Approved: March 10, 2009
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:30 p.m. on February 11, 2009, in Room 106 of the Landon Building

All members were present except Senator Mary Pilcher-Cook who was excused.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes, was excused
Doug Taylor, Office of the Revisor of Statutes
Kelly Navinsky-Wenzl, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Jan Lunn, Committee Assistant

Presentation on Healthcare Disparities in Kansas by:
Dr. David Williams

Dr. David Williams was introduced; Dr. Williams' presentation related to health care disparities was entitled: "Working Together for a Healthier Kansas" (Attachment 1).

Dr. Williams indicated the charge for the report was to review the current status of health in Kansas and to evaluate the uneven gaps that existed. He reported that good health is necessary to achieve the American dream and that in order to achieve good health, it is necessary to take steps to ensure children have a healthy and prosperous life. He presented infant mortality rates in Kansas compared to national and international rankings and by income status and race. Data related to smoking, obesity, and blood pressure were reviewed.

Dr. Williams spoke about how to close the gap in healthcare disparities. He indicated personal and social responsibility is a key to removing barriers and creating opportunities for better health. Social policies can facilitate healthy lifestyle choices. He spoke about the logic of prevention and discovering ways to live healthier lives. Dr. Williams indicated that redefinition of health policy is also key to reformation; public/private partnerships can impact healthier choices by providing incentives and opportunities to improve health by restricting access to alcohol and cigarettes, providing exercise opportunities, expanding on green spaces, limiting exposure to lead and radon, and supporting crime prevention, etc. Dr. Williams spoke about the importance of social support and education as being one of the strongest relationships to improved health. He provided various examples of public/private partnerships that excelled in educating children, assisting poor, pregnant women and their infants, providing healthcare that assesses underlying causes for illness, and accessing nutritional foods in impoverished neighborhoods.

Dr. Williams concluded that the keys to success are leadership, innovation, community leadership, cooperation, commitment to values, as well as public/private partnerships. He indicated that collaborative work is required, and the men and women of Kansas can make a difference. Dr. Williams stressed the importance of infrastructure development, focusing on improving health particularly in early childhood, improving consequences of living in a chronic poverty environment, and encouraging incentives to businesses that promote communities of wellness.

Chairman Barnett adjourned the meeting at 2:28pm

Dr. David R. Williams is the Florence and Laura Norman Professor of Public Health at the Harvard School of Public Health and Professor of African and African American Studies and Sociology at Harvard University. His first six years as a faculty member were at Yale University where he held appointments in both Sociology and Public Health. The next 14 years were at the University of Michigan where he served as the Harold Cruse Collegiate Professor of Sociology, a Senior Research Scientist at the Institute of Social Research and a Professor of Epidemiology in the School of Public Health. He holds a master's degree in public health from Loma Linda University and a Ph.D. in Sociology from the University of Michigan.

He is an internationally recognized authority on social influences on health. His research has focused on trends and determinants of socioeconomic and racial disparities in health, the effects of racism on health and the ways in which religious involvement can affect health. He is the author of more than 150 scholarly papers in scientific journals and edited collections and his research has appeared in leading journals in sociology, psychology, medicine, public health and epidemiology. He has served as a member of the editorial board of eight scientific journals and as a reviewer for more than 50 others. According to ISI Essential Science Indicators, he was one of the Top 10 Most Cited Researchers in the Social Sciences during the decade 1995 to 2005. The Journal of Black Issues in Higher Education ranked him as the second Most Cited Black Scholar in the Social Sciences in 2006. In 2001, he was elected as a member of the Institute of Medicine of the National Academy of Sciences. In 2004, he received one of the inaugural Decade of Behavior Research Awards and in 2007 he was elected to membership in the American Academy of Arts and Sciences.

He has been involved in the development of health policy at the national level in the U.S. He has served on the Department of Health and Human Services' National Committee on Vital and Health Statistics and on six panels for the Institute of Medicine of the National Academy of Sciences. He has held elected and appointed positions in professional organizations, such as the American Sociological Association, Academy Health and the American Public Health Association. Currently, he is a member of the MacArthur Foundation's Research Network on Socioeconomic Status and Health.

His current research includes studying the health of Black Caribbean immigrants in the U.S., examining how race-related stressors (racial discrimination in the U.S. and exposure to torture during Apartheid in South Africa) can affect health, and assessing the ways in which religious involvement is related to health.

Table of Contents

Introduction

Good health is one of life's most precious treasures. It is the foundation upon which success, in many areas of life, is built. Americans invest a lot in health. We spend more per person on medical care than any other country in the world, and we lead the world in spending on medical research. However, there is growing national concern that the American population is not as healthy as it could be, and that there are large shortfalls in health by race and ethnicity. Research studies continue to find that we rank near the bottom of the major industrialized countries in terms of health. Clearly, we are not getting our money's worth when it comes to our investment in health.

Where do things stand in Kansas? What is the health profile of our state? And what can we do to improve the health of every Kansan? These are the questions that drive this report. This report seeks to provide a hard look at the health statistics for Kansas. It considers our overall health, as well as, the gaps in health by race and ethnicity. Importantly, it also considers variation in health by two indicators of socioeconomic status (SES) – income and education. It is often found that the gaps in health by income and education are larger than those by race. SES plays a large role in accounting for racial differences in health. Both race/ethnicity and SES, separately and together, affect one's chances of getting sick and we need a greater appreciation of how they combine to affect the health.

This report also utilizes the best available knowledge to point to concrete steps that can be taken to improve health. We need to improve the health of every resident of Kansas and we also need special efforts to improve the health of those groups that have large shortfalls in health more rapidly than the rest of the population, so that we can close the racial/ethnic and socioeconomic gaps in health. Accordingly, this report identifies specific actions that can be taken by government, the private sector, community organizations and private citizens to improve health.

What Would a Healthy Kansas Really Look Like?

The U.S. Constitution promises life, liberty and the pursuit of happiness to every American. But good health is absolutely necessary to achieve the American dream. We need to take steps now to ensure that every child born in Kansas can have a healthy and prosperous future.

What would a healthy Kansas for every child look like? A Healthy Kansas is a place where:

- Everyone lives in well-maintained neighborhoods that are safe and that have access to needed goods and services
- Everyone has received the training and skills to create business opportunities or to obtain a decent job that pays a living wage
- Everyone can work in a healthy occupational environment, free from physical or chemical exposures that are harmful to health
- Everyone has access to adequate income that enables them to meet the basic needs of their families
- Everyone has access to high-quality, affordable housing
- Everyone can breathe clean air that is free from tobacco and other pollutants
- Everyone has access to and can afford to obtain nutritious food
- Everyone has the opportunities to be physically active
- Everyone has access to reliable, safe, affordable and accessible means of public or private transportation
- Everyone has access to high-quality medical care
- Every child can develop normally, free from poverty, abuse and neglect
- Every child can be ready for academic success when they begin school and will have access to school environments that support academic, emotional, social and physical well-being
- Everyone has equitable opportunities and is hopeful and optimistic about the future

We need to take steps now to ensure that every child born in Kansas can have a healthy and prosperous future.

The State of Health In Kansas

The health in Kansas should be understood within the larger context of the state of health in the United States.

This chart shows that America is not the healthiest nation in the world. In 2004, the U.S. ranked 22nd in the world on life expectancy. More disconcerting is the fact that we have been losing ground over the last several decades. In 1960, the U.S. ranked 16th in the world.

Life Expectancy (LE) at birth, Total years

1960	Rank	2004	Rank
Netherlands, LE = 73.5	1	Japan, LE=81.8	1
Norway	2	Iceland	2
Sweden	3	Spain	3
Iceland	4	Switzerland	4
Denmark	5	Australia	5
Switzerland	6	Sweden	6
Canada	7	Italy	7
New Zealand	7	Canada	8
Australia	9	Norway	9
United Kingdom	10	France	10
Czech Republic	11	New Zealand	11
Belgium	12	Austria	12
Slovak Republic	13	Netherlands	12
France	14	United Kingdom	14
Ireland	15	Finland	14
United States, LE = 69.9	**16**	Germany	16
Greece	16	Luxembourg	17
Italy	18	Belgium	18
Spain	19	Greece	18
Germany	20	Ireland	20
Luxembourg	21	Portugal	21
Finland	22	Denmark	22
Austria	23	**United States= 77.2**	**22**
Hungary	24	Korea	24
Poland	25	Czech Republic	25
Japan	25	Mexico	26
Portugal	27	Poland	27
Mexico	28	Slovak Republic	28
Korea	29	Hungary	29
Turkey, LE = 48.3	30	Turkey, LE = 68.7	30

Source: Health United States, 2007; World Development Indicators Database

Infant mortality, which refers to the deaths of infants before their first birthday is another widely used marker of the health of a nation in international comparisons. In 2004, the U.S. ranked 29th in the world – tied with Poland and Slovakia – on infant mortality. Children born in Cuba and Hungary are more likely to survive to their first birthday than children born in the U.S. We have also lost ground on this indicator of health. In 1960, the U.S. was ranked 11th in the world.

In 1960, the US ranked 11th in the world on infant mortality, the US ranked 29th in 2004.

Infant Mortality Rates and International Rankings

(per 1,000 live births)

1960	Rank	2004	Rank
Sweden, IMR = 16.6	1	Singapore, IMR = 2.6	1
Netherlands	2	Hong Kong	2
Norway	3	Japan	3
Czech Republic	4	Sweden	4
Australia	5	Norway	5
Finland	6	Finland	6
Switzerland	7	Spain	7
Denmark	8	Czech Republic	8
England and Wales	9	France	9
New Zealand	10	Portugal	10
United States, IMR = 26.0	**11**	France	11
Scotland	12	Germany	11
Northern Ireland	13	Italy	11
Canada	14	Netherlands	11
France	15	Switzerland	15
Slovakia	16	Belgium	16
Ireland	17	Denmark	17
Japan	18	Austria	18
Israel	19	Israel	18
Belgium	20	Australia	20
Singapore	21	Scotland	21
Germany	22	Ireland	21
Cuba	23	England and Wales	23
Austria	24	Canada	24
Greece	25	Northern Ireland	25
Hong Kong	26	New Zealand	26
Puerto Rico	27	Cuba	27
Spain	28	Hungary	28
Italy	29	**United States, IMR = 6.7**	**29**
Bulgaria	30	Poland	29
Hungary	31	Slovakia	29
Poland	32	Puerto Rico	32
Costa Rica	33	Chile	33
Romania	34	Costa Rica	34
Portugal	35	Russian Federation	35
Chile, IMR = 120.3	36	Bulgaria, IMR = 12.3	36

Source: Health United States, 2007

The State of Health In Kansas

The next chart looks at how the state of Kansas compares to the other 49 states on infant mortality. In 2005, Kansas ranked 33rd among the 50 states in taking care of infants before their first birthday. And just as the U.S. is losing ground compared to other countries, Kansas is losing ground compared to other states. As recently as 1989, Kansas was ranked 21st among the states in infant death rates. Since 1989, the infant death rate has continued to decline in Kansas, but our fall in the rankings reflects the fact that other states have been more successful than Kansas in reducing death rates.

The chart also reveals that some Kansans enjoy much better health than others. If White citizens of Kansas were a state, it would rank 7th in the country. In contrast, if Black (or African American) citizens of Kansas were a state, it would rank at the very bottom of all the states – tying with Mississippi for the lowest ranking.

