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The State of Black Asheville: Health Care Report

The student researchers involved in compiling this report decided that in order to give a clearer idea of the significance of Buncombe County's health statistics, it would be prudent to offer comparative data. The group examined similar statistics from the counties of Gaston and Durham, the two counties in North Carolina that are closest to Buncombe in total population. Part of the comparisons made involve disparity rates between races. Disparity rates and their significance are defined at the end of this report. Many of the racial comparative data was between Whites and minorities and in most cases, the team could get no more specific data. However, Blacks comprise 87%-90% of the minority population in the state of North Carolina.

I. GENERAL COMPARATIVE INFORMATION

There is a recognized correlation between level of education and how long one can expect to live. On average, an individual who has attained a 4 year college degree can expect to live significantly longer than an individual who has not completed a high school education. Additionally, there is a recognized correlation between level of income and general health and wellbeing. The inverse relationship between socioeconomic status and health is one of the most consistently established in epidemiological literature.

II. EDUCATION INFORMATION

According to 2000 US Census data, among Asheville's White population of 25 years of age or more, 85% have attained a high school education or higher, and 34.6% have attained a bachelor's degree or higher. Among the Black population of the same age group, 71.4% have attained a high school education or higher, and 9.4% have attained a bachelor's degree or higher. Among the total White population 25 years of age and older in Asheville, 9.4% are high school dropouts (achieved anywhere from 9^{th} to 12^{th} grade

education, no diploma). Among the total Black population, 20.4% are high school dropouts.

Both a higher percentage and a higher number of Whites have achieved higher education levels than Blacks; this difference is much greater at the collegiate level—almost four times higher for Whites. Also, the number of high school dropouts among the Black population is over twice the number among Whites. These numbers indicate that White citizens in Asheville-Buncombe routinely achieve levels even in basic education beyond those of their Black counterparts, leaving Black citizens less educated than White citizens. As there is a recognized correlation between levels of education and quality of health, this necessarily leads to the conclusion that Black citizens in Asheville-Buncombe also experience poorer overall health and well-being than their White counterparts.

III. HOUSEHOLD/FAMILY INFORMATION

According to 2000 US Census data, 77% of the total White households in Asheville are married-couple households; 39% of Black households are married-couple households.

17.5% of the total White households have single female householders; 52.6% of them are mothers with children under 18 years of age. 52.5% of the total Black households are single females; 63.2% of them are mothers with children under 18 years of age.

Among White grandparents living in a household with one or more of their own grandchildren under 18 years of age, 34.9% are legally responsible for their grandchildren. Among Black grandparents, 64.7% are legally responsible for their grandchildren.

According to this data, more Black households in Asheville-Buncombe than White face particular difficulties which may obstruct access to health care and/or a healthy lifestyle. While the overwhelming majority of White households are married-couple, the overwhelming majority of Black households are not, and therefore may be

dependent on a single income. Most Black households are run by single women, most of whom have at least one dependent child. Also, among older members of the community, most in the Black community have dependent grandchildren—almost twice the percentage as in the White community. Not only do a great number of Black women and seniors have children to care for without the assistance of other householders, a great number of Black children live in households dependent on a single (possibly fixed, in the case of seniors/grandparents) income, limiting their access to health care.

IV. POVERTY INFORMATION

According to 2000 US Census data, of the 437 White families in Asheville with single female householders, 20.6% are below the poverty level. Of those with related children under 18 years of age, 28.9% are below the poverty level; of those with related children under 5 years of age, 47.8% are below the poverty level.

Of the 726 Black families in Asheville with single female householders, 46.4% are below the poverty level. Of those with related children under 18 years of age, 54.8% are below the poverty level; of those with related children under 5 years of age, 63.5% are below the poverty level.

Of the 756 White families in Asheville, 5.7% are below the poverty level; of the 846 Black families in Asheville, 29.1% are below the poverty level.

