

From the Executive Director

Greetings from the Arkansas Minority Health Commission,

The goal of the Arkansas Minority Health Commission (AMHC) is to be a catalyst in bridging the gap in the health status of the minority population and that of the majority population in Arkansas. To achieve this goal, the commission focuses on addressing existing disparities in minority communities, educating communities on healthier lifestyles, promoting awareness of services and accessibility within our current health care system. The Commission is also charged with:

- Studying issues relating to the delivery and access of health services;
- Identifying gaps in health delivery systems; and
- Making recommendations to relevant agencies and the General Assembly for improving health and health care delivery in Arkansas

I am pleased to present to you the *Arkansas Racial and Ethnic Health Disparity Study I: a minority health update*. This is the first statewide telephone survey addressing minority health issues in Arkansas. It also contains the largest voice from the Hispanic community in Arkansas. This product continues the efforts of AMHC to increase awareness for health disparities in general and to inform the development of intervention strategies to decrease hypertension, strokes and other disorders that disproportionately impact minorities as directed by the 2001 Initiated Act 1. We hope this work will not only inform you about racial and ethnic health disparities but also move you to join us as we seek to improve the health of minority Arkansans.

Sincerely,

Idonia Trotter, JD, MPS
Executive Director,
Arkansas Minority Health Commission

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Arkansas Department of Health

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Arkansas Department of Health

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Executive Summary

Race and race relations affect all segments of society including health and health care. The election of the first African American President marks great progress but exists in a society with marked disparities in areas such as wealth, income, education, incarceration, housing and health care. There is a large body of research that shows that minorities have less access to the health care system and when they do gain access they receive lower quality health care. This translates into unhealthy communities and increased human and economic costs for all. The US in general and Arkansas in particular have persistent racial and ethnic health disparities across most diseases. There are a growing number of activities in the state and the nation to improve health, most of which are disease specific and few focus on disparities. Efforts that do not specifically target communities with disproportionate shares of health disparities and the health care system are unlikely to have full impact in minority communities.

The 2009 Arkansas Racial and Ethnic Health Disparity Study describes the current state of health disparities and follows the first study report produced by the Arkansas Minority Health Commission (AMHC) in 2004. It aims to increase awareness and further understand disparities in the state of Arkansas in order to inform the development of comprehensive strategies to improve health across the state.

The specific goals of this study were:

- 1.** To develop methodology to over-sample minority communities in order to obtain more accurate surveillance data on which to base health policy decisions
- 2.** To quantitatively assess the perceptions of health care quality by race and ethnicity
- 3.** To assess additional factors in improving health in communities of color
- 4.** To inform future interventions in Arkansas that aim to eliminate racial and ethnic health disparities in the Black and Hispanic communities and via the interface between those communities and the health care system

The following are some key findings from the 2009 survey:

The 2004 study highlighted the challenging social context for Arkansas, particularly for minority Arkansans, and described the negative impacts of social determinants on the overall health of the individual and community. Minorities tend to have less educational attainment, lower household incomes and are more likely to be disabled. A quality health care system should be able to respond to the needs of the individual, prevent disease and promote health in the community, while taking social determinants into account. The survey conducted for the 2009 Study further explored the interface between Arkansans and the health care system. The survey targeted a large number of minority residents and revealed that:

- 79-82% of all groups characterized racial relations in their county as very good or somewhat good
- More than 60% of Arkansans felt that different racial and ethnic groups have the same amount of health problems
- Most thought disparities were caused by dietary factors and economic issues
- Nearly 1 of 4 respondents said their health was fair or poor
- More than 40 % of survey respondents had a current health problem; however, only 16% of Hispanics reported a current problem
- Rural and urban Blacks and particularly Hispanics had the highest uninsured rates of 22%, 25% and 52%, respectively
- Hispanic respondents were the group least likely to have health insurance; half are without a regular health care provider and half report that no one of their ethnicity is on staff where they regularly go for health care
- Minority and rural populations have little to no choice in where they go for health care
- There is a lack of racial and ethnic diversity in doctors and health care staff
- Although nearly 70% of Hispanic respondents needed an interpreter to help them speak with a health care provider, less than 30% were provided a professional interpreter and more than 40% used a friend or relative as their interpreter
- While more than 80% of people are satisfied or somewhat satisfied with their health care and have confidence in doctors and medications, more minorities state that people like themselves are treated less fairly, specifically, 40% of urban blacks, 29% of rural blacks and 25% of Hispanics
- 20% of Hispanic respondents have been the victim of discrimination while getting health care
- 15-16% of blacks reported discrimination while getting health care
- When asked to describe differential or disrespectful treatment due to race or ethnicity, respondents reported inferior treatment, negative attitudes of health care providers, lack of money, denial of care or priority given to other patients

The initial findings of the survey described in this report are timely, given the current environment on health care reform in the country. Although this initial analysis shows that survey respondents felt positively about race relations and a majority of each racial or ethnic group felt all groups had the same amount of health problems, troubling issues emerge from the responses to this survey. While health care reform may lead to a greater number of Arkansans with health insurance, responses to this survey by minority Arkansans indicate that health insurance alone will not be sufficient to address significant system level issues.

In order to improve the health of minority Arkansans the following recommendations emerge from the initial findings of this survey:

- **Increase awareness about racial and ethnic health disparities.** Despite the large amount of research and community efforts to decrease disparities, a significant portion of Arkansans believe that Hispanics, Blacks and Whites have the same amount of health problems. Communities and policy makers must be broadly informed about the problem: the presence and effects of racial and ethnic health disparities. More importantly, we must understand the factors that contribute to disparities in Arkansas in order to find effective solutions.
- **Improve health care access and choice.** While health care reform is discussed throughout the country and may improve access for many, access for the most disadvantaged in Arkansas requires added attention. Minorities are the most likely Arkansans to be uninsured and the least likely to have choice in where they receive medical services. Access to quality health care and choice is critical to improving health in minority communities.
- **Address disparities as a part of quality improvement.** Large portions of minorities perceive unequal treatment within the health care system. Research has documented this fact across many diseases and areas regardless of payer status. Health care quality measures must be examined by race and ethnicity to determine if quality care is received equally by all populations. As disparities are identified, they can be addressed through both targeted and general quality improvement efforts.
- **Improve cultural competency and diversify the healthcare workforce.** A culturally competent health care system and workforce is one that is capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency. The barriers to quality care for minorities identified in this survey included a lack of interpreter services and a lack of diversity in Arkansas' health care workforce. Because most respondents to this survey were not treated by a medical provider of their race or ethnicity, knowledge of cultural factors impacting health and the standards of care in treating diverse patients must be understood by all providers, including support staff in clinics and hospitals.

The 2009 Racial and Ethnic Health Disparity Study is the first statewide telephone survey to examine racial and ethnic health disparities. Minority populations were successfully sampled to provide the most detailed picture of minorities' interaction with the health care system in the state. While this report focuses on the initial findings of key areas in the survey, analysis is ongoing that will lead to more specific research. This process and information will be important as we seek to find ways to improve the health care system for all Arkansans. In conclusion, the 2009 Racial and Ethnic Health Disparity Study will inform AMHC's work and collaborations with organizations and communities to reach our ultimate goal of improved health for all Arkansans.

Introduction

As Arkansas continues to address health improvement, the persistent racial and ethnic health disparities that plague our communities deserve particular attention. Health disparities are defined as differences in the presence of disease, access to care, quality care and/or health outcomes. The 2001 report Crossing the Quality Chasm by the Institute of Medicine identified qualities that constitute a desirable health care system: a system that is safe, effective, patient centered, timely, efficient and equitable. Current research has shown that while 16.2% of the gross domestic product (GDP) is spent on health care, the U.S. health care delivery system does not provide consistent, high-quality medical care to all people. Indeed, between the health care that we now have and the health care that we could have lies not just a gap, but a chasm. (1) Racial and ethnic minorities fall into this chasm. A September 2009 study commissioned by the Joint Center for Political and Economic Studies and carried out by leading researchers from Johns Hopkins University and the University of Maryland estimated the economic burden of health disparities for minorities in the United States using three measures: (1) direct medical costs of health inequalities, (2) indirect costs of health inequalities, and (3) costs of premature death. The study estimates that eliminating health disparities for minorities would have reduced direct medical care expenditures by \$229.4 billion for the years 2003-2006 in the United States. The diversity of Arkansas and the nation has continued to flourish since the first Arkansas Racial and Ethnic Health Disparity study report in 2004. Therefore, health disparities and quality improvement efforts must be specifically addressed if a healthy, economically viable state and nation are to be achieved.

Table 1: Age Adjusted Mortality in Arkansas by Race and Ethnicity 1990-2007*

	Total	Black	White	BW Disparity	Hispanic	HW Disparity
All cause	953.4	1202.5	922.7	1.30	335.5	0.36
Infant Mortality*	8.9	13.8	7.6	1.82	6.6	0.87
HIV	3.8	11.1	2.6	4.27	2.3	0.88
All cancer	212.8	262.1	207.3	1.26	65.8	0.32
Colorectal Cancer	20.9	29.6	19.8	1.49	6.6	0.33
Lung Cancer	68.7	69	68.7	1.00	15.4	0.22
Diabetes	24.1	51.2	20.7	2.47	12.3	0.59
Ischemic Heart Disease	196.9	240	192.4	1.25	69.8	0.36
Cerebrovascular Disease	76.4	107.9	72.7	1.48	19.6	0.27
Suicide	13.5	6.2	14.9	0.42	4.4	0.30
Homicide	9.4	30.3	5.3	5.72	5.7	1.08
Asthma	1.8	4.1	1.5	2.73	1.4	0.93
MVA	24.7	24.2	25.2	0.96	16.6	0.66
Breast Cancer	26	35.6	24.7	1.44	8.1	0.33
Cervical cancer	3.6	7.1	3.2	2.22	1.6	0.50
Prostate Cancer	33.6	74	28.9	2.56	9.6	0.33

Arkansas Department of Health

Differences in health outcomes between minorities and non-minorities have been documented over time. The most striking differences are seen in the higher death rate among minorities. The disparity is calculated by dividing the respective age-adjusted mortality rates. If the quotient is 1, the mortality rate is the same. If the quotient is less than or greater than 1 the mortality rate is lower or higher, respectively. When examining mortality data from 1990-2007, Blacks have an overall death rate that is 30% higher than Whites as shown in Table 1. The causes of death with the highest disparity include HIV/AIDS, diabetes and stroke (cerebrovascular disease). The mortality rates for Hispanics are lower than those for Whites for most of the conditions listed and may reflect the younger age of the Hispanic population in Arkansas, a lower chronic disease burden, smaller numbers of deaths or inaccurate data. Over this time period, there were less than 1200 deaths reported for Hispanics, an average of less than 100 per year. Additionally, there is little information on other minority populations, specifically Asians and American Indians.

These data are the end result of the root causes of health disparities that exert influence through the lifespan of individuals and communities. The data reflect a complex interaction of genetic, environmental, social, behavioral, health care access and healthcare system factors that vary by population, geography and culture. The end result is that all Arkansans have poorer health and in many communities, there exists more disability, disease, early death and lower life expectancy.

The purpose of this update of the Arkansas Racial and Ethnic Health Disparity Study is fourfold:

1. To develop methodology to over-sample minority communities in order to obtain more accurate surveillance data on which to base health policy decisions
2. To quantitatively assess the perceptions of health care quality by race and ethnicity
3. To assess additional factors important in improving health in communities of color
4. To inform future interventions in Arkansas that aim to eliminate racial and ethnic health disparities in the Black and Hispanic communities and via the interface between those communities and the health care system

Progress

Since the first Arkansas Racial and Ethnic Health Disparity Study Report in 2004, several activities and programs have been started to improve the health of Arkansans in general, and, in some cases, to specifically target minority health and health disparities. The following examples illustrate these activities and are not intended to be an exhaustive list.

The Arkansas Minority Health Commission (AMHC) has conducted or partnered in additional research activities since 2004. These include a Childhood Hypertension Study in two minority-heavy school districts, the Marianna Examination Survey on Hypertension (MESH), the Arkansas Cardiovascular Health Examination Survey (ARCHES) and the survey described in detail in this update.

The Arkansas Department of Health (ADH) has made significant improvements to data collection efforts in the areas of risk factor surveillance and hospital discharge so that reliability of data in regard to minority populations has improved. The ADH also publishes periodic reports on racial and ethnic health disparities, comparing state data to Healthy People 2010 objectives (2) (3).

In the area of infant mortality, among the starkest examples of health disparity in Arkansas, the ADH has convened a working group to identify best practices to impact this issue and recommend action steps that can be taken in the state.

At the UAMS Fay W. Boozman College of Public Health, the Arkansas Center for Health Disparities, an exploratory research center of excellence funded by the National Institutes of Health/National Center on Minority Health and Health Disparities, was established in 2007 and is engaged in several research projects around the state focused on minority communities. In 2006, Arkansas Children's Hospital convened a group of stakeholders to begin the development of a strategic plan to address child health in the state. Now known as the Natural Wonders Partnership Council, the group includes over 20 organizational partners, is co-chaired by First Lady Ginger Beebe and has issued two reports on child health status.(4)The Council is currently working on minority community engagement, delivery of dental services and dissemination of a health literacy curriculum. Lastly, two notable policy interventions must be mentioned: In order to begin to address workforce diversity, the 87th General Assembly of 2009 passed Act 1489 of 2009 and Act 1490 of 2009 that requires healthcare workforce demographic data collection and minority representation on health boards and commissions. Act 1374 of 2009 creates a colorectal screening program for underserved communities. The latter piece of legislation was first passed in a pilot project format during the 86th General Assembly of 2005.

Finally, in 2004 the Behavioral Risk Factor Surveillance System (BRFSS) telephone survey piloted a set of questions related to health disparities. One question asked respondents:

“Within the past 12 months when seeking health care, do you feel your experiences were worse than, the same as or better than people of other races?”

Of note, seven times as many Blacks (13.8%) felt that they had been treated worse than other races (2%) when receiving health care and 10% of Whites reported being treated better than people of other races. The survey did not ascertain the reason for this perception, but the sentiment is consistent with the focus group findings in the 2004 Arkansas Racial and Ethnic Health Disparity Study. Current literature has also shown that in many disease states and health care quality measures, minorities do not receive the same quality of care as others in the health care system.