Infant Mortality Rates and State Rankings

1989	Rank	2005	Rank
Maine, IMR = 6.6	1	Utah, IMR = 4.5	1
Vermont	1	Washington	2
Utah	3	Minnesota	3
Massachusetts	3	Massachusetts	4
Hawaii	3	New Jersey	5
New Hampshire	6	New Hampshire	6
Minnesota	7	Iowa	7
California	7	California	7
Kansas White, IMR = 7.8		**Kansas White, IMR = 5.5**	
Texas	9	Nebraska	9
Connecticut	9	Nevada	10
Oregon	11	New York	11
Washington	11	Connecticut	12
North Dakota	11	Oregon	13
Oklahoma	11	Alaska	14
Nebraska	15	North Dakota	15
Iowa	16	Idaho	16
New Jersey	17	New Mexico	17
New Mexico	17	Colorado	18
Wyoming	17	Rhode Island	19
Wisconsin	17	Hawaii	20
Kansas, IMR = 8.5	**21**	Vermont	21
Nevada	22	Texas	22
Colorado	23	Wisconsin	23
Rhode Island	23	Kentucky	24
Kentucky	23	Wyoming	25
Arizona	23	Maine	26
Idaho	27	Arizona	27
Montana	28	Montana	28
Ohio	28	Florida	29
Maryland	30	South Dakota	30
West Virginia	31	Maryland	31
Alaska	32	Pennsylvania	31
Pennsylvania	33	**Kansas, IMR = 7.4**	**33**
Indiana	34	Illinois	34
Florida	35	Virginia	35
New York	36	Missouri	36
South Dakota	37	Arkansas	37
Missouri	38	Michigan	38
Virginia	39	Indiana	39
Arkansas	40	Oklahoma	40
Louisiana	40	West Virginia	41
Tennessee	40	Georgia	42
Michigan	43	Ohio	43
North Carolina	44	North Carolina	44
Illinois	45	Tennessee	45
Delaware	46	Delaware	46
Alabama	47	Alabama	47
Mississippi	48	South Carolina	48
South Carolina	49	Louisiana	49
Georgia, IMR = 11.9	50	Mississippi, IMR = 11.4	50
Kansas Black, IMR = 15.8		**Kansas Black, IMR = 11.4**	

Source: Health United States, 2007

Racial Disparities in Health, Kansas

Race/Ethnicity	White	Black	Hispanic
Physically inactive %	61.7	69.0	68.1
Currently depressed %	6.4	11.5	6.9
Cigarette smoking %	18.2	22.3	18.5
High blood pressure %	26.2	37.4	14.3
Obese %	26.1	40.2	30.2
Eating less than 5 servings of fruits and vegetables daily %	80.7	82.3	84.5

Source: 2004-2007 Kansas Behavioral Risk Factor Surveillance System

The disparity seen in infant death rates in Kansas exists for many other indicators of health. This chart shows a few examples. The focus here is on some of the more common health-related behaviors and conditions that contribute to the leading causes of illness and death:

- The majority of Kansans are physically inactive, but African Americans and Hispanics (or Latinos) having higher rates of inactivity than Whites.
- Almost one in five Kansans smoke cigarettes and the rate is slightly higher for African Americans than for Whites and Latinos.
- Depression is one of the more common mental disorders in the U.S. and the rates are also uneven by race/ethnicity. Almost 12% of Blacks are currently depressed compared to 6% of Whites and 7% of Latinos.
- High blood pressure is a chronic illness that is a major risk factor for heart disease and the leading risk factor for strokes. Large disparities are evident for this health condition with 26% of White Kansans, 37% of African Americans and 14% of Hispanics having high blood pressure.
- Rates of overweight and obesity have been increasing in the U.S. in recent years. Obesity increases an individual's risk of diabetes, heart disease, cancer, and many other illnesses. One in four whites in Kansas is obese and the rate is even higher for Hispanics (30%) and African Americans (40%).
- There is growing scientific evidence documenting the importance of fruits and vegetables to a healthy diet. However, four out of five Kansans, regardless of race and ethnicity, do not eat five servings of fruits and vegetables daily.

Almost one in five Kansans smoke cigarettes and the rate is slightly higher for African Americans than for Whites and Latinos.

Socioeconomic Disparities in Health, Kansas

Income	Physically Inactive %	Currently Depressed %
<15K	70.1	20.2
15-25K	65.6	10.7
25-35K	65.6	6.3
35-50K	61.9	8.9
>50K	59.8	3.0

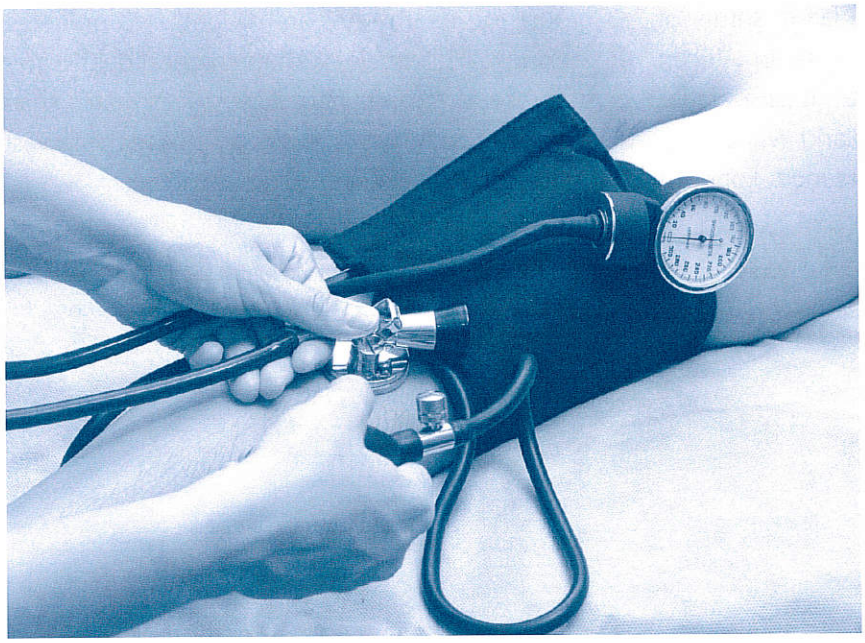
Education	Physically Inactive %	Currently Depressed %
< H.S.	67.9	12.3
H.S.	63.4	8.4
Some College	61.7	7.1
College Grad +	60.9	4.2

Source: 2004-2007 Kansas Behavioral Risk Factor Surveillance System

The gaps in health by race and ethnicity should be understood within the context of large racial gaps in socioeconomic status (SES). SES refers to differences in living conditions that are captured by income, education, wealth or occupational status. This chart shows how both physical inactivity and depression are patterned by education and income in Kansas. There is a stepwise progression in health improvement as levels of education and income increase. As education and income increase, the chances of being physically inactive and depressed declines. Other research indicates that a similar pattern exists across the United States and the world for most indicators of health.

As education and income increase, the chances of being physically inactive and depressed declines.

1-9



The highest risk of high blood pressure is found at the lowest levels of income and education.

Blood Pressure Disparities by race/ethnicity and Socioeconomic Status, Kansas

% high blood pressure

Income	All races/ethnicities	White	Black	Hispanic
All income levels				
<15K	33.0	34.2	48.7	14.1
15-25K	31.3	35.0	39.6	13.7
25-35K	28.1	29.3	30.1	18.9
35-50K	25.5	25.9	34.7	15.4
>50K	20.8	20.8	35.1	18.3

Education	All races/ethnicities	White	Black	Hispanic
< H.S.	27.2	32.3	46.8	12.1
H.S.	29.3	30.9	37.7	11.7
Some College	25.3	25.3	38.0	19.7
College Grad +	21.8	22.1	31.5	17.9

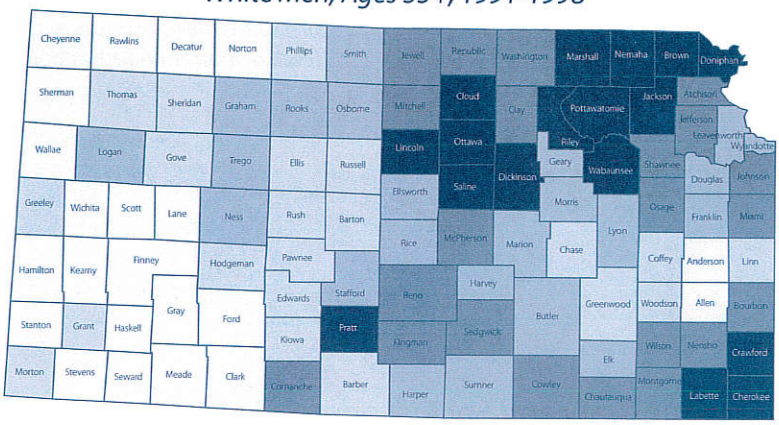
Source: 2005-2007 Kansas Behavioral Risk Factor Surveillance System

A similar pattern is evident for high blood pressure for Whites and Blacks. The highest risk of high blood pressure is found at the lowest levels of income and education. For Hispanics, a more complex pattern is evident, where the highest levels of hypertension are found at the highest level of income and education. Other research indicates that Hispanic immigrants, who tend to be low in SES, are likely to enjoy very good levels of health. Unfortunately, as time in the U.S. increases and SES improves, the health of Latinos gets worse as they adopt the patterns of American society. Thus, higher SES Latinos in Kansas tend to be longer term Hispanic immigrants while lower SES groups of Hispanics tend to be more recent, poorer but healthy immigrants. It is also noteworthy that even those Hispanics with the highest rates of hypertension have lower rates of this disease than high SES Whites and African Americans.

The next chart illustrates how large some of the shortfalls in health are in Kansas for African Americans, compared to Whites. It shows the death rates from stroke for Black and White men aged 35 and older by place of residence. For each group, the death rates are divided into quintiles. Strikingly, White males with the highest death rates of stroke for Whites have lower death rates than those African American males who have the lowest stroke deaths for African Americans.

Kansas- Stroke Death Rates

White Men, Ages 35+, 1991-1998

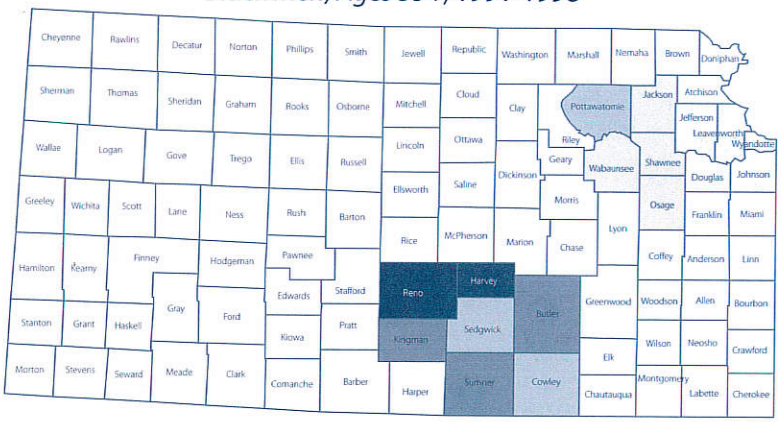


Age-adjusted Average (Annual) Deaths per 100,000

- 86-105
- 106-115
- 116-122
- 123-132
- 133-146

Kansas- Stroke Death Rates

Black Men, Ages 35+, 1991-1998



Age-adjusted Average (Annual) Deaths per 100,000

- 163-181
- 217-230
- 243-263
- 267-272
- 276-278
- Insufficient Data

Source: CDC

The highest category of rates among white men (35+) is lower than the lowest category of rates among Black men (35+).

White males with the highest death rates of stroke for Whites have lower death rates than those African American males who have the lowest stroke deaths for African Americans.

