because the other people are getting that first and where are blacks concerned? I mean if we don't stop it now it's going to get on to something worse later on. I think something needs to be done now.”

- **Focus group members often made recommendations on how to improve the problems that were discussed.**
- “Yo nomás quiero afinar un punto aquí...yo no creo que nosotros los hispanos estamos esperando que venga el gobierno a traernos programas especiales porque somos Mexicanos, no creo que nadie estamos pidiendo eso. Nosotros solamente pedimos que ya están estos programas llevando, siendo llevado a cabo en otras partes, que se presenten también a nosotros. Yo creo que si pagamos impuestos tenemos los mismos derechos y yo no digo que tengan esto porque son Mexicanos, no, nosotros también pagamos impuestos, somos ciudadanos la mayoría, ya aquí o residentes, y estamos pagando impuestos. Y si ya estos programas están llevando a cabo en otras partes que también se ofrezcan a nosotros. (I just want to clarify a point here...I don't think that as Hispanics we're waiting for the government to bring us special programs because were Mexican, I don't think any of us are asking for that. All we are asking for is the

programs that are already being done in other places that they also are made available to us. I think that if we are paying taxes we have the same rights and I'm not saying they should have this because they are Mexican, no; we also pay taxes, the majority of us are citizens or residents and paying taxes. And if these programs are being carried out in other places they should also be offered to us.)"

### **Recommendations:**

- As this study documents, there are large disparities in death rates and disease burden between minority and non-minority populations. These disparities in death rates have persisted and for diseases such as colorectal cancer, breast cancer, prostate cancer and diabetes seem to be worsening. Public and health policy decisions must be evaluated in light of these disparities. Furthermore, those decisions must be based on accurate data for specific populations.
  - All health, healthcare quality and mortality data must be consistently recorded and reported by race and Hispanic origin.
  - Minority populations must be over-sampled in health surveys to have sufficient numbers of responses on which to base conclusions, and survey tools needs to be administered in languages other than English.
  - The Arkansas Tobacco Settlement Commission (ATSC) must be a check and balance body to ensure all new and

expanded programs that utilize tobacco funds accurately record and report the impact of the programs on the populations that experience the disparities documented in this study.

- Consideration should be given to a health information survey done with minority Arkansans to assess health inequalities on a large scale.
- Focus group participants sought providers, often of their own race, cultural backgrounds or spoken language, because they felt better cared for and better understood. Other participants simply wanted a provider, regardless of race or ethnicity, who would listen to them and make an effort to understand their needs. However, given the low percentage of minority trainees and faculty documented in this study, it is essential to improve not only the diversity of students and faculty but also the cultural competence of all trainees and faculty currently in medical, nursing, pharmacy, allied health and public health schools.
  - Recruitment and retention of minority faculty and students must be increased.
  - Cultural competency must be integrated throughout the health professions curriculum.
- Healthcare institutions play a clear role in the treatment of disease on the individual level, but as the focus groups illustrated, populations with

poor health outcomes and negative experiences with healthcare systems have lost trust in the very institutions that are in their community. This loss of trust impacts the behavior of consumers and would delay treatment at best, or hasten death at worst. Hospitals, provider groups and public health clinics cannot eliminate health disparities alone, but are an important element of service improvement to all populations, specifically those experiencing inequalities in care.

- Formal and informal minority leaders must be included on hospital boards, planning committees and other decision-making bodies at the local and state levels in order to restore trust in healthcare providers and institutions.
- Institutions must be more aware of the diverse cultures, languages and needs of their patient population. Institutions must then move from improved awareness to increased responsiveness to the particular needs of the populations they serve, including those subject to the disparities outlined in this study.
- The workforce data show that Arkansas has a lower density of physicians than the national average and that the fewest healthcare providers in number and proportion are frequently in the Southeast and Southwest public health regions. The African American population and some

Hispanic communities are more concentrated in these regions. Healthcare consumers already disadvantaged by low provider density spoke in the focus groups of a higher value placed on positive relationships with their healthcare providers. Indeed, what outcome can be expected when a physician spends less than five minutes with a patient from a different culture about whom the physician knows little, if anything? Stories told about healthy provider-patient relationships often were based on the personal concern shown by the provider. This was even more helpful when the provider was of a different racial or ethnic background and did not speak the primary language of the consumer. Therefore, as the current healthcare workforce understands more about the communities they serve, these relationships will improve.

- The current healthcare workforce must improve its cultural competence.
- The cultural and linguistic appropriateness of health services must be increased.
- The health disparities documented in this study cannot be solved by one agency, institution, provider or community working alone. However, communities are a natural avenue for engagement around racism and discrimination experienced in the healthcare system. Additionally, discussing healthcare access and quality issues, engaging in risk factor education and targeted, population-based interventions to address particular problems identified in the

community can be done. Mention was made in many focus groups for the need to know that healthcare providers and systems care about the health of minority residents. Effort must be made to include formal and informal minority leaders in this process as well as on hospital boards, planning committees, quorum courts, and other decision-making bodies at the local, state and national levels in order to restore trust in healthcare providers and institutions. Counties with the highest age-adjusted all-cause mortality rates, for any racial or ethnic group (Phillips, Mississippi and Crittenden, for example), would be a natural place to begin this work, with special attention paid to diseases for which large disparities exist between Whites and African

Americans (HIV/AIDS, Diabetes, Prostate Cancer, Stroke, for example).

- In order to improve health, racism must be evaluated as an element of healthcare inequality.
- Local communities must identify problems with healthcare access and quality and formulate solutions.
- Local communities and consumers must identify problematic risk factors and develop strategies for reducing risky behaviors that fit their community.