For example:

- Blacks in Arkansas are more than twice as likely to be admitted for hypertension and congestive heart failure
- Blacks are 3.3 times more likely to be admitted for uncontrolled diabetes
- Blacks are almost twice as likely to die in infancy
- Hispanics in Arkansas are 2.7 times more likely to be admitted with uncontrolled diabetes.(5)

- **Seven times as many Blacks (13.8%) felt that they had been treated worse than other races (2%) when receiving health care and 10% of Whites reported being treated better than people of other races.**

Racial and Ethnic Health Disparity Study 2009

The Racial and Ethnic Health Disparity Study of 2009 expands on the 2004 study. Focus group data in 2004 described themes that confirmed that the experience of disparities is complex and something that is experienced at both the individual and community levels. Those themes illustrated a far from perfect healthcare system for anyone, but worse so for a poor, minority, uninsured, elderly, or non-English speaking person in Arkansas. Furthermore, troubling stories were told of how minority individuals face additional obstacles due to skin color, language or preconceptions of caregivers about minorities.

In 2008 the UALR Institute of Government Survey Research Center (SRC) conducted the UALR Racial Attitudes Survey with Focus on Health and Health Care in Pulaski County in collaboration with the Arkansas Minority Health Commission. Issues of race and race relations have affected all aspects of our society, including health and health care, and may contribute to the presence and persistence of racial and ethnic health disparities.

In that survey, more insight emerged to help clarify issues around health and health care in the context of race in Pulaski County. This study focused on Black and White community perceptions and did not survey the Hispanic community. Exploring this topic stimulated discussion and further action to eliminate racial and ethnic health disparities.

The 2009 study moves Arkansas forward in addressing racial and ethnic health disparities. Broadly, it seeks to quantify the themes articulated by communities in 2004, expand to a statewide assessment of health disparities, and suggest further interventions and research needed to impact the issue. Specifically, the objectives of this work are:

- To develop methodology to over-sample minority communities in order to obtain more accurate surveillance data on which to base health policy decisions
- To quantitatively assess the perceptions of health care quality by race and ethnicity
- To assess additional factors in improving health in communities of color
- To inform future interventions in Arkansas that aim to eliminate racial and ethnic health disparities in the Black and Hispanic communities and via the interface between those communities and the health care system

Study Methodology:

This study is based on a landline telephone survey conducted by the UALR Institute of Government Survey Research Center (SRC) and the Arkansas Minority Health Commission between February 12 and June 26, 2009. A total of 2,347 interviews were conducted with a stratified random sample of all residents age eighteen and older living in Arkansas. This study primarily focuses on minority health disparities. The data analysis is divided into four geo-racial groups and Hispanic ethnicity.

Urban Black:

Black respondents living in counties within Metropolitan Statistical Areas

Rural Blacks:

Black respondents living in counties outside of Metropolitan Statistical Areas

Urban Whites:

White respondents living in counties within Metropolitan Statistical Areas

Rural Whites

White respondents living in counties outside of Metropolitan Statistical Areas

Hispanic Ethnicity

Hispanics living in the state of Arkansas regardless of county

Metropolitan Statistical Areas are geographic entities defined by the federal Office of Management and Budget for use by federal statistical agencies, based on the concept of a core area with a large population nucleus, plus adjacent communities having a high degree of economic and social integration with that core.

Each geo-racial and ethnic group contains between 299 and 556 respondents. The Hispanic group was obtained from respondents who self-identified as being "Hispanic or Latino" regardless of their racial identification. In order to obtain an adequate number of Hispanic interviews, a Hispanic surname oversample was used. Surname oversamples are commonly used in health research to increase the number of persons from minority racial and ethnic groups represented in general population surveys. The survey interviews were conducted in both English and Spanish. Spanish language interviewers were scheduled to conduct the interviews as needed when a language barrier household was encountered. The rural black group was also oversampled to obtain adequate numbers. The response rate for the survey was 38.3% with a cooperation rate of 75.2 percent, based on standards established by the Council of American Survey Research Organizations.

Research shows that responses to racial issue questions can be influenced by whether interviewers and respondents perceive themselves to be of the same or a different race or ethnicity as one another. For this study a methodology was utilized whereby the races/ethnicity of the respondents and the telephone interviewers were matched. Many of the questions used in the survey are based upon questions developed and used by The Commonwealth Fund and Princeton Survey Research Associates in their 2001 Survey on Disparities in Quality of Health Care. A selected group of questions used in the survey are based upon questions used by the Gallup Organization in a series of studies on Black/White race relations in the United States (c1997-2008 The Gallup Organization. All rights reserved. Reprinted with permission from www.gallup.com). We gratefully acknowledge The Commonwealth Fund and The Gallup Organization for allowing UALR to utilize questions from their surveys.

No cell phone numbers were eligible for this survey. This protocol had the effect of creating a specific demographic group organized around the kind of telephone used by members in this group. This group's members may or may not share other identifying characteristics. Thus, in addition to sampling error, the wording of the questions, and practical issues associated with conducting a survey, the cell-phone versus home-phone issue can introduce bias into the findings of any public opinion survey.

The data were weighted in order for the sample estimates to be representative of the overall Arkansas population over the age of 18. The data were weighted for age and gender for each of the four geo-racial groups and one ethnicity. The 2000 Census Summary File 1 provided the sample estimates that formed the basis for weighting. There were 3 age groups: 18 to 44 years of age, 45 to 64, and 65 and over. This resulted in a total of 30 weighted groups (3 age groups x 2 gender categories x 4 geo-racial and 1 ethnic group). The Hispanic population was also weighted for age and gender separately.

This survey examines multiple domains relevant to health, health care and minority health in Arkansas. Survey questions were obtained from national surveys and piloted in a county survey prior to fielding statewide. The survey was a 59 question survey that addressed multiple domains including health status, health behavior, access to health care, awareness of health disparities, perceptions of treatment, cultural competency, medical errors, alternative medicine and sources of health information. This report will summarize a subset of the survey questions and provide the most up to date and detailed snapshot of minority health and health disparities for the state of Arkansas. Further statistical analysis is currently being planned to address specific hypotheses and questions of interest to the state. Finally, this report will make recommendations to address racial and ethnic health disparities in Arkansas.

- The survey was a 59 question survey that addressed multiple domains including health status, health behavior, access to health care, awareness of health disparities, perceptions of treatment, cultural competency, medical errors, alternative medicine and sources of health information.

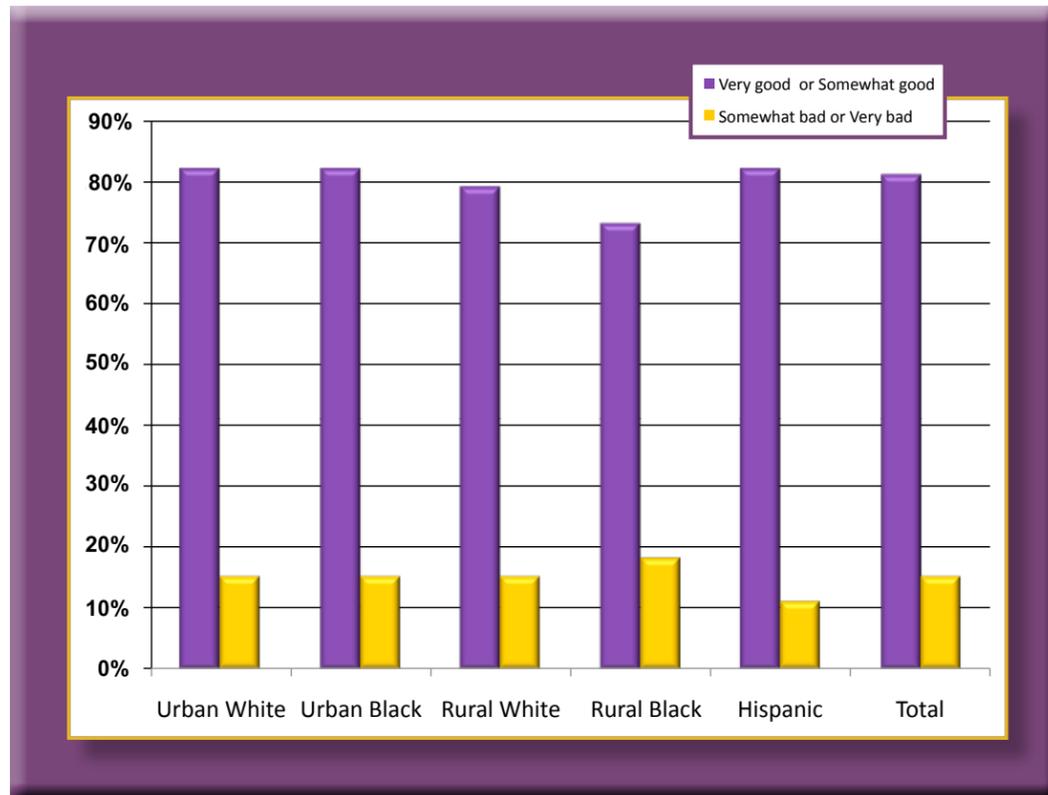
Demographics:

Un-weighted Respondent Characteristics by Group

	Urban White	Urban Black	Rural White	Rural Black	Hispanic
Unweighted N	556	506	553	299	433
Age					
18-34	8%	14%	8%	11%	35%
35-50	22%	29%	20%	22%	42%
51-64	30%	31%	33%	34%	14%
65+	39%	22%	36%	28%	3%
Gender					
Male	38%	27%	39%	28%	48%
Female	62%	73%	61%	72%	52%
Education					
<high school	9%	17%	15%	26%	50%
High School	31%	30%	38%	37%	22%
Some college	28%	26%	25%	20%	13%
College grad	19%	15%	16%	8%	5%
Post graduate	12%	8%	6%	5%	4%
Income					
Less than 20,000	15%	32%	24%	46%	41%
20,000-34,999	25%	26%	28%	21%	29%
35,000-49,999	14%	11%	16%	11%	6%
50,000-74,999	14%	12%	14%	6%	4%
More than 75,000	26%	9%	13%	3%	5%
Work status					
Working full-time	36%	43%	31%	34%	39%
Working part-time	7%	5%	11%	7%	19%
Unemployed	6%	7%	7%	10%	11%
Full-time homemaker	11%	3%	7%	3%	17%
Retired	32%	19%	29%	20%	4%
Student	1%	1%	2%	2%	1%
Disabled	8%	17%	11%	19%	3%

Race Relations:

Figure 1: We'd like to know how you would rate relations between blacks and other racial and ethnic minorities and whites in your county. Would you say relations between racial and ethnic minorities and whites are:



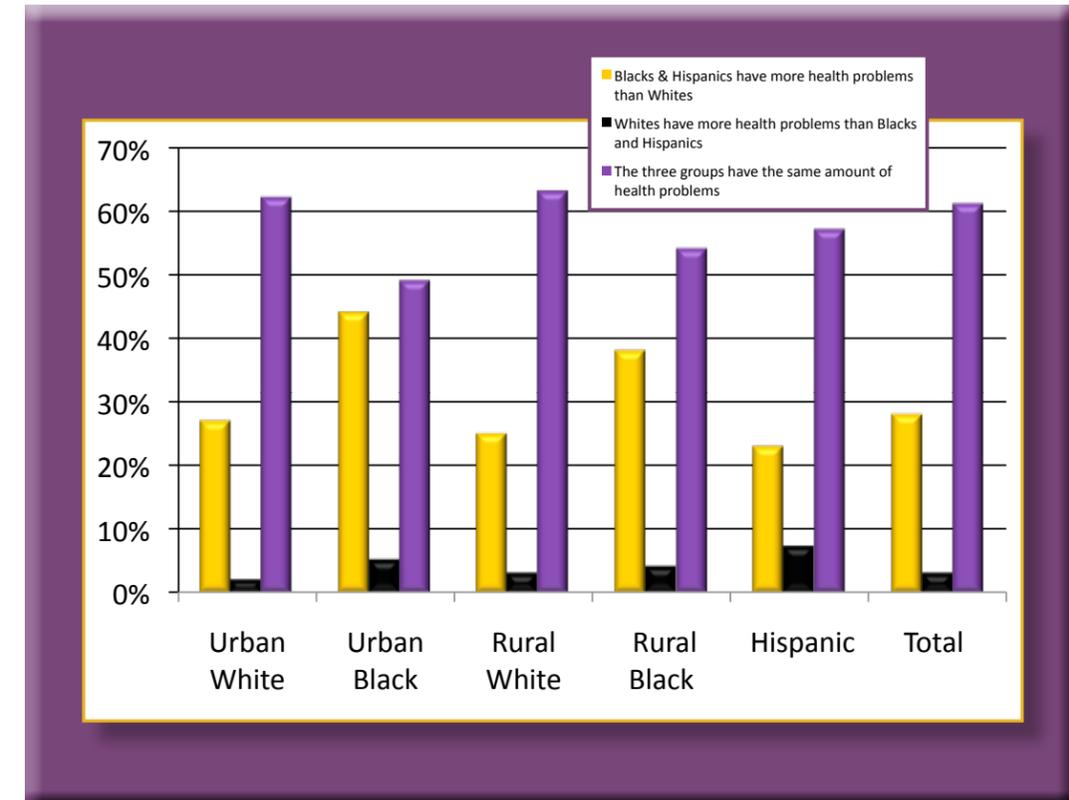
- The survey was conducted in February 2009 after the election of the first Black President of the United States. This event may have had an impact on the perception of race relations.
- Overall, 73-82% of all groups stated that racial relations in their county were very good or somewhat good
- Overall, 15% believed that race relations were somewhat bad or very bad
- 18% of Rural Blacks believed that race relations were somewhat bad or very bad

18% of Rural Blacks BELIEVE

race relations are somewhat bad

Awareness of Health Disparities:

Figure 2: Which comes closer to your beliefs, overall? Blacks & Hispanics have more health problems than Whites; Whites have more health problems than Blacks and Hispanics; the three groups have the same amount of health problem

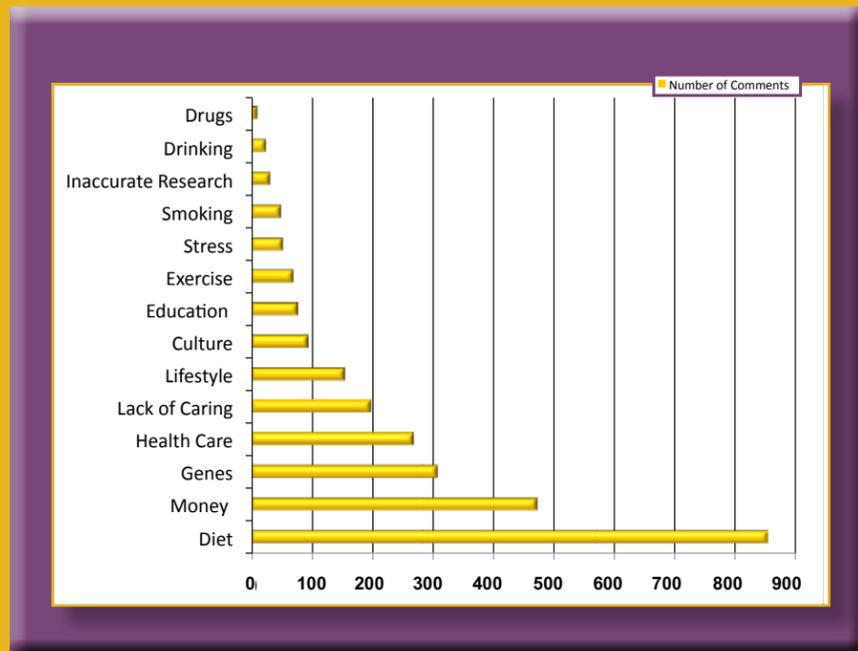


- There is a general lack of awareness of the presence of racial and ethnic health disparities
- More than 60% of Arkansans felt that different racial and ethnic groups have the same amount of health problems
- More urban and rural Blacks than Whites and Hispanics believe that minorities have more health problems

l a c k o f a w a r e n e s s

racial and ethnic health disparities

Figure 3: Research shows that Blacks and Hispanics are more likely than Whites to have health problems such as heart disease, diabetes, strokes, and cancer. What do you think is the main reason that racial and ethnic minorities are more likely to have more health problems? **Open Ended**