1-11

Steps to a Healthier Kansas

Good health does not occur by chance and it is not determined simply by having insurance or the quantity and quality of healthcare that we receive. Health care is very important and every Kansan should have access to timely, appropriate, high quality medical care. However, our health care system does a great job of taking care of us when we get sick. To a large degree, it functions as a repair shop that provides badly needed assistance when all is not functioning properly. But needed medical care is not the key to good health. Instead, a large body of scientific research indicates that where we live, learn, work, play and worship has a lot to do with our opportunities for being healthy.[2] One of our greatest challenges is to develop greater awareness that the most important determinants of health are outside of the healthcare system. Relatedly, we need a new vision of what health policy really is. Health policy needs to be re-defined to include policies in all areas of society that affect health. Thus, improving the health of all Kansans and reducing disparities in health will require multiple departments of the State of Kansas working collaboratively with the Kansas Department of Health and Environment. But it requires more. The ingenuity, creativity and resources that need to be combined to improve health exist within and without the public sector. It will require the public and private sector, individuals and community organizations working together to achieve success. There is no single magic bullet, but working together, we can develop creative solutions, made in Kansas, that would give every Kansan an opportunity for good health.

To a large degree, our behaviors and lifestyles can place us on a path to health or on a highway to disease. There is an important role of individual responsibility. Each individual has to make healthy choices. But social responsibility is also required because everyone does not have the same opportunities to choose health. Research reveals that there is much that can be done to reduce barriers to good health and create new opportunities to support healthy choices. Social policies can make it easier for all to start a new journey toward better health. Thus, improving the health of Kansas will require the commitment of every Kansan to make healthy choices and the commitment of every institution in Kansas to make it easier for everyone to choose health.

We now consider several factors that have been shown to influence health and outline specific examples of the kinds of actions that are necessary, in each area, to promote a healthier future for every Kansan. These recommendations are not comprehensive, but representative and illustrative of the kinds of interventions that are needed.

Creating a Healthy Future for Kansas

Adequate Income

Money is a resource that we use to obtain a broad range of goods and services such as healthy foods, appropriate clothing, housing, a good education, recreation and cultural opportunities that we need in order to live a healthy life. Without adequate income, obtaining the basics of life and making healthy choices becomes a difficult uphill struggle. Research has shown that lower levels of income are linked to many risk factors for disease such as cigarette smoking, physical inactivity, poor nutrition and unhealthy weight.[1] In the United States, how much income people have has a substantial impact on how healthy they are and how long they live. High income families have lower rates of disease, disability and death than low income ones.[1,3] Research has also shown that providing additional income to vulnerable families can lead to improvements in health.[4] And it is not just about poverty. Middle class families have worse health than wealthy ones. As a society we need a new commitment to ensure that every Kansan has the opportunity to obtain adequate income for health.

What the Government and Public-Private partnerships can do:

1. Ensure that every worker in Kansas receives adequate income to choose a healthy lifestyle. This can be accomplished through living wage laws and minimum wage increases.
2. Ensure that every citizen of Kansas who is able to work can find a decent job.
3. Provide adequate assistance to vulnerable social groups such as the elderly, the disabled and newborns.
4. Create incentives to encourage savings.
5. Provide earned income tax credits to low income individuals.

What churches and community organizations can do:

1. Advocate for policies that would ensure adequate income for all.
2. Offer programs and outreach services to low income individuals to ensure that they receive all of the government benefits to which they are entitled.

What every citizen can do:

1. Volunteer to work with national, state, community and faith groups that provide advocacy and support services for the poor.
2. Write your elected political leaders about the relationship between adequate income and health and enlist their support for new initiatives to improve health.

Research has also shown that providing additional income to vulnerable families can lead to improvements in health.[4]

1-13

Education

A basic education is necessary to take advantage of the opportunities for personal and financial success that our society offers. As our world becomes increasingly sophisticated, most people will need more education in order to be competent. Research reveals that education and health are strongly related to each other. Higher levels of education are associated with fewer unhealthy choices, lower rates of disease and longer, more productive lives. Research also indicates that the early years of life lay the foundation for academic success in elementary school and beyond and for health throughout the life course.[1,4]

What the Government and Public-Private partnerships can do:

1. Provide access to high-quality early childhood educational enrichment programs for every child.
2. Provide pre-natal and post-natal support services for vulnerable parents and ensure that all parents have the knowledge and skills to provide safe, supportive and nurturing environments for their children.
3. Reform school financing so that every school has the financial and manpower resources to ensure that each child has the opportunity for high-quality experiences from kindergarten through college.
4. Increase opportunities and reduce financial barriers so that every student who wants to can attend a community or 4-year college.
5. Provide incentives so that every school can become a center of wellness for its students, staff and the surrounding community.

What churches and community organizations can do:

1. Offer classes and programs that would enable every parent to become competent in nurturing children.
2. Advocate for investment in high-quality early childhood enrichment programs and an academically rigorous and welcoming school system.

What every citizen can do:

1. Become a mentor for children who are at risk of academic failure. This group includes children:
   - Whose first language is not English.
   - Who are being raised by a single parent.
   - Who have a parent in jail or prison.
   - Who are falling behind in school.

What every parent can do:

1. Make early and regular contact with your child's teacher.
2. Advocate for high-quality teachers. Teacher quality is the most important factor in student achievement.[5]

Housing and Neighborhoods

Clean, safe, affordable housing is an important foundation for good health. Neighborhoods that have parks, playgrounds, safe streets and stores that sell healthy food are also essential to a healthy life. These conditions make it easier for residents to choose a healthy diet and to walk and engage in other forms of exercise. Other features of housing and neighborhood can affect residents' exposure to air and water pollution, accessible transportation, libraries, violence, crime and other social disorders. People lead healthier lives when they can easily access healthy foods, parks, green spaces, recreational facilities and safe places to walk.

Due to the history of the development of segregated neighborhoods based on race, there is currently a strong relationship between racial segregation and access to good schools, great jobs, desirable neighborhood conditions, and access to a broad range of societal resources, including medical care. Efforts to improve the quality of life and health, especially for disadvantaged racial/ethnic populations, must break the link between residential segregation and the concentration of poverty and social ills. Aggressive efforts must be made to develop and strengthen the structures that support social and economic opportunity in racially and economically segregated areas. Such investments will have ripple effects on improving health and reducing disparities in health.[4]

What Government and Public-Private partnerships can do:

1. Ensure that everyone has access to affordable housing.
2. Implement policies and programs to limit exposures to factors such as lead, radon, asbestos, cockroaches, and ensure access to smoke detectors, safe housing conditions (e.g. stairs), help with utility bills, and well-functioning heating and cooling systems.
3. Ensure that every family has access to a neighborhood that is supportive of good health and provides opportunities to make healthy choices. This will require support for:
   - Strong crime prevention policies.
   - Zoning policies that reduce noise and pollution.
   - Initiatives that support adequate access to healthy foods and restricted access to fast food, alcohol and tobacco.
   - Programs and a built environment that encourages physical exercise and recreation.

What Churches and Community Organizations can do:

1. Advocate for policies that support healthy homes and neighborhoods.
2. Offer programs and services that increase awareness of how health is affected by where we live, learn, work, play and worship.
3. Refer people to resources that exist for help with low cost housing, home repairs and safety, emergency shelters, and other neighborhood problems.

What every citizen can do:

1. Volunteer for programs that address housing issues, such as fair housing agencies, Habitat for Humanity, emergency shelters, and other community housing programs.
2. Develop and support crime watch programs; look out for your neighborhood.
3. Work closely with community-based organizations and neighborhood groups to give them an active voice in working with government entities and the business sector in designing local solutions to neighborhood problems.

Nutrition

Eating nutritious meals is often out of the reach of many Kansas families. Sweets, fats and refined grain products are often cheaper than wholesome, healthier foods. Prices for many healthy foods such as fruits, vegetable, milk and whole grain bread have markedly increased in recent years. Many Americans live in communities that are food deserts – neighborhoods that have corner stores and fast food restaurants with affordable, high-calorie foods but do not have supermarkets that provide access to inexpensive, healthy foods.[2,6]

Prices for many healthy foods such as fruits, vegetable, milk and whole grain bread have markedly increased in recent years.

What Government and Public-Private partnerships can do:

1. Expand access to healthy food:
   - Increase support for the SNAP (formerly Food Stamp) program. Studies by the USDA indicate that expanding the Food Stamp Program is a sound investment that helps to strengthen the economy. Every $5 of food stamps stimulates $9.0 in local economic activity.[7]
   - Provide grants and loans to foster the development of supermarkets and grocery stores in underserved areas. The Pennsylvania Fresh Food Financing Initiative is a public/private program that has enhanced access to healthy foods.[8]
2. Provide incentives for schools and workplaces to do more to enhance people's knowledge of food and nutrition and encourage healthy food choices.

What Churches and Community Organizations can do:

1. Support the development of farmer's markets and community gardens to improve access to fresh fruits and vegetables.

What every citizen can do:

- Eat more fruits and vegetables.
- Use whole grain breads and cereals as the foundation of your diet – they provide important vitamins, minerals and fiber.
- Use low-fat or non-fat milk, cheese and yogurt.
- When preparing foods, use the 3B approach: Bake, Boil, Broil instead of deep fat frying.
- Read food labels so that you can know how much fat, fiber, sugar and salt is in the food.
- Use less salt because too much salt can raise your blood pressure.
- Reduce calories and fat by limiting your use (or using low-fat alternatives) of mayonnaise, vegetable oils, butter, margarine and most salad dressings. They have 100 calories per tablespoon.
- Skin chicken and turkey to reduce fat content.

1-16

Stress

Everyone experiences some stress, but chronic and extreme stress is dangerous to health.[2] Repeated, frequent stress, especially for individuals who have limited resources to cope can disrupt normal body functions and can contribute to an increased risk of many diseases. Many people cope with stress by eating too much, smoking cigarettes, consuming alcohol and using drugs. These ways of dealing with stress can also negatively affect health.

What government and Public-Private partnerships can do:

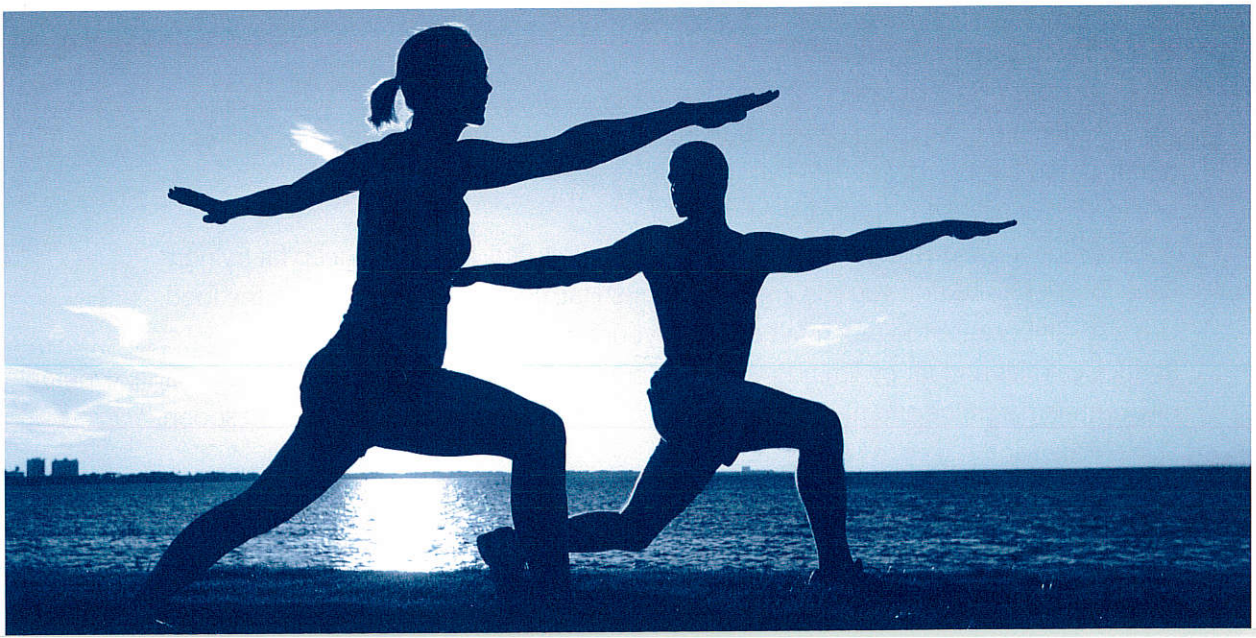
1. Improve work and residential environments to reduce the levels of stress. These include:
   - Enhancing employees control over work.
   - Providing more opportunities for advancement.
   - Ensuring appropriate compensation and rewards.
   - Strengthening leave policies and worker protections.

