9. SEDGWICK COUNTY: HEALTH STATUS AND ITS SOCIAL CONTEXT

Report of the Community Perceptions Subcommittee
Sedgwick County Community Health Assessment Project

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TABLE OF CONTENTS

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Summary Remarks

Generalizability and Reliability - We are confident that the results of the telephone survey are generalizable to and representative of the Sedgwick County population. The demographic characteristics of the survey respondents closely resemble the demographic characteristics of the Sedgwick County adult population, with the exception an under representation minority racial/ethnic groups and low income persons. Door-to-door surveys were implemented in low income and minority neighborhoods to improve our ability to report on these groups.

Health Status - Results from the survey show that Sedgwick County is an affluent and generally a healthy community. The overall health status of Sedgwick County is similar to the health status of the nation according to a standardized measure of health status. The quality of life is good for the general population and is associated more with socioeconomic factors than with the supply or the quality of available health care.
There are pockets within Sedgwick County where people reported poorer health status (i.e. poor African, Latino, Southeast Asian, and White communities). These "pockets" have a disproportionately high share of factors that combine to produce poorer health status including low education and income, high unemployment, health risk behaviors such as smoking, and crime. These groups might be described as suffering from problems of a "traumatic" nature, suggesting multiple problems that put the survival of the neighborhood at risk and that require immediate expert intervention. The problems in these neighborhoods are more troubling than the symptoms.

Said in another way, *unhealthy neighborhoods are like dying plants with dry leaves and almost lifeless forms. The destitution affects the entire community. Sedgwick County is an array of beautiful, flourishing plants. But within all of this beauty and life, neighborhoods -- human beings -- members of the same community are becoming lifeless. There is no hope because no future can be seen.*

Uninsured - The proportion of the population that is uninsured is projected to grow. Increasing use of contract workers and the beginning of Welfare reform are two examples of trends that will lead to increasing numbers of uninsured. In Sedgwick County, being uninsured is a complicating condition that occurs along with other conditions in a person's life such as divorce, becoming a widow(er), job change/loss, low education, low income, lack of adequate housing, poor air & water quality, etc. Compared to people with insurance, the uninsured are more likely to be impaired by health problems (physical, mental or emotional) that cause them to describe their health as poor or keep them from their usual activities. Furthermore, the uninsured are much less likely to enjoy the benefits of continuity of care because they are less likely to see physicians regularly. Finally, the uninsured are more likely to perceive barriers to obtaining care and tend to be less satisfied with the care they do receive.

Health care providers - Most people expressed high levels of confidence and satisfaction with health care providers. As barriers to care, cost and inability to pay for care are more prevalent than knowledge barriers (how and where to go) or issues with health care providers (access, interaction, hours of operation etc.).

Recommendations

The health care system must look farther than visits to the doctor or trying to create ways to deliver more services. The vision must include ways to address root causes or needs. One author stated that addressing root causes will drive clinical improvements. If acknowledged and if all parties realize that it is not too late to change imminent problems and that we do have the resources, then we can move forward by formulating partnerships to make positive and effective changes.

One non-clinical definition of insanity is doing the same things over and over while expecting different results. To improve the health status of all people in Sedgwick County, we must consider new approaches to solving the problems. We have several "continuous quality improvement" experts in our community regarding system analysis and evaluation. We can also learn about the "tools for change" to achieve healthier communities from successful projects in which the communities have taken ownership in economic development such as in Newark and Philadelphia.

Since problems are localized, interventions should be localized. Targeted methods should be employed instead of mass media. For example, to manage the health of defined populations, the resources from health foundations or corporations would be more effective if applied to specific neighborhoods rather than a broad based media campaign for the whole region. In addition, local corporations could adopt an area, providing technical assistance (managerial, grant writing, job training, etc.), or partnerships with community members, organizations and groups.

Significant long term gains in health status will come through improvements in the socioeconomic status of specific subpopulations. Short term gains can be expected from improvements in health services access for acute needs.

We need to recognize that Wichita is not alone. Other communities in our nation have similar and even more acute problems, but are a step ahead in the development of solutions. What is needed is leadership, benchmarking, and learning from other communities that have encountered both success and failure.

Plan

Set up measures for measuring improvements and for accountability.

Develop focused stop-gap measures to meet acute needs.

Budget for leadership.

Invite local community leaders and leaders from community-based initiatives in other cities to a conference to discuss the results of our research, explore alternative solutions, and create an action plan.

SEDGWICK COUNTY: THE POPULATION AS A WHOLE

The first part of the report will provide information about Sedgwick County as a whole, including population health status, activity limitations, use of health care services, access to health care, and satisfaction with services. It will also include information on some behavioral risk factors and their prevalence in the population. The information in this section will be useful as a standard to which the vulnerable populations in Sedgwick County can be compared as well as an indicator of the well-being of the community as a whole in comparison to the state or the nation.

Where Was This Information Obtained?

The information in this report on the general population was obtained from a sample of Sedgwick County residents who were interviewed by telephone in February and March 1996. They were selected for the study using random-digit-dialing. The Wichita State University Center for Communications Research conducted the interviews with 952 persons 18 years old and older. The completion rate for the survey was 70 percent. When demographic information from the telephone survey of the general population is compared to 1995 U.S. Census Bureau estimates for Sedgwick County, we find the sample to be similar to the population in terms of sex, age, and median years of school (See Table 1). For example, the median years of schooling completed for respondents in the telephone sample is 13.6 years compared to the 1995 U.S. Census estimate of 13.5 years. However, the survey somewhat under-represents low income residents and ethnic/racial minorities. These underestimates are not unexpected for a telephone survey, and for this reason, a door-to-door survey in low income, racially and ethnically diverse neighborhoods was undertaken (See Vulnerable Populations: 4 Neighborhoods later in this report). However, the under-representation may result in underestimates of the uninsured and Medicaid recipients in the telephone survey. Nevertheless, we have confidence that the findings from the telephone survey are quite representative of the population of Sedgwick County, as a whole, since the proportion of low income and racial/ethnic minorities is relatively small in the County. In the analyses that follow, all group comparisons were assessed using the chi-squared test and only reported for $p <= .05$.

Table 1
Demographic Characteristics of Persons 18 Years and Older
Sedgwick County
1996 Telephone Survey v. U.S. Bureau of the Census

	Survey	Census
Gender*		
Male	48.3%	49.0%
Female	51.7	51.0
Race/Ethnicity**		
White, not Hispanic	90.4	86.0
African-American	4.2	7.7
Asian or Pacific Islander	1.0	1.9
Native American	1.5	1.1
Hispanic Origin	1.3	3.3
Age*		
18-24	10.7	12.2
25-34	18.1	23.1
35-44	22.2	22.3
45-54	17.5	15.2
55-64	12.3	10.8
65-74	11.0	9.3
75-84	5.4	5.3
85+	2.7	1.8
Median Years of School*	13.6	13.5

Key:

* 1995 U.S. Bureau of the Census Estimates
** 1990 U.S. Bureau of the Census, Modified Age, Race, and Sex File
Hispanic Native Americans counted as Native Americans

What Are the Demographic Characteristics of the Population?

The results of the telephone survey of the general population indicate that Sedgwick County, as a whole, has a fairly typical small Midwestern city profile in terms of age, sex, racial/ethnic composition, and marital status. The adult population of the county was 48.5% male. About 51% of the population were between 18 and 44 years old, 30% were between 45 and 64 years, and 19% were 65 years and older. The non-Hispanic white population was about 90% of the whole, and the nonwhite population was composed of people with African, Hispanic, Asian, and Native American origins, with African Americans predominating. Nearly 60% of

adults in Sedgwick County are married, 23% are divorced, separated, or widowed, and 17% had never been married.

In terms of income, education, and employment status, Sedgwick County is what might be called "securely middle class." Only about 9% of adults had not graduated from high school. About 52% had more than a high school education (See Table 2).

Table 2
Educational Attainment in Sedgwick County, 1996*

	%	N
Less than High School	9.5	84
High School Graduate	34.4	305
More than High School	56.1	498
Total	100.0	887

* Source: Sedgwick County Community Health Assessment, Telephone Survey, 1996

With respect to income, the largest single category was persons with an annual household income of $50,000 or more. Only 7.2% earned less than $10,000, and 12.9% earned between $10,000 and $19,999 (See Table 3). Nearly 51% of adults were employed full-time, and only 3.8% were looking for work (See Table 4).

