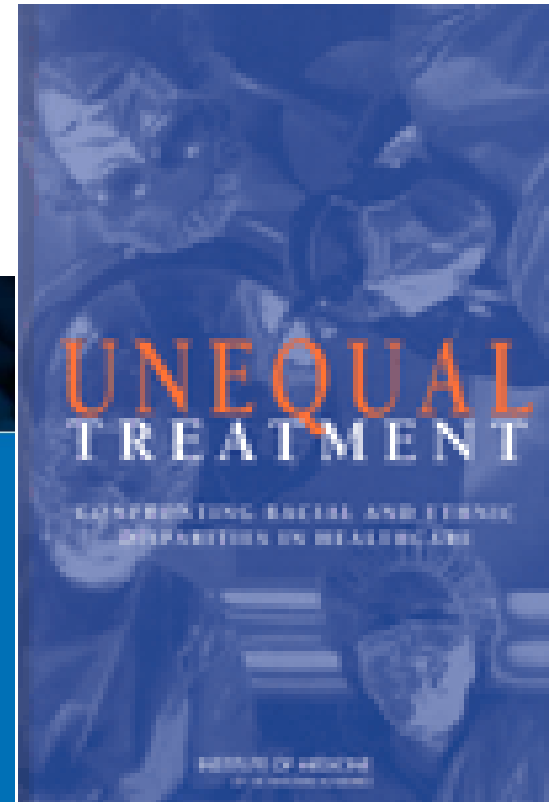
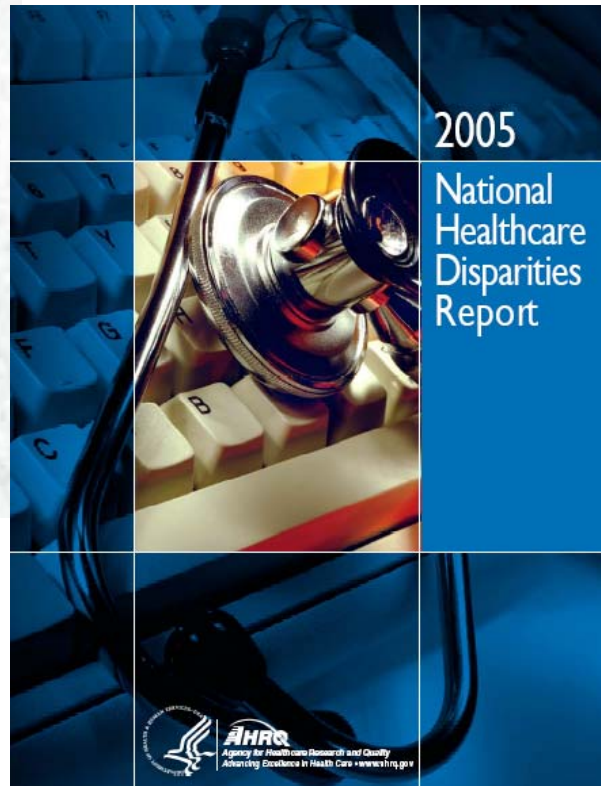
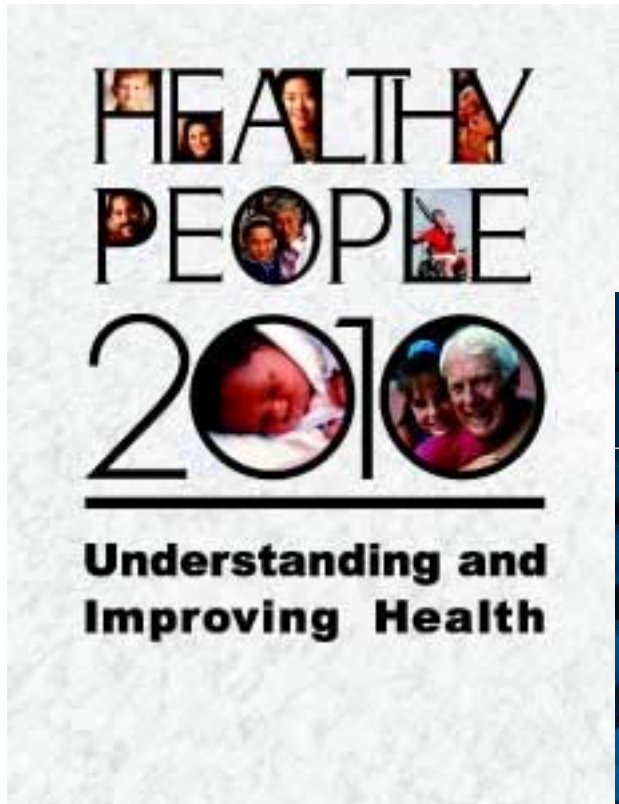


Health Disparities

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Health Disparities Nationally