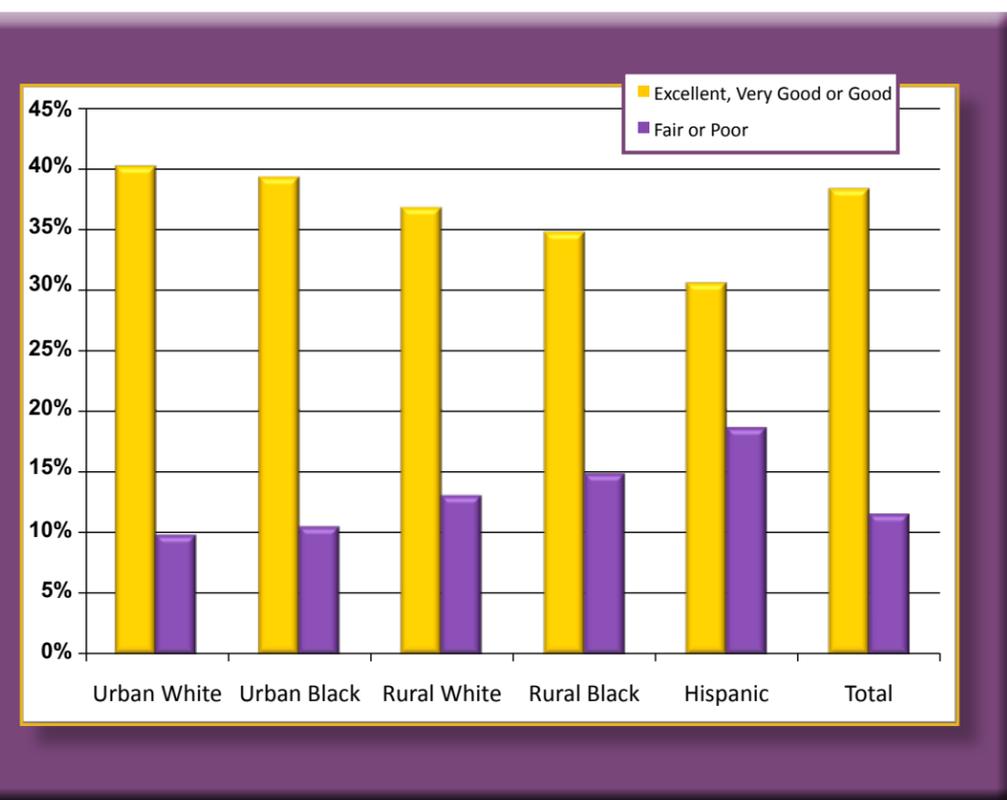


The themes that emerged from this open-ended question included:

- Individual Lifestyle factors: poor choices; ways of living; diet; weight; nutrition; childhood nutrition; lack of exercise; smoking; alcohol; drugs
- Lack of Care: Lack of personal care; don't look after selves; don't prioritize health or think it's unimportant
- Economic conditions: Lack of money to afford insurance; medical treatments; doctor visits; health care; healthy foods and healthy lifestyle
- Education: Lack of education about health; nutrition; recognizing symptoms of disease; Lack of knowledge; information; education; awareness
- Health care: Poor health care; postponement of doctor's appointments until critical owing to lack of access; no preventive care; health care disparities between blacks and whites
- Culture: Cultural differences; upbringing; environment; living conditions; working environment
- Stress: Depression; pressure
- Genetics: inheritance; DNA
- Relationship and Attitude: Attitude towards doctors and medical care; don't trust doctors; don't actively seek care; don't visit doctor regularly; procrastination; no preventative action taken; don't take doctors' advice; don't keep follow-up up appointments
- Inaccurate: biased; discriminatory; untrue research

General Health Status:

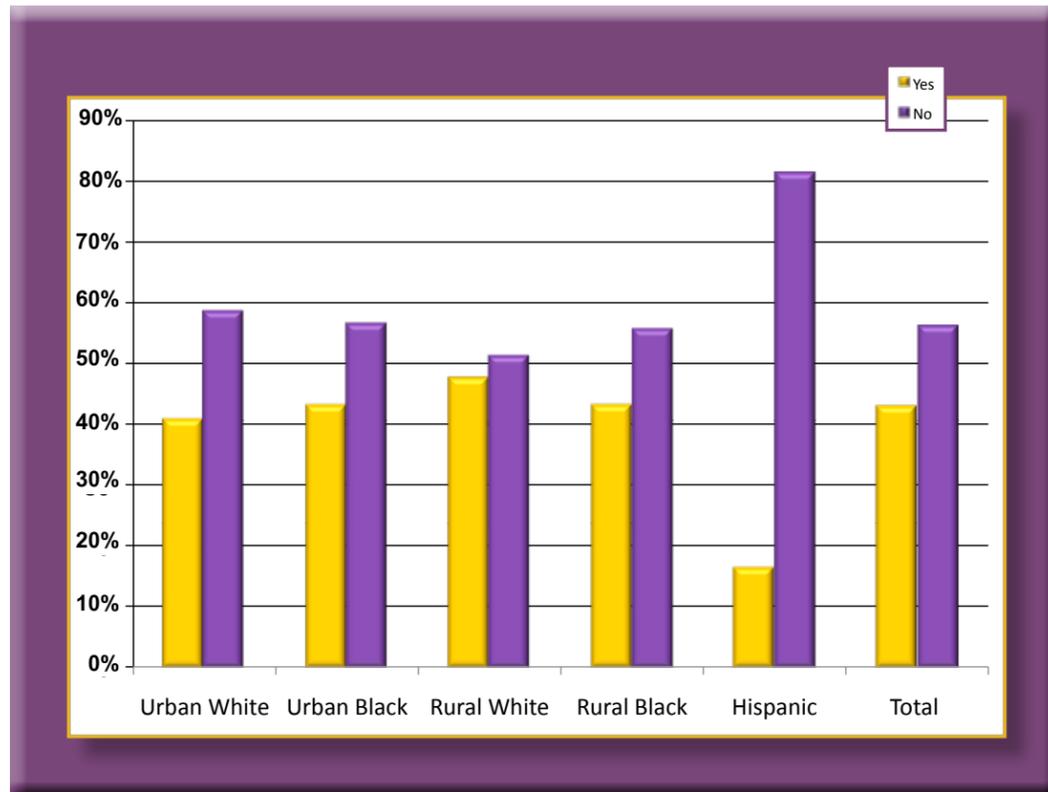
Figure 4: In general, how would you describe your own health? Would you say it is Excellent, Very Good, Good, Only Fair, or Poor?



- Self-reported health status has been shown to be a strong prognostic indicator for subsequent mortality for both genders and all racial/ethnic groups(6)
- 23% of the overall population stated that their health was fair or poor
- The highest percentages of those reporting fair or poor health status are Blacks in rural areas and Hispanics

Self-reported health status
has been shown to be a strong
prognostic indicator

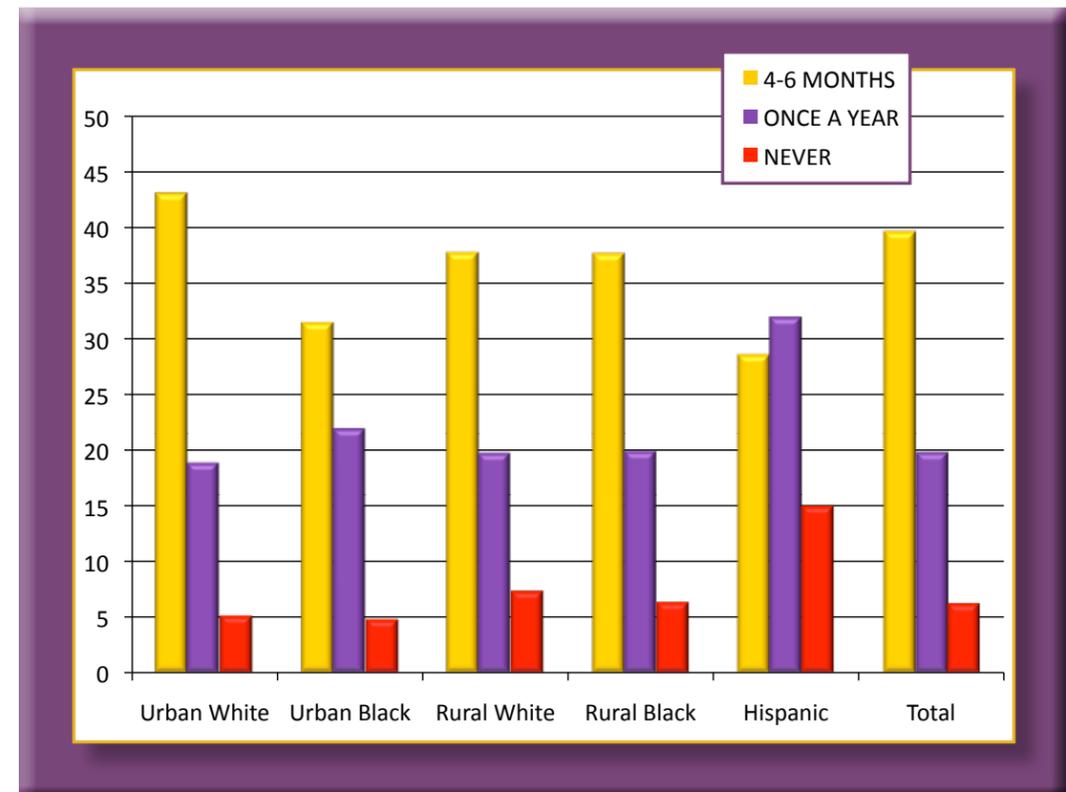
Figure 5: Do you currently have any health problems such as diabetes, heart disease, high blood pressure, or cancer?



- Whether or not you have chronic health problems such as those in the question can determine your interaction with and perception of health and the health care system
- More than 40% of the participants reported a current health problem
- Only 16% of the Hispanic population reported a current health problem

40% of the participants reported a current health problem

Figure 6: In general, how often do you visit a doctor or medical clinic for any reason, including check-ups or visits to the emergency room or hospital?

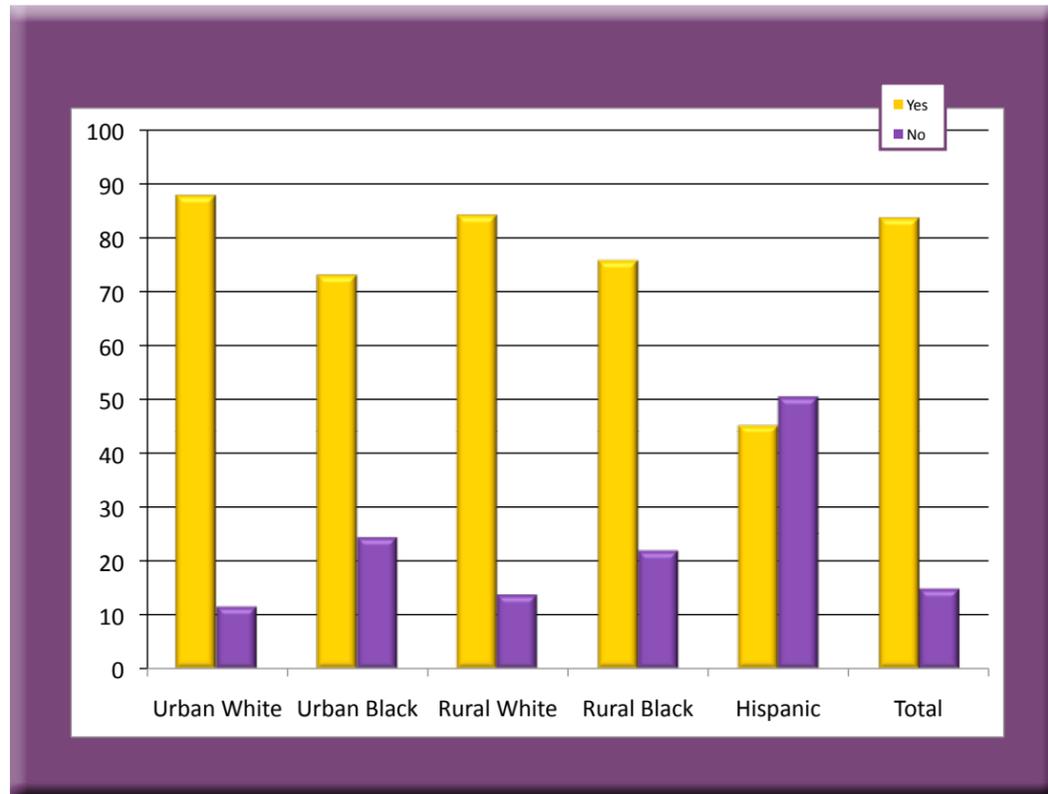


- Overall the survey population utilized the health care system
- 40% go to the doctor every 4-6 months and 20% go to the doctor once a year
- 15% of Hispanics report never visiting a doctor for any reason

15% of Hispanics report **never** visiting a doctor for **any reason**

Access to Health Care:

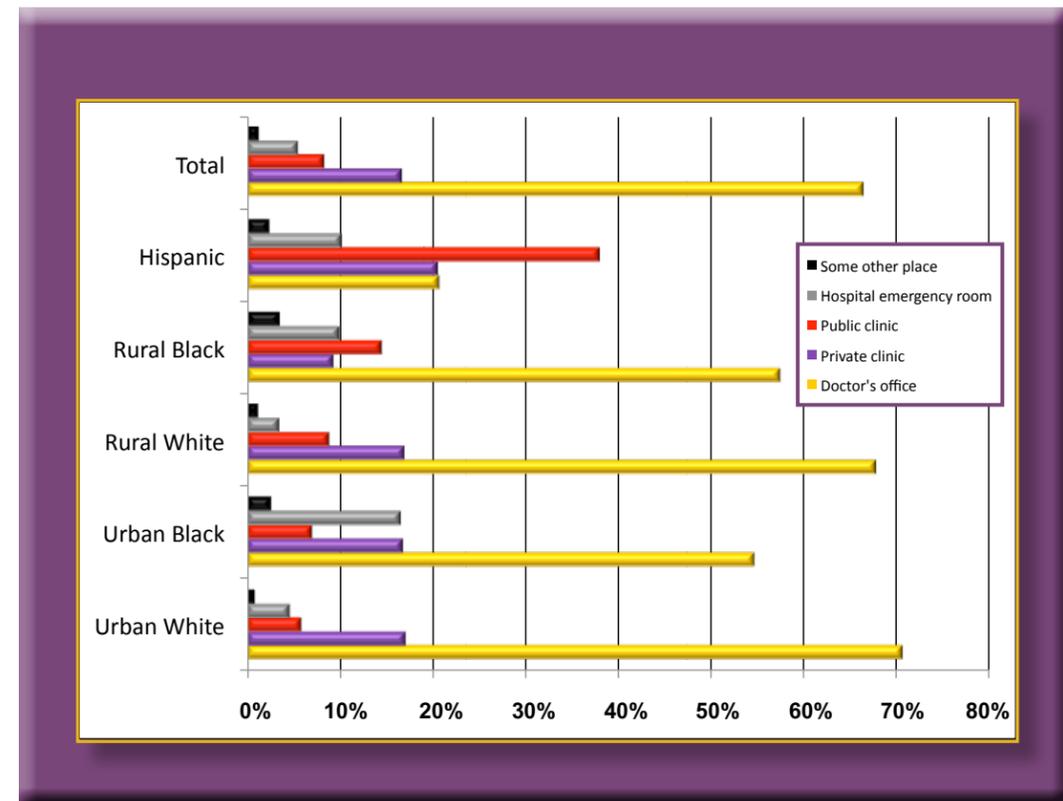
Figure 7: Do you have any kind of health care coverage, including health insurance, pre-paid plans such as HMO's, or government plans such as Medicare?



- Having health insurance is critical to health care access in Arkansas and the US
- Overall, 14% had no health care coverage of any kind
- By race and ethnicity, Hispanics and rural and urban Blacks had the highest uninsured at rates of 52%, 25% and 22%, respectively

14% had no health care coverage of any kind

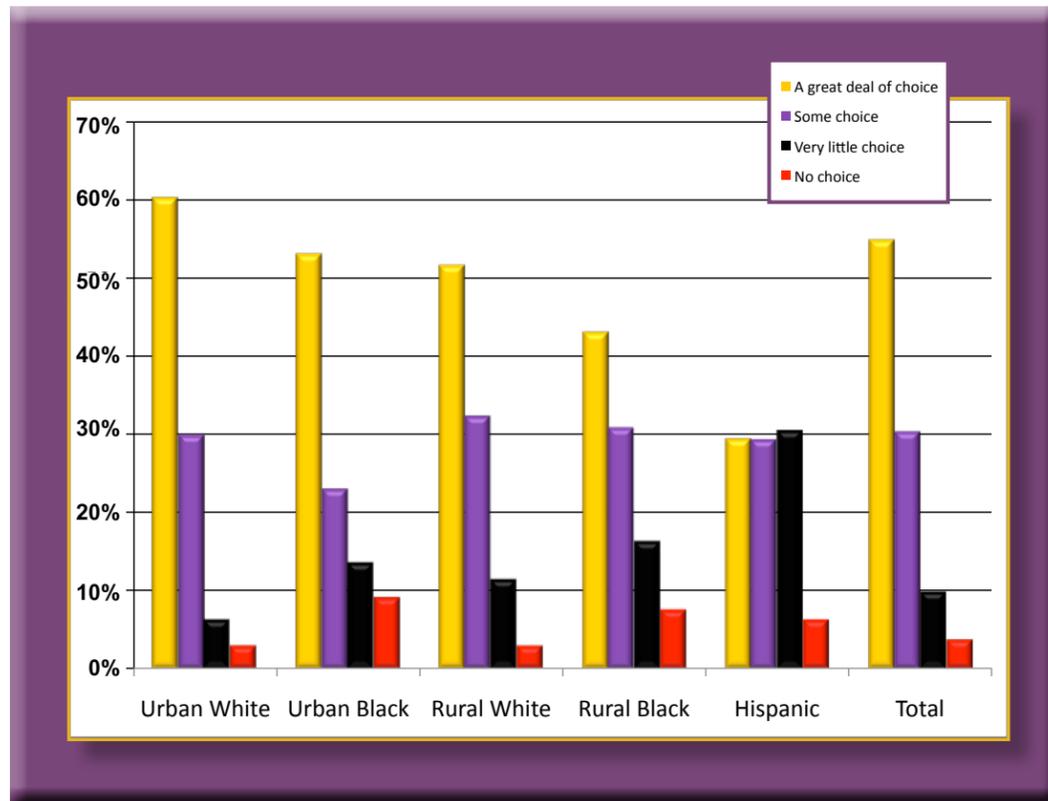
Figure 8: Where do you usually go when you are sick or need health care?



- A usual source of care and medical homes improves health care and health outcomes (7)
- Urban whites are the group with the largest receipt of care in a doctor's office
- Hispanics and rural Black are more likely to report receiving care in public clinics
- More urban Blacks reported emergency room use for health care than urban Whites

A USUAL SOURCE of care and medical homes improves health care and health **OUTCOMES**

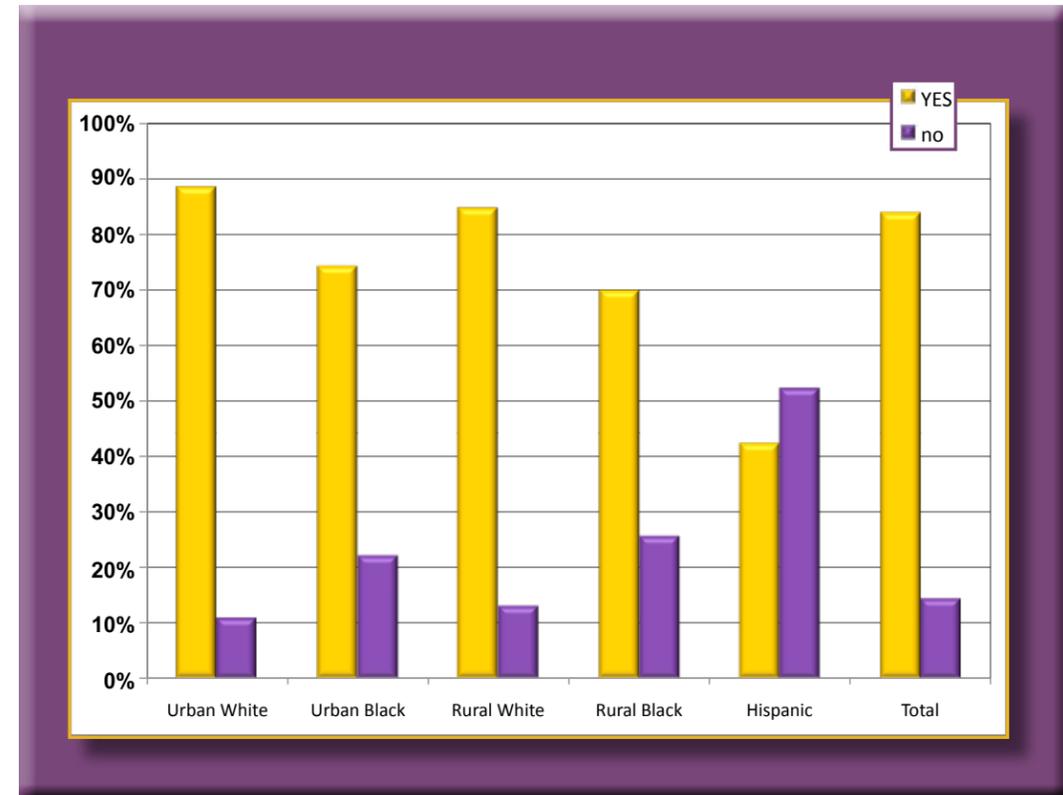
Figure 9: How much choice do you have in where you go for medical care?



- 90% of the urban White population has a great deal of choice or some choice in seeking medical care
- Rural populations report less choice in where to go for health care
- Urban and rural Blacks and Hispanics report they have very little to no choice at 22%, 24% and 36% respectively

90% of the urban White population has a **great deal of choice**

Figure 10: Do you have a regular doctor or other health professional, such as a nurse or a midwife, that you usually go to when you are sick or need health care?

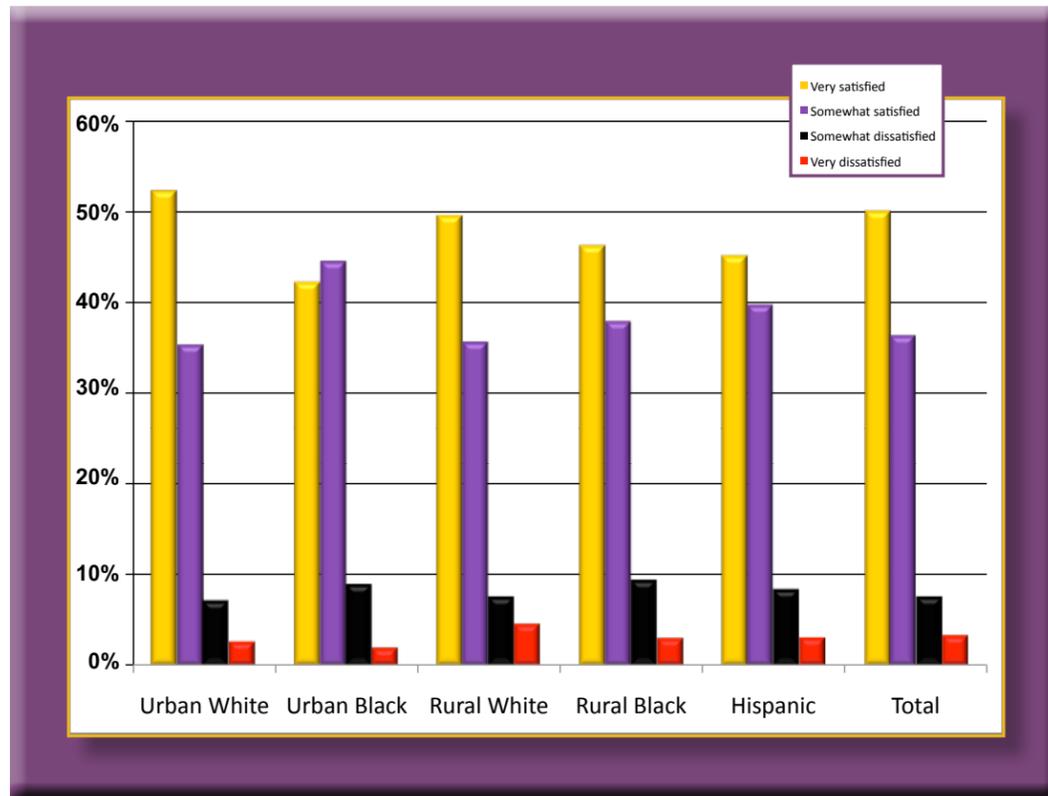


- A usual source of care provides more effective and efficient health care. Patients who have a usual source of care receive more preventive services and have better control of chronic medical conditions (8)
- 50% of the Hispanic population does not have a regular health care provider
- 22-24% of Blacks, urban and rural, do not have a regular doctor

50% of the Hispanic population **does not have** a regular health care provider

Satisfaction with the Health Care System:

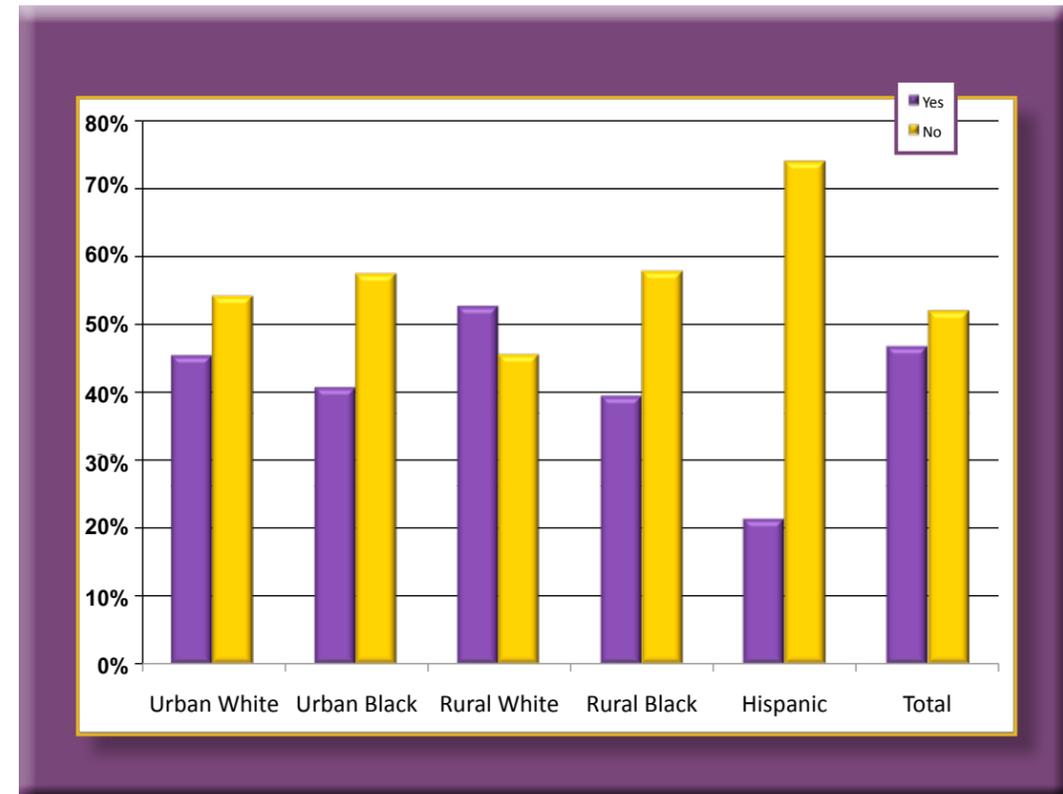
Figure 11: Overall, how satisfied or dissatisfied are you with the quality of health care you have received during the last 2 years?