Table 3
Annual Household Income in Sedgwick County, 1996*+

	%	N
< $10,000	7.2	47
$10-19,999	12.9	84
$20-29,999	15.5	101
$30-39,999	15.2	99
$40-49,999	13.4	87
$50,000+	35.8	233
Total	100.0	651

* Source: Sedgwick County Community Health Assessment, Telephone Survey, 1996
+ 31.6% missing (n=301)

Table 4
Employment Status in Sedgwick County, 1996*

	%	N
Full-time	53.7	484
Part-time	10.1	91
Retired/disabled	24.0	216
Looking for work	3.8	34
Homemaker	8.4	76
Total	100.0	901

* Source: Sedgwick County Community Health Assessment, Telephone Survey, 1996

The results from the telephone survey about the "solidly middle class" complexion of Sedgwick County as a whole are confirmed by data from Claritas/NPDC Demographics. Claritas has developed the GeoUnit Quality Score for each block group in the U.S. This score is a function of household income, educational attainment of people over 25, occupation of the civilian labor force, and home value. The GeoUnit Quality Score ranges from 1-100. Figure 1 displays the comparison of GeoUnit Quality Scores for Sedgwick County and the U.S. Most scores for both Sedgwick County and the country as a whole fall between 40-59. However, Sedgwick County has a slightly higher percentage of block groups in this category and in the next higher category--scores of 60-69--than the U.S. as a whole. Also, Sedgwick County has a slightly smaller portion of block groups in the lower category--scores of 30-39.

What Is the Health Status of the Population?

The telephone survey contained four questions about the health status of the respondent. These questions comprise the core of the Quality of Life and Functional Status measure which was developed by the Aging Studies Branch of the Centers for Disease Control for use with the Behavioral Risk Factor Surveillance System (BRFSS). These questions have been in use since January 1993, and over 150,000 adults aged 18 and older have responded to these core BRFSS questions. In this report, we will compare the unweighted responses to the four questions in the Sedgwick County CHAP telephone survey to results from the 1993 BRFSS that were published in the Mortality and Morbidity Weekly Review (MMWR) ("Quality of Life as a New Public Health Measure--Behavioral Risk Factor Surveillance System, 1993." MMWR, 43(20), May 27, 1994, 375-380).

The first question is "Would you say that, in general, your health is excellent, very good, good, fair, or poor?". About 15% of telephone survey respondents reported their health as fair or poor, 28% said good, and 56% judged their health as excellent or very good. This distribution is nearly identical to the results obtained from the 1993 BRFSS survey in 22 states--15%, 27%, and 58%, respectively.

The second question is "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" The response distributions for this question from the Sedgwick County CHAP survey and the BRFSS are contained in Table 5. Comparison indicates that a smaller proportion of the adult population in Sedgwick County than in the U.S. have no days in which their health is poor.

Table 5
Number of Days When Physical Health Was Poor, Sedgwick County and the U.S.

Sedgwick County*	U.S.**	
60%	68%	0 days
15%	11%	1-2 days
13%	10%	3-7 days
12%	11%	8+ days

* Source: Sedgwick County Community Health Assessment, Telephone Survey, 1996
** Source: 1993 BRFSS

The third question in the Quality of Life and Functional Status measure is, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how may days during the past 30 days was your mental health not good?" Comparison of the national and Sedgwick County results indicate a similar distribution of responses (See Table 6).

Table 6
Number of Days When Mental Health Was Poor, Sedgwick County and the U.S.

Sedgwick County*	U.S.**	
70%	68%	0 days
7%	10%	1-2 days
11%	11%	3-7 days
12%	11%	8+ days

* Source: Sedgwick County Community Health Assessment, Telephone Survey, 1996
** Source: 1993 BRFSS

The fourth question is, “In the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?” Comparison of the Sedgwick County and U.S. results suggest a great similarity between them (See Table 7).

Table 7
Number of Days When Activity Was Limited Due to Poor Physical or Mental Health, Sedgwick County and the U.S.

Sedgwick County*	U.S.**	
78%	81%	0 days
9%	7%	1-2 days
5%	6%	3-7 days
8%	6%	8+ days

* Source: Sedgwick County Community Health Assessment, Telephone Survey, 1996
** Source: 1993 BRFSS

Overall, the findings about health status obtained from the Sedgwick County CHAP telephone survey are quite similar to those reported for the 1993 BRFSS. Without information about possible differences between the two samples in underlying demographic and socioeconomic distributions, it appears that Sedgwick County is very similar to the U.S. as a whole with respect to reported health status.

What Portion of People Have Activity Limitations?

People were asked, “Are you limited in any way in any activities because of any impairment or health problem?” Only 23.5% reported being limited in their activities. Table 8 displays the major health problems which limited activities among respondents to the survey who were limited and the percent of people (of those 23.5% who were limited) who reported being limited by each problem.

Table 8
Health Problems Responsible for Limiting Activity, Sedgwick County*

	Persons Limited by Each Health Problem	
	%	N
Arthritis	17.3	38
Back and neck problems	16.4	36
Fractures	9.5	21
Walking problems	9.5	21
Heart problems	8.2	18
Lung or breathing problems	6.4	14
Diabetes	5.0	11
Vision or eye problems	4.5	10
Other	23.2	51

* Source: Sedgwick County Community Health Assessment, Telephone Survey, 1996

What Are the Patterns of Health Services Utilization in the Population?

The persons surveyed reported the number of visits they had made in the prior 12 months to a physician, emergency room, dentist, mental health or drug abuse service, the County Health Department, or other health care provider (i.e., chiropractor, physical therapist, physician assistant, or nurse practitioner). The percent of people who reported at least 1 visit to each of the above providers is displayed in Table 9.

Table 9.
Provider Visits in the Past 12 Months, Sedgwick County*

	Persons Who Reported One or More Visits	
	%	N
Physician	79.6	750
Emergency room	20.2	192
Dentist	66.2	630
Mental health or drug treatment service	9.1	87
County Health Department	6.2	59
Other provider	37.2	354

* Source: Sedgwick County Community Health Assessment, Telephone Survey, 1996

The survey also asked about hospitalizations. About 15% of respondents reported being hospitalized for at least 1 day in the prior year. About 46% of respondents to the survey had

visited a doctor within the past year for a routine checkup while 34% had been seen within 1 to 2 years. Only 2.2% had never had a routine checkup.

Finally, people were asked if they went to a particular place when they were sick or needed advice about their health. Few people reported that they had no place to go (5.2%) while most people said they went to a doctor's office or group practice (76.8%). Another 17.9% went to other places including the McConnell Clinic, a school clinic, a hospital outpatient clinic, the County Health Department, or a neighborhood or other health center such as Hunter, Guadalupe, United Methodist, Urban Ministry, Good Samaritan, or Brookside.

What Portion of the Population Has Health Insurance?

With respect to health insurance status, we grouped people as: 1) uninsured for the 12 months prior to the interview; 2) uninsured for some part but not all of the prior 12 months; and 3) insured for 12 months. The continuously insured was the largest group (79.4%), followed by the periodically uninsured (14.9%), and finally the uninsured (5.7%). Of those with health insurance at the time of the interview (86.3% of the sample), most had some type of commercial insurance (71.8%). About 20% had Medicare with supplemental coverage while 4.2% had Medicare without supplemental coverage. Only about 4% of survey respondents reported having Medicaid.

What Portion of the Population Perceives Barriers to Obtaining Health Care?

People were asked if the cost of care had prevented them from getting emergency room care, dental care, prescription medications, and any other medical care in the prior 12 months. The majority of survey respondents were not prevented from getting care but a substantial minority reported that cost had prevented them from obtaining at least one of these services (18.7%).

People were also asked to rate problems on a scale of 1 to 5 where 1 = no problem and 5 = a major problem in their household. Financial barriers to care included: 1) not being able to afford health insurance; 2) not being able to afford dental care; 3) not being able to stay eligible for health insurance; 4) not being able to get health care because of previous medical bills; and 5) not being able to afford medicines and other treatments recommended by a doctor. Fully 1 in 10 (12%) had a score of 3 or higher on this scale.