What Churches and Community Organizations can do:

1. Offer programs that help individuals manage stress and support their access to services that provide resources to reduce levels of stress.

What every citizen can do:

1. Make time in your life for regular exercise.
   - Start slowly and gradually increase.
   - Pick an activity that you enjoy.
   - Exercise with a friend.
   - Build exercise supplements (such as taking the stairs) into your daily life.
   - Check with your doctor before starting an exercise program.
2. Take time to relax.
3. Learn your signs of stress and take a break when they occur.
4. Talk to a friend.
5. Avoid debt. Don't purchase what you cannot pay for.
6. Get adequate sleep every night.
7. If you are still having trouble, get help.
   Seeking professional help is not being weak – it is being smart.



Social Support

Good social relationships can have a positive effect on health. Meaningful relationships with others can provide emotional support and caring and practical assistance in times of need. Having others in your life that you can share your thoughts and feelings with is a powerful health resource because it can help to reduce the negative effects of stress on health. Some research suggests that being socially isolated is as bad for one's health as is cigarette smoking. Because emotional and practical support is patterned by SES, reducing SES inequalities can help to create a sense of community and inclusiveness.[2]

What government and Public-Private partnerships can do:

1. Workplaces, residential area and public facilities should be designed to encourage social interaction.
2. Develop policies that build support at the local level by strengthening social networks, fostering economic development and empowerment and increasing civic participation and trust.
3. Develop policies that strengthen opportunities for relationships at work.

What churches and other organizations can do:

1. Ensure that organizational norms and practices communicate inclusiveness and equality regardless of an individual's personal or social background.
2. Facilitate local community organizations (and churches) becoming an important source of friendships for many individuals.

What every citizen can do:

1. Spend more time with people in distress. Be patient, sensitive and understanding.
2. Volunteer to work for a crisis hotline or intervention center in your community.
3. Get to know your neighbors.

Personal Behaviors

Many of the most common diseases in our society are very closely related to the way in which we live. Our personal behaviors can place us either on a path to good health or on a fast track to disease. Getting regular exercise, wearing seat belts, eating well, getting adequate sleep are important factors that reduce the chance of illness and death. In contrast, cigarette smoking, alcohol abuse, eating high-fat and high calorie foods, and engaging in risky sex are behaviors that lead to higher levels of disease, disability and death. Good health behaviors are strongly patterned by socioeconomic status.[2] Persons of higher income and education have greater knowledge or health risks and more resources to follow a healthy lifestyle. In the final analysis, every individual has to make choices for good health. But not everyone has the same opportunity to make healthy choices. There is an important social responsibility to reducing the barriers that make it very difficult for some to make healthy choices, and to increase opportunities that make it easier to choose health.[1]

What Government and Public-Private Partnerships can do:

1. Implement policies and programs that reduce barriers for engaging in healthy behaviors and provide incentives and opportunities to make healthy choices. Examples include:
   - Reducing the number and density of fast food restaurants, particularly in low-income areas.
   - Restrict access to alcohol in low-income areas: limit the number of retails outlets, the hours of operations and the sale of inexpensive, higher alcohol content beverages.
   - Ban the sale of soft drinks and junk foods in schools and workplaces and replace them with healthier options.
   - Increase taxes on alcohol, tobacco, and junk foods and earmark this revenue to support programs that encourage healthy choices.
   - Provide incentives for persons to enroll in smoking cessation and drug and alcohol abuse programs. Expand the number of such programs.
   - Increase access to facilities for physical activity by creating new facilities (such as parks or playgrounds) and encouraging the creative use of existing ones, such as the after-school use of schools, and the early morning use of enclosed shopping malls.

What Churches and Community Organizations can do:

1. Model healthy behaviors in all programs and services, such as serving healthier lunches at meetings or at church-sponsored functions.
2. Make facilities available after hours for exercise classes and health promoting activities to local community residents.

What every citizen can do:

1. Become informed regarding the multiple behaviors that affect health.
2. Volunteer with groups and organizations that are working to create healthier communities.
3. Take care of your own health. Too many Kansans take better of their cars than their bodies.

Medical Care

Timely and appropriate medical care is an important predictor of health.[2] The U.S. is the only industrialized nation that does not provide access to care or all its citizens. Many Kansans lack access to care, many have limited coverage, and many minorities and low income Kansans receive poorer quality care than others. The effective health care delivery must take the socioeconomic context of the patient's life seriously. Thus, the health problems of vulnerable groups must be understood within the larger context of their lives. The delivery of health services must address the many challenges that they face. Taking the special characteristics and needs of vulnerable populations into account is critical to the effective delivery of health care services.

Timely and appropriate medical care is an important predictor of health.

What Government and Public-Private Partnerships can do:

1. Ensure that everyone has access to high quality care.
2. Provide for the psychosocial and material needs of individuals in the health care context.

What every health care facility can do:

1. Provide culturally appropriate programs and translation services to meet the needs of specific populations. Particular attention should be given to low- income and lower literacy groups.
2. Give emphasis to prevention in the delivery of care.
3. Provide effective treatment.
4. Develop incentives to reduce social inequalities in the quality of care.
5. Provide care that addresses the social context. This will involve consideration of extra-therapeutic change factors: the strengths of the client, the support and barriers in the client's environment and the non-medical resources that may be mobilized to assist the client.

What Churches and Community Organizations can do:

1. Advocate for health care coverage for all.
2. Provide information and resources on health care rights and link local residents to programs that provide access to those who lack insurance.

What every citizen can do:

1. Get medical, dental and eye checkups.
2. If you lack insurance, seek to identify community clinics that serve everyone.
3. Do not hesitate to go to an emergency room if your life or someone else's life is at risk. By law, emergency rooms have to treat you if your life is at risk, even if you do not have insurance and you cannot afford to pay.

Keys to Success

Advocacy

Advocacy on behalf of health and well-being must take place throughout all institutions to ensure commitment and accountability toward the goal of improving health.[9] This involves the state legislature, state agencies, city councils and county boards of supervisors, business, not-for-profit groups, consumer groups, community and religious organizations, as well as, parents, students, health professionals and every resident of Kansas. To achieve this it will be necessary to provide training and resources to community organizations and leaders to enhance their knowledge and skills to advocate for health.

Raising Awareness

A state-wide campaign must be waged to raise awareness levels that all Kansans are not as healthy as they could be and that some groups are experiencing large shortfalls in terms of health. Without such awareness it will be difficult to have meaningful mobilization efforts. Such initiatives should make clear that efforts to enhance health and reduce disparities are in the best interests of the entire society. Poor health and health disparities reduce the economic productivity of our citizens and the economic competitiveness of the state. A recent economic analysis of the Robert Wood Johnson Foundation's Commission to Build a Healthier America found that if all adult Americans experienced the level of illness and mortality of college graduates, the annual national economic benefit would be at least one trillion dollars.[1] These substantial costs emphasize the importance of concerted efforts to improve health and reduce disparities in health. They also highlight the urgency of now.

Working Together

This report indicates that we can all do better in terms of health. A recent state-by-state report on child health illustrates this. It reveals that the infant mortality rate for Black, White and Latino women in Kansas are higher than a national benchmark on infant mortality.[10] That is, infants of all racial groups in Kansas are not as healthy as they could be. Similarly, even those Kansas infants that are born to mothers with a college degree or more education are also falling below the achievable national benchmark for infant mortality. Infant mortality is a key indicator of health and these data clearly indicate that the health of all children in Kansas could be better. The challenge of health improvement is not just about poverty or racial/ethnic minorities. It is about improving the health of every Kansan. We all have to take ownership of the problem and make a commitment to invest in new initiatives to meet our goal of being as healthy as we can be. And health is not created in physicians' offices and hospital facilities. It is created in our homes, schools, workplaces, communities and churches. Success will require all of us to work together. Working together means taking responsibility for our health and working collaboratively with all institutions in our state to reduce barriers to good health and to create opportunities and provide incentives for healthier lifestyles.

"The only thing necessary for the triumph [of evil] is for good men to do nothing."