- Only 2% of the total population had no health care in the last 2 years
- 86% of the population was very satisfied or somewhat satisfied with their health care
- 10-12% of population reports being dissatisfied or very dissatisfied with health care

10%-12% of population reports being dissatisfied

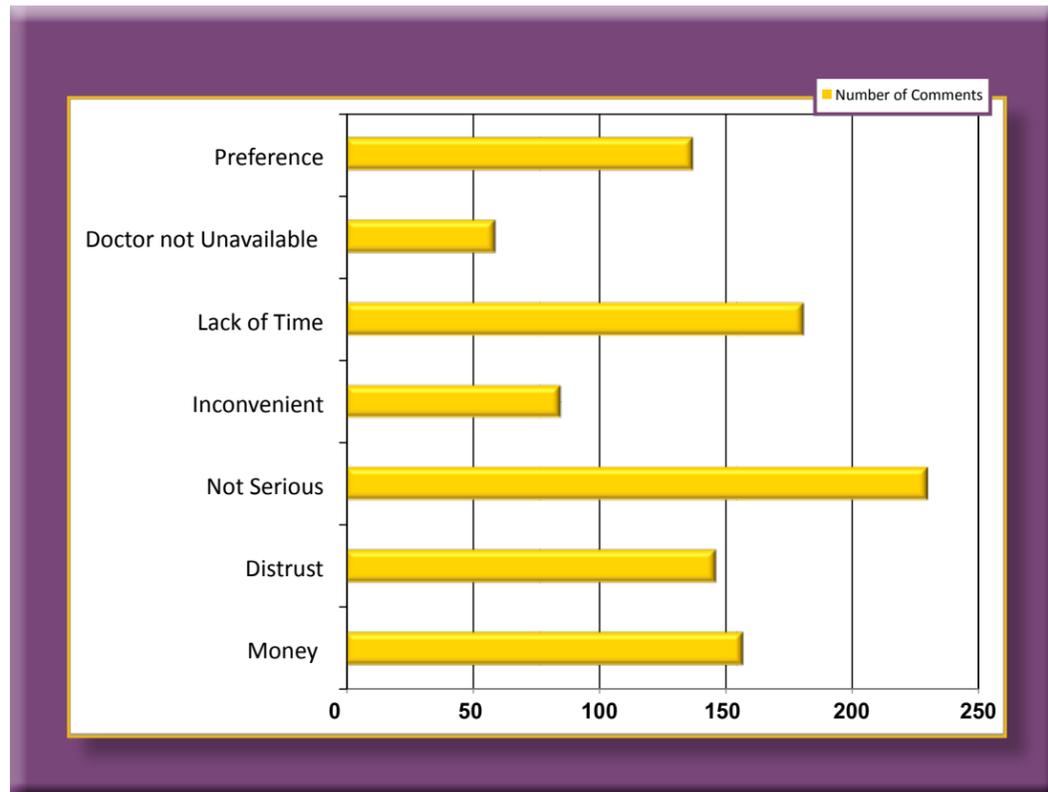
Figure 12: Has there ever been a time when you had a medical problem but put off, postponed, or did not seek medical care when you needed to?



- 47% of the total population has put off medical care in the past
- 21% of Hispanics reported having a medical problem and postponing health care
- 53% of rural Whites have postponed medical care when needed
- 39% of rural Blacks have postponed medical care when needed

21% of Hispanics reported having a medical problem and postponing health care

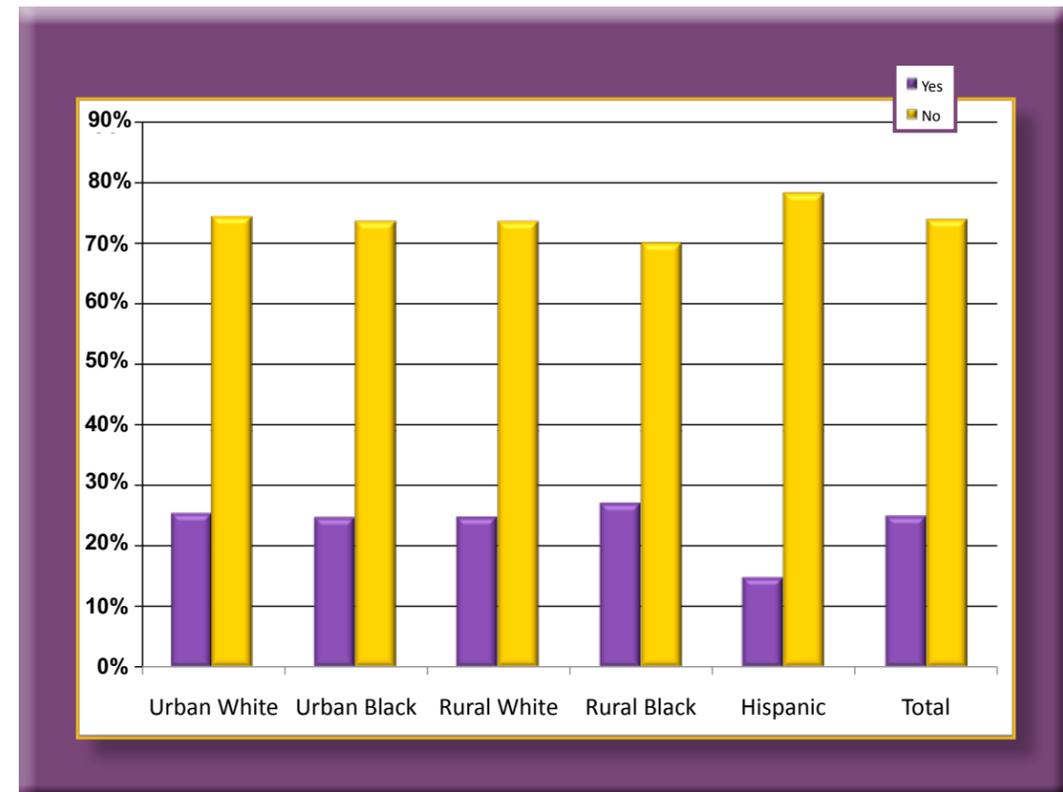
Figure 13: What was the most important reason why you put off, postponed, or did not get the medical care you needed? Open Ended



The themes that emerged from this open-ended question included:

- Insurance/Money:**
 No insurance, insufficient insurance, high deductible, couldn't afford co-pay, medical bills too expensive
- Distrust:**
 Doesn't like or trust doctors; fears of procedure, medications or diagnosis; doctors ineffective; doctors don't listen, understand, or care
- Not Serious:**
 Condition not serious enough, prefer to take over the counter medications, prefer to diagnose / treat self, didn't need doctor
- Inconvenient:**
 Too inconvenient to go to doctor; doctor far away; no transport, too sick to go to the doctor; no one to take patient to doctor, inconvenient day (e.g. at the weekends when only ERs are available)
- Unavailable:**
 Couldn't get appointment; doctor too busy / away, too long to wait in line or to get an appointment, have no regular doctor, too hard to find a doctor, no specialist available, not enough choice, refused by doctor
- Lack of Time/Work:**
 Too busy, other priorities / commitments; can't get time off work, too busy at work
- Want:**
 Didn't want to go; didn't feel like going, procrastination, lazy; stubborn; didn't get around to it; personal choice; no reason to go; forgot or missed appointment

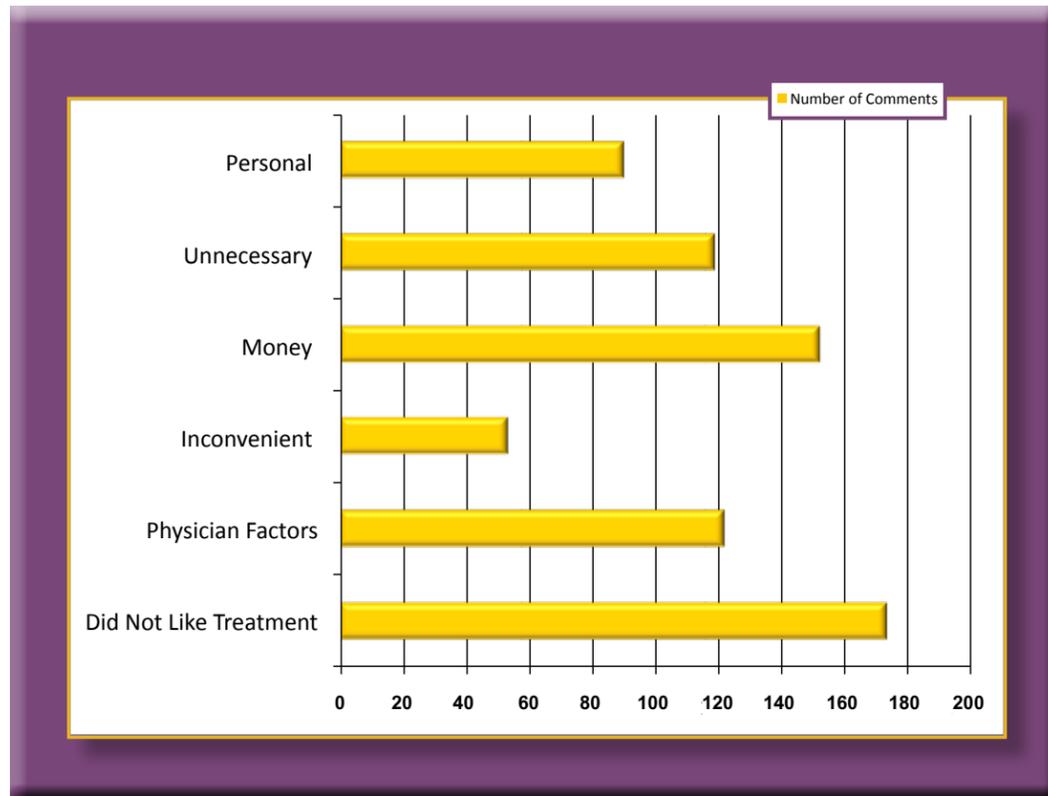
Figure 14: Has there ever been a time you did not follow a doctor's advice to take medicine, have follow-up treatment, or see a specialist (such as an eye doctor, heart doctor, or psychiatrist)?



- About 25% of all respondents stated that they did not follow a doctor's advice
- Of those that did not follow advice, most reported a lack of follow-up
- Only 15% of Hispanics report not following advice

15% of Hispanics reported not following advice

Figure 15. What were the most important reasons why you did not follow the doctor's advice?
Open Ended

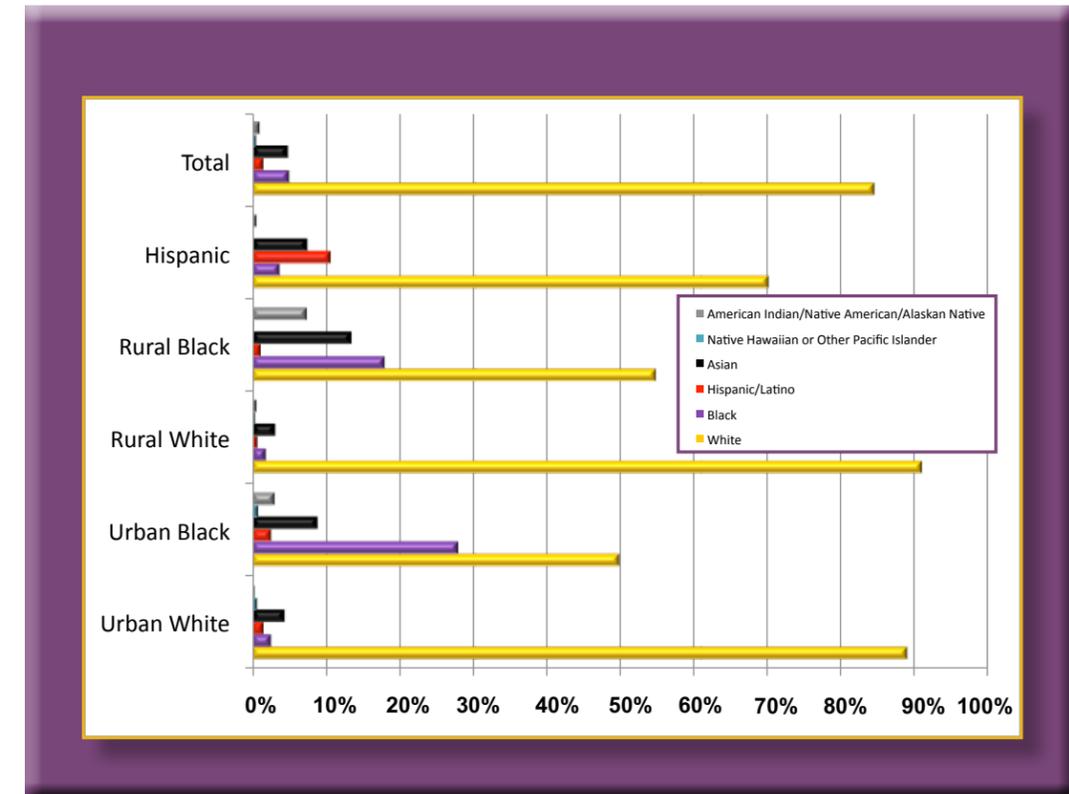


The themes that emerged from this open-ended question included:

- Treatment-related:**
 Didn't like treatment; side effects of medicine; felt medication didn't work; didn't want to take medicine, didn't want to carry out treatment plan (too difficult)
- Doctor-related:**
 Didn't like, trust doctor; didn't believe advice; doctor misdiagnosed condition or prescribed wrong medication; wanted second opinion
- Inconvenience:**
 Too busy, work, scheduling, no ride, too far to travel
- Money/Insurance:**
 Couldn't afford cost of doctor's visit or treatment; co-pay too high; visits and treatment too expensive, little or no insurance
- Unnecessary:**
 Got better without medical help; self-treated or used over-the-counter medicines; didn't feel treatment and follow-up was necessary; need not serious enough
- Personal:**
 Personal reasons; stubborn, procrastinated, tired of going, just didn't, didn't want to, forgot to go / take medicine

Cultural Competency:

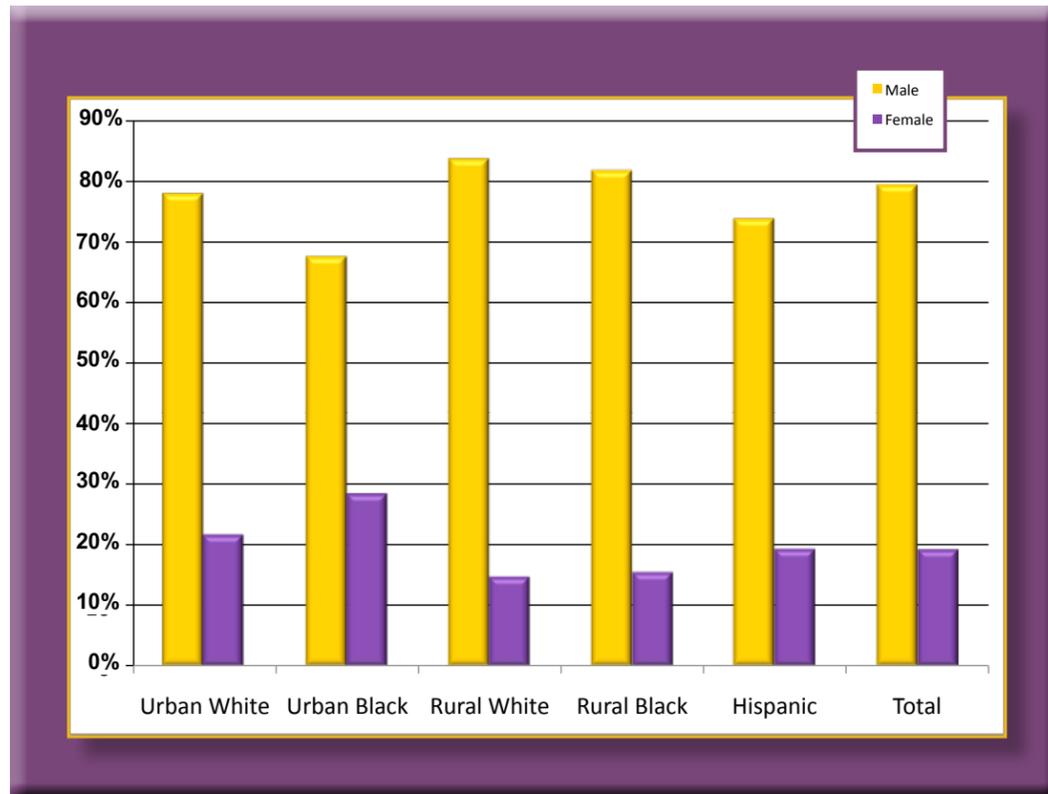
Figure 16: Which best describes the race of your regular doctor? [or] the doctor you last saw for health care?