People were also asked to rate the problem of non-financial barriers to health care including knowledge barriers and barriers presented by health care organizations themselves. Knowledge barriers included: 1) not knowing where to go for health care; 2) not knowing where to go for counseling; 3) not knowing where to go for drug or alcohol treatment; and 4) not being able to find places to get pregnancy care. Only 3.4% scored 3 or more on this scale.

Barriers related to health care organizations themselves included: 1) having to wait too long for an appointment; 2) having to wait too long in a doctor's office; 3) health care facilities

were closed when needed; 4) health care workers did not educate people about prevention; and 5) health care workers did not spend enough time with patients. Only 6.4% scored 3 or more on this scale.

What Portion of the Population Is Satisfied with Health Care Providers?

People were asked to rate their confidence in health care providers including doctors, dentists, hospitals, and the County Health Department on a scale of 1 to 5 where 1 = no confidence and 5 = total confidence. Most people had a great deal of confidence in health care providers. Few people scored 1 or 2 on this scale. The least amount of confidence was expressed in the County Health Department although 57% of people did not feel knowledgeable enough to express an opinion of this provider. Table 10 presents the percent who scored 4 or more for each provider:

Table 10
Confidence in Health Care Providers, Sedgwick County*

	Persons Who Scored 4 or 5	
	%	N
Physicians	84.6	763
Dentists	81.8	670
Hospitals	76.2	588
County Health Department	57.5	211

* Source: Sedgwick County Community Health Assessment, Telephone Survey, 1996

The survey also asked the question, "Thinking of all the health care services you used in the past 12 months, how satisfied are you with them overall--very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, or very dissatisfied?" Most respondents were either satisfied or very satisfied with the care they had received (See Table 11).

Table 11
Satisfaction with Health Care Services in Past 12 Months, Sedgwick County*

	%	N
Very dissatisfied	2.2	19
Dissatisfied	5.0	44
Neither satisfied nor dissatisfied	9.7	85
Satisfied	51.1	446
Very satisfied	32.0	279
Total	100.0	873

* Source: Sedgwick County Community Health Assessment, Telephone Survey, 1996

What Portion of the Population Smokes Tobacco and How Do Smokers Differ from Non-smokers?

People were asked about their smoking behavior. A minority of people interviewed were current smokers (26.1%). A large percentage of respondents had never smoked (45.3%), 3.6% had quite smoking in the past year, and 24.1% had quit smoking for one year or more.

Smokers differed from nonsmokers on age, educational attainment, and income but not on sex. In this sample, men were no more likely than women to smoke. The analysis indicated that:

People 18-44 years were the most likely to be current smokers while those over 65 were the least likely. Those over 65 were also the most apt to report never having smoked. However, those 18-44 were the second the most likely never to have started smoking (nearly 50%) (See Figure 2).

People with less than a high school education were the most likely and those with more than a high school education the least likely to smoke (See Figure 3).

The persons most likely to smoke were those with an annual household income of less than $10,000. People with household incomes of $40,000 or more were the least likely to smoke. They were also the most likely never to have smoked (See Figure 4).

What Portion of the Population Is Exposed to Second-Hand Smoke?

A substantial minority of people interviewed reported being regularly exposed to second-hand smoke in their home or workplace (36.3%). Persons who reported being exposed to second-hand smoke differed from the non-exposed in age, educational attainment, and income but not in sex. In this sample, men were no more apt than women to report exposure to second-hand smoke. The results of the analysis indicated that:

Exposure to second-hand smoke decreased with increasing respondent age and was least likely among persons 65 years or older (See Figure 5).

People with less than a high school education were more apt to report exposure to second-hand smoke than persons with a high school education or more. People with more than a high school education were the least likely to say they were exposed to second-hand smoke (See Figure 6).

People with incomes of $40,000 or more were substantially less likely than persons with lower incomes to report being exposed to second-hand smoke (See Figure 7).

What Portion of the Population Uses Seatbelts?

The majority of people (61.6%) reported always using seatbelts while 13.8% reported using them very often, and 9.3 said they used them sometimes. Only 8.6% said they never used seatbelts.

Persons using seatbelts differed from those who did not on sex and educational attainment but not on age and income. Among the people surveyed, younger people were no more or less apt to use seatbelts than older persons. Nor did people of different incomes differ in their reported seatbelt use. The analysis indicated that:

Men were less likely than women to report wearing seatbelts sometimes, usually, or always (See Figure 8).

People with less than a high school education were the least likely to report seatbelt use sometimes, usually, or always. High school graduates and those with more than a high school education were similar in their reported seatbelt use (See Figure 9).

What Portion of the Population Is Obese?

Obesity was determined using the Quetelet Index, a commonly employed measure based on an individual's height and weight and standardized for sex. About 31% of the people interviewed were obese using this indicator. The only attribute that differentiated the obese from the non-obese was age. Men were no more likely than women to be obese. Nor did educational attainment or income distinguish those who were obese from those who were not. The results indicated that:

Likelihood of obesity was greatest among persons 45-64 years. It was substantially lower among those 18-44 years and persons 65 and over (See Figure 10).

About Racial and Ethnic Differences in Behavioral Risk Factors

We found no differences between whites and nonwhites in smoking, exposure to second-hand smoke, use of seatbelts, or obesity. This may be due to the low percentage of nonwhites in the sample, consistent with the actual demographics of Sedgwick County. Also, the nonwhite category included Blacks, Hispanics, Asians, and others, and these behaviors have been found to differ substantially among different racial and ethnic groups in other studies. Both problems may have made it impossible to detect differences in the telephone survey.

VULNERABLE POPULATIONS IN SEDGWICK COUNTY: THE UNINSURED

While Sedgwick County, as a whole, may be well-off in terms of socioeconomic status, health status, access to medical care, and satisfaction with medical care, there are groups of people within the larger community that are at risk for health, medical, and social problems. The uninsured are one such group, being particularly vulnerable to health and health services access problems. This section of the report describes the uninsured in Sedgwick County--their health status, their use of health care services, their problems with access to services, their satisfaction with these services, and their problems in other areas of life. The information was obtained from a telephone survey of a representative sample of Sedgwick County residents conducted in February and March 1996. Although 958 persons 18 years old and older were interviewed for the study, we report only on the 692 persons who were under 65 at the time of the interview since virtually everyone over 65 is insured through the federal Medicare program. We grouped people as: 1) uninsured for the 12 months prior to the interview; 2) uninsured for some part but not all of the prior 12 months; and 3) insured for 12 months. For this report, we will refer to the 3 groups as the uninsured, the periodically uninsured, and the insured. Among people under 65, the insured was the largest group (76.6%), followed by the periodically uninsured (16.6%), and finally the uninsured (6.6%).

Who Are the Uninsured?

Although the uninsured were a heterogeneous group, on average, they were younger, less educated, and poorer than the insured (See Figures 11, 12, and 13). While 15% of the uninsured had less than 12 years of schooling only 7% of the insured have this level of education. Only 50% of the uninsured had more than 12 years of schooling versus 60% of the insured. With respect to income, 58% of the uninsured earned less than $20,000 annually and only 16% earned more than $50,000. In contrast, 45% of the insured earned $50,000 or more and only 11% earned less than $20,000. The uninsured were also much more likely to be nonwhite (25% v 9%) (See Figure 14).

With respect to marital status, the uninsured were more likely to be single or divorced, separated, or widowed than the insured (See Figure 15). In terms of employment, they were more liable to be employed part-time and less likely to be employed full-time. They were also more apt to report that they are looking for work (15% v 3%) and less apt to be disabled or retired (2% v 10%) (See Figure 16).

The periodically uninsured were usually intermediate between the insured and uninsured. In income, for example, they were not as poor as the uninsured but not as well-off as the insured. Though intermediate, in some characteristics they were more similar to the uninsured than the insured in educational attainment, age, and full and part-time employment status. However, they were more similar to the insured in race. Neither sex was more likely to be in any of the three insurance status categories.

Are the Uninsured in Worse Health than the Insured?

In response to the question, "Would you say that, in general, your health is excellent, very good, good, fair, or poor?", there was no statistical difference between the three groups--the uninsured, periodically uninsured, and insured. About 13% in each group reported fair or poor, and about 55% judged their health as excellent or very good.