Edmund Burke, British Philosopher

April 2007

Key Health and Health Care Indicators by Race/Ethnicity and State

	Infant Mortality Rate* (deaths per 1,000 live births)				Diabetes-Related Mortality Rate* (deaths per 100,000 population)				Annual AIDS Case Rate* (per 100,000 population)			
	All	White	African American	Hispanic	All	White	African American	Other	All	White	African American	Hispanic
United States	**6.9**	**5.7**	**13.6**	**5.6**	**25.3**	**23.0**	**49.2**	**21.5**	**14.0**	**7.2**	**68.6**	**23.3**
Alabama	9.0	6.7	14.1	7.0	30.0	24.2	55.3	NSD	11.4	4.9	38.0	15.5
Alaska	6.8	5.4	NSD	NSD	27.3	28.9	NSD	NSD	3.9	2.4	19.8	0.0
Arizona	6.6	6.1	13.7	6.2	20.7	19.0	51.3	45.0	10.8	10.8	45.4	15.8
Arkansas	8.5	7.4	13.1	5.3	29.8	26.6	60.3	NSD	8.7	6.5	30.2	17.0
California	5.3	5.0	11.2	5.1	22.5	21.4	46.8	20.2	11.3	12.3	43.5	14.7
Colorado	6.0	5.5	14.6	6.3	19.0	18.4	41.1	NSD	7.7	6.6	42.5	13.7
Connecticut	6.0	5.0	13.2	6.3	16.7	15.3	37.6	NSD	19.0	9.9	82.4	74.5
Delaware	9.5	7.5	16.3	6.9	28.2	25.2	48.2	NSD	20.9	9.1	85.5	27.1
District of Columbia	10.9	4.8	14.4	7.2	32.2	11.8	42.8	NSD	128.4	26.4	236.5	138.5
Florida	7.4	5.7	13.3	5.3	21.8	19.4	52.1	14.2	27.9	14.1	124.2	32.5
Georgia	8.7	6.4	13.5	6.4	24.3	20.0	41.4	NSD	25.7	10.9	81.7	19.3
Hawaii	7.1	5.7	NSD	6.8	14.5	10.6	NSD	16.0	8.5	21.8	11.4	14.1
Idaho	6.2	6.2	NSD	7.0	27.8	27.3	NSD	NSD	1.7	1.8	31.8	3.2
Illinois	7.6	5.9	15.5	5.9	24.4	21.8	44.7	18.4	15.1	7.9	69.7	21.1
Indiana	7.7	6.9	13.8	6.4	27.7	25.7	59.5	NSD	6.5	5.1	32.8	15.5
Iowa	5.6	5.4	12.1	6.5	20.0	19.7	NSD	NSD	3.2	2.5	45.1	10.1
Kansas	7.1	6.4	15.7	7.3	23.1	21.3	67.2	NSD	3.9	2.3	31.0	13.3
Kentucky	6.6	6.3	10.0	4.9	31.4	30.1	57.4	NSD	6.2	4.9	34.0	25.9
Louisiana	9.8	6.9	13.9	4.5	40.8	30.3	73.4	NSD	21.2	8.1	64.0	17.3
Maine	5.2	5.1	NSD	NSD	26.0	26.0	NSD	NSD	1.6	1.6	11.8	9.7
Maryland	8.0	5.5	13.1	6.0	27.9	22.9	48.3	13.3	28.5	7.4	101.9	16.2
Massachusetts	4.9	4.4	9.5	6.3	20.0	19.2	41.6	19.0	10.8	5.8	73.7	52.0
Michigan	8.2	6.5	16.8	7.3	26.0	24.2	38.5	31.8	8.1	3.9	44.6	11.6
Minnesota	5.1	4.7	8.8	5.7	24.7	23.8	51.6	51.6	4.4	2.4	57.6	22.4
Mississippi	10.5	7.1	14.8	NSD	24.1	18.0	40.3	NSD	13.2	5.8	34.8	17.2
Missouri	7.9	6.6	15.7	7.0	27.1	24.8	56.3	NSD	6.7	4.5	32.6	20.6
Montana	7.3	7.0	NSD	NSD	25.5	23.5	NSD	96.7	2.1	2.1	58.6	0.0
Nebraska	6.4	5.8	14.9	6.2	20.9	20.1	53.1	NSD	3.0	1.9	25.5	12.5
Nevada	5.8	5.1	12.8	4.4	15.0	14.6	27.1	NSD	12.3	11.4	58.0	14.6
New Hampshire	4.3	4.3	NSD	NSD	23.2	23.0	NSD	NSD	2.6	2.4	50.0	13.8
New Jersey	5.9	4.6	12.5	6.1	26.9	24.1	55.3	13.8	14.7	5.7	72.1	29.7
New Mexico	6.1	6.0	NSD	5.9	33.0	30.3	NSD	69.9	7.1	7.1	18.8	9.6
New York	6.0	4.9	10.9	5.6	20.7	18.6	36.5	14.7	32.7	11.1	131.2	78.8
North Carolina	8.3	6.2	15.1	6.1	29.2	23.2	57.8	39.3	10.9	4.6	43.8	10.4
North Dakota	7.5	6.9	NSD	NSD	26.8	24.9	NSD	NSD	1.6	1.2	71.9	0.0
Ohio	7.8	6.4	15.5	8.2	30.4	28.1	54.2	NSD	6.8	4.4	35.4	18.9
Oklahoma	7.8	7.1	14.4	5.6	30.2	25.5	70.0	65.3	7.9	7.6	28.3	14.7
Oregon	5.6	5.5	9.3	4.7	27.1	26.9	53.3	25.3	6.0	6.4	33.1	10.9
Pennsylvania	7.4	6.3	14.3	8.0	24.5	23.3	39.4	NSD	12.1	5.1	81.7	39.5
Rhode Island	6.9	6.3	11.1	8.8	20.2	19.7	NSD	NSD	8.3	5.8	54.5	23.6
South Carolina	8.9	6.0	14.5	5.3	28.0	20.0	55.6	NSD	15.7	6.1	49.1	23.8
South Dakota	6.9	5.8	NSD	NSD	22.9	20.4	NSD	90.4	2.4	1.6	89.3	0.0
Tennessee	9.1	7.0	16.9	6.6	31.5	28.3	60.3	NSD	14.1	7.1	65.9	21.6
Texas	6.2	5.6	12.0	5.4	31.4	29.7	54.6	14.1	13.6	9.9	60.5	15.0
Utah	5.2	5.0	NSD	6.4	31.2	30.9	NSD	NSD	2.6	2.5	23.2	8.9
Vermont	5.1	5.1	NSD	NSD	27.2	27.3	NSD	NSD	1.0	1.2	0.0	0.0
Virginia	7.5	5.7	14.0	4.9	22.8	19.1	43.4	18.2	8.5	4.0	32.6	17.3
Washington	5.7	5.4	9.7	5.2	25.8	24.5	71.7	31.9	7.7	7.3	47.5	13.2
West Virginia	7.9	7.7	12.9	NSD	36.9	36.1	74.0	NSD	4.1	4.0	25.9	7.8
Wisconsin	6.8	5.6	17.5	6.9	22.6	21.3	52.7	42.9	2.2	1.3	18.2	10.0
Wyoming	6.1	5.8	NSD	NSD	27.7	26.8	NSD	NSD	1.2	1.0	0.0	3.8

* See back for years of data, sources, and notes.

THE HENRY J. KAISER FAMILY FOUNDATION www.kff.org
2400 Sand Hill Road Menlo Park, CA 94025 Phone: 650-854-9400 Fax: 650-854-4800
Washington Office: 1330 G Street, N.W. Washington, DC 20005 Phone: 202-347-5270 Fax: 202-347-5274

Key Health and Health Care Indicators by Race/Ethnicity and State

	Percent Living in Poverty*				Percent with Medicaid*				Percent Uninsured*			
	All	White	African American	Hispanic	All	White	African American	Hispanic	All	White	African American	Hispanic
United States	**17.3%**	**11.6%**	**33.0%**	**29.0%**	**13.5%**	**9.3%**	**25.2%**	**21.6%**	**17.9%**	**13.2%**	**20.9%**	**34.3%**
Alabama	22.3	14.1	43.1	NSD	15.9	10.5	29.7	NSD	16.3	14.3	18.3	NSD
Alaska	13.3	9.6	NSD	NSD	15.9	11.5	NSD	NSD	18.6	16.5	NSD	NSD
Arizona	19.6	11.5	NSD	31.0	17.4	10.6	NSD	27.6	21.3	13.7	NSD	33.7
Arkansas	19.7	16.0	37.3	NSD	16.3	14.0	25.7	NSD	19.8	17.9	24.7	NSD
California	19.3	11.2	29.5	28.5	16.5	9.5	25.4	24.6	21.0	12.6	18.2	31.9
Colorado	13.7	8.9	NSD	29.3	7.4	4.1	NSD	14.8	18.4	12.8	NSD	37.2
Connecticut	12.9	8.3	24.9	35.0	11.2	6.7	22.3	29.8	12.9	10.0	21.4	25.8
Delaware	13.9	9.9	23.2	26.9	11.2	8.2	19.3	18.5	15.4	12.9	15.9	34.8
District of Columbia	25.2	8.4	34.7	24.4	22.2	NSD	33.8	21.7	14.5	NSD	14.3	36.2
Florida	16.2	10.6	31.6	23.3	11.6	7.9	22.8	13.4	24.1	18.7	27.1	37.4
Georgia	18.3	11.3	29.2	27.9	14.5	9.4	22.8	21.4	19.9	14.9	20.9	46.5
Hawaii	15.8	7.9	NSD	23.4	10.9	NSD	NSD	21.2	10.7	NSD	NSD	NSD
Idaho	13.1	10.2	NSD	32.6	12.7	10.5	NSD	28.2	17.1	13.9	NSD	36.3
Illinois	16.7	10.8	38.1	24.4	10.9	7.2	22.9	16.6	15.9	11.4	24.8	29.2
Indiana	16.0	12.8	37.9	32.8	12.8	10.1	30.5	NSD	15.9	14.7	20.2	30.4
Iowa	13.2	10.7	49.6	32.5	11.8	9.4	NSD	24.0	10.4	8.8	NSD	31.0
Kansas	15.1	12.2	36.8	29.5	10.6	8.3	29.7	NSD	12.4	10.5	NSD	30.1
Kentucky	20.3	19.4	28.4	NSD	15.3	14.8	22.8	NSD	15.4	14.7	NSD	NSD
Louisiana	23.1	14.8	39.7	NSD	16.0	9.8	27.4	NSD	20.2	16.3	27.0	NSD
Maine	15.5	14.8	NSD	NSD	21.5	20.6	NSD	NSD	12.0	11.7	NSD	NSD
Maryland	15.0	9.3	25.7	16.2	9.1	5.5	15.9	NSD	15.9	11.1	19.6	39.1
Massachusetts	13.5	10.4	NSD	31.1	14.9	10.6	NSD	43.5	12.1	10.4	NSD	22.0
Michigan	16.6	12.3	38.3	24.8	14.1	10.3	32.5	20.9	13.0	11.5	18.8	NSD
Minnesota	10.4	7.9	34.9	27.4	9.2	7.1	32.9	NSD	9.7	8.3	NSD	37.3
Mississippi	25.3	13.4	43.0	NSD	20.3	11.8	32.7	NSD	19.3	14.9	22.5	NSD
Missouri	15.9	12.3	36.7	NSD	14.4	11.9	27.8	NSD	14.1	12.5	20.9	NSD
Montana	17.5	14.8	NSD	NSD	12.1	10.6	NSD	NSD	21.4	19.1	NSD	NSD
Nebraska	11.8	8.7	34.4	25.7	10.9	8.5	NSD	19.4	13.0	10.4	NSD	26.3
Nevada	15.5	12.0	29.4	20.8	7.0	5.5	NSD	8.2	20.3	15.5	NSD	35.9
New Hampshire	8.5	8.1	NSD	NSD	6.0	6.0	NSD	NSD	11.9	11.7	NSD	NSD
New Jersey	12.8	7.2	25.1	26.3	8.0	4.2	18.5	15.0	16.5	9.0	24.8	35.9
New Mexico	22.4	12.5	NSD	28.2	18.3	12.0	NSD	23.7	23.6	15.0	NSD	27.2
New York	19.3	12.3	34.3	31.5	19.0	11.5	32.3	33.7	15.1	11.6	17.4	23.0
North Carolina	18.4	12.3	33.1	29.4	13.2	9.1	25.0	NSD	17.7	13.1	18.1	49.7
North Dakota	12.1	9.4	NSD	NSD	8.7	6.3	NSD	NSD	13.3	9.8	NSD	NSD
Ohio	15.5	12.1	36.0	24.6	12.8	9.9	30.0	NSD	13.5	12.1	18.4	NSD
Oklahoma	18.1	13.9	31.3	35.3	13.7	10.2	30.4	NSD	22.1	19.2	NSD	46.7
Oregon	16.3	14.1	NSD	34.4	12.5	10.3	NSD	28.4	18.8	16.0	NSD	37.7
Pennsylvania	15.8	12.3	37.8	27.5	12.2	9.5	25.3	25.0	12.9	11.4	17.4	26.4
Rhode Island	16.7	12.2	30.8	41.1	17.4	12.2	37.3	41.6	12.8	10.6	NSD	25.2
South Carolina	20.0	14.1	31.7	NSD	15.5	11.4	23.0	NSD	18.6	17.2	19.9	NSD
South Dakota	15.3	10.6	NSD	NSD	12.1	8.3	NSD	NSD	14.0	11.5	NSD	NSD
Tennessee	20.0	15.7	35.1	37.5	17.4	15.2	27.3	NSD	16.1	12.1	23.2	55.6
Texas	22.1	11.6	31.4	33.3	12.5	6.3	18.4	18.6	27.2	17.2	25.1	40.3
Utah	13.7	11.4	NSD	27.7	10.6	9.9	NSD	17.5	16.7	12.6	NSD	38.3
Vermont	10.3	9.8	NSD	NSD	20.7	20.2	NSD	NSD	12.9	12.7	NSD	NSD
Virginia	13.4	10.3	21.4	21.9	7.8	5.5	17.0	NSD	15.5	11.4	19.8	38.6
Washington	14.4	12.1	NSD	24.5	12.4	10.0	NSD	31.2	15.2	13.7	NSD	29.3
West Virginia	19.2	18.9	NSD	NSD	15.4	14.8	NSD	NSD	20.0	19.9	NSD	NSD
Wisconsin	14.4	11.2	38.7	32.8	12.8	9.5	43.6	24.2	11.5	9.9	NSD	27.6
Wyoming	13.6	11.8	NSD	28.8	11.0	9.9	NSD	NSD	16.8	15.1	NSD	33.6