Women who head their households face particular income challenges, as evidenced by the percentages found below the poverty level; there is also a noticeable trend among those with children: the younger the children, the greater the percentage of families found below the poverty level. With Black families, the percentages are significantly higher, beginning at well over twice the percentage of White families and climbing with the addition of children, particularly young children. This makes it clear that a single woman, particularly one with children or infants in her care, will have a much lower chance of achieving the income level that will allow her or her children access to adequate health care or the necessary choices (in diet, for example) that allow for a healthy lifestyle. For Black women, the chances are virtually none. And for Black

families in general, chances of achieving income levels to allow adequate health care or healthiness are much lower than for White families, as they fall below the poverty level at a rate over five times that of Whites.

These data sets (Education, Household, and Poverty Information) serve to describe the general lifestyle and challenges of Black citizens of Asheville-Buncombe. As Black citizens live at both a lower level of education and a lower level of income than the White population, Black citizens can expect to have a lower life expectancy, and a worse quality of general health and well-being than their White counterparts. Some citizens facing particular difficulties, such as single females or senior citizens with fixed incomes and limited health benefits, must care for children or infants, lowering the amount of income and access per individual and extending the same access barriers and general difficulties to the children in their care, leading to a continuation of poor health in the Black community and, unsurprisingly, higher infant mortality rates (See Section VII).

V. PATIENT/PHYSICIAN RATIO

According to 2005 SHEPS Center Statistics, Buncombe County has 35 physicians for every 10,000 people residing in the county. Gaston County has 18.1 physicians for every 10,000 of its residents and Durham has 68.5 physicians per 10,000 residents. Overall, Buncombe had the 6th highest physician to patient ratio out of the state's one hundred counties.

Asheville-Buncombe is one of the state leaders in physician to patient ratio. Access to physician care is, on the surface, readily available to all of the county's population, and at a very high degree of care. It could be postulated from the physician to patient ratio of the three counties that the health of all of Buncombe county's residents would be of a higher standard than all residents of Gaston, but of a lesser standard than all the residents of Durham. However, the researchers found that this was not the case; minorities, of which Black citizens make up the majority, in Asheville-Buncombe are less likely to have access to health care and health care options than Whites. There are some

very obvious and very large disparities between the health of Buncombe County's White population, and the health of the county's minority population. Having access to proper medical care is important to diagnose and treat potentially serious illnesses, and the research team surmised that Buncombe County's minority citizens, specifically members of the Black community, were less likely to be diagnosed and treated for more serious illnesses, and would therefore be more likely than Whites to have poor health. The information collected by the team on disease and mortality rates helped to support the validity of this conclusion.

VI. DISEASE RATES

According to the 2005 Buncombe County Health Assessment, those with less education were 3 times more likely, and those with lower incomes were 5 times more likely to be diagnosed with diabetes.

According to the previous economic and educational data, Black citizens in Asheville-Buncombe achieve lower levels of education and lower incomes than Whites, and are therefore more likely to be diagnosed with diabetes.

According to the 2005 Buncombe County Health Assessment, minorities experience a significantly higher obesity rate than Whites, (21.6% of Whites are obese in Buncombe, compared to 35.9% of minorities).

VII. MORTALITY

Data collected on mortality rates is a compilation of statistics obtained from the years 2001-2005, courtesy of the North Carolina State Center for Health Statistics. The mortality statistics for Buncombe County are, for the most part, no more encouraging than the disease rate statistics. Of the 23 leading causes of death in the state of North Carolina, there were only 8 causes that Buncombe County's minority citizens did not suffer a disparity in. In comparing the mortality rate disparity ratios of Buncombe County, Gaston County, and Durham County, some truly startling numbers became

apparent. It is best to keep in mind that according to the U.S. Census Bureau, in 2005 Whites made up 90.2% of Buncombe County's population, 83.1% of Gaston County's population, and only 56.2% of Durham County's population. (For information on calculation of disparity ratios, see final page.)