However, when asked about the prior 30 days, both groups of uninsured were far more likely to state that there had been more than 3 days when their physical health, including physical illness and injury, had been poor (See Figure 17). This was also true for number of days when their mental health, including stress, depression, and problems with emotions, had been poor (See Figure 18). In addition, both groups of uninsured reported more days when their physical or mental health had kept them from their usual activities such as self-care, work, or recreation.

In summary, both groups of uninsured were in poorer health than the insured as indicated by number of days when physical health was poor, mental health was poor, and activities were limited due to physical or mental health.

Are the Patterns of Health Services Utilization among the Uninsured Different from those of the Insured?

The persons surveyed reported on the number of visits they had made in the prior 12 months to a physician, emergency room, dentist, mental health or drug abuse service, the County Health Department, or other health care provider (i.e., chiropractor, physical therapist, physician assistant, or nurse practitioner). Both groups of uninsured were less likely to have seen a physician even once (See Figure 19) or to have visited a dentist even once (See Figure 20). Both groups of uninsured were more likely than the insured to have visited the County Health Department (See Figure 21). There was no statistically significant difference between the groups in use of the emergency room, mental health or drug abuse services, or other health care providers. Nor were the uninsured more apt to have had a hospital stay. Finally, there were no statistically significant differences between the insured and the uninsured in having a special place to go for health care.

In summary, the uninsured were less likely to see a physician or dentist and more likely to use the County Health Department.

Do the Uninsured Perceive More Barriers to Obtaining Health Care than the Insured?

People were asked if the cost of care had prevented them from getting emergency room care, dental care, prescription medications, and any other medical care in the prior 12 months. Both groups of uninsured were more likely than the insured to report that cost had prevented them from obtaining at least one of these services (See Figure 22).

People were also asked to rate problems on a scale of 1 to 5 where 1 = no problem and 5 = a major problem in their household. Financial barriers to care included: 1) not being able to afford health insurance; 2) not being able to afford dental care; 3) not being able to stay eligible for health insurance; 4) not being able to get health care because of previous medical bills; and 5) not being able to afford medicines and other treatments recommended by a doctor. Both groups of uninsured were much more apt to rate these problems as 3 or higher (See Figure 23).

People were also asked to rate the problem of non-financial barriers to health care including knowledge barriers and barriers presented by health care organizations themselves. Knowledge barriers included: 1) not knowing where to go for health care; 2) not knowing where to go for counseling; 3) not knowing where to go for drug or alcohol treatment; and 4) not being able to find places to get pregnancy care. Again, both groups of the uninsured were more liable to rate these problems as 3 or higher than the insured (See Figure 24).

Barriers related to health care organizations themselves included: 1) having to wait too long for an appointment; 2) having to wait too long in a doctor's office; 3) health care facilities were closed when needed; 4) health care workers did not educate people about prevention; and 5) health care workers did not spend enough time with patients. Both groups of uninsured were more likely than the insured to rate these problems as 3 or higher (See Figure 25).

In summary, the uninsured were much more likely than the insured to perceive barriers to obtaining health care.

Are the Uninsured as Satisfied with Health Care Providers as the Insured?

People were asked to rate their confidence in health care providers including doctors, dentists, hospitals, and the County Health Department on a scale of 1 to 5 where 1 = no confidence and 5 = total confidence. The uninsured were a bit more likely to report scores of 1 or 2 than the insured. There was also a difference between the three groups on their responses to the question, "Thinking of all the health care services you used in the past 12 months, how satisfied are you with them overall--very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, or very dissatisfied?" Both groups of uninsured were less likely than the insured to be very satisfied with their care (25% and 22% v 33%).

In summary, both groups of uninsured were somewhat less satisfied than the insured with the health care they had received.

Are the Uninsured More Likely than the Insured to Have Other Problems?

People were asked to rate problems other than health concerns on a scale of 1 to 5 where 1 = no problem in their household and 5 = a major problem. These problems were related to general economic/financial well-being, the physical environment, violence, access to services for children and youth, access to services for the elderly and handicapped, neighborhood crime, and behavioral risk factors. The general economic/financial problems included: 1) not having money

to buy enough food; 2) the availability of affordable housing; 3) homelessness; and 4) access to jobs that generate enough money to maintain a household. On this scale, both groups of uninsured were more likely than the insured to rate these problems as a 3 or higher (See Figure 26).

On perceived environmental problems including: 1) poor indoor air quality; 2) poor outdoor air quality; and 3) poor water quality, the uninsured were also more liable to rate these problems as a 3 or higher (See Figure 27).

Concerning other problems including violence (e.g., child abuse and neglect, spousal abuse, homicide, sexual assault, youth violence, and suicide), neighborhood crime, access to services for youth and the elderly, and behavioral risk factors (i.e., lack of exercise, obesity, and overeating), there were no statistical differences between the three groups in their likelihood of perceiving these as serious problems in their household.

VULNERABLE POPULATIONS IN SEDGWICK COUNTY: FOUR NEIGHBORHOODS

Another way to investigate vulnerable populations is to compare people by the neighborhoods in which they reside. Although residents of Sedgwick County, on average, are well off in terms of socioeconomic status, health status, and access to health care services, some people are not well off, and often, these people are clustered by neighborhood. Therefore, the Sedgwick County Community Health Assessment Project (CHAP) sampled persons in four neighborhoods characterized by two factors that are associated with poor health outcomes and barriers to health care services--low socioeconomic status and significant presence of minority ethnic or racial groups. The four neighborhoods selected were the Colvin/Plainview region of Wichita, the Northeast/Atwater section of Wichita, the North Midtown region of Wichita, and Oaklawn. This section of the report compares the persons in each neighborhood to those in the telephone survey of the general population. As with the report on the uninsured, we describe each group's health, use of health care services, problems with access to services, satisfaction with these services, and problems in other areas of life.

The information was obtained from personal interviews with adult residents of the four neighborhoods. People were selected at random based on dwelling location, and all interviews were conducted in the respondents' homes between March and June 1996. About 100 adults in each neighborhood were surveyed, and they are compared to the persons who responded to the telephone survey. One problem in making these comparisons is that each sample has a different age and sex distribution. For example, the proportion of elderly women varied from 2 percent in Oaklawn to 21 percent in Northeast/Atwater. Since the age and sex of an individual highly influences that person's health status, use of health care services, and access to services, we decided to eliminate their effect on the results by weighting the four neighborhood samples so that their age and sex distributions matched that of the general population sample. For example, each sample is weighted so that it has approximately 11 percent women and 8 percent men over 64 years of age, just as the general population sample has (See Tables 12 and 13). Therefore, we can be confident that differences between the neighborhoods and the general population are not

due to variation in the proportion of age and sex groups within the samples. We analyzed responses from the 885 respondents from the telephone survey who had no missing data on age and sex and compared them to responses from the neighborhood samples.

Table 12
Unweighted Age and Sex Distribution in the Telephone and Neighborhood Surveys

	Male			Female			
	18-44	45-64	65+	18-44	45-64	65+	
	%	%	%	%	%	%	Total N
Colvin/Plainview	23.0	8.0	3.0	36.0	20.0	10.0	100
North Midtown	20.0	14.7	6.3	43.2	8.4	7.4	95
Northeast/Atwater	12.0	5.4	6.5	29.3	26.1	20.7	92
Oaklawn	22.4	6.1	6.1	56.1	7.1	2.0	98
General Population	26.0	14.7	8.0	25.0	15.1	11.2	885

Table 13
Weighted Age and Sex Distribution in the Telephone and Neighborhood Surveys

	Male			Female			
	18-44	45-64	65+	18-44	45-64	65+	
	%	%	%	%	%	%	Total N
Colvin/Plainview	26.0	15.0	8.0	25.0	15.0	11.0	100
North Midtown	26.0	14.6	8.3	25.0	14.6	11.5	95
Northeast/Atwater	26.1	15.2	7.6	25.0	15.2	10.9	92
Oaklawn	26.3	14.1	8.1	25.3	15.2	11.1	98
General Population	26.0	14.7	8.0	25.0	15.1	11.2	885

How Do the Neighborhoods Differ from the General Population, Demographically?