Key Facts

Race, Ethnicity & Medical Care

January 2007



www.kff.org

Health Status

Coverage

Preventive and
Primary Care

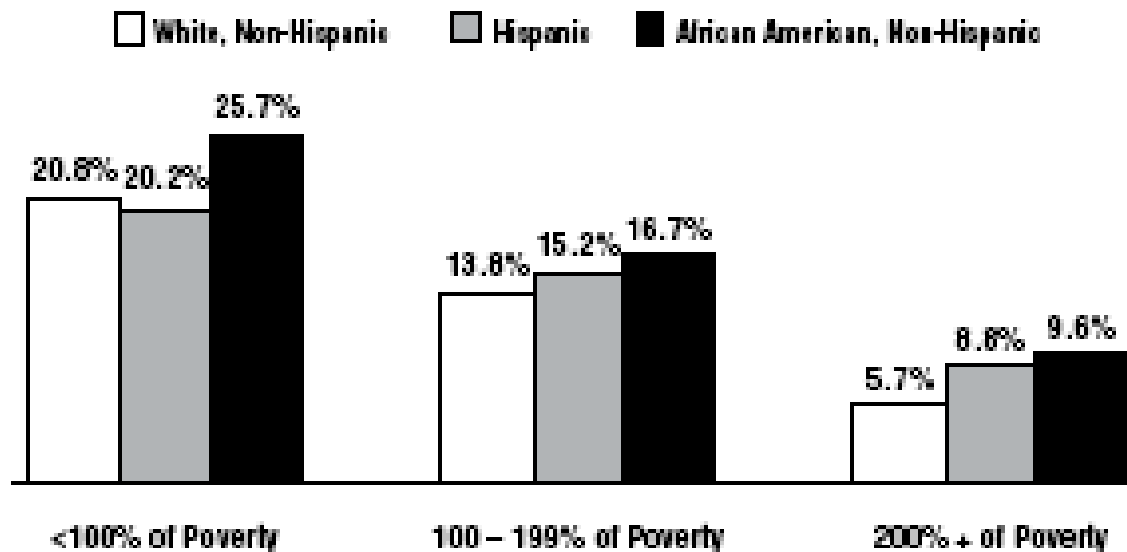
Diabetes

HIV/AIDS

Asthma

Figure 7
**Fair or Poor Health Status
by Race/Ethnicity and Income, 2004**

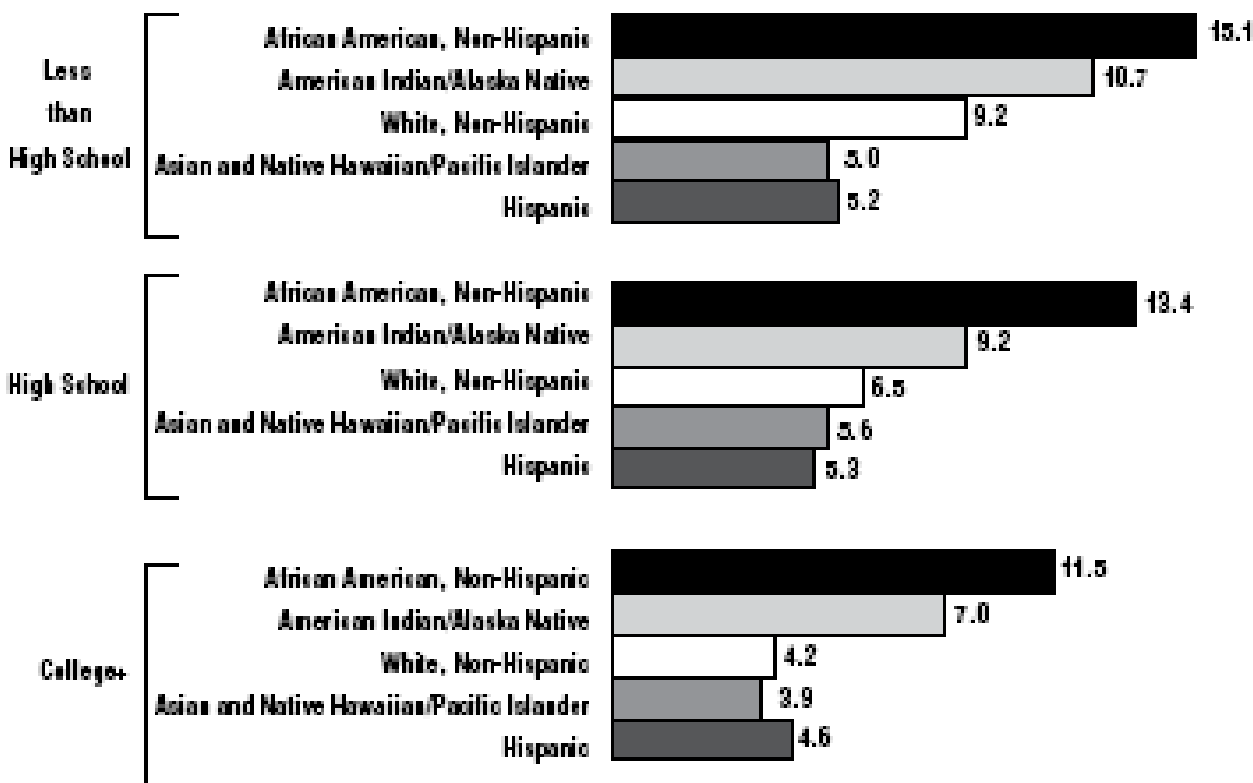
Share reporting fair or poor health:



People with family incomes below 100% of poverty are more likely to rate their health as fair or poor compared to the near-poor and non-poor. When comparing racial/ethnic groups of similar incomes, the disparity in self-reported health is reduced but not eliminated.

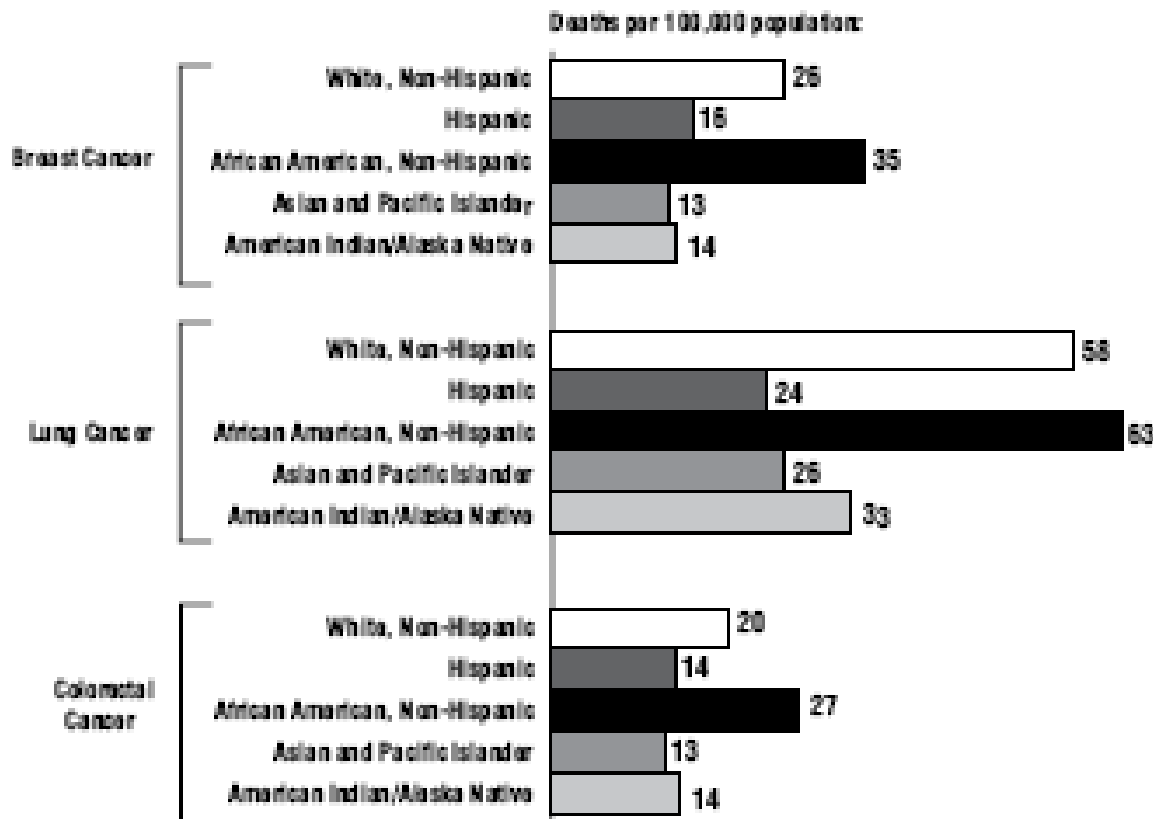
Figure 9

Infant Mortality Rates for Mothers Age 20+ by Race/Ethnicity and Education, 2001–2003



Infant mortality rates, considered one of the most sensitive indicators of the health and well-being of a population, are higher among African Americans and American Indians/Alaska Natives than among other racial/ethnic groups, even when comparing women of similar socioeconomic conditions, as measured by years of education completed.