Of the three counties, Buncombe had the highest disparity ratio for heart disease deaths at 1.31, with Durham coming in second at a ratio of 1.2, and Gaston having the lowest ratio at 1.05. Buncombe County had the highest disparity ratio of the three counties when it came to deaths resulting from diabetes, with a disparity ratio of 3.09, compared to 2.59 for Gaston and 2.8 for Durham. Buncombe also had the highest disparity ratio for breast cancer deaths at 1.46, with Gaston exhibiting negative parity with a ratio of 0.06, and Durham coming closest to complete parity with a ratio of 0.99. Furthermore, according to the 2005 Buncombe County Health Assessment, between the years of 2000-2004, a Black infant in Buncombe County was three times more likely than a White infant to die before reaching his or her first birthday. This is despite Buncombe County having one of the highest physician-to-patient ratios in the state, and the smallest minority population of the three counties thoroughly examined for this report.

In all three counties, Black males were significantly more likely than any other group to be a victim of homicide. However, disparities between the races in incidences of homicides were most notably present in Buncombe County, where at a disparity ratio of 4.61, minorities were approximately four-and-a-half times more likely to be victims of homicides than their White counterparts. This compares to a disparity ratio of 2.37 in Gaston County and a ratio of 3.41 in Durham County.

The tri-county comparative data does not always see Buncombe County with the highest disparity ratio. In comparing Alzheimer's related deaths, Buncombe County demonstrated negative parity with a disparity ratio of 0.66. Gaston County also demonstrated negative parity, but at a ratio of 0.79. Durham County brought up the rear with a disparity ratio of 1.21. Buncombe County was also the most highly ranked in disparity ratios for deaths related to prostate cancer. Buncombe County's disparity ratio for prostate cancer mortality was 2.0, compared to Gaston County's disparity ratio of 2.77 and Durham County's slightly higher 2.79. However, it should be noted that while

Buncombe County has the lowest disparity ratio in this illustration, minority male residents still die from prostate cancer at a rate that is twice that of White male residents.

Strokes are one of the few areas of mortality that have seen consistent progress in achieving equality. Minorities have seen some improvement in stroke deaths, and figures suggest that stroke mortality is reaching an acceptable level of parity in Buncombe County. The ratios for mortality rates between minorities and whites in Asheville-Buncombe are improving in several areas; however, most areas still contain significant disparities. Some areas have even seen their disparity ratios increase instead of decrease.

VIII. OTHER

Many feel as though health factors like smoking or teen pregnancy are choices that can be avoided. However, this does not take into consideration the amount of societal pressures, leading up to these situations. In 2004, Minority teen girls (age 15-19) were about twice as likely to get pregnant than their White counterparts. Buncombe County minorities are almost twice as likely to currently smoke as Buncombe County Whites. (23.2% of Whites currently smoke compared to 45.3% of minorities)

Teen pregnancy can greatly affect the possibilities one has to succeed in one's goals. "A 1997 study showed that only 41 percent of teenagers who have children before age 18 go on to graduate from high school compared to 61 percent of teens from similar social and economic backgrounds who did not give birth until ages 20 or 21.[5]"(SCHS) Teen pregnancy can also affect the health of the baby:

> A teenage mother is at greater risk than women over age 20 for pregnancy complications such as premature labor, anemia and high blood pressure. These risks are even greater for teens who are under 15 years old.[2] These youngest mothers also may be more than twice as likely to die of pregnancy complications than mothers ages 20 to 24.[3]

Also:

> Pregnant teens are more likely to smoke than pregnant women over age 25. In 2002, 13.4 percent of pregnant teens ages 15 to 17 and 18.2 percent of those ages 18 to 19 smoked compared to 11.4 of all pregnant women.[2] Smoking doubles a woman's risk of having a low-birth weight baby, and also increases the risk of pregnancy complications, premature birth and stillbirth.

About the same amount of Black and White mothers smoke before and during pregnancy. However, Blacks mothers are 5.3 % more likely to smoke after pregnancy than White mothers in North Carolina.