Demographically, the neighborhoods differ substantially from the general population in Sedgwick County, even after adjusting for the age and sex distributions of the samples. (Actually, the weighting changed the demographic profiles of the neighborhoods very little). There were considerably more nonwhites in the neighborhoods than in Sedgwick County as a whole (See Figure 28). However, there was also great variation between the neighborhoods. Colvin/Plainview contained all race and ethnic groups but predominantly non-Hispanic whites (40 percent), Asians (31 percent), and African-Americans (16 percent). North Midtown was

largely Hispanic. Our adjusted sample was 75 percent Hispanic and 20 percent white. African-Americans predominated in the Northeast/Atwater neighborhood (94 percent). In Oaklawn, non-Hispanic whites were the majority (76 percent) while African-Americans made-up 14 percent and the remaining 10 percent were Hispanics, Asians, Native Americans, and others.

On average, the socioeconomic status in the neighborhoods is lower than in the general population. In all four neighborhoods, the annual household income for the majority of people was under $20,000 whereas the majority of respondents to the telephone survey earned $40,000 or more. The largest single income category for the Colvin/Plainview, North Midtown, and Northeast/Atwater neighborhoods was under $10,000 while the largest single income category for the general population sample was $50,000 or more (See Figure 29). As would be expected given these income distributions, educational attainment was also very different in the general population and the neighborhood samples. Only 9 percent of people in the general population sample had less than a high school education while between 37.4 and 65.6 percent of persons in the neighborhoods had not graduated from high school. Among the neighborhood samples, people in North Midtown were the most likely to be in the lowest educational category (65.6 percent) and residents of Atwater the least likely (26.4 percent). Figure 30 displays these comparisons.

In terms of employment, the neighborhoods also differ statistically from the general population. Neighborhood residents were less liable than persons in the general population to be employed full-time, more likely to be retired or disabled, and more likely to be looking for work. In Colvin/Plainview and North Midtown they were more likely to report being housewives (See Figure 31).

With respect to marital status, there is no statistically significant difference between the neighborhoods and the general population. However, this is likely due to the similarity of both the Colvin/Plainview and Oaklawn neighborhoods to the general population where about 59 percent of persons were married and 23 percent were widowed, divorced, separated, or living with someone. The North Midtown and Atwater/Northeast neighborhoods had very different profiles, with people in North Midtown more likely than in other neighborhoods to be married (73 percent) and those in Northeast/Atwater less likely to be married (38 percent).

In summary, the four neighborhoods differ substantially from the general population in that their residents were more likely to be nonwhite and poor. They were less likely to have completed high school and to have full-time employment.

Are Neighborhood Residents in Worse Health than the General Population?

In response to the question, “Would you say that, in general, your health is excellent, very good, good, fair, or poor?”, persons in the neighborhoods were less likely than those in the general population to report excellent or very good. The least likely to perceive their health as excellent or very good were people in North Midtown (only 15.6 percent). Conversely, neighborhood residents were much more likely to judge their health as poor or fair, again with persons in North Midtown the most likely (51 percent) (See Figure 32).

When asked about the prior 30 days, neighborhood residents did not differ statistically from the general population in the number of days when their physical health was not good. However, this was not true for the number of days when their mental health, including stress, depression, and problems with emotions, had been poor. Except for residents of North Midtown, neighborhood residents were less likely to report that they had no days when their mental health had been poor. All neighborhood residents were more likely to say that their mental health had been poor for 8 days or more (See Figure 33). In addition, residents of all neighborhoods were more liable than the general population to report that their physical or mental health had kept them from their usual activities such as self-care, work, or recreation for 8 days or more (See Figure 34).

In summary, residents of all the neighborhoods were in worse health than the general population as indicated by number of days when mental health was poor, activities were limited due to physical or mental health, and perceived health status.

Are the Patterns of Health Services Utilization among Neighborhood Residents Different from Those of the General Population?

Persons surveyed reported on the number of visits they had made in the prior 12 months to a physician, emergency room, dentist, mental health or drug abuse service, the County Health Department, or other health care provider (i.e., chiropractor, physical therapist, physician assistant, or nurse practitioner). There were considerable differences between neighborhood residents and the general population in their use of health care services. In all neighborhoods, people were less likely than the general population to have seen a physician, visited a dentist, or seen another health care provider such as a chiropractor, physical therapist, or nurse practitioner even once in the past year (See Figures 35, 36 & 37). Persons in all neighborhoods were more likely than the general population to have visited the County Health Department, particularly those in North Midtown (See Figure 38). They were also more likely to have visited the emergency room (See Figure 39) and to have had a hospital stay (See Figure 40). Residents of Colvin/Plainview and North Midtown were the least likely to have used mental health or drug abuse services while residents of Northeast/Atwater and Oaklawn were similar to the general population in their use (See Figure 41). Finally, there were no statistically significant differences between the neighborhoods and the general population in having a special place to go for health care. Most reported that they went to a physician's office (about 75 percent).

Is the Health Insurance Status of Neighborhood Residents Different from That of the General Population?

The insurance status of survey respondents was classified as follows: 1) uninsured for the 12 months prior to the interview; 2) uninsured for some part but not all of the prior 12 months; and 3) insured for 12 months. In the general population, the insured was the largest group (76.6%), followed by the periodically uninsured (14.9%), and finally the uninsured (5.6%). Only the Northeast/Atwater neighborhood was similar to the general population in insurance status.

Residents of the other three were more apt to be uninsured for all or part of the preceding year than the general population (See Figure 42).

Figure 43 displays the results about type of insurance for people who reported having insurance at the time of the interview. Residents of all four neighborhoods were more likely to be uninsured at the time of the interview than the general population. Among those who were insured, they were more likely to have Medicaid and less likely to have commercial insurance than the general population. Residents of Colvin and North Midtown reported higher levels of Medicaid coverage than the general population or any other group. However, because the samples have been adjusted for age, we question whether this result was due to misunderstanding the difference between Medicare and Medicaid among many people for whom English is a second language.

Do Neighborhood Residents Perceive More Barriers to Obtaining Health Care than the General Population?

People were asked if the cost of care had prevented them from getting emergency room care, dental care, prescription medications, and any other medical care in the prior 12 months. Residents of all four neighborhoods were more liable than the general population to report that cost had prevented them from obtaining at least one of these services. Persons in North Midtown were the most likely (78.5 percent) and those of Oaklawn the least likely (32 percent) of neighborhood residents to perceive cost as a barrier (See Figure 44).

People were also asked to rate health care access problems on a scale of 1 to 5 where 1 = no problem and 5 = a major problem in their household. Financial barriers to care included: 1) not being able to afford health insurance; 2) not being able to afford dental care; 3) not being able to stay eligible for health insurance; 4) not being able to get health care because of previous medical bills; and 5) not being able to afford medicines and other treatments recommended by a doctor. Residents of all neighborhoods were much more apt to rate these problems as 3 or higher than the general population (See Figure 45).

People were also asked to rate the problem of non-financial barriers to health care including knowledge barriers and barriers presented by health care organizations themselves. Knowledge barriers included: 1) not knowing where to go for health care; 2) not knowing where to go for counseling; 3) not knowing where to go for drug or alcohol treatment; and 4) not being able to find places to get pregnancy care. Residents of the Colvin, North Midtown, and Northeast/Atwater neighborhoods were more liable to rate these problems as 3 or higher than the general population (See Figure 46). Residents of Oaklawn were similar in their responses to the general population.

Barriers related to health care organizations themselves included: 1) having to wait too long for an appointment; 2) having to wait too long in a doctor's office; 3) health care facilities were closed when needed; 4) health care workers did not educate people about prevention; and 5) health care workers did not spend enough time with patients. Responses to these questions were similar to those for knowledge barriers to care. Residents of Colvin and North Midtown

were the most likely to rate these problems as 3 or higher while those of Oaklawn were similar to the general population. Residents of Northeast/Atwater were intermediate between these two groups (See Figure 47).

In summary, residents of the four neighborhoods were much more likely than the general population to perceive barriers to obtaining health care.

Are Neighborhood Residents as Satisfied with Health Care Providers as the General Population?