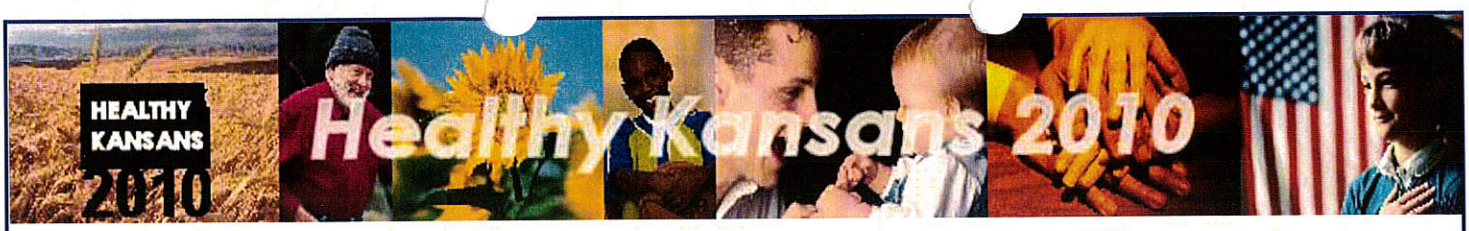
Notes and Sources

"NSD" or "Not Sufficient Data" where the figure does not meet the standard of reliability. White and Black categories are non-Hispanic for AIDS Case Rate, Poverty, Medicaid, and Uninsured. "Other" includes American Indian, Alaska Native, Asian and Pacific Islander race groups. Medicaid and Unisured rates are non-elderly population; AIDS case rate is adult and adolescent populations.

*Infant Mortality Rates (2001-2003), Diabetes Mortality Rates (2003), AIDS Case Rates (2005): The Centers for Disease Control and Prevention, National Center for Health Statistics. Poverty (2004-2005), Medicaid (2004-2005), Uninsured (2004-2005) Rates: KCMU and Urban Institute analysis of the Current Population Survey, March 2005 and 2006.

Visit Kaiser's **statehealthfacts.org** website for more health and health care topics available by race/ethnicity for all 50 states, Washington DC and the United States.
Other topics include: **Teen Births, Preterm Births, Prenatal Care, Child Immunizations, All-Cause Mortality, Cancer Incidence, Cancer-Related Mortality, Heart Disease-Related Mortality, Stroke-Related Mortality, Firearms-Related Mortality, Smoking Rates, Obesity, Mental Health, and more.**

Additional copies of this publication (#7633) are available on theKaiser Family Foundation's website at www.kff.org



Healthy Kansans 2010…encourage change…improve the health of all Kansans.

Throughout 2005, a group of Kansans representing multiple disciplines and organizations came together to identify and adopt health priorities that will improve the health of all Kansans. Healthy Kansans 2010 builds on a comprehensive, nationwide health promotion and disease prevention agenda, Healthy People 2010. Healthy People 2010 is designed to achieve two overarching goals:

(1) Increase quality and years of healthy life. This goal is to help people of all ages increase life expectancy *and* improve their quality of life.

(2) Eliminate health disparities. This goal is to eliminate health disparities among different segments of the population by specifically targeting the segments that need to improve the most.

These goals are supported by specific objectives in multiple health focus areas. A review of Kansas trends, needs, and strengths in these focus areas provided a foundation for the Healthy Kansans process.

Healthy Kansans 2010 Health Focus Areas

- Maternal Infant Child Health
- Oral Health
- Hearing
- HIV & STD
- Family Planning
- Arthritis
- Childhood & Adult Immunization
- Disability
- Environmental Health
- Nutrition and Physical Activity
- Respiratory Health
- Occupational Health
- Vision
- Heart Disease and Stroke
- Diabetes
- Mental Health
- Substance Abuse
- Injury and Violence
- Cancer
- Tobacco
- Chronic Kidney Disease
- Public Health Infrastructure
- Access to Care

The Healthy Kansans 2010 process resulted in a set of recommendations for change. If implemented, they will markedly improve the health of all Kansans. Progress is measured by the 10 Leading Health Indicators, a snapshot of health in the first decade of the 21st century.

How were the recommendations identified? Participants involved in the Healthy Kansans 2010 identified three cross-cutting issues impacting multiple Leading Health Indicators:

- **Reducing and Eliminating Health and Disease Disparities**: This cross-cutting issue builds on one of the two national Healthy People goals. In order to improve the health of *all* Kansans, it is necessary to reduce and eliminate health and disease disparities among segments of the population that need to improve the most. Health disparities stem from many factors, including race/ethnicity, age, gender, geography (rural/urban), social and economic status, and disability status.

10 Leading Health Indicators

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Responsible Sexual Behavior
- Mental Health
- Injury and Violence
- Environmental Quality
- Immunization
- Access to Health Care

- **System Interventions to Address Social Determinants of Health**: "Social determinants" – issues such as income, education, and social supports – impact the health of Kansans. Recommendations that address social determinants are essential for improving the health of Kansas' population.
- **Early Disease Prevention, Risk Identification and Intervention for Women, Children and Adolescents**: Preventing each potential health problem at the earliest possible point in life is crucial to improving the health of all Kansans.

The next two pages present a few of over 200 specific steps for change that have been identified through the Healthy Kansans 2010 process. The issues listed here are among those that the participants selected for immediate action. We encourage you to visit our website at http://www.healthykansans2010.org to view other recommendations and action steps identified by participants that will impact the 10 Leading Health Indicators and improve the health of Kansans. By working together, we can make Kansas a healthier state.

Tobacco: Support a comprehensive tobacco use prevention and control program to reduce exposure to tobacco.

Why is this important?

Twenty percent of adult Kansans smoke (compared to a Healthy People 2010 objective of 16%) contributing to 3,800 deaths annually and $180.4 million in total Medicaid expenditures. One in eight pregnant Kansas women smoke, resulting in poor birth outcomes.

What can I do?

- If you are a smoker, contact the Kansas Tobacco Quitline at 1-866-KAN-STOP
- If you are a health provider, refer patients to the Kansas Tobacco Quitline
- Support tobacco-free policies and ordinances in your community

What can my organization or my community do?

- Adopt tobacco-free policies and ordinances
- Hold meetings and events in tobacco-free facilities and on tobacco-free grounds
- Provide tobacco cessation opportunities for employees.
- Encourage businesses to fully comply with youth tobacco access laws

What can our state do?

- Increase funding to the Comprehensive Tobacco Program best-practices level ($18.1 – $44.7 million) recommended by the Centers for Disease Control
- Pass a no-compromise, statewide clean indoor air law

Disparities Data: Routinely collect and report data on *all* segments of the population (race/ethnicity, gender, rural/urban, economic status, disability status) to identify where improvements are most needed.

Why is this important?

Kansas' population is becoming increasingly diverse (e.g., the racial/ethnic minority population has more than doubled since 1980). Without targeted interventions, those with the "worst" health will continue to experience poor and declining health outcomes.

What can I do?

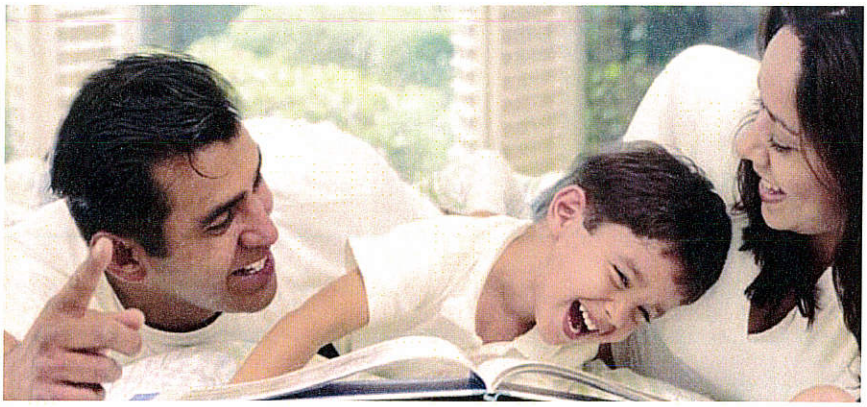
- Participate in valid surveys conducted by state agencies and reputable organizations
- Fill out forms (e.g., hospital admission, birth certificate, Medicare) consistently, completely, and correctly
- Make sure providers are correctly recording your race and ethnicity

What can my organization or my community do?

- Invest in improving your data collection and reporting capacity. Capture all indicators needed to describe the disparate needs of the population you are serving and use standardized data definitions
- Encourage collaboration between data resources
- Participate in state-local partnerships

What can our state do?

- Ensure data collected for all state programs use, at a minimum, federal race/ethnicity collection standards
- Provide data training to communities
- Create a system to monitor multiple health outcomes over the lifespan of Kansans



Cultural Competency: Promote culturally competent health practices among health providers and organizations.

Why is this important?

Culturally competent health providers and organizations are necessary to minimize medical errors and ensure all segments of the population have appropriate health care and prevention services.

What is cultural competency?

An ability to understand and relate to others within the context of culture in a trustworthy manner

What can I do?

- Clearly communicate your needs and your culture to your health provider
- If you are bilingual, consider becoming trained as a medical interpreter
- If you are a health provider, educator, law enforcement official, etc., attend cultural competency training

What can my organization or my community do?

- Conduct an assessment of your organizations' cultural competency
- Based on your assessment results, implement steps to improve cultural competency

What can our state do?

- Organize, develop, and maintain a statewide cultural competency clearinghouse and resource center
- Promote strategies that improve linguistic accountability and competency, such as expanding and decentralizing health care interpreter programs

Overweight and Obesity: Adopt and implement the five national overweight/obesity prevention goals:

1. Increase fruit and vegetable consumption
2. Increase physical activity
3. Decrease "screen" time (TV, leisure computer, video games)
4. Increase breastfeeding
5. Balance caloric intake with expenditure

Why is this important?

Kansas obesity rates have steadily increased over the last decade for adolescents and adults. Obesity contributes to a number of health problems, including diabetes and heart disease. If the current trend continues, by 2020 one out of four healthcare dollars will pay for obesity-related treatments.

What can I do?

- Adopt the national overweight/obesity goals for you and your family, and – if you are a health provider – encourage your patients to adopt this healthy lifestyle.

What can my organization or my community do?

- Adopt policies that support and encourage the national obesity goals among your employees and community members, such as provide breastfeeding-friendly workplaces and hospitals
- Create a "built" community environment that promotes physical activity and non-automobile transportation

What can our state do?