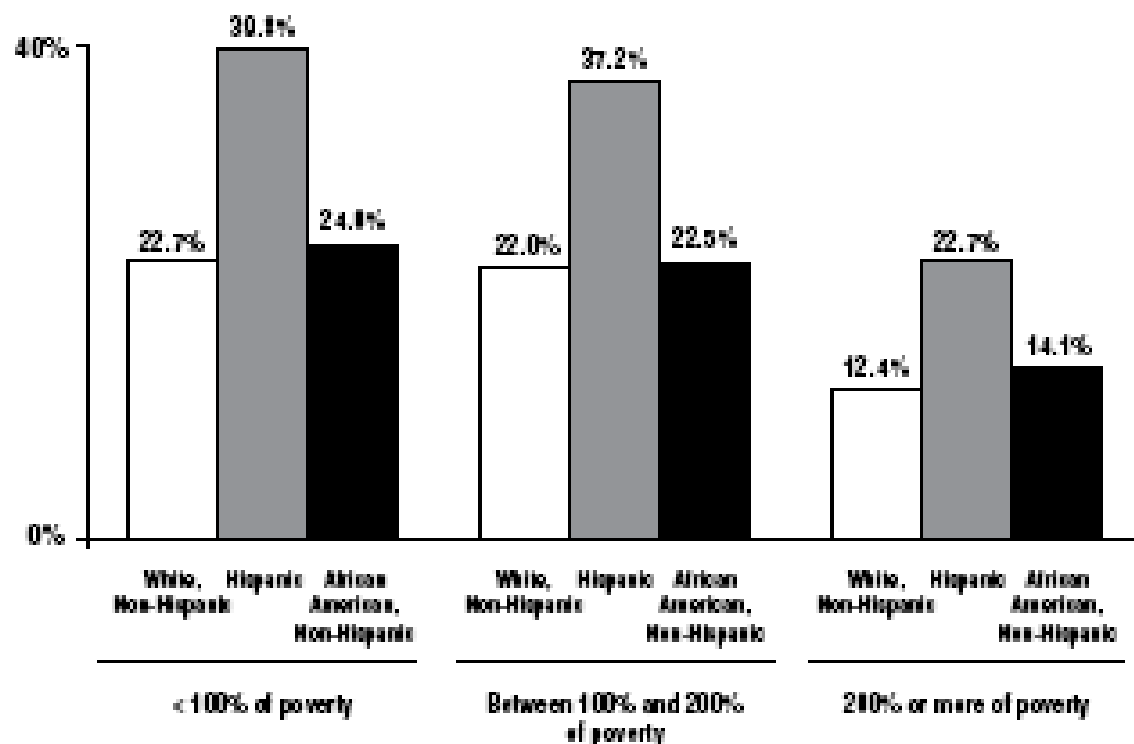
Figure 12
Cancer Death Rates by Race/Ethnicity, 2002



African Americans have a higher death rate from breast, lung, and colorectal cancer than any other racial or ethnic group. American Indians/Alaska Natives, Hispanics, Asians and Pacific Islanders have lower death rates for breast, lung, and colorectal cancer than Whites.

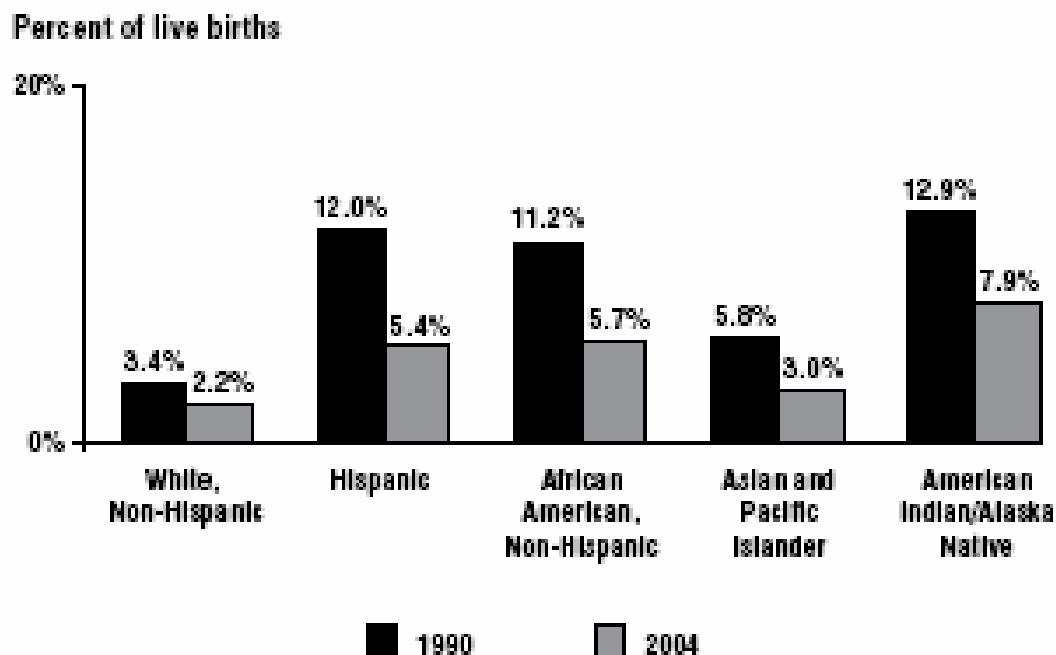
Figure 27

No Usual Source of Health Care: Adults 18–64 by Race/Ethnicity and Poverty Status, 2003–2004



When comparing racial/ethnic groups of similar income, the disparity in usual source of care is nearly eliminated for African Americans but not for Hispanics. However across racial/ethnic groups, the percentage with no usual source of care is higher among people with incomes below the poverty level and between 100% and 200% of the poverty level compared to those with incomes above 200% of poverty.

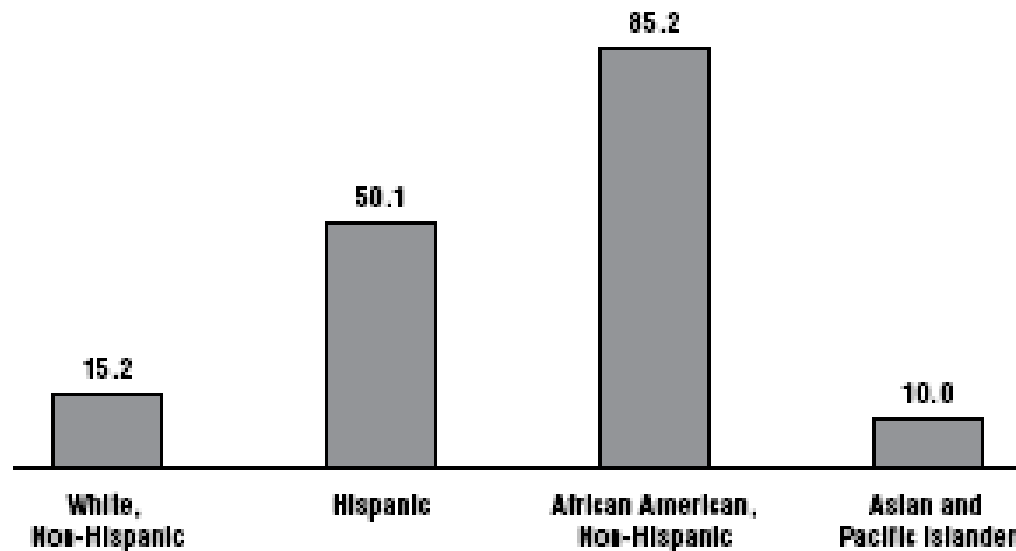
Figure 30
**Late or No Prenatal Care
 by Race/Ethnicity, 1990 and 2004**



Prenatal care that begins in the first trimester of pregnancy improves maternal health and birth outcomes. Though the percent of live births to mothers who received late or no prenatal care has decreased over the past fifteen years, Hispanics, African Americans and American Indian/Alaska Natives are still more likely than Whites and Asians and Native Hawaiians/Pacific Islanders to receive late or no prenatal care.

Figure 39
**Hospital Admissions for Uncontrolled Diabetes
by Race/Ethnicity, 2002**

Admissions per 100,000 population:



The rates of hospital admissions for uncontrolled diabetes for African Americans and Hispanics were more than 5 and 3 times respectively, the rate for Whites and Asians and Pacific Islanders. Asians and Pacific Islanders had the lowest rates of hospital admissions with 10 admissions per 100,000.

Health Disparities in Arkansas



The State of Diabetes in Arkansas



2004 Pulaski County Adult Health Survey

CATHOLIC HEALTH INITIATIVES

St. Vincent

Inspired.

Coordinated by:
Pulaski County Hometown Health
and
The Arkansas Department of Health
Center for Health Statistics

BRFSS

Data & Research

Vital Information for a healthy Arkansas!