People were asked to rate their confidence in health care providers including doctors, dentists, hospitals, and the County Health Department on a scale of 1 to 5 where 1 = no confidence and 5 = total confidence. Except for residents of Oaklawn, people in the neighborhoods were more likely to report scores of 1 or 2 than the general population. Residents of Oaklawn were less likely than even the general population to report scores of 1 or 2. There was also a difference between the three groups on their responses to the question, "Thinking of all the health care services you used in the past 12 months, how satisfied are you with them overall--very satisfied, satisfied, neither satisfied nor dissatisfied, dissatisfied, or very dissatisfied?" Again, except for residents of Oaklawn, there were fewer responses of very satisfied in the neighborhoods than in the general population (See Figure 48).

In summary, except for residents of Oaklawn, persons in the neighborhoods were somewhat less satisfied than the general population with the health care they had received in the past year.

Are Neighborhood Residents More Likely than the General Population to Have Other Problems?

People were asked to rate problems other than health concerns on a scale of 1 to 5 where 1 = no problem in their household and 5 = a major problem. These problems were related to sexuality and alcohol, general financial/economic well-being, the physical environment, access to services for the elderly and handicapped, violence, and behavioral risk factors. Although no problems were rated as serious by a large proportion of respondents, the neighborhood residents were much more likely than the general population to rank them highly.

The problems related to sexuality and alcohol included: 1) teenage pregnancy; 2) sexually transmitted diseases such as AIDS, gonorrhea, or chlamydia; and 3) drinking and driving. People in all four neighborhoods were more likely to rate these as a serious problem (See Figure 49).

General financial/economic problems included: 1) not having money to buy enough food; 2) the availability of affordable housing; 3) homelessness; and 4) access to jobs that generate enough money to maintain a household. On this scale, residents of all neighborhoods were much more likely than the general population to rate these problems as a 3 or higher (See Figure 50).

On perceived physical environmental problems including: 1) poor indoor air quality; 2) poor outdoor air quality; and 3) poor water quality, the neighborhood residents were also more liable to rate these problems as a 3 or higher (See Figure 51).

Access to services for the elderly and handicapped included: 1) not enough services for older people; 2) not enough services for handicapped people; 3) availability of adult day care; 4) availability of home health care and in-home services for the elderly; and 5) availability of services for the physically handicapped. On this scale, residents of all neighborhoods were much more apt than the general population to rate these problems as a 3 or higher (See Figure 52).

Similarly, on problems including violence (e.g., child abuse and neglect, spousal abuse, homicide, sexual assault, youth violence, and suicide) and behavioral risk factors (i.e., lack of exercise, obesity, and overeating), neighborhood residents were more apt to score these problems as 3 or higher, although the differences between the neighborhoods and the general population were not as great as for previously discussed problems (See Figures 53 & 54).

Do Neighborhood Residents Differ from the General Population in Smoking Behavior?

Smoking was more prevalent in all of the neighborhoods than in the general population. However, it was much more likely among persons living in the Colvin/Plainview and Oaklawn neighborhoods, probably attributable in part to a higher proportion of Asian residents in these areas. Neighborhood residents were also less likely than the general population to have stopped smoking in the past year or more. Residents of the North Midtown area were the most likely, even compared to the general population, never to have smoked (See Figure 55).

Do Neighborhood Residents Differ from the General Population in Exposure to Second-Hand Smoke?

Residents of all neighborhoods except North Midtown were more likely than the general population to report exposure to second-hand smoke. This finding is consistent with the level of smoking reported in each neighborhood (See Figure 56).

Do Neighborhood Residents Differ from the General Population in Use of Seatbelts?

Residents of all neighborhoods except North Midtown were less likely to report using seatbelts sometimes, usually, or always. The residents of North Midtown had a higher rate of seatbelt use than any other group including the general population (See Figure 57).

Do the Neighborhoods Differ from the General Population in the Prevalence of Obesity?

The highest level of obesity was found in the North Midtown and Northeast/Atwater neighborhoods. However, the differences were not statistically significant (See Figure 58).

In summary, these neighborhood comparisons suggest that efforts to reduce smoking and exposure to second-hand smoke and increase seatbelt use among Sedgwick County residents might be fruitfully targeted to specific neighborhoods. Three of the four neighborhoods studied for the 1996 CHAP--Colvin/Plainview, Northeast/Atwater, and Oaklawn--had significantly higher proportions of people with these problems than the general population. A geographically targeted strategy would also be supported by the findings of previous analyses indicating that low educational attainment and income were associated with more smoking, exposure to second-hand smoke, and lower seatbelt use. Neighborhoods are usually fairly homogeneous with respect to socioeconomic status, as were the neighborhoods studied here. However, demographically targeted efforts might be undertaken as well since smoking was found to be more prevalent among young people, obesity among the middle aged, and lower seatbelt use among men.

PERCEIVED HOUSEHOLD AND COMMUNITY PROBLEMS

The following section provides information about the importance of certain health and social problems to respondents of the telephone and neighborhood surveys.

How Were the Health and Social Problems Categories Developed?

The survey administered to the general population and residents of the four neighborhoods contained 54 health and social problems ranging from “Not being able to afford health insurance” to “Teenage pregnancy” to “Availability of child development programs.” Respondents were asked to rate on a scale of 1-5 the importance of each problem: 1) for the people in their home; and 2) for the community. The scale metric was 1=no problem and 5=a major problem.

In order to facilitate the analysis and understanding of this information, the individual survey items were grouped into 11 problem categories. We used factor analysis and internal consistency reliability scores (Cronbach’s alpha) to construct and validate the groupings. The measures were constructed using the telephone data for household problems and then validated on the community problems and the neighborhood survey data. The items were grouped as follows. The Cronbach’s alpha score refers to the reliability score obtained for perceptions about household problems using the telephone data. The perceived community problems follow the same categories.

1. Financial Barriers to Obtaining Health Care (Cronbach's alpha=.81)
    - Not being able to afford health insurance
    - Not being able to afford dental care
    - Not being able to stay eligible for health insurance such as keeping medical card
    - Not being able to get health care because previous medical bills haven't been paid
    - Not being able to afford medicines and other things the doctor recommends

2. Knowledge Barriers to Obtaining Health Care (Cronbach's alpha=.69)
    - Not knowing where to go for health care
    - Not knowing where to go for counselling
    - Not knowing where to go for drug or alcohol treatment
    - Not being able to find places to get pregnancy care

3. Organizational Barriers to Obtaining Health Care, (Cronbach's alpha=.76)
    - Having to wait too long for an appointment
    - Having to wait too long in a doctor's office
    - Health care facilities are not open when needed
    - Health care workers do not educate people about prevention
    - Health care workers do not spend enough time with patients
    - Not being able to get health care in one place
    - Not having translators available in health care facilities
    - Key health care facilities are far from home

4. Problems with Access to Services for the Elderly and Handicapped, (Cronbach's alpha=.70)
    - Not enough services for older people
    - Not enough services for handicapped people
    - Availability of adult day care
    - Availability of home health care and in-home services for elderly
    - Availability of services for the physically handicapped

5. General Financial/Economic Problems, (Cronbach's alpha=.71)
    - Not having money to buy enough food
    - Availability of affordable housing
    - Homelessness
    - Access to jobs that generate enough money to maintain a household

6. Behavioral Risk Factor Problems Related to Eating and Overweight, (Cronbach's alpha=.66)
    - Not getting enough exercise
    - Obesity
    - Poor eating habits

7. Violence Problems, (Cronbach's alpha=.87)
    - Youth violence
    - Violence between spouses or partners
    - Suicide
    - Sexual assault
    - Child abuse and neglect
    - Homicide
    - Neglect and abuse of elderly

8. Behavioral Risk Factor Problems Related to Sexuality and Alcohol, (Cronbach's alpha=.84)
    - Drinking and driving
    - Sexually transmitted diseases such as AIDS, gonorrhea, or chlamydia
    - Teenage pregnancy

9. Physical Environment Problems, (Cronbach's alpha=.67)
    - Poor indoor air quality (i.e., second-hand smoke, sick building syndrome)
    - Poor outdoor air quality (i.e., air pollution)
    - Poor water quality

10. Problems with Access to Services for Children and Youth, (Cronbach's alpha=.74)
    - Affordable health care for children
    - Availability of child care
    - Availability of child care for mildly ill children
    - Availability of youth development programs

11. Problems With Neighborhood Crime, (Cronbach's alpha=.57)
    - Burglary
    - Vandalism
    - Street lighting
    - Can't exercise because of unsafe neighborhoods

For this analysis, we calculated the mean score for each community and household problem category for both the general population and each of the four neighborhoods. For each problem category, we compared general population and neighborhood means to each other. The mean scores were weighted so that the neighborhood samples match the general population in age and sex. This procedure assures that differences in scores are not attributable to underlying variation in the age and sex distribution of the samples. A chi-squared test indicates that the mean scores for the neighborhoods and the general population are different for each problem category. Neighborhood means for both household and community problems were always higher than those for the general population, indicating more concern.