In a 2001 survey done by the BRFSS that assesses how much of the population has exercised in the past month, Blacks exercise about 8.1% more than Whites. This could be accounted to the fact that more Blacks do not have cars in Buncombe County. Walking to a bus stop frequently can be considered exercise in this survey. This does not mean that the Black population is healthier, and therefore better off than the White population, however, because Blacks are experiencing a much higher mortality rate from diabetes and heart disease and much higher morbidity rates in obesity and diabetes in Buncombe County. Therefore Blacks are afforded a diet and healthcare opportunities that more than compensate for the higher rates of exercise.

IX. SEXUALLY TRANSMITTED DISEASE

When examining gonorrhea rates in the three counties, the data was found not in White ratios to minority ratios like most, but in total ratios to minority ratios. Durham county minorities accounted for 89.25% of the county's total gonorrhea cases from 2001-2005. However, in 2000 Durham Blacks only accounted for 39.46% of the population. Gaston minorities accounted for 71.42% of the gonorrhea cases, but Blacks only accounted for13.87% of the population in the last census. Buncombe minorities accounted for 59.69% of the gonorrhea cases, but Blacks only accounted for 13.38% of the population in the last census. As seen in all three counties, Black citizens make up

relatively small sections of the total population, but account for most, if not almost all, of the gonorrhea cases.

In the category of number of reported syphilis cases, Buncombe County fared the best of the three counties with minorities accounting for 16.67%. Gaston County's minorities accounted for 57.14% of syphilis cases reported and Durham County minorities accounted for 81.73 % (01-05). While minorities in both Gaston and Durham Counties make up for the majority of syphilis cases, minorities in Buncombe county account for syphilis cases in a similar percentage to their actual population presence.

For the years of 2001-2005, Buncombe County had a disparity ratio of 19.62 for AIDS deaths. This means minorities were almost 20 times more likely to die of AIDS than their White counterparts. Durham and Gaston had similar rates, with ratios of 14.71 and 16.13 respectively. This is easily the most disturbing set of data, as it accounts for *deaths* from HIV/AIDS, not reported cases. In all three counties, minorities are approximately 15-20 times more likely to *die* of HIV/AIDS than their White counterparts; this does not account for the percentage more likely to be infected with the disease.

Though Buncombe County is relatively close to achieving parity in syphilis diagnoses (compared to the other two counties), there is great disparity in occurrences of other sexually transmitted diseases, and a great disparity in both diagnoses and mortality rates for HIV/AIDS. This points to a disturbing occurrence in Asheville-Buncombe, as well as the other counties examined: although minorities, particularly Blacks, account for a small segment of the population, they account for almost all of the cases of sexually transmitted diseases in the county. This indicates that at some point—whether in education, availability of preventive measures and/or treatment—White citizens have a distinct advantage in health access or care when it comes to sexually transmitted diseases.

White citizens in Asheville-Buncombe clearly have some advantage when it comes to HIV/AIDS, as their *mortality* rates (not necessarily infection rates) are so much lower. These data indicate that, in the case of HIV/AIDS, White citizens likely have some access to treatment that is somehow unavailable to Black citizens, most likely through either income, insurance or both.

X. MENTAL HEALTH

Mental Health is one of the largest denominators to health in general. There are several specific problems that have surfaced as themes throughout the interviews and research on Black Asheville's mental health institutions such as: 1) the issue of cultural differences and its barriers to entrance into the system, 2) the misdiagnoses of Black individuals, 3) recidivism involved with mentally ill within the institution, 4) the recent transformations in healthcare all of which are prefaced by the socio-economic disadvantages encountered by Blacks in mental healthcare.