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Query System

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- Arkansas Center for Health Statistics Query System [Main Menu](#)
- Arkansas's Hospital Discharge Data [Main Menu](#)
Click on "Data Review from BRFSS"

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Mortality

- Detailed Reports [Data](#)
- Statistics [Data](#)

Publications

- Arkansas Prevention Needs Assessment Survey [Data](#)

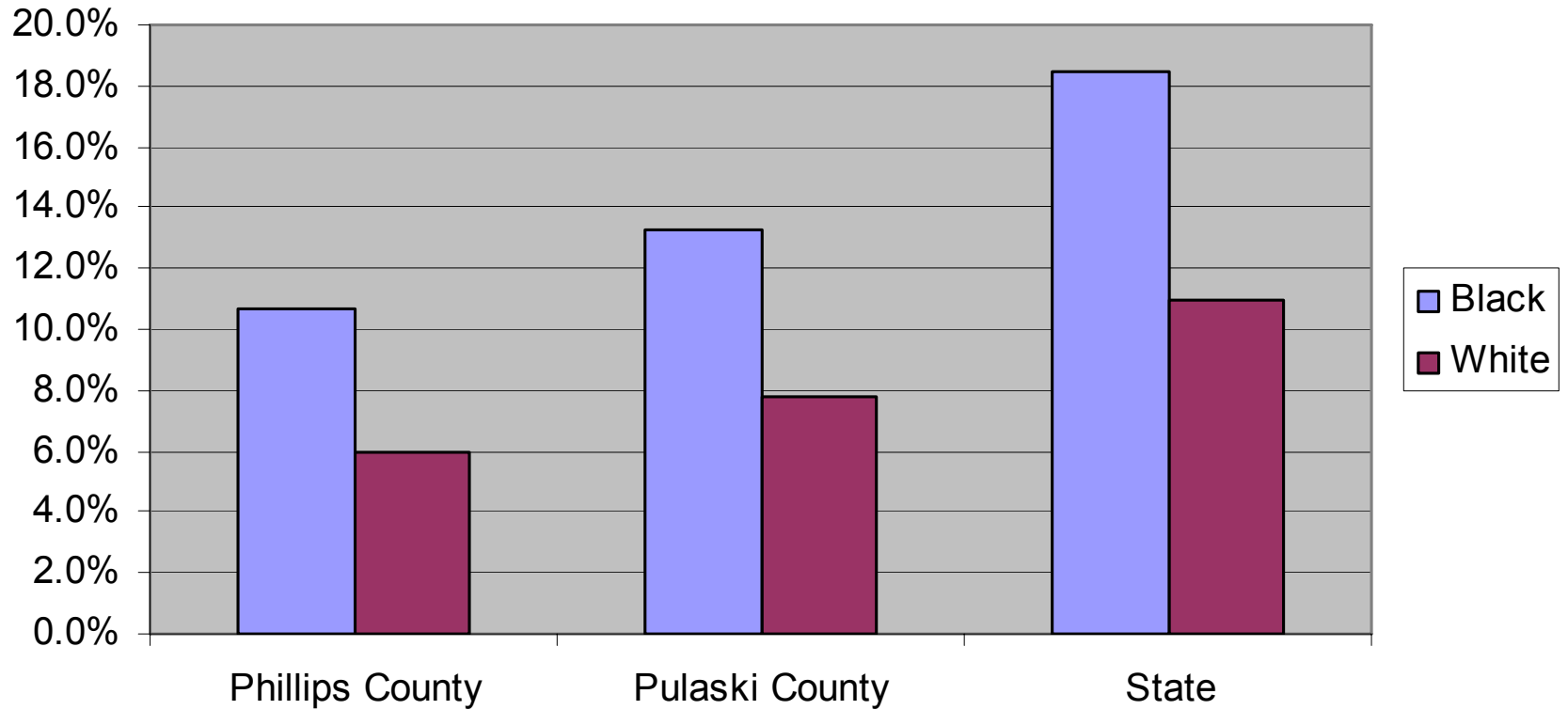
2002 Delta Cardiovascular and Diabetes Risk Factor Survey

Coordinated by:
Arkansas Department of Health
Center for Health Statistics
and
Arkansas Minority Health Commission

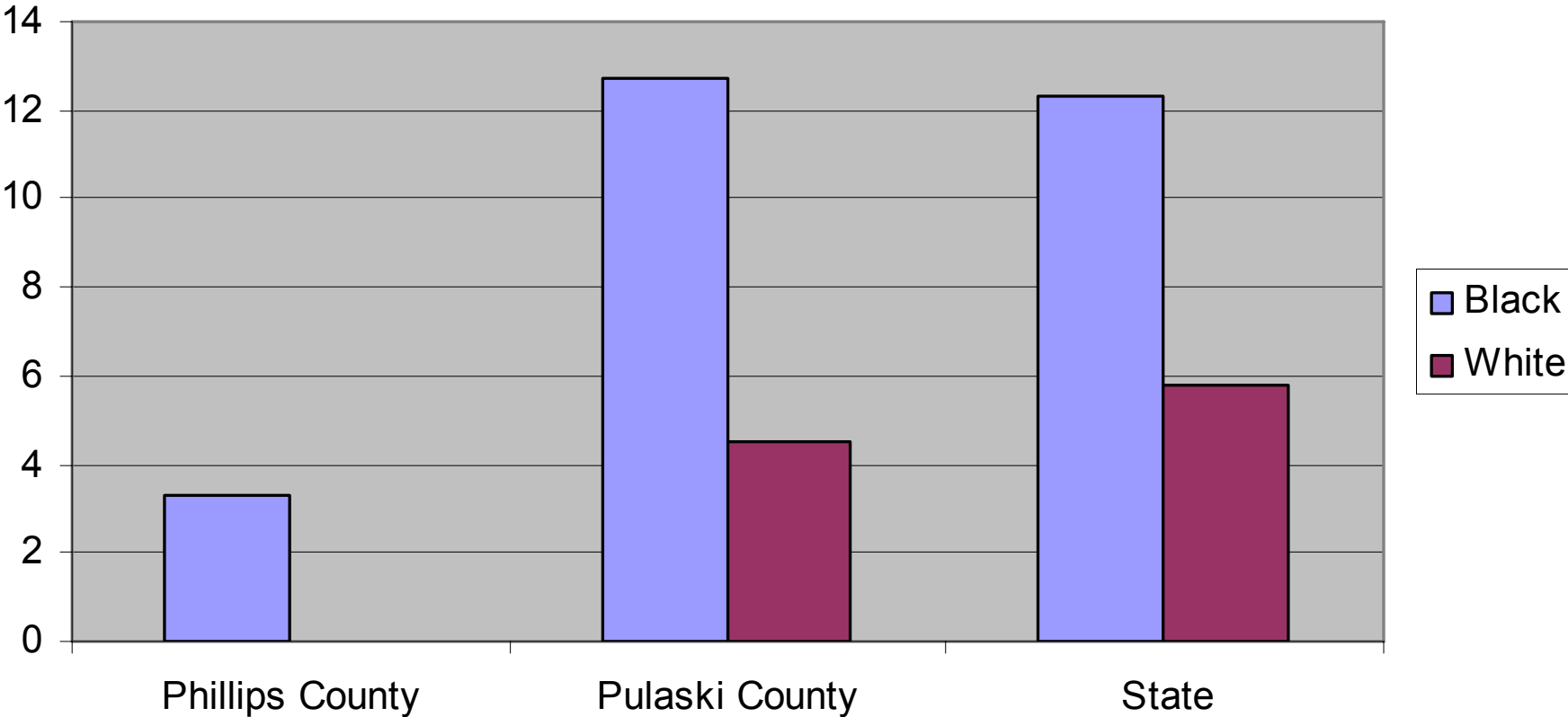
2002 Phillips County Cardiovascular and Diabetes Risk Factor Survey