These mean scores were also arranged in descending order for the general population and each neighborhood sample. Therefore, the first score in the table is the highest, indicating the problem category about which people in that group were most concerned (See Tables 14 to 23).

Table 14.
Mean Scores for Perceived Household Problems, General Population

Problem Categories	**Mean**	**N**
Behavioral Risk Factor Problems Related to Eating and Overweight	2.0167	919
Physical Environment Problems	1.6589	927
Organizational Barriers to Obtaining Health Care	1.5939	935
Financial Barriers to Obtaining Health Care	1.5849	933
General Financial/Economic Problems	1.4656	928
Problems with Neighborhood Crime	1.4581	934
Problems with Access to Services for Children and Youth	1.3265	919
Problems with Access to Services for Elderly and Handicapped	1.3013	932
Knowledge Barriers to Obtaining Health Care	1.2425	939
Behavioral Risk Factor Problems Related to Sexuality and Alcohol	1.2419	917
Violence Problems	1.2200	925

Table 15.
Mean Scores for Perceived Community Problems, General Population

Problem Categories	**Mean**	**N**
Behavioral Risk Factor Problems Related to Sexuality and Alcohol	3.0639	924
Behavioral Risk Factor Problems Related to Eating and Overweight.	2.9131	926
Financial Barriers to Obtaining Health Care	2.8056	933
Violence Problems	2.7565	930
General Financial/Economic Problems	2.6768	929
Problems with Access to Services for Children and Youth	2.6153	926
Problems with Neighborhood Crime	2.5560	933
Problems with Access to Services for Elderly and Handicapped	2.2812	931
Organizational Barriers to Obtaining Health Care	2.251	935
Physical Environment Problems	2.1638	929
Knowledge Barriers to Obtaining Health Care	2.0246	937

Table 16.
Mean Scores for Perceived Household Problems, Colvin-Plainview

Problem Categories	**Mean**	**N**
Financial Barriers to Obtaining Health Care	2.2809	94
Behavioral Risk Factor Problems Related to Eating and Overweight	2.1511	93
Physical Environment Problems	2.109	94
Problems with Neighborhood Crime	1.9829	93
Organizational Barriers to Obtaining Health Care	1.9663	97
General Financial/Economic Problems	1.8852	95
Knowledge Barriers to Obtaining Health Care	1.7463	97
Problems with Access to Services for Elderly and Handicapped	1.7033	89
Problems with Access to Services for Children and Youth	1.5454	85
Behavioral Risk Factor Problems Related to Sexuality and Alcohol	1.4628	93
Violence Problems	1.4335	90

Table 17.
Mean Scores for Perceived Community Problems, Colvin-Plainview

Problem Categories	**Mean**	**N**
Financial Barriers to Obtaining Health Care	3.1064	72
Behavioral Risk Factor Problems Related to Sexuality and Alcohol	2.9131	74
Problems with Neighborhood Crime	2.8206	82
General Financial/Economic Problems	2.8064	82
Problems with Access to Services for Children and Youth	2.7896	66
Behavioral Risk Factor Problems Related to Eating and Overweight	2.771	74
Physical Environment Problems	2.6527	82
Problems with Access to Services for Elderly and Handicapped	2.6172	77
Violence Problems	2.6025	80
Organizational Barriers to Obtaining Health Care	2.5444	81
Knowledge Barriers to Obtaining Health Care	2.3064	86

Table 18.
Mean Scores for Perceived Household Problems, North Midtown

Problem Categories	**Mean**	**N**
Financial Barriers to Obtaining Health Care	2.9311	95
General Financial/Economic Problems	2.7273	95
Organizational Barriers to Obtaining Health Care	2.5984	95
Problems with Neighborhood Crime	2.5254	95
Physical Environment Problems	2.4314	95
Behavioral Risk Factor Problems Related to Eating and Overweight	2.4100	93
Problems with Access to Services for Children and Youth	2.1618	92
Problems with Access to Services for Elderly and Handicapped	2.0863	88
Knowledge Barriers to Obtaining Health Care	1.9363	95
Violence Problems	1.7786	94
Behavioral Risk Factor Problems Related to Sexuality and Alcohol	1.4996	89

Table 19.
Mean Scores for Perceived Community Problems, North Midtown

Problem Categories	**Mean**	**N**
Financial Barriers to Obtaining Health Care	4.3613	91
General Financial/Economic Problems	4.2295	93
Behavioral Risk Factor Problems Related to Sexuality and Alcohol	4.0443	87
Problems Related to Access to Services for Children and Youth	3.9460	88
Problems with Access to Services for Elderly and Handicapped	3.8804	84
Behavioral Risk Factor Problems with Eating and Overweight	3.7986	85
Problems with Neighborhood Crime	3.7610	94
Violence Problems	3.5931	92
Knowledge Barriers to Obtaining Health Care	3.4957	91
Organizational Barriers to Obtaining Health Care	3.4823	94
Physical Environment Problems	3.1350	88

Table 20.
Mean Scores for Perceived Household Problems, Northeast/Atwater

Problem Categories	**Mean**	**N**
Physical Environment Problems	2.3499	86
Financial Barriers to Obtaining Health Care	2.2203	90
General Financial/Economic Problems	2.0759	90
Behavioral Risk Factor Problems Related to Eating and Overweight	2.0170	90
Problems with Neighborhood Crime	2.0083	87
Problems with Access to Services for Elderly and Handicapped	1.7755	81
Organizational Barriers to Obtaining Health Care	1.7591	90
Problems with Access to Services for Children and Youth	1.601	84
Behavioral Risk Factor Problems Related to Sexuality and Alcohol	1.5894	80
Violence Problems	1.5272	90
Knowledge Barriers to Obtaining Health Care	1.4038	90

Table 21.
Mean Scores for Perceived Community Problems, Northeast/Atwater

Problem Categories	Mean	N
Financial Barriers to Obtaining Health Care	3.7558	77
Behavioral Risk Factor Problems Related to Sexuality and Alcohol	3.6092	68
General Financial/Economic Problems	3.4150	78
Problems with Access to Services for Elderly and Handicapped	3.3627	75
Behavioral Risk Factor Problems Related to Eating and Overweight	3.2952	70
Problems with Access to Services for Children and Youth	3.1958	73
Violence Problems	3.1787	84
Problems with Neighborhood Crime	2.9876	80
Organizational Barriers to Obtaining Health Care	2.9401	79
Physical Environment Problems	2.9011	77
Knowledge Barriers to Obtaining Health Care	2.6065	84

Table 22.
Mean Scores for Perceived Household Problems, Oaklawn

Problem Categories	**Mean**	**N**
Financial Barriers to Obtaining Health Care	2.0772	98
Behavioral Risk Factor Problems Related to Eating and Overweight.	2.0500	92
General Financial/Economic Problems	1.9736	98
Physical Environment Problems	1.8830	96
Problems with Neighborhood Crime	1.8077	98
Problems with Access to Services for Children and Youth	1.7739	97
Problems with Access to Services for Elderly and Handicapped	1.7664	96
Organizational Barriers to Obtaining Health Care	1.6864	98
Behavioral Risk Factor Problems Related to Sexuality and Alcohol	1.4425	89
Violence Problems	1.3930	96
Knowledge Barriers to Obtaining Health Care	1.3218	97

Table 23.
Mean Scores for Perceived Community Problems, Oaklawn

Problem Categories	Mean	N
Behavioral Risk Factor Problems Related to Sexuality and Alcohol	3.5623	69
Financial Barriers to Obtaining Health Care	3.4716	55
Behavioral Risk Factor Problems Related to Eating and Overweight	3.3592	62
Problems with Access to Services for Children and Youth	3.2671	67
General Financial/Economic Problems	3.0280	71
Organizational Barriers to Obtaining Health Care	3.0141	64
Problems with Neighborhood Crime	2.9666	71
Problems with Access to Services for Elderly an Handicapped	2.9641	71
Violence Problems	2.9321	76
Knowledge Barriers to Obtaining Health Care	2.6429	62
Physical Environment Problems	2.3580	70

What Household Problems Are Judged Most Important by the General Population and Residents of the Neighborhoods?