1) The issue of differences in culture has proven to be the largest barrier to mental healthcare for Blacks in Asheville. It is statistically proven that Blacks are less likely to visit a mental healthcare provider than their White or Hispanic/Latino counterpart. Although data could not be found on how many Black mental health service providers there were in Asheville; only 2% of psychiatrists, 2% of psychologists, and 4% of social workers in the United States are Black. When asked how many providers in Asheville were Black, Arthur Carder, Director of Western High lands LME, said "very few". The educators training the future mental health service providers are rarely Black as well. The lack of Black presence in mental healthcare's leadership and decision making roles makes a deficiency of adaptability in the institution. Without the Black perspective in mental healthcare communication will fail along with treatment and then follows the decrease in the likelihood of Blacks seeking treatment for mental illness. Because Blacks are seen less by providers the providers see less of a demand for adapting to understand the needs of the Black community. This cycle perpetuates mental illness within the Black community.

2) Along with cultural misunderstanding comes the problem of misdiagnosis. The most frequent mental illness diagnosed in America is depression. However, more Blacks are diagnosed as being psychotic. Also, it is more probable for Blacks to be misdiagnosed as having schizophrenia instead of bi-polar than their White counterpart. This misdiagnosis stems from misunderstanding, mistrust and fear. The mistrust is on both sides of the relationship. Black persons often withhold information from White doctors because of the issue of trust, and the feeling that the information divulged is

going to a mind oblivious of the system's real structural problems. In an interview with Randall Richardson, former department chair for mental healthcare at Mission Hospital and present chair of the diversity committee, put it like this "med-school teaches a certain criteria for training psychiatrists how to diagnose, but they didn't receive training with or from people of color. So, they often have to rely on their instincts and subconscious to diagnose." Because many times humans fear what they don't know, these subconscious and instincts often form themselves in an almost defensive manner from the providers. Because of this misunderstandings and dependence on instincts providers justify their own reality by diagnosing Blacks as more severely mental ill instead of looking at the situation from the perspective that they might not know what is going on with a patient. Misdiagnosis leads to mistreatment, and when one is not treated for the problem their chance of recidivism of mental illnesses increases greatly.

3) The system does not offer much hope for Blacks and encourages recidivism. Because problems go untreated, many persons with mental illness end up in prison. This environments offers sobriety and some of the medications needed to deal with some mental illnesses, however is ultimately a punitive system and is inadequately qualified to fully treat the people it holds. In the US According to a September 2006 Department of Justice survey as many as 60% of state and local jail populations have serious and persistent mental illnesses such as unipolar depression, bipolar, and schizophrenia. For example, well above 50% of the inmate population in the Buncombe County Detention Center qualifies as mentally ill. Persons who are in prison are actually at higher risk to develop mental illnesses. So, the lack of an adequate system to deal with mental healthcare for Blacks is the cause of its recidivism.

Another cause for recidivism is the repeated exposure to harsh environments that contribute to Blacks having an increased chance of developing mental illnesses. Children in foster care and the child welfare system are more likely to develop mental illnesses. Black children comprise 45% of the public foster care population in America. 40% of the Blacks in Asheville live in Low income housing, which are concentrated areas in Asheville that account for the majority of the crime rate. Also, Black citizens comprise 40% of the homeless population and only 12% of the U.S. population. People experiencing homelessness and higher risk environments are at a greater risk of

developing a mental illness, and when repeatedly exposed to these situations are at greater risk for recidivism.

4) There have been two major changes in mental healthcare; the divesting of state institutions and the change in budgeting and regulations for Medicaid. The state of North Carolina has recently (within the past 7 years) started to divest almost its entire larger public mental healthcare providing institutions. This switches the cost of organization from the government to the private sector. Blue Ridge Center for Mental Health, Mountain Laurel and New Vistas all were terminated, due to delays of already insufficient state funding and therefore inability to function in a way to adequately support all of its patients. Jacque Combs, former employee of Mountain Laurel-New Vistas and now director of the non-profit sixth street psychiatric rehab partners in Hendersonville, claimed that towards the end of the Mountain Laurel-New Vistas organization they offered a 12 week waiting period for non-emergency patients. So, change needed to happen, but privatization was not gradual and at the time of termination there was not nearly enough private providers producing a shock to the system.