Coordinated by:
Arkansas Department of Health
Center for Health Statistics
and
Arkansas Minority Health Commission

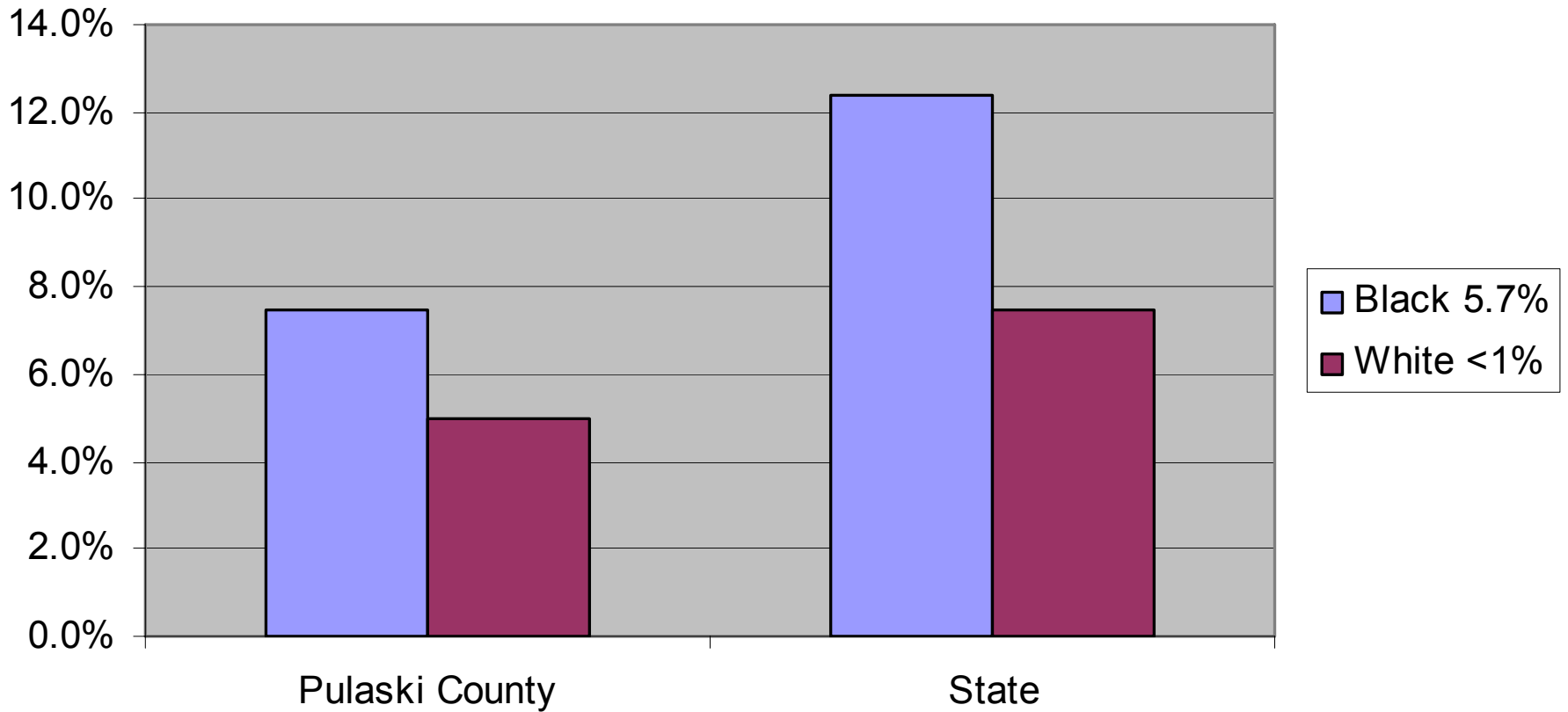
Low Birthweight in Arkansas (03)



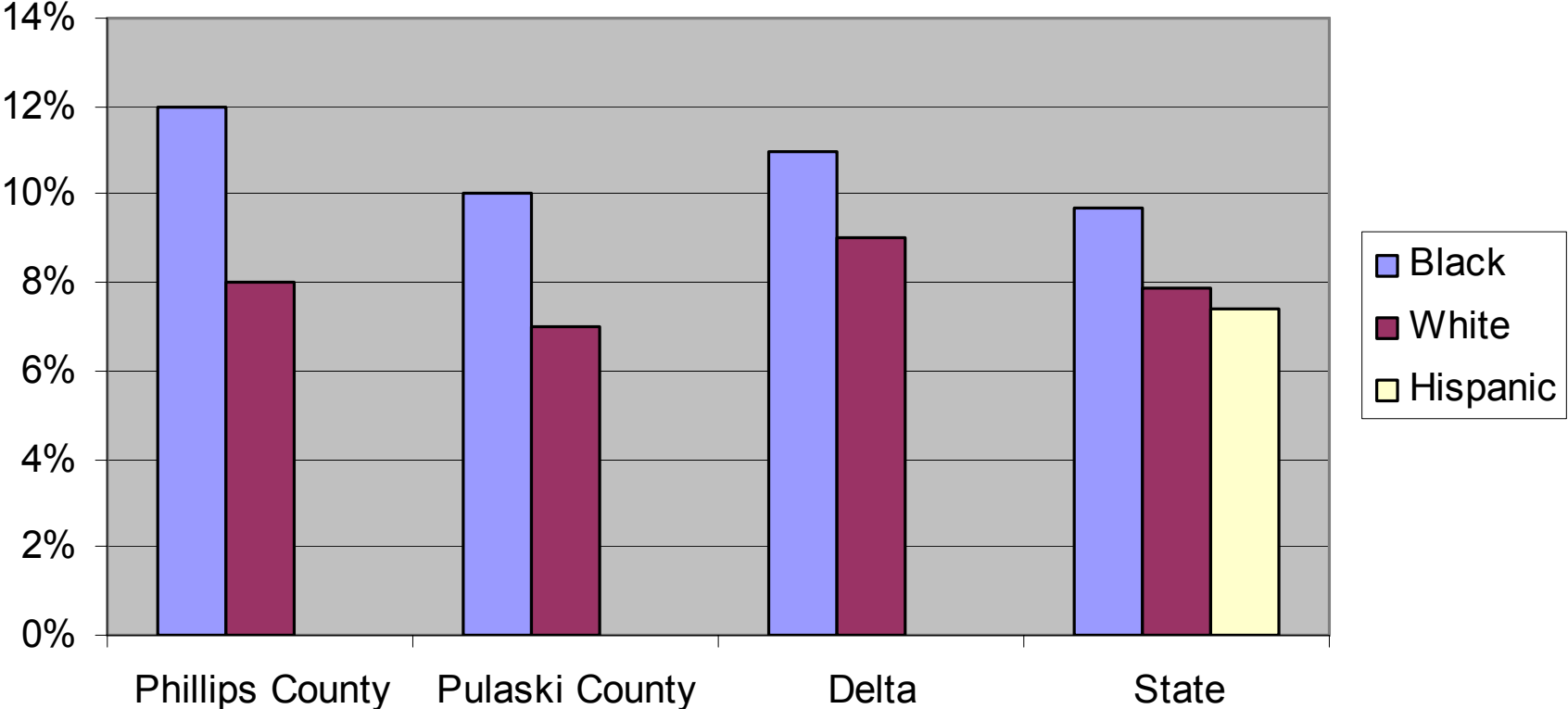
Infant Mortality in Arkansas (03)