Table 14 displays the household problems in order of their importance to telephone survey respondents. The top six problems, starting with the first, were:

1. Behavioral risk factor problems related to eating and overweight
2. Physical environment problems
3. Organizational barriers to obtaining health care
4. Financial barriers to obtaining health care
5. General financial/economic problems
6. Problems with neighborhood crime

Tables 16, 18, 20, and 22 display the same results for the four neighborhoods. There was much agreement between residents of the neighborhoods and the general population concerning the household problems considered most important. With two exceptions, the top 6 problems in the neighborhoods were the same as the top 6 in the general population. The exceptions were:

1. Northeast/Atwater
   Organizational barriers to obtaining health care was not ranked high enough to be among the top 6 problems. Instead problems with access to services for the elderly and handicapped was one of the top 6 problems.

2. Oaklawn
   Organizational barriers to obtaining health care was not ranked highly enough to be found among the top 6 problems in Oaklawn. Instead problems with access to services for children and youth was one of the top 6 problems.

What Are the Differences Between the Neighborhoods and the General Population Regarding Perceptions of Household Problems?

The first difference has to do with the ranking of problems. Judging by the order of the problems within the neighborhood and general population lists, neighborhood residents were more concerned about financial barriers to obtaining health care and general financial and economic problems. Also, there was some tendency for neighborhood crime to be ranked higher in the neighborhoods than in the general population.

1. Financial barriers to obtaining health care had either the first or second highest score among all neighborhoods whereas it had the 4th highest score on the general population list.

2. Except in the Colvin neighborhood where is was sixth, general financial and economic problems were 2 or 3 on the neighborhood lists compared to 5 on the general population list.

3. Neighborhood crime problems were a little higher on the neighborhood than the general population lists. (GP=6; Neighborhoods either 4 or 5)

Two problems tended to be less important to residents of the neighborhoods than to the general population as indicated by the order of their mean scores: 1) physical environment problems; and 2) organizational barriers to obtaining health care.

1. Physical environment problems achieved the second highest score among the general population but, except for Northeast/Atwater where this problem had the highest mean score, the neighborhoods judged the problem as less important (ranks of 3,4, or 5).

2. Organizational barriers to obtaining health care had the third highest mean score among the general population. Among residents of the neighborhoods, its rank was much lower with either the third, fifth, seventh, or eighth highest score.

The second difference between the neighborhoods and the general population is in the magnitude of their scores. The top six general population mean scores ranged from 1.46 to 2.02, and the second highest score was 1.66. In contrast, the mean scores of the sixth ranked problem in all neighborhoods were higher than all but the first ranked problem in the general population (See Table 24). This finding indicates that, overall, these household problems were of greater concern to residents of the four neighborhoods than to the general population of Sedgwick County.

Table 24.
Range of Top 6 Mean Scores for Perceived Household Problems in the Four Neighborhoods, Sedgwick County*

	Mean for 6th Problem	Mean for 1st Problem
Colvin/Plainview	1.89	2.28
North Midtown	2.41	2.93
Northeast/Atwater	1.78	2.35
Oaklawn	1.77	2.08

* Source: Sedgwick County Community Health Assessment Project, 1996

Finally, there are neighborhood-specific differences in perceptions of household problems. First, problems related to eating and overweight were ranked much lower in Northeast/Atwater and in North Midtown than in the other neighborhoods and among the general population.

Second, physical environment problems obtained the highest mean score among residents of Northeast/Atwater. It was problem of much greater concern in this area than in any of the other neighborhoods or among the general population.

Third, access problems for specific populations were of more concern in Oaklawn and Northeast/Atwater than in other neighborhoods or in the general population. Among residents of Northeast/Atwater, access to services for the handicapped and elderly were of concern. Residents of Oaklawn were more concerned about access to services for children and youth. The residents of both neighborhoods were also less concerned about organizational barriers to health care.

What Community Problems Are Judged Most Important by the General Population and Residents of the Neighborhoods?

Table 15 displays the community problems in order of their importance to telephone survey respondents (i.e., the general population). The top six problems, starting with the first, were:

1. Behavioral risk factor problems related to sexuality and alcohol
2. Behavioral risk factor problems related to eating and overweight
3. Financial barriers to obtaining health care
4. Violence problems
5. General financial/economic problems
6. Problems with access to services for children and youth

Tables 17, 19, 21, and 23 display the same results for the four neighborhoods. Again, there was much agreement between residents of the neighborhoods and the general population concerning the problems perceived to be most important in the community. Five of the six problems of most concern to the general population were also on the top 6 list in the four neighborhoods. Only violence problems, which had the fourth highest mean score among the general population, was not one of the top 6 problems in any of the neighborhoods. Instead, the neighborhood residents were more concerned about access to services:

1. Northeast/Atwater and North Midtown
   Problems with access to services for the elderly and handicapped, rather than violence problems, were among the top 6 problems in these neighborhoods.

2. Oaklawn
   Organizational barriers to obtaining health care was among the top 6 concerns of Oaklawn residents not violence problems.

3. Colvin/Plainview
   Neighborhood crime problems were of greater concern to residents of Colvin/Plainview than violence problems.

What Are the Differences Between the Neighborhoods and the General Population Regarding Perceptions of Community Problems?

In addition to differences related to the importance of violence problems, the general population and residents of the four neighborhoods differed on the relative importance of the top 6 problems and their level of concern about these problems. With regard to the relative importance of each community problem, the perceptions of neighborhood residents and the general population were less disparate than they were for household problems.

1. Residents of all four neighborhoods and the general population seemed to have a high level of concern about problems related to teen sexuality and alcohol abuse. It was the problem with the highest score among the general population and it was scored 1, 2, or 3 in the neighborhoods.

2. Financial barriers to obtaining health care was a great concern of both the general population and all neighborhood residents, although somewhat more of a concern here. It was scored 1 in Colvin, North Midtown, and Northeast/Atwater, 2 in Oaklawn, and 3 in the general population.

3. Problems with access to services for children and youth was one of the leading concerns among the general population and neighborhood residents. It was also closer to the bottom on all top 6 lists. The mean score was 6 on the general population list and either 4, 5, or 6 on all neighborhood lists.

4. A significant difference between the perceptions of the general population and those of neighborhood residents concerns problems related to eating and overweight. This was perceived by the general population as the second most important community problem whereas among neighborhood residents it was ranked 3, 5, or 6.

A neighborhood-specific difference in relative importance was noted in the ranking of general financial/economic problems. Residents of the North Midtown and Northeast/Atwater neighborhoods differed from both the general population and residents of Colvin/Plainview and Oaklawn in their ranking of the general financial/economic problems. This problem was a top 6 concern for all groups--neighborhood and general population--but it was a greater concern for residents of North Midtown and Northeast/Atwater. They ranked it as 2 and 3, respectively, while other groups ranked it as 4 or 5.

The magnitude of mean scores suggests that the general population also differed from the neighborhoods in their level of concern about these problems. The top six general population mean scores ranged from 2.6153 to 3.0639. In contrast, the mean scores of the sixth ranked problem in all neighborhoods but Colvin/Plainview were nearly as high or higher than the first ranked problem in the general population (See Table 25). This finding indicates that, overall, these community problems were of greater concern to neighborhood residents of North Midtown, Northeast/Atwater, and Oaklawn than to the general population of Sedgwick County and to residents of Colvin/Plainview.

Table 25.
Range of Top 6 Mean Scores for Perceived Community Problems in the Four Neighborhoods, Sedgwick County*

	Mean for 6th Problem	Mean for 1st Problem
Colvin/Plainview	2.7710	3.1064
North Midtown	3.7986	4.3613
Northeast/Atwater	3.1958	3.7558
Oaklawn	3.0141	3.5623

* Source: Sedgwick County Community Health Assessment Project, 1996