Medicaid budgeting and regulation changes were more damaging changes for Blacks. Medicaid has now categorized is funding, meaning that given a certain diagnosis it will only fund a certain treatment, and other diagnosed metal illnesses are not funded. Combs also said that "since privatization the required paperwork has quadrupled…For a person diagnosed with schizophrenia, depression, or bipolar there are 108 pieces of paper that need to be filled out before the person can be treated, and that's anyone, not just persons with state funded." This increases complications and decreases accessibility mental healthcare. Also, Medicaid has moved to a pay-for-performance model in funding the providers. The pay-for-performance was built to increase efficiency, and motivate providers to take on larger caseloads to pick up the slack during the divestment, so patients did not fall through the cracks. The program paid providers for how many people they could treat. This shifted the focus of treatment from quality to quantity. Providers also now had incentive to take on "lower risk", easier to manage patients. In a recent article published in Health Affairs, The policy journal of the health sphere, Lawrence P. Casalino and Arthur Elster comment that pay-for performance programs "may adversely affect the income of physicians practicing in minority communities--particularly poor minority communities--thereby potentially reducing both the number of

physicians who work in such communities and their ability to invest in processes to improve quality."

The types of treatment that are sponsored now are not the traditional one on one therapy secessions; they focus on life skill building and community relationships. Often group therapies are funded. Carder explains how "this can be a very good thing, the community support programs, but it is difficult for providers to learn the transition to practice out in the field and many don't want to." These programs being in the communities that they serve would greatly increase Blacks ability to access treatment (seeing that 40% of Blacks live in low income neighborhoods and have difficulty finding access points for mental healthcare), better the cultural relationship between Blacks and service providers, and decrease disparities in treatment. However, because low income housing is Black by majority and dangerous (because it holds most of the crime rate for Asheville) White service providers will not work there. This program that has so much potential and intention to help has backfired, and actually decreased access points for the Black community, because now the narrow access point of the traditional treatments are disappearing. Also, the overall funding for Medicaid was cut and Buncombe County now ranks 76 out of North Carolina's 100 counties in funding for services for mental health, developmental disabilities, and drug addiction issues.

Finally, the privatization of healthcare encourages providers to either not treat Black people or to treat them inadequately. Three times more Blacks use Medicaid compared to Whites. "At one point Medicaid and state funding took up to 6 months to retrieve" recalls Dr. James Pitts, professor of Sociology and former board member of New Vistas. Because funding is being cut and it can take a very long time to get to the provider from the state, providers prefer to take cash in hand or insurance patients. Twice the ratios of Blacks are without insurance. This provides another barrier for Blacks.

(statistics courtesy of NAMI's 2004 African American Community Mental Health Fact Sheet and Dr. Jim Pitts)

XI. ACCESS

Blacks in Buncombe County experience much less access to healthcare and information on basic healthcare needs. Of course this is due to a series of injustices Asheville offers such as lack of adequate income, housing, and education, but there are some more direct factors that affect access in Asheville.

In Buncombe County in 2005, 21.3% of Whites lacked health insurance, compared to 41.4% of minorities. However, the percentage of Buncombe County Whites who are employed for wages that lack health insurance is 12.6% compared to 44.5% of minorities. Also, in Buncombe County (2006), 12.12% of Whites are on Medicaid, compared to 30.12% of Blacks. Statistically, Black females are more likely to be on Medicaid than White males/females and Black males. Of those on Medicaid, 24.09% are White, and 59.81% are Black; 34.6% are Black females.

These are not only economic factors but factors of simplicity. It is infinitely more difficult to navigate the Medicaid and Welfare systems than utilizing insurance plans or having cash in hand. Recent changes in funding and regulations have played as a strong deterrent in access to healthcare. The ability to pay a co-pay is also decreased for Blacks.