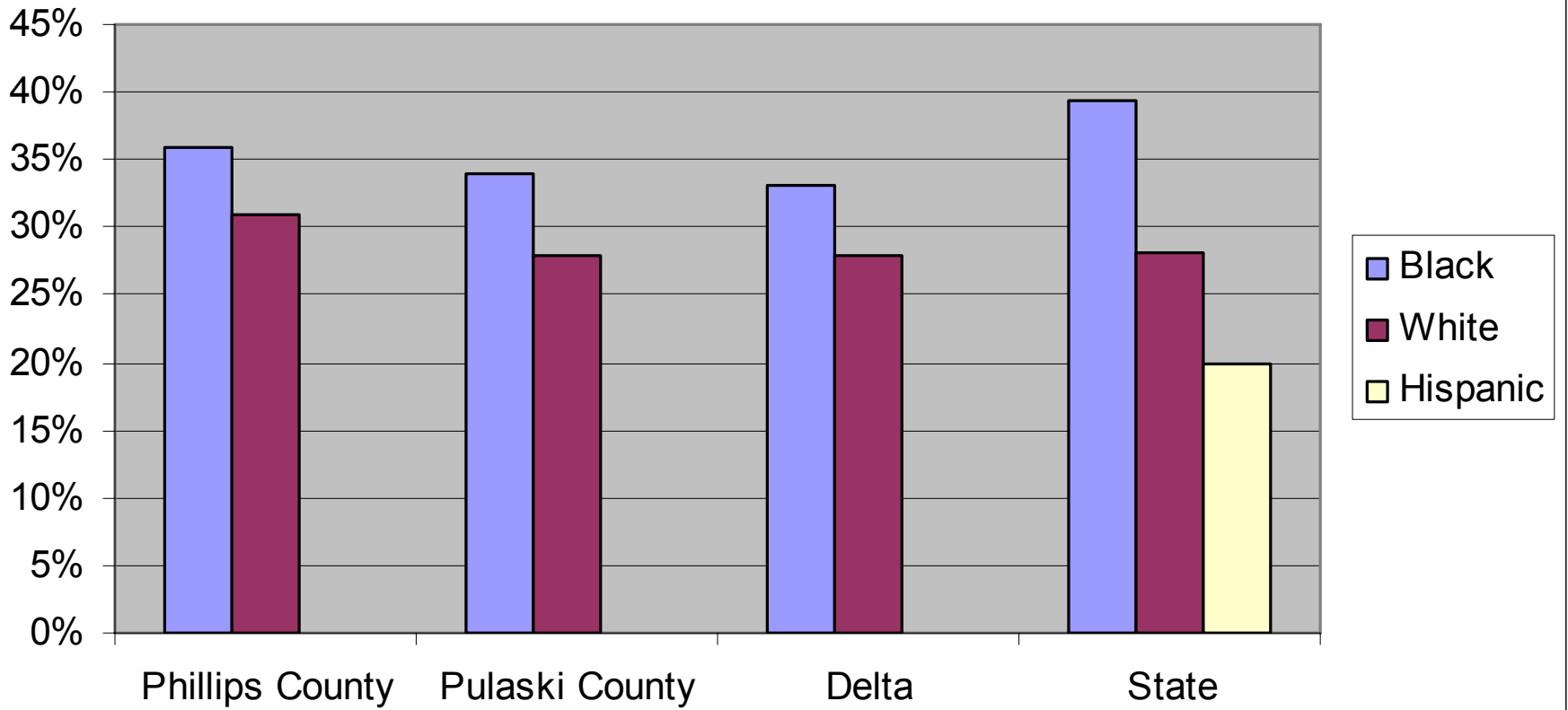
Premature Births in Arkansas (03)