- The fact that the nation's health professions have not kept pace with changing demographics may be an even greater cause of disparities in health access and outcomes than the persistent lack of health insurance for tens of millions of Americans (9)(10)
- 85% of the population sees White physicians for health care
- Urban and rural Blacks see Black physicians more than other populations
- Hispanics are more likely to see Hispanic physicians for health care

**Hispanics are more likely to see
HISPANIC PHYSICIANS**

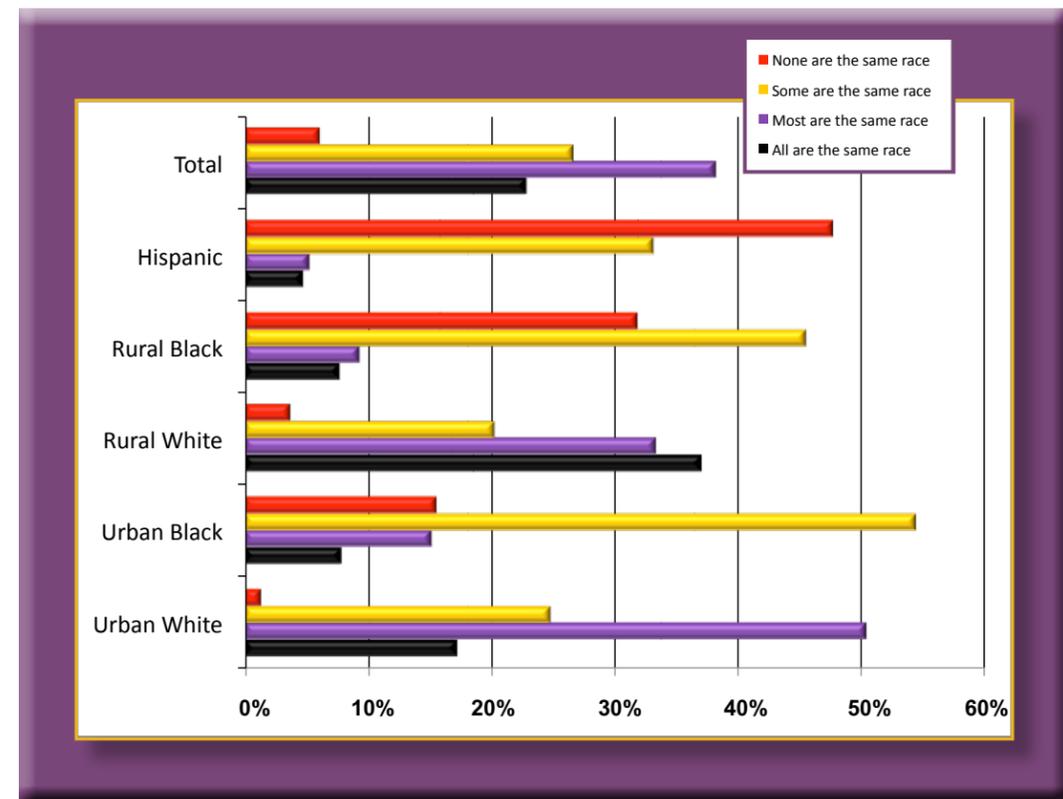
Figure 17: Is your regular doctor [or] the doctor you last saw for health care a male or female?



- 79% of Arkansans see male physicians for health care
- 28% of Urban blacks see female physicians for health care

79% of Arkansans see male physicians for health care

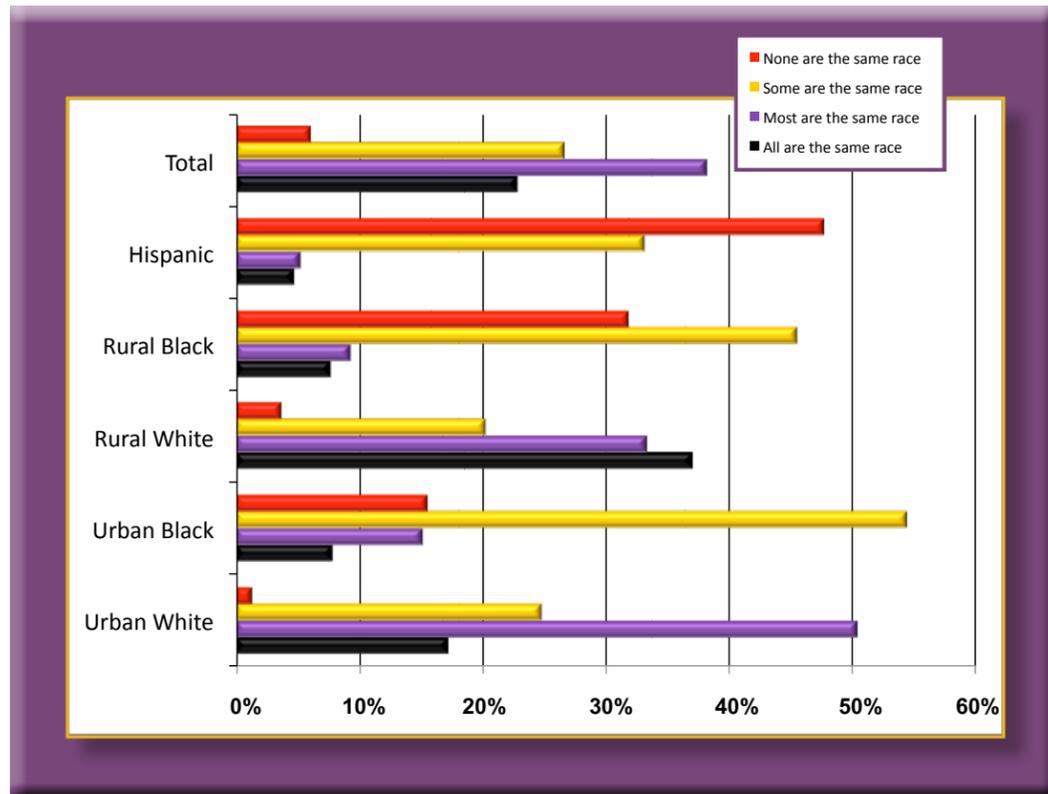
Figure 18: Which best describes the race of the staff where you regularly go for health care?



- The absence of a sound patient–provider relationship is one factor that contributes to disparities in the quality of care received by minority populations. Some research has shown the importance of a racially diverse workforce for improving underserved populations’ access to care (11)
- In Arkansas there is a general lack of diversity in the health care workforce
- 48% of Hispanics report that there is no one of their ethnicity on staff where they regularly go for health care
- 32% of rural blacks report there is no one of their race on staff where they go regularly for health care

48% of Hispanics report that there is no one of their ethnicity on staff

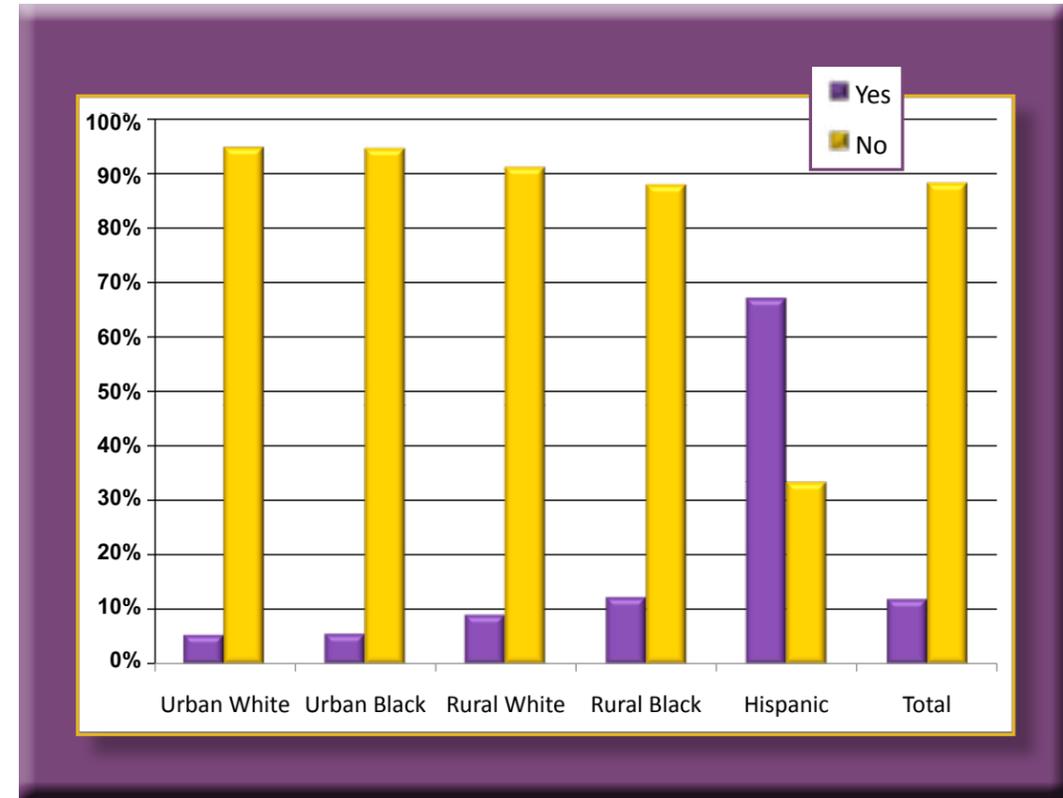
Figure 19: Thinking about your most recent care, how often did you have a hard time speaking with or understanding a doctor, a nurse or other health provider?



- Language barriers can impede access to health care, lower the quality of care, and lead to dissatisfaction with care (12)
- 58% of Hispanics always, usually or sometimes have problems communicating with health care providers
- Even with speaking English communication can be a barrier
- 30% of rural Blacks always, usually or sometimes have problems communicating with health care providers

58% of Hispanics have problems communicating with health care providers

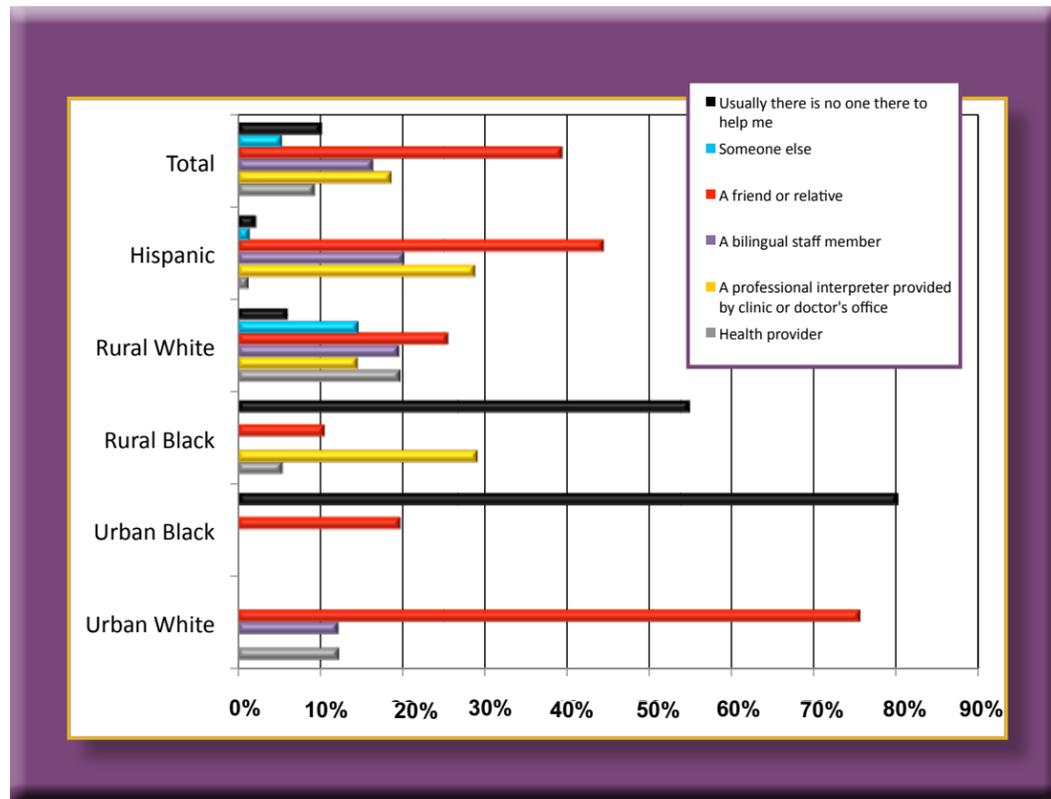
Figure 20: Again thinking about your most recent care, did you need an interpreter to help you speak with doctors or other health providers?