According to US Census data for 2000, median household income for Whites was $35,765 annually; median family income was $48,532. For Blacks, median household income was $18,772 annually and median family income was $22,601. The greatest percentage of Whites (17.9%) fall in the $35,000 to $49,999 income bracket, with an almost equal percentage (17.8%) fall in the $50,000 to $74,999 bracket of household income. The greatest percentage of Black households (25.8%) fall into the less than $10,000 income bracket, followed by the $15,000 to $24,999 bracket (21.1%). Also, because of the lower level job positions Blacks are given, Blacks quite often do not have access to health insurance through their employers. In Asheville, 37.7% of employed Whites work in management, professional, and related occupations, 27.1% work in sales and office occupations, and 15.1% work in service occupations. Among the Black employed population, 32.4% work in service occupations, 21.7% work in sales and office occupations, and 20.3% work in management, professional and related occupations. According to this data, Blacks are less likely to be insured by their employers, and will

thus have less access to health care, perpetuating a racist system that significantly blocks access to healthcare for Blacks.

XII. POLICY/PROGRAMS

As a group, the researchers experienced difficulties in uncovering any recent Buncombe County or Asheville city policies relating to the elimination of disparities in healthcare. Although the research team was not subject to the type of active obstructions to information collection experienced by the research teams for Law Enforcement and Education, nevertheless the group was forced to combat obstacles such as failure of individuals to respond to our requests for data.

The Buncombe County Commissioners provide funding for Project Access, a community based initiative meant to provide access to medical care for the county's low-income, uninsured citizens. However, Project Access is a program based in the Buncombe County Medical Society Foundation, which is a physician and community led charitable organization separate from local government. The Buncombe County Medical Society is itself dedicated to eliminating disparities in the healthcare system.

The Buncombe County Commissioners have set up a "Healthy Buncombe" organization in order to assist the county's residents in learning about nutrition and proper exercise. However, no mention is made of addressing racial disparities on this program's website, nor could the program's administrators be reached for comment. The organization also fails to address the possibility of structural components being responsible for some elements of poor health.

The Buncombe County Health Center's Health Promotion Department offers programs to help individuals stop smoking, promote good nutrition and exercise, provide dental screenings for good oral health, and establish school based health programs. However, on the Health Promotion department's website, the "Healthy Communities" section proffers a link to the Project Access website as a way for the community to "offer

access to health care services that focus on both treatment and prevention for all members of the community." The County Health Center therefore refers individuals to a program that is not administered by the County or City government. No link could be found for a similar access program that is a part of the Buncombe County or Asheville City government. Several attempts were made to reach the Health Promotion Department for further comment and clarification, but no contact was ever made despite repeated efforts on the part of the research team.

The Buncombe County Board of Health is a government body under the auspices of the Buncombe County Board of Commissioners that was established to govern the policies surrounding the Buncombe County Health Center. Minutes of the meetings held by the Board of Health from as far back as 2003 have been posted on the Board of Health's website. In the minutes examined by the research team, there was little to no mention of correcting health disparities between Whites and minorities.

XIII. OTHER SOLUTIONS

In the 2006 publication The Covenant with Black America, Tavis Smiley composes a snapshot of the state of life for Blacks in America, analyzing both successes and shortcomings, presenting data, and proposing solutions to be implemented on local (individual) and national levels.

Smiley gives a number of suggestions that could be implemented in Asheville-Buncombe within the next five years to begin improving overall health and closing disparity gaps. He organizes these suggestions by separating them into the categories of what individuals can do to improve their own health, and what leaders and elected officials can do to improve the health of the citizens they represent.

Smiley's first suggestion for leaders and officials is that they "Improve data collection and analysis at local regional, state, and national levels" (16). This is a crucial step for Asheville-Buncombe in improving the health of its citizens, Black and White alike, and in narrowing and eventually eliminating the disparities in health and health care between Blacks and Whites.

During the data collection stage of formulating this report, the students involved faced numerous obstacles and difficulties in collecting basic data needed to begin analysis. The obstacle most often encountered was the fact that there is no central collection and distribution point for health care information and statistics in Asheville or in Buncombe County. Public data, such as the number of patients treated per annum by clinics set up by the Buncombe County Health Board, were unavailable, and many statistical sets were not compiled in a way that made analysis of parity possible. Eventually the students involved were forced to gather data from state and national entities, as the necessary information was not available inside Asheville-Buncombe.