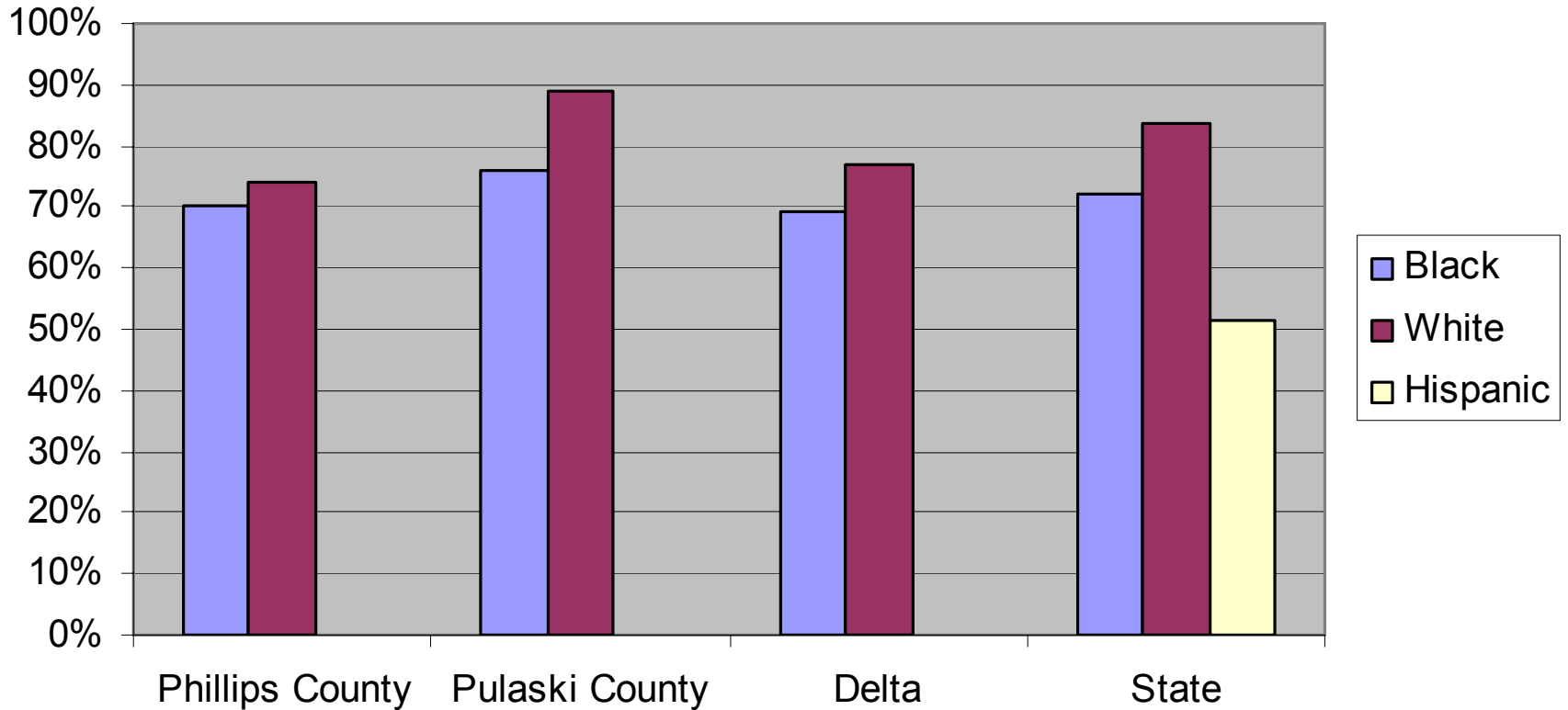
Diabetes in Arkansas



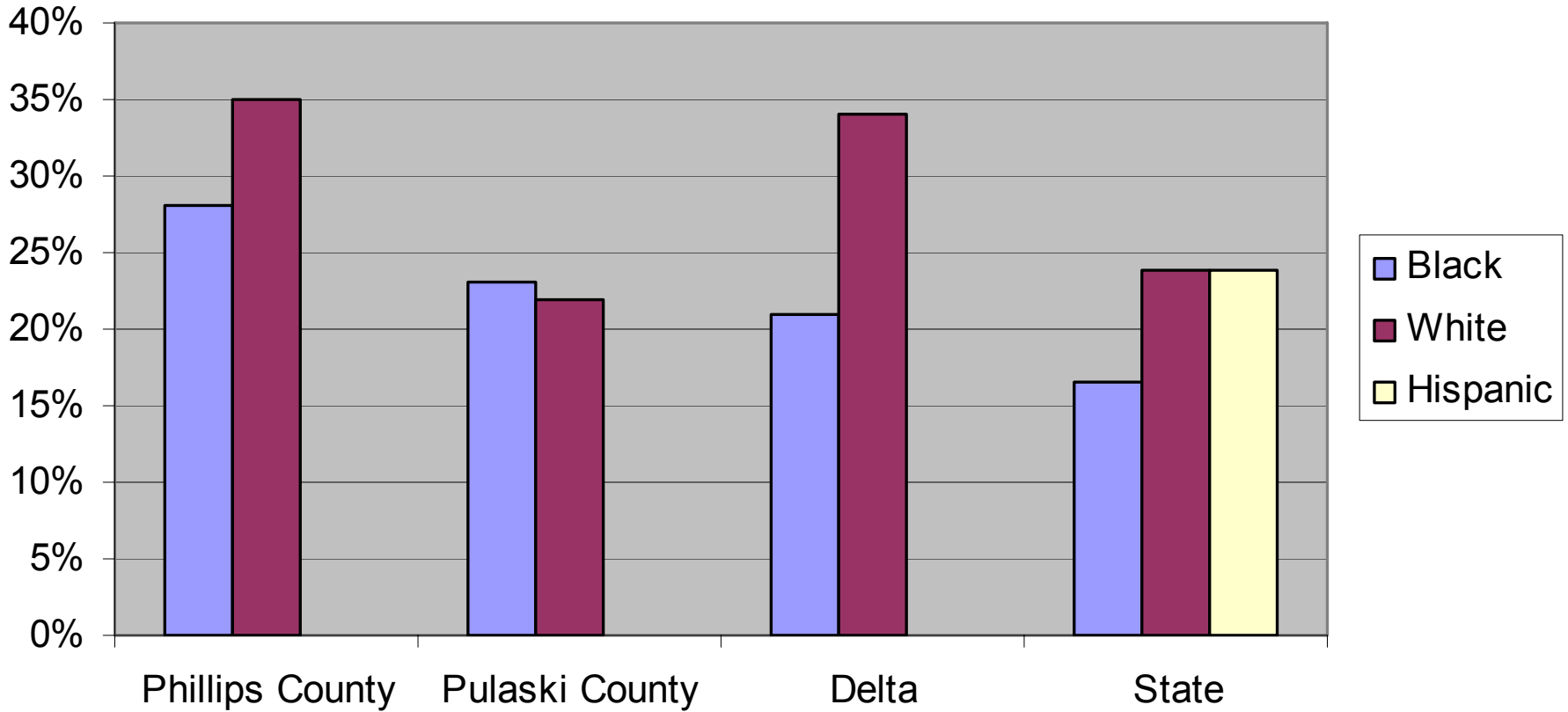
Hypertension in Arkansas



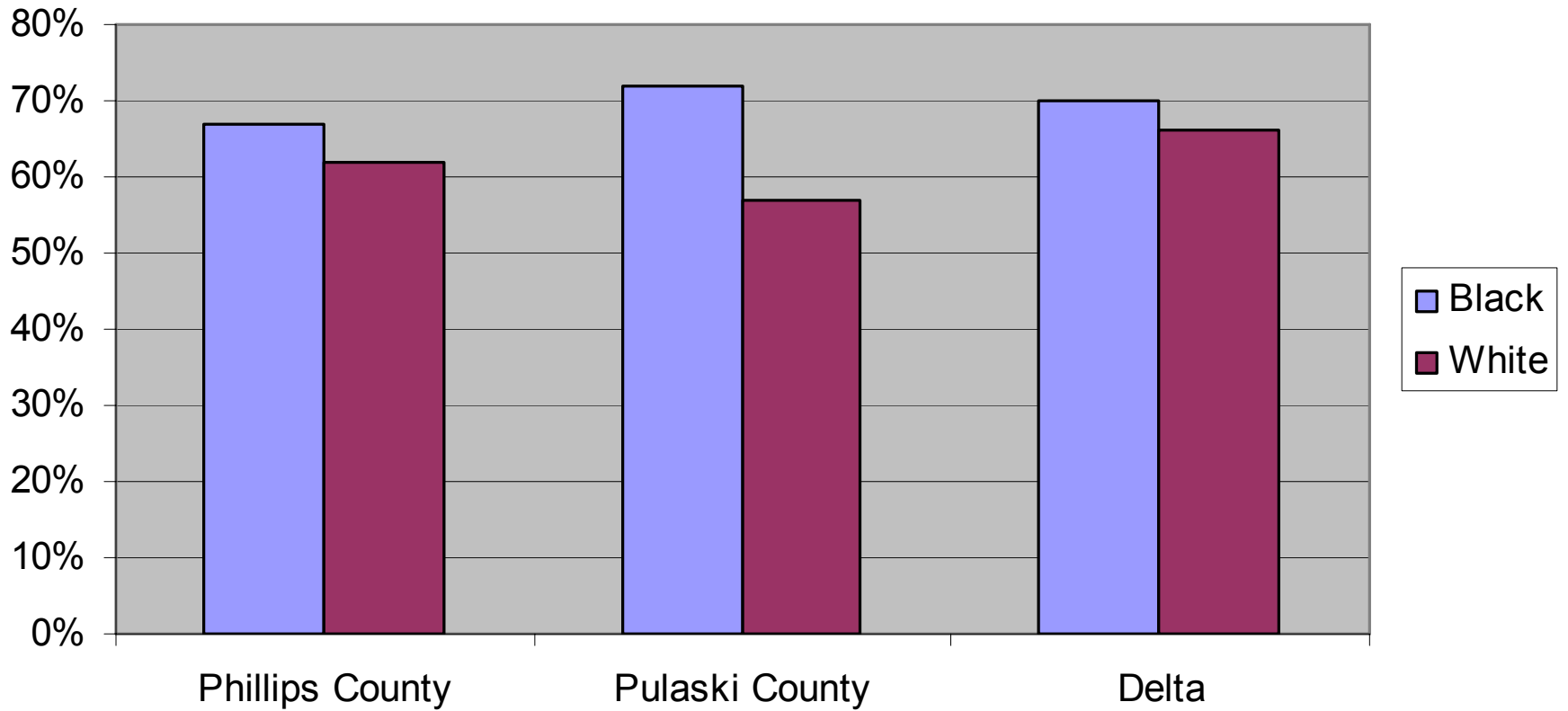
Health Care Coverage in Arkansas



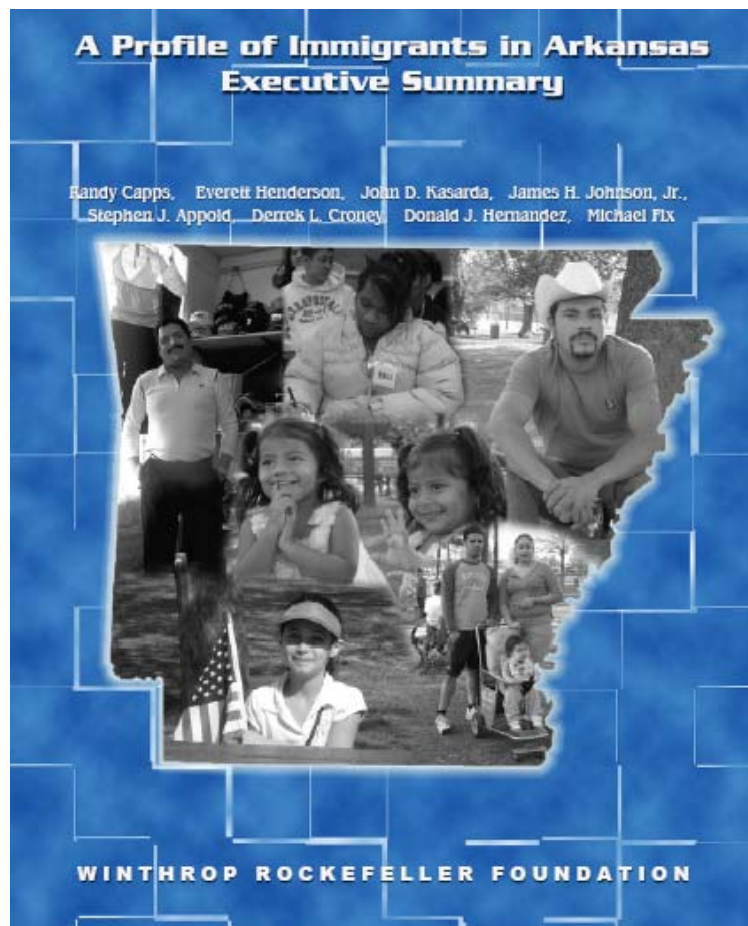
Tobacco Use in Arkansas



Overweight in Arkansas



Immigrants and Health Disparities in Arkansas



April 2007

Urban Institute

www.urban.org

Demographics

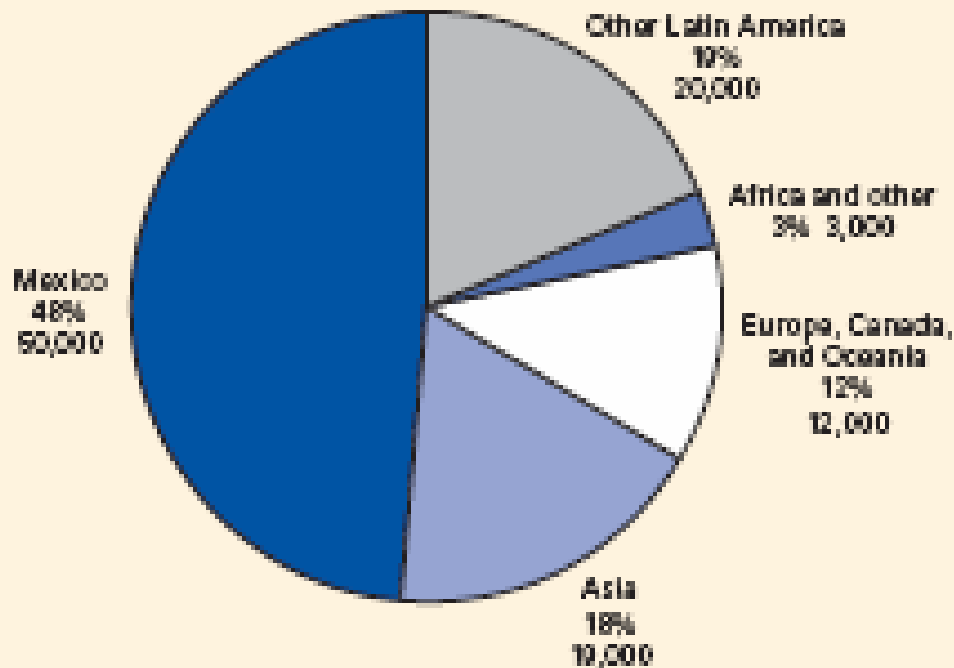
Labor Force

Children and Families

Economic Impact

Arkansas Foreign-Born Population

Figure 1. Region of Origin for Arkansas Immigrants, 2005



Source: Urban Institute analysis of 2005 American Community Survey, 1 percent PUMS.

- Largest communities in Springdale, Rogers, Fayetteville, and Fort Smith
- About half of Arkansas immigrants are undocumented, most coming to the state for work
- Manufacturing Industry employs the most immigrants
- Fastest growing Hispanic population nationwide between 2000 and 2005

Healthy Immigrant Effect