- 67% of Hispanics needed an interpreter to help with health care providers
- Additionally, 12% of rural Blacks needed interpreter services

67% of Hispanics needed an interpreter

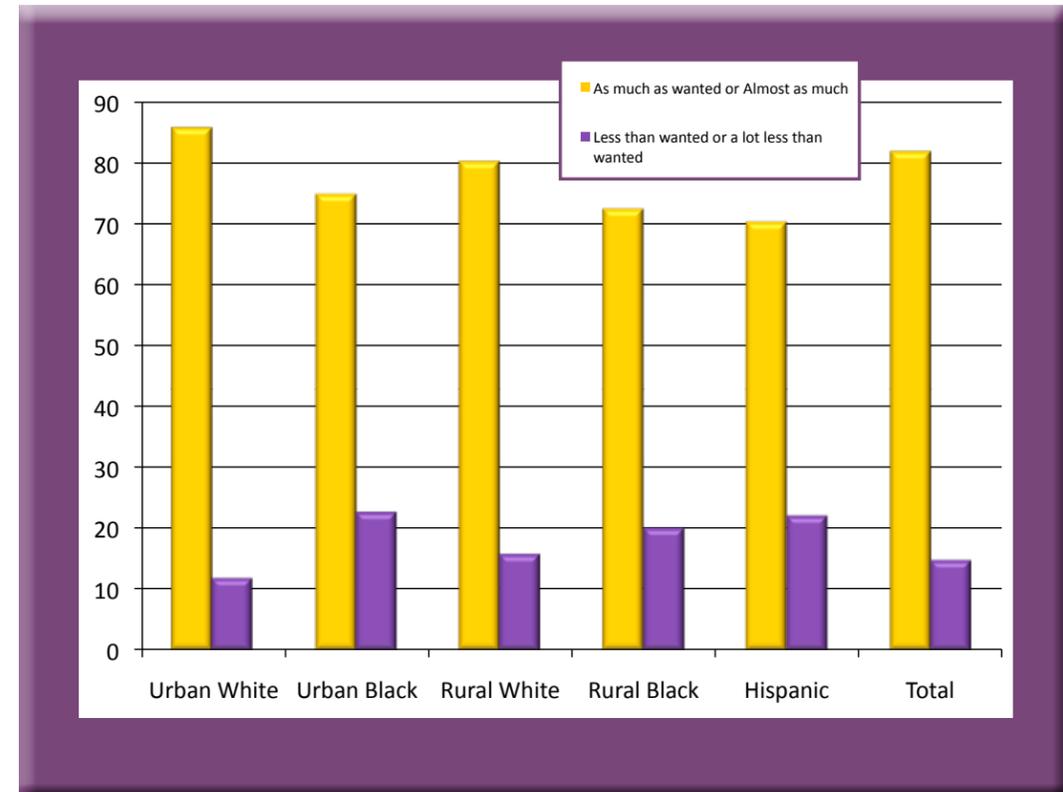
Figure 21: Who usually serves as an interpreter for you when receiving medical care?



- 44% of Hispanic respondents used a friend or relative as an interpreter
- 29% of Hispanics used professional interpreters
- 20% of Hispanics utilized bilingual staff at the clinic or doctor's office
- Urban and rural Blacks usually have no one to help interpret

44% of Hispanic respondents used a friend or relative as an

Figure 22: In general, have doctors involved you in decisions about your care as much as you wanted, almost as much as you wanted, less than you wanted, or a lot less than you wanted?

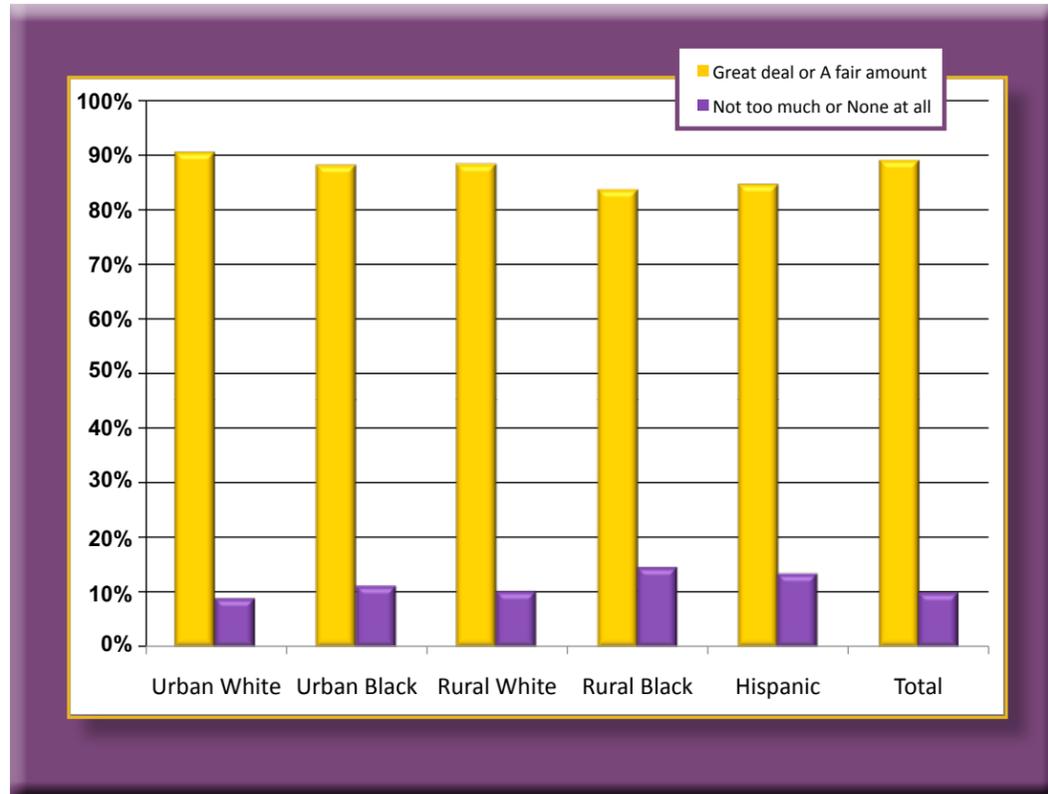


- 82% of the total population was involved in health care decisions as much as they wanted or almost as much as they wanted
- Rural Blacks and Hispanics, 20% and 22%, respectively, were involved less than they wanted or a lot less than they wanted

20% of blacks and **22%** hispanics involved less than they wanted

Trust of Health Care System

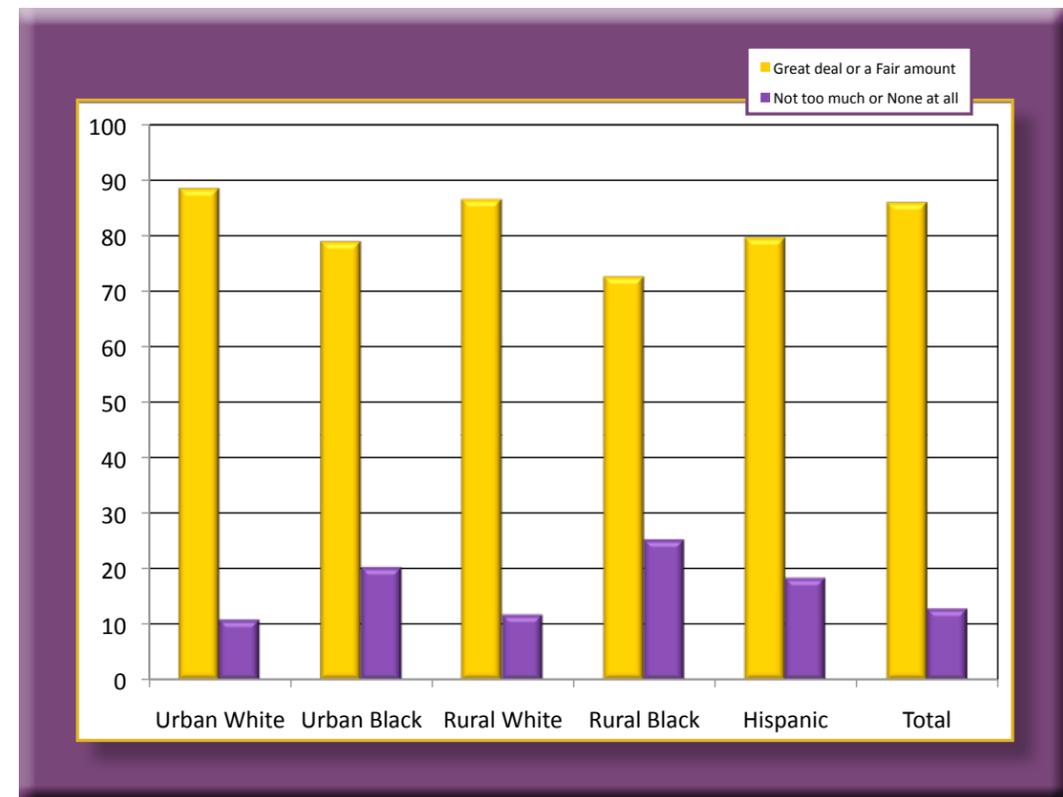
Figure 23: In general, how much confidence and trust do you have in doctors?



- Most respondents trust the health care system 89% have a great deal or a fair amount of confidence in doctors
- 13% of Hispanics and 14% of rural Blacks have not too much or no confidence at all in doctors

13% Hispanics 14%
rural blacks not too much or
no confidence
IN DOCTORS at ALL

Figure 24: In general, how much confidence and trust do you have in medications?



- Most people have trust and confidence in medications 86% of the total population have a great deal or a fair amount of trust and confidence in medications
- 25% of rural Blacks have not too much or no confidence in medications

25% of rural Blacks have
not too much
or no confidence
IN MEDICATIONS

Sources of Health Information

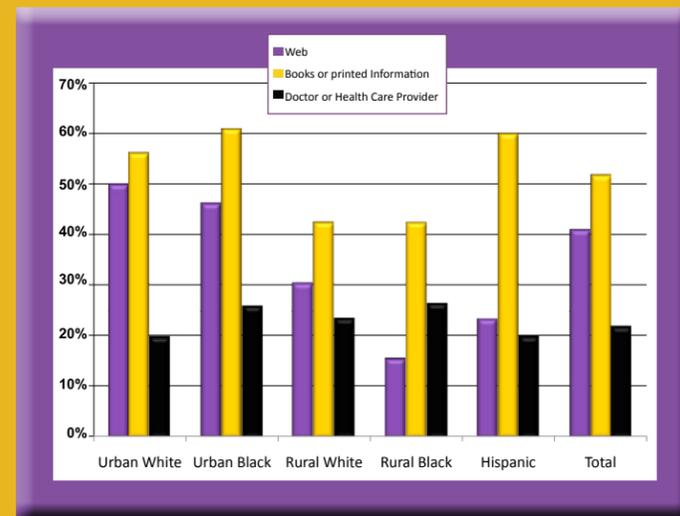
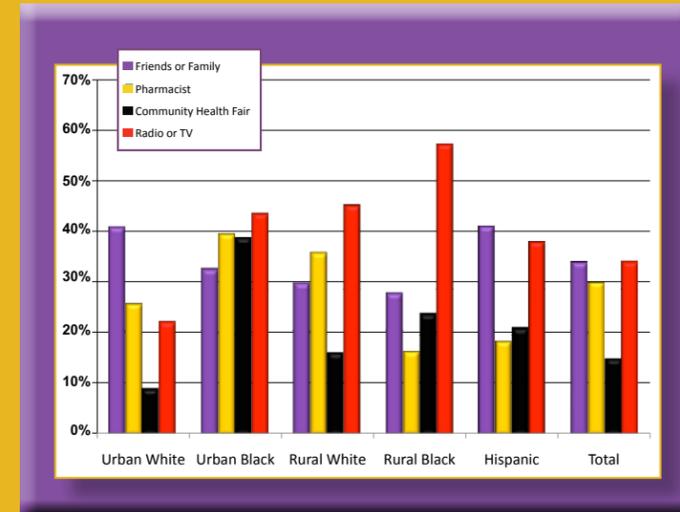


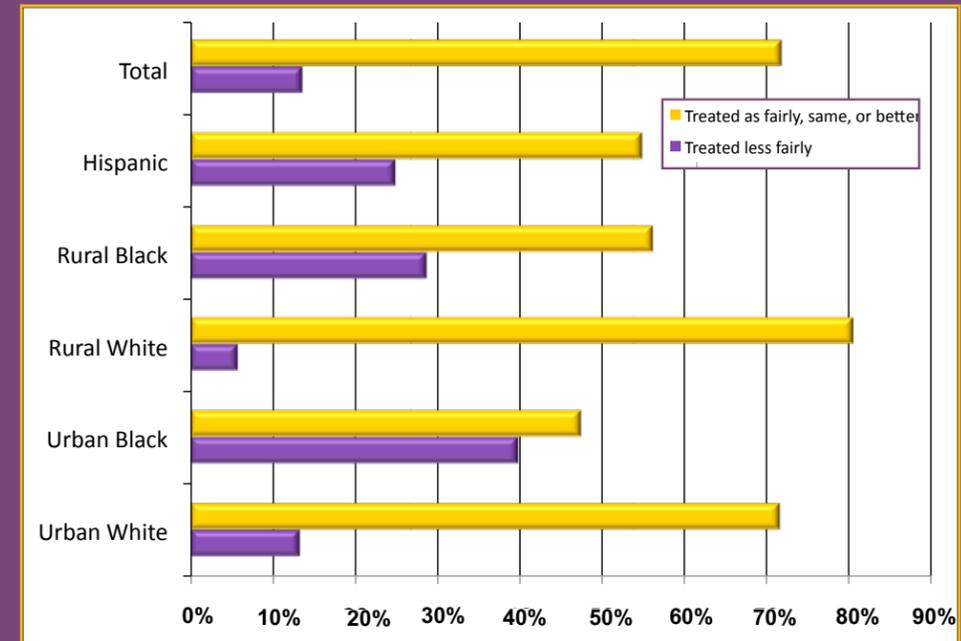
Figure 25: Have you somewhat, often or very often gotten information about health and medicine from:



- Rural blacks have low utilization of the internet for health information at 16%
- Urban populations have higher utilization of the internet, 50% for Whites and 46% for Blacks
- People in rural areas have low utilization of written material for health information
- Only 22% of the population get health information from a doctor or other health care provider
- Friends and family are an important source of health information for 34% of the total population
- Rural Blacks and Hispanics get less get health information from pharmacists than urban Whites
- Rural and urban Blacks and Hispanics utilize health fairs, TV and radio for health information