If the leaders and elected officials of Asheville-Buncombe wish to support the efforts to extend access to Asheville-Buncombe's Black citizens, they must not turn a blind eye to the existing problems, or be content to have necessary analysis and problem-solving delayed by the unavailability of data. Health statistics and information must be gathered in a central location in such a way as to make collection and analysis efficient. If leaders and officials wish the citizens of Asheville-Buncombe to continue to suffer unequally, they need simply to allow things to continue as they are, and allow public data to be kept out of the reach of the public through inefficiency.

Smiley also suggest that "Health advocates must...encourage the use of [funds] for environmental assessment and needed physical remediation," and that "local and state officials support and promote public education campaigns targeting the general public, as well as specific neighborhoods, with demonstrated high levels of environmental hazards" in order to limit the risks and occurrences of "illnesses and diseases such as lead poisoning, asthma, birth defects and cancers" (18). Leaders and officials in Asheville-Buncombe can take steps to investigate areas such as housing projects for environmental health risks, and to alleviate the situations that cause such risks. They can also support programs that raise community awareness of these environmental risks and aid in their efforts to help individuals protect their own health.

Smiley's suggestions for the individual are far more general. He asks that individuals take responsibility to improve their own diets as the foremost step to improving their overall health; specifically, that each individual "eat at least one additional fruit or vegetable daily" (12). He also suggests that parents and other

caretakers extend their health responsibilities to children, making sure that they "have healthy diets, get their daily exercise, and are fully immunized" (12). He insists as well that individuals keep themselves informed regarding disease and health risks, as a preventive measure (12).

While these are helpful suggestions that can improve overall health, Black citizens in Asheville-Buncombe may face obstacles in achieving such simple health improvement measures as consuming the daily recommended servings of fresh fruits and vegetables. If an individual, for example, lives below the poverty line (as many Black citizens, particularly single mothers, do), the income necessary to purchase fresh produce may be devoted to other concerns, or simply unavailable. Individuals who live in poverty are often severely limited in their ability to choose healthy diet options by the price and availability of foods; if grocers nearby do not stock fresh produce, or if the equivalent price will provide larger amounts of other foods (usually less healthy), adding even a single fruit or vegetable to one's diet daily may be impossible.

Smiley's most emphatic suggestion for the individual is that each citizen "Hold all leaders and elected officials responsible and demand that they change current policy" (12). By creating and/or supporting advocacy groups, remaining informed about candidates for public office and voting in local elections, and supporting research and analysis efforts, citizens of Asheville-Buncombe can take an active role in improving their own health, and assist their leaders and elected officials in closing the disparity gap.

DISPARITY RATES

Disparity rates calculate the differences in data that are found between the White and minority/Black data sets. The rate simply divides the minority/Black data by the White data. The disparity rate number tells us how much more or less likely minorities/Blacks are to be affected by whatever the data is representing. For example, when looking at infant deaths in Buncombe County from 2001-2005, 16.7% of Black infants die whereas only 7.2% of White infants die. To find the disparity rate one would simply divide 16.7 by 7.2 and get a disparity rate of 2.319. Therefore one could gather from this that a Black infant is 2.319 times more likely to die than a White infant, in Buncombe County. However, if we take the data from Alzheimer's mortalities in Buncombe County from 2001-2005 (Whites died at a rate of 30.6 and minorities at a rate of 20.2), the disparity rate is .66, meaning that the minority population is actually less likely to die from Alzheimer's than the White population. This is known in the healthcare community as "negative parity." While negative parity is favorable for the minority community, it indicates that the White population is more likely to suffer from a particular condition, which is itself an indication of inequality. Ideally, to demonstrate true health parity, the disparity ratio should be 1, indicating that Whites and minorities are suffering from a condition at an equal rate.