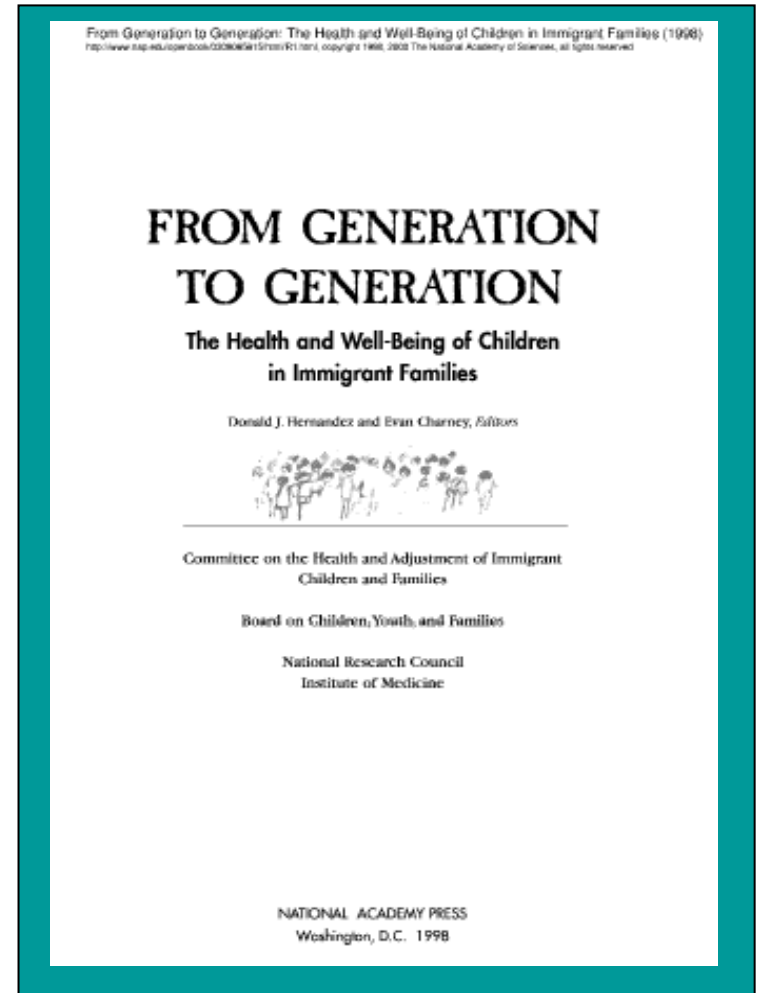
- Immigrant adults tend to be healthier than US-born adults of similar socio-economic status
- Lower infant mortality, lower rates of mental health problems
- Effect fades with time in the US

Health Risks and Needs for Immigrants

- Chronic illness
- Workplace hazards
- Racial/ethnic disparities
- Lack of adequate access to preventive care and healthcare coverage
- Language often a barrier to adequate healthcare
- Health risks of poverty

Health of Children of Immigrants

- Most children of immigrants are US citizens
- Begin to take on health risks of US-born population of similar socioeconomic status
- Additional risks from poor adjustment that are common to immigrants born to non-English speaking parents with low educational levels
- Second generation risks:
 - increased mental health issues
 - lack of success in school
 - increased risk for teen pregnancy, juvenile delinquency, drug/alcohol dependency



Health Disparities

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