- Develop a comprehensive statewide plan for adopting and implementing the national overweight/obesity goals
- Improve statewide data tracking of overweight/obesity

Access: Assure access to quality health care (including oral health and mental health) and preventive services for all.

What can I do?

- Seek informational resources about health service options in your community and talk with your health provider about when it's appropriate to access care, particularly emergency services

What can my organization or my community do?

- Implement care coordination/case management models proven effective in other communities
- If you are a health or social services organization, expand use of lay health workers or community volunteers to augment services

What can our state do?

- Encourage, develop, and support health career pathways for all ages
- Create incentives and remove barriers to provider coverage to previously uninsured individuals and improve quality of care

Who Is Working on It?

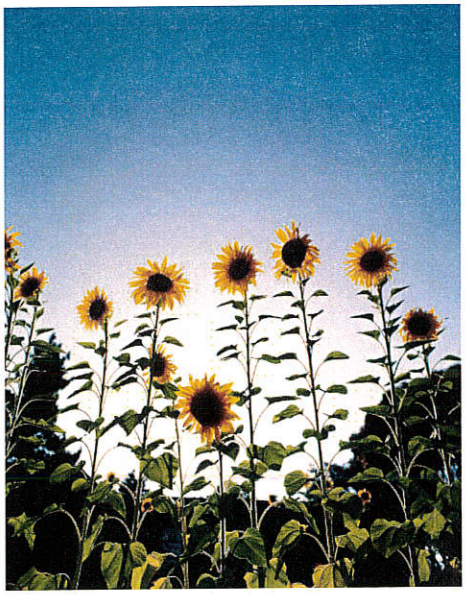
Approximately 40 people representing a broad spectrum of Kansas organizations engaged in the decision-making process where they considered research, sorted information, and defined key cross-cutting or health-themed issues Another 150 community representatives, experts, and others with a passion for population health participated in one or more of six groups that investigated these issues in depth. Based on all these discussions, crucial action steps were identified, prioritized, and recommended.

To realize these goals, *all* Kansans – individuals, health professionals, communities, businesses, state and local organizations – must partner together in implementing community-wide changes for improving the health of Kansans.

What Happens Next?

During 2006, the following activities are taking place:

- Increase awareness of the Healthy Kansans 2010 process and what individuals, organizations, communities, and state leaders can do to improve the health of Kansans
- Encourage action on the recommendations for change
- Implement a process to monitor improvements in the health of Kansans, specifically, improvements in the 10 Leading Health Indicators



Where Can I Find More Information?
How Can I Become More Involved?

Visit our website at http://www.healthykansans2010.org or contact

Office of Health Promotion
Kansas Department of Health and Environment
1000 SW Jackson, Suite 230
Topeka, KS 66612-1274
(785)291-3742
info@healthykansans2010.org

HEALTHY KANSANS 2010

What Is Health Equity? Excerpted from the UNNATURAL CAUSES Action Toolkit

Health equity is a new idea for most people. It's not hard to grasp, but it does require us to reframe the way in which health differences are usually presented and perceived.

When the Robert Wood Johnson Foundation showed focus group participants evidence of glaring socio-economic and racial disparities in health, many felt that these were "unfortunate but not necessarily unfair." People tended to attribute health differences to behaviors, genes or nature, and inevitability: "That's just the way things are." And it is true that some outcomes are random or result from accidents of nature or individual pathology.

However, health equity concerns those differences in population health that can be traced to unequal economic and social conditions and are systemic and avoidable – and thus inherently unjust and unfair.

Most of us can readily see how air pollution and toxic waste might harm health. But social structures can also get under the skin and disrupt our biology. Epidemiologist Sir Michael Marmot put it this way: "Real people have problems with their lives as well as with their organs. Those social problems affect their organs. In order to improve public health, we need to improve society."

Tackling health inequities requires widening our lens to bring into view the ways in which jobs, working conditions, education, housing, social inclusion, and even political power influence individual and community health. When societal resources are distributed unequally by class and by race, population health will be distributed unequally along those lines as well. One way to understand what Marmot calls the "causes of the causes" is to ask new questions:

Conventional question: How can we promote healthy behavior?
Health equity question: How can we target dangerous conditions and reorganize land use and transportation policies to ensure healthy spaces and places?

Conventional: How can we reduce disparities in the distribution of disease and illness?
Health equity: How can we eliminate inequities in the distribution of resources and power that shape health outcomes?

Conventional: What social programs and services are needed to address health disparities?
Health equity: What types of institutional and social changes are necessary to tackle health inequities?

Conventional: How can individuals protect themselves against health disparities?
Health equity: What kinds of community organizing and alliance building are necessary to protect communities?

Just as the roots of illness and wellbeing encompass more than individual factors, so too do the solutions. Historians attribute much of the 30-year increase in U.S. life expectancy over the 20th century not just to the invention of drugs or new medical technology but to social reforms. The eight-hour workday, a minimum wage, universal schooling, prohibitions on child labor, business regulation, social security and progressive tax policies all helped ensure that improvements in productivity would be shared, at least in part, by all Americans. The passage of civil rights laws in the 1960s extended these benefits to African Americans, whose health also improved in both absolute and relative terms.

For the past 30 years, however, the U.S. has been moving in the opposite direction. The top one percent of the population now holds as much wealth as the bottom 90 percent. Approximately 22 percent of our children live in poverty. The United States has by far the greatest inequality of the industrialized countries—and the worst health.

The good news is that the conditions that drive health inequities are neither natural nor inevitable but are the consequence of public policies. We've changed them in the past and can do so now. A good start is recognizing how other campaigns for social justice represent opportunities to improve our health and wellbeing. Struggles over jobs and wages, employment security and working conditions, housing, food security, social supports and transportation are as much health-promoting initiatives as anti-smoking campaigns, emergency preparedness and increasing access to health care. Forging alliances with groups working on these issues can increase everyone's power and effectiveness, leading to a more equitable society and better health.

As Dr. David Williams of the Harvard School of Public Health says in UNNATURAL CAUSES, "Housing policy is health policy. Educational policy is health policy. Anti-violence policy is health policy. Neighborhood improvement policies are health policies. Everything that we can do to improve the quality of life of individuals in out society has an impact on their health and is a health policy."

UNNATURAL CAUSES

...is inequality making us sick?

Produced by California Newsreel with Vital Pictures. Presented by the National Minority Consortia.
Public Engagement Campaign in Association with the Joint Center for Political and Economic Studies Health Policy Institute.

Ten Things to Know about Health

1. **Health is more than health care.** Doctors treat us when we're ill, but what makes us healthy or sick in the first place? Research shows that social conditions – the jobs we do, the money we're paid, the schools we attend, the neighborhoods we live in – are as important to our health as our genes, our behaviors and even our medical care.

2. **Health is tied to the distribution of resources.** The single strongest predictor of our health is our position on the class pyramid. Whether measured by income, schooling, or occupation, those at the top have the most power and resources and on average live longer and healthier lives. Those at the bottom are most disempowered and get sicker and die younger. The rest of us fall somewhere in between. On average, people in the middle are almost twice as likely to die an early death compared to those at the top; those on the bottom, four times as likely. Even among people who smoke, poor smokers have a greater risk of dying than rich smokers.

3. **Racism imposes an added health burden.** Past and present discrimination in housing, jobs and education means that today people of color are more likely to be lower on the class ladder. But even at the same rung, African Americans typically have worse health and die sooner than their white counterparts. In many cases, so do other populations of color. Segregation, social exclusion, encounters with prejudice, the degree of hope and optimism people have, differential access and treatment by the health care system – all of these can impact health.

4. **The choices we make are shaped by the choices we have.** Individual behaviors – smoking, diet, drinking, and exercise – matter for health. But making healthy choices isn't just about self-discipline. Some neighborhoods have easy access to fresh, affordable produce; others have only fast food joints, liquor and convenience stores. Some have with nice homes, clean parks, safe places to walk, jog, bike or play, and well-financed schools offering gym, art, music and after-school programs, and some don't. What government and corporate practices can better ensure healthy spaces and places for everyone?

5. **High demand + low control = chronic stress.** It's not CEOs who are dying of heart attacks, it's their subordinates. People at the top certainly face pressure but they are more likely to have the power and resources to manage those pressures. The lower in the pecking order we are, the greater our exposure to forces that can upset our lives – insecure and low-paying jobs, uncontrolled debt, capricious supervisors, unreliable transportation, poor childcare, no healthcare, noisy and violent living conditions – and the less access we have to the money, power, knowledge and social connections that can help us cope and gain control over those forces.

6. **Chronic stress can be toxic.** Exposure to fear and uncertainty triggers a stress response. Our bodies go on alert: the heart beats faster, blood pressure rises, glucose floods the bloodstream – all so we can hit harder or run faster until the threat passes. But when threats are constant and unrelenting our physiological systems don't return to normal. Like gunning the engine of a car, this constant state of arousal, even if low-level, wears us down over time, increasing our risk for disease.

7. **Inequality – economic and political – is bad for our health.** The United States has by far the most inequality in the industrialized world – and the worst health. The top 1% now owns as much wealth as the bottom 90%. Tax breaks for the rich, deregulation, the decline of unions, racism and segregation, outsourcing and globalization, and cuts in social programs destabilize communities and channel wealth and power – and health – to the few at the expense of the many. Economic inequality in the U.S. is now greater than at any time since the 1920s.

8. **Social policy *is* health policy.** Average life expectancy in the U.S. improved by 30 years during the 20th century. Researchers attribute much of that increase not to drugs or medical technologies but to social changes – for example, improved wage and work standards, universal schooling, improved sanitation and housing and civil rights laws. Social measures like living wage jobs, paid sick and family leave, guaranteed vacations, universal preschool and access to college, and universal health care can further extend our lives by improving our lives. These are as much health issues as diet, smoking and exercise.