Perceptions of Discrimination

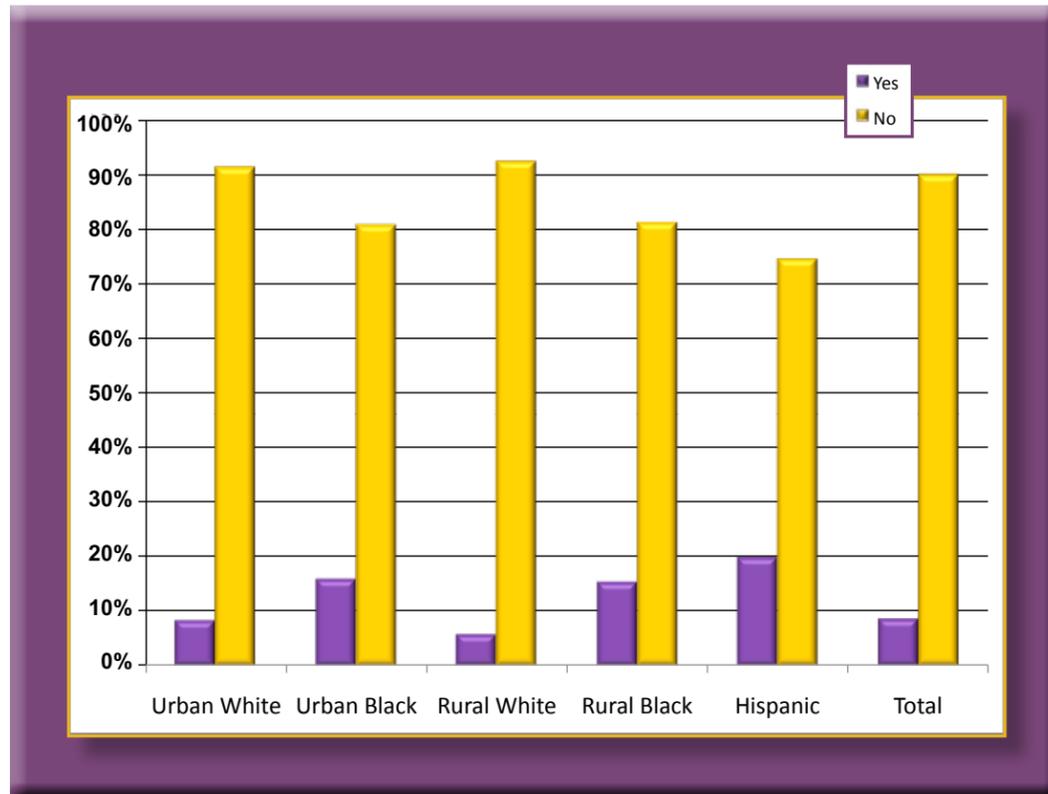
Figure 26: Are blacks and other racial and ethnic minorities in your community treated as fairly as or less fairly than whites in getting healthcare from doctors or hospitals?



- Research has shown that minorities tend to receive lower quality of care than others in the health care system (13)
- 14% of respondents stated that other racial and ethnic minorities are treated less fairly than whites
- More minorities state that minorities are treated less fairly, 40% of urban blacks, 29% of rural blacks and 25% of Hispanics

minorities tend to receive lower quality of care than others

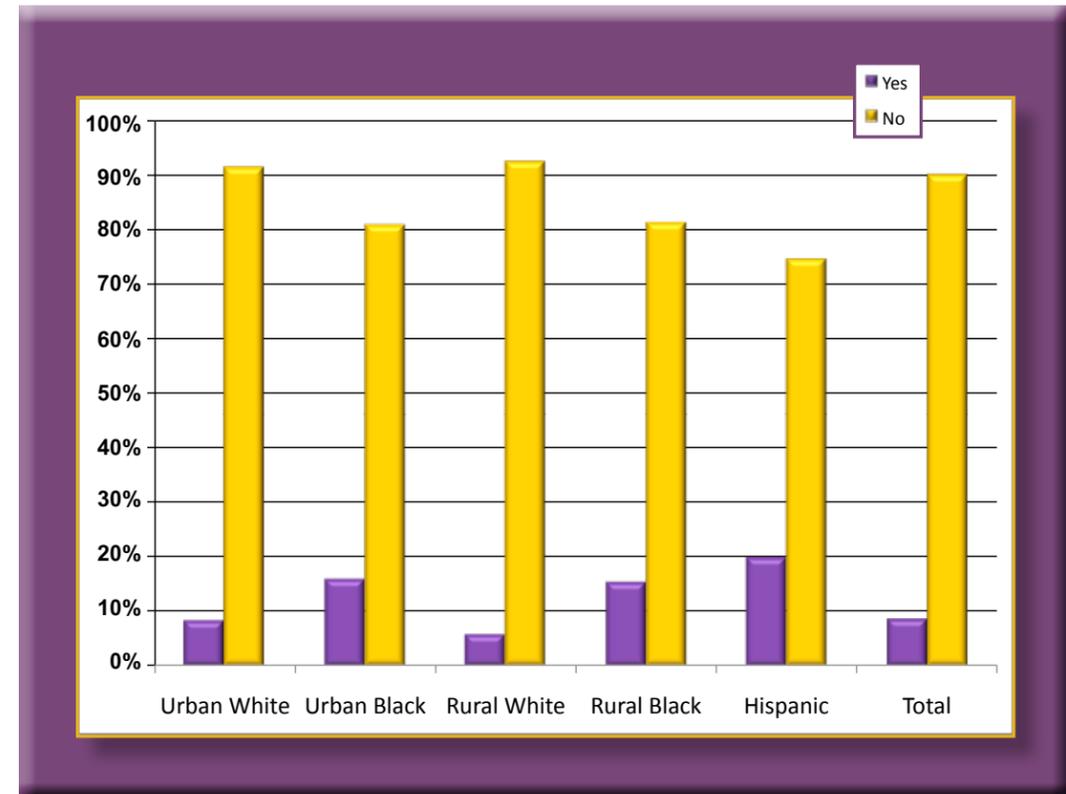
Figure 27: Have you ever been the victim of discrimination or reverse discrimination while getting healthcare for yourself or a family member?



- 20% Hispanics have experienced discrimination while getting health care
- 15-16% of Blacks report discrimination while getting health care

15%-16%
report discrimination while getting health care

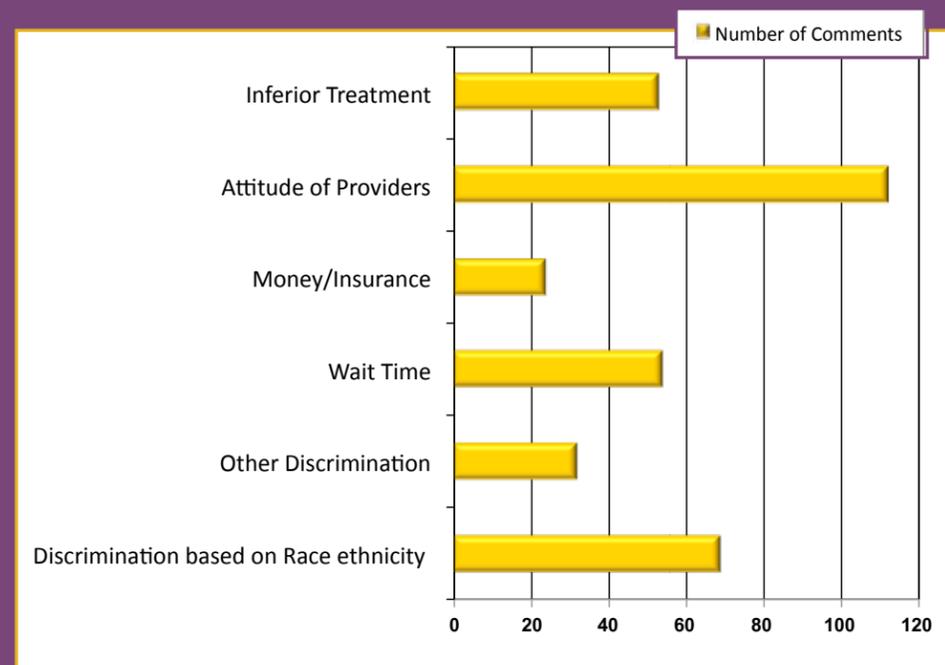
Figure 28: Have you ever felt that the doctors or medical staff you saw judged you unfairly or treated you with disrespect because of your race, ethnicity, nationality, religion, gender, or sexual orientation?



- 13% of Arkansans report being judged unfairly or treated with disrespect by doctors or medical staff
- More minorities than urban Whites reported unfair treatment or disrespect
- The majority of reports were based on race or ethnicity

The majority of reports were based on **race** or **ethnicity**

Figure 29: What happened to make you feel you were judged unfairly or treated with disrespect?



The themes that emerged from this open-ended question included:

Discrimination based on race / ethnicity:

Suffered prejudice / discrimination on basis of race or ethnicity; suffered discrimination e.g.; gender, age, religion, sexuality, weight

WAIT:

Kept waiting for a long time, priority given to other patients

Money / Insurance:

Inferior care; denied care owing to lack of insurance or Medicaid or Medicare insurance, being made to pay before service at the ER, high fees

Attitude of health care provider:

Doctors, nurses, staff rude or patronizing; poor attitude or demeanor, impersonal; disinterested; unhelpful; unfair / unequal treatment, ignored / overlooked; rushed, disrespectful, manner of talking / looking; inappropriate language

Treatment:

Received inferior treatment, refused treatment, misdiagnosed, didn't believe patient (respondent), patient not taken seriously

Conclusion

The 2009 update of the Arkansas Racial and Ethnic Health Disparity Study describes the results of the first telephone survey on the intersection of health and racial issues of a large, statewide sample of Arkansans, including nearly 1800 minority residents.

Telephone surveys are cost effective for obtaining good quality data on a population in a relatively short amount of time. However, sampling of minorities and the underserved has been an issue. This survey successfully oversampled difficult to reach populations of Hispanics and rural Blacks. Good quality is evidenced by acceptable response rates and cooperation rates that are comparable to national surveys. Nonetheless, there are some limitations to consider. First, despite the multiple factors that have been associated with racial and ethnic health disparities, this survey only asked a small number of questions. Secondly, this survey was of adult Arkansans with listed hard line telephone numbers. Some research suggests that this population may be different from populations without phones or those with cell phones only. Finally, the issues of race and health disparities can be complex and sensitive issues to discuss. Responses to racial issue questions can be influenced by whether interviewers and respondents perceive themselves to be of the same or a different race or ethnicity as one another. Race and/or ethnicity concordance and training of the interviewers helped to minimize this potential bias.

This telephone survey is notable for being the largest known survey to date of Hispanics in Arkansas on a variety of health issues. Furthermore, a large number of interviews with Hispanics were conducted in Spanish, adding weight to the findings for this group. Hispanic respondents were quite different from other groups completing the survey in several respects: 77% were under age 50, whereas the majority of other respondents were over age 50; 48% were male, where the next highest percentage of males was 39%; 50% had less than a high school education and 5% were college graduates, representing

the highest and lowest percentage of each category; and 58% were working full or part time, the highest combined percentage for any group. Additionally, income demographic data for Hispanics indicate that the respondents to this survey approximate statewide income profiles for Hispanics. However, it is worth reiterating that this survey was conducted with land line phones and not cell phones, possibly introducing bias into the findings.

The initial findings of the survey described in this report are timely, given the current environment on health care reform in the country. Although this initial analysis shows that survey respondents mostly felt race relations were very or somewhat good and a majority of each racial or ethnic group felt all groups had the same amount of health problems, troubling issues emerge from the responses to this survey. While health care reform may lead to a greater number of Arkansans with health insurance, responses to this survey by minority Arkansans indicate that health insurance alone will not be sufficient to address significant system level issues.

In terms of access to the health care system, Hispanics respondents rarely went to a doctor's office or private clinic to receive health care services, and often accessed public clinics for services. Their emergency room utilization for health care services was similar to rural Blacks, but less than urban Blacks. As one might expect given the high uninsured percentage for Hispanic respondents to this survey, they were the group that felt the least amount of choice in where to go for medical care and the least likely to have a regular doctor or health care provider. For Hispanic respondents, once they get to the place where medical services are provided, they are the group not likely to see a provider or any office staff of their ethnic group and over half reported communication barriers with the provider. Although 2 of 3 Hispanic respondents needed an interpreter during the health care encounter, less than 1 in 3 was provided with

the services of a professional interpreter by the clinic or office.

Between 25 and 40% of Hispanics, rural Blacks and urban Blacks felt that racial and ethnic minority individuals in their community were treated less fairly than White individuals by doctors or hospitals. Additionally, between 15-20% of minority respondents felt they had been discriminated against while receiving health care services. Similar percentages of minority respondents felt that they had been judged unfairly or treated with disrespect because of their individual characteristics. This judgment or treatment manifested in long wait times, rudeness, refusal to treat, collection of payment before treatment, inferior treatment and use of inappropriate language in the medical care setting. These data are particularly disturbing if one envisions increased numbers of minority Arkansans attempting to access

the health care system by virtue of being newly insured after reform of the health insurance environment. No improvement in insurance status, payment rates or financing mechanisms can compensate for unfair or poor treatment in a clinic, office or emergency room.

System-wide interventions to specifically address the issues raised by these survey responses will be necessary to improve treatment of minority Arkansans when access to the health care system is improved. Community and statewide initiatives, many of which are underway in the areas of obesity and tobacco prevention, must also have minority-specific components to address the disparity in health status between Hispanics, Black, rural residents and the rest of Arkansas and chronic disease disparity between rural and urban survey respondents.

Recommendations:

- 1. Increase awareness about racial and ethnic health disparities.** Despite the large amount of research and community efforts to decrease disparities, a significant portion of Arkansans believe that Hispanics, Blacks and Whites have the same amount of health problems. Communities and policy makers must be broadly informed about the problem: the presence and effects of racial and ethnic health disparities. More importantly, we must understand the factors that contribute to disparities in Arkansas in order to find effective solutions.
- 2. Improve health care access and choice.** While health care reform is discussed throughout the country and may improve access for many, access for the most disadvantaged in Arkansas requires added attention. Minorities are the most likely Arkansans to be uninsured and the least likely to have choice in where they receive medical services. Access to quality health care and choice is critical to improving health in minority communities.
- 3. Address disparities as a part of quality improvement.** Large portions of minorities perceive unequal treatment within the health care system. Research has documented this fact across many diseases and areas regardless of payer status. Health care quality measures must be examined by race and ethnicity to determine if quality care is received equally by all populations. As disparities are identified, they can be addressed through both targeted and general quality improvement efforts.
- 4. Improve cultural competency and diversify the healthcare workforce.** A culturally competent health care system and workforce is one that is capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency. The barriers to quality care for minorities identified in this survey included a lack of interpreter services and a lack of diversity in Arkansas' health care workforce. Because most respondents to this survey were not treated by a medical provider of their race or ethnicity, knowledge of cultural factors impacting health and the standards of care in treating diverse patients must be understood by all providers, including support staff in clinics and hospitals.