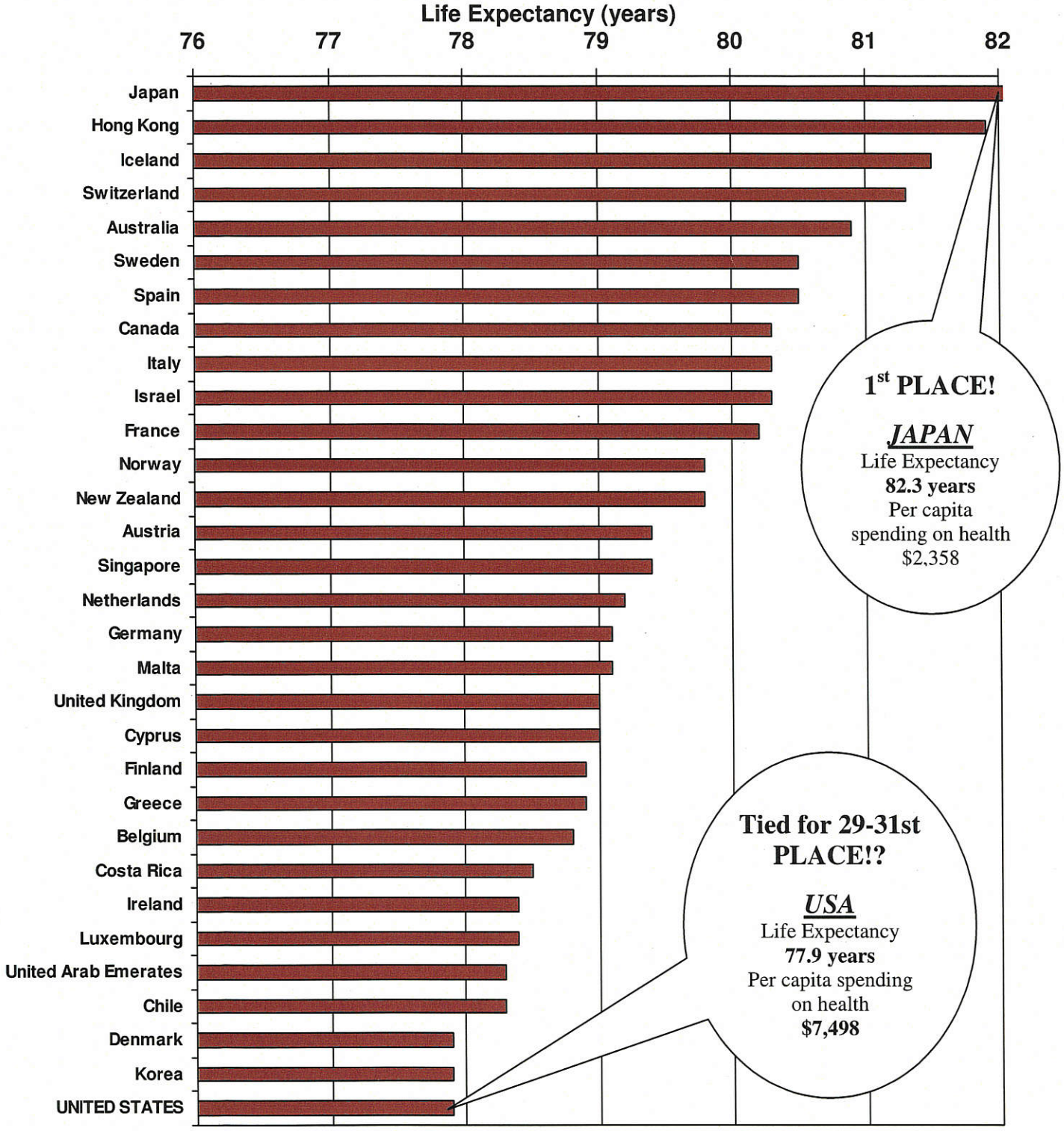
9. **Health inequalities are not natural.** Health differences that arise from our racial and class inequities result from decisions we as a society have made – and can make differently. Other rich nations already have, in two important ways: they make sure inequality is less (e.g., Sweden's relative child poverty rate after transfers is 4%, compared to our 22%), and they try to ensure that everyone has access to health promoting resources regardless of their personal wealth (e.g., good schools and health care are available to everyone, not just the affluent). They live healthier, longer lives than we do.

10. **We all pay the price for poor health.** It's not only the poor but also the middle classes whose health is suffering. We already spend $2 trillion a year to patch up our bodies, more than twice per person than the average rich country spends, and our health care system is strained to the breaking point. Yet our life expectancy is 29th in the world, infant mortality 30th and lost productivity due to illness costs businesses more than $1 trillion a year. As a society we face a choice: invest in the conditions that can improve health today, or pay to repair the bodies tomorrow.

Adapted from the four-hour PBS documentary series *UNNATURAL CAUSES: Is Inequality Making Us Sick?*
To learn more about the series, health equity and how you can make a difference, please visit: www.unnaturalcauses.org

CALIFORNIA NEWSREEL
500 Third Street, #505, San Francisco, CA 9410, Tel: (415) 284-7800
www.unnaturalcauses.org, www.newsreel.org

HOW DOES THE U.S.A. RANK IN THE HEALTH OLYMPICS?
FIRST? SECOND? THIRD?



We spend twice as much per person on health care.
Yet our life expectancy is among the worst compared to other rich countries.

COURTESY Dr. Stephen Bezruchka, Population Health Forum *http://depts.washington.edu/eqhlth/.*
Japan Health Expenditure data from: 2007 OECD report http://puck.sourceoecd.org/vl=6637900/cl=12/nw=1/rpsv/health2007/g5-1-01.htm. *US Health Expenditure data from: 2007 projections are available from HHS for the US* http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf. *Life Expectancy data from: The Human Development Report 2007-8. http://hdr.undp.org*

1-31

SNAPSHOT>>

Kansas

Overall Rank: 23
Change: ⇩6

Strengths:
- Few poor mental and physical health days
- Low incidence of infectious disease
- Ready access to adequate prenatal care

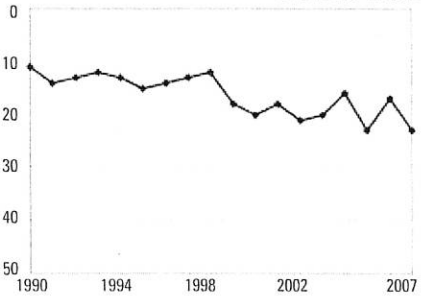
Challenges:
- High percentage of children in poverty
- Limited access to primary care
- Low immunization coverage

Significant Changes:
- In the past year, the prevalence of smoking increased by 12%
- In the past year, the rate of uninsured population increased by 19%
- Since 1990, the percentage of children in poverty increased by 38%
- Since 1990, the infant mortality rate declined by 27%

Kansas

RANKING: Kansas is 23rd this year; it was 17th in 2006.

OVERALL RANK



STRENGTHS:
Strengths include few poor mental and physical health days per month at 2.9 days and 3.0 days in the previous 30 days, respectively, a low incidence of infectious disease at 7.9 cases per 100,000 population and ready access to adequate prenatal care with 79.1 percent of pregnant women receiving adequate prenatal care.

CHALLENGES:
Challenges include a high percentage of children in poverty at 19.7 percent of persons under age 18, low immunization coverage with 79.2 percent of children ages 19 to 35 months receiving complete immunizations and limited access to primary care with 101.6 primary care physicians per 100,000 population. Kansas ranks lower for health determinants than for health outcomes, indicating that overall healthiness may decline over time.

SIGNIFICANT CHANGES:
- ⇧ In the past year, the prevalence of smoking increased from 17.8 percent to 20.0 percent of the population.
- ⇧ In the past year, the rate of uninsured population increased from 10.3 percent to 12.3 percent.
- ⇧ Since 1990, the percentage of children in poverty increased from 14.3 percent to 19.7 percent of persons under age 18.
- ⇩ Since 1990, the infant mortality rate decreased from 9.2 to 6.7 deaths per 1,000 live births.

HEALTH DISPARITIES:
In Kansas, blacks experience 70 percent more premature death than whites. Deaths from cancer are 43 percent more prevalent among blacks than whites.

STATE HEALTH DEPARTMENT WEB SITE: www.kdheks.gov/

	2007		2006		2000		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
DETERMINANTS								
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	20.0⇧	24	17.8	6	21.0	11	30.2	27
Prevalence of Binge Drinking (Percent of population)	15.3	25	12.4*	13*	11.7*	8*	—	—
Prevalence of Obesity (Percent of population)	25.9⇧	30	23.9	22	18.9	22	13.1	40
High School Graduation (Percent of incoming ninth graders)	77.9	22	76.9	20	73.3*	21*	84.1*	8
COMMUNITY ENVIRONMENT								
Violent Crime (Offenses per 100,000 population)	425⇧	27	389	26	397	21	361	21
Occupational Fatalities (Deaths per 100,000 workers)	6.1	25	6.0	26	7.4	40	11.5*	32
Infectious Disease (Cases per 100,000 population)	7.9	11	7.9	11	14.0	10	23.3	16
Children in Poverty (Percent of persons under age 18)	19.7⇧	38	17.8	31	18.5	35	14.3	11
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	12.3⇧	19	10.3	8	11.4	22	9.0	12
Per Capita Public Health Spending (Dollars per person)	$95	39	$95	39	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	79.2	35	83.8	13	70.7	34	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	79.1	16	79.1	16	80.3*	12*	76.2*	9*
Primary Care Physicians (Number per 100,000 population)	101.6	38	100.1	38	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	80.8⇧	34	76.4	30	—	—	—	—
ALL DETERMINANTS	2.2	26	6.1	16	1.5	23	5.9	14
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	2.9	9	2.8	5	2.3	3	—	—
Poor Physical Health Days (Days in previous 30 days)	3.0	6	3.0	3	2.6	3	—	—
Infant Mortality (Deaths per 1,000 live births)	6.7	27	7.1	29	7.2	24	9.2	14
Cardiovascular Deaths (Deaths per 100,000 population)	308.0	28	315.3	28	337.7	22	367.6	12
Cancer Deaths (Deaths per 100,000 population)	199.3	21	201.6	23	199.7	14	181.0	8
Premature Death (Years lost per 100,000 population)	7,236	24	7,114	21	6,933	21	7,581	14
ALL HEALTH OUTCOMES	2.0	20	1.8	23	4.4	16	6.0	9
OVERALL RANK	4.1	23	7.9	17	5.9	20	11.9	11

⇩ and ⇧ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable.

Social Determinants Related to Tobacco Use

Office of Health Promotion

February 9, 2009

The U.S. Centers for Disease Control (CDC) recommends four goals areas for comprehensive tobacco control programs, one of which is the elimination of tobacco-related health disparities defined as a difference in health between some specific population and the general population. Although health disparities are frequently described by race/ethnicity, they are influenced by many factors, including disability, age, gender, geography, occupation, and socioeconomic status.

Racial/Ethnic Disparities in Adults

The state of Kansas is home to a sizeable minority population. Approximately 11% of Kansans are not White with Blacks comprising 6% of the total population. Additionally, persons of Hispanic ethnicity (all races) are currently 9% of the Kansas population, a 29% increase since the 2000 census. Nationally, Kansas ranks in the lower quartile for adult smoking prevalence with modest racial/ethnic disparities. Smoking prevalence for Whites and Hispanics is similar (18.2% and 18.5%, respectively) with prevalence for Blacks (22.3%) slightly higher (BRFSS, 2004 – 2007).

Age Disparities

While Kansas has slowed the advance of adult smoking, young adults and youth in Kansas are especially vulnerable to tobacco use. Currently, young adults aged 18 – 34 years account for a disproportionate segment (36%) of Kansas adult smokers. Smoking rates in youth under age 18 have remained stagnant at 21% since 2002. Smoking prevalence is similar among White and Hispanic students and slightly lower for Black students. Moreover, these rates are short of the 16% goal in Healthy People 2010 and rank Kansas in the highest third, nationally, for youth smoking rates.

Other Health Disparities

The Kansas experience mirrors that of other states with respect to disparities in gender, education, occupation, socioeconomic status, geography, and disabilities. Slightly more men (9.5%) than women (8.0%) smoke in Kansas. Kansans with less than a high school education are 3 times more likely to smoke than those with college degrees. Of those Kansans unemployed, 36.8% are current smokers compared to 18.6% of those employed. Kansans making less than $50,000 per year are about twice as likely to smoke as those with higher incomes. More Kansas smokers live in urban and semi-urban areas (61.2%) than in densely settled rural, rural, and frontier areas (38.8%), reflecting the state's population distribution. Age-adjusted smoking prevalence among persons with a disability is 29.0% compared to 18.6% for those without a disability.

Addressing Health Disparities in Kansas

A Specific Populations Workgroup was convened from March to June, 2007 to identify critical steps for reducing tobacco-related health disparities among specific populations in Kansas. The Workgroup recommendations included: (1) increase community-level quantitative and qualitative data to eliminate identified data gaps among selected populations; (2) increase population-specific prevention and cessation resources that can be integrated into community programs; and (3) increase advocacy for the elimination of tobacco-related health disparities among specific populations in Kansas. A key to achieving these goals is continued cooperation between the public and private sectors with support from community leaders, community-based organizations, and funding organizations.