RWJF Culture of Health
Sentinel Community Snapshot:

Maricopa County, Arizona
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**About This Report**

The Sentinel Communities project, conducted by RTI International in collaboration with the RAND Corporation, is sponsored by the Robert Wood Johnson Foundation. The project will monitor activities in each of 30 diverse communities around the country for at least 5 years. This Snapshot is the first in a series of planned reports about this Sentinel Community. Using data compiled in early 2016, it provides an initial overview of the community’s history, challenges, and approaches to building a Culture of Health. Visit cultureofhealth.org to see the full list of communities and links to other reports and information about the project.
Introduction

Maricopa County, located in southwest Arizona in the Sonoran Desert, is known for its sunshine and warm climate. The county comprises 25 cities and towns, including the county seat and state capital, Phoenix, the sixth most populous city in the United States.\(^1\) Although the American Indian population in Maricopa County is quite small, all or parts of five American Indian reservations are contained within county borders.\(^3\)

Since the late 1800s, when the first European settlers arrived, the county has experienced rapid population growth. Before that, the area was inhabited by several bands of American Indians, including the Apache, Maricopa, and Pima tribes. The first European settlers established a mining settlement and had success with farming, because of the rich soils and availability of water from the Salt and Gila rivers. Mining, agriculture, and livestock industries flourished, driving further population expansion.\(^4\) The “Five Cs” (copper, cotton, climate, citrus, and cattle) have historically made up most of Arizona and Maricopa County’s economy. However, by the mid-20th century, the influx of technology companies and the establishment of military air bases and training facilities led to a population and technology boom. Currently, less than half of 1% of Maricopa County’s workforce is employed in agriculture.\(^2\) In the past 24 years, the county’s population has almost doubled, from 2,122,101 residents in 1990\(^6\) to 4,087,191 in 2014.\(^2\) Maricopa County is the fourth most populous county in the United States and, as of the 2014 census, was more populous than 25 states.\(^2\)
Maricopa County’s population is predominantly white (58%) and Hispanic (30%), with small populations identified as black (5%), Asian (4%), American Indian/Alaska Native (2%), and Native Hawaiian/Pacific Islander (less than 1%). Climate and jobs, along with Maricopa County’s proximity to Mexico, attract increasing numbers of immigrants, approximately 60% of whom come from Latin America. Of those, nearly 90% come from Mexico. Approximately 29% of Hispanics living in Maricopa County are not U.S. citizens, and 11% of all Maricopa County residents are not U.S. citizens, compared with 7% for U.S. residents (note: census figures cited in this report include all residents, citizens and noncitizens, who responded to the census). The Maricopa County Department of Public Health is charged with providing a wide range of health services to this large, diverse, and continually growing population. However, a lack of local funding for public health has forced public health leaders to rely on public-private partnerships and cross-sector collaboration to implement preventive health programs and to address a variety of issues, such as child safety, access to health care, and teen pregnancy. Maricopa County as a whole fares well on most social and health indicators; however, significant racial and ethnic disparities exist in income, education, employment, health insurance coverage, and, ultimately, health. Hispanic residents, in particular, are the least educated and most impoverished. Local and federal policies—including controversial local immigration policies targeting Maricopa County’s Hispanic population and federal policies that limit immigrant access to health care—also present significant challenges to health equity.

**POSITIVE INDICATORS MASK SHARP DISPARITIES**

Maricopa County rates better than the nation on many socioeconomic indicators and health outcomes; for example, 30% of Maricopa residents have a bachelor’s degree compared with 29% of the U.S. population. Maricopa County fares better than the nation on several health outcomes, such as smoking prevalence (16% Maricopa County, 18% U.S.), percentage of the population that is overweight (23% Maricopa County, 30% U.S.), diabetes prevalence (8% Maricopa County, 10% U.S.), days of poor physical or mental health (3% Maricopa County, 4% U.S.), and premature death (6,053 per 100,000 Maricopa County; 6,997 per 100,000 U.S.). However, these largely positive indicators mask significant racial and ethnic disparities in the county.

In Maricopa County, rates of overall and childhood poverty are higher for Hispanic residents than for white and black residents. Hispanics are nearly three times as likely as white residents to live in poverty (Figure 1). As of 2014, approximately 37% of Hispanic individuals living in poverty were children. The median income for white residents is $61,007, compared with $39,579 for Hispanic residents.

Educational attainment in Maricopa County is higher than in the state; however, 37% of Hispanic residents and 20% of American Indians have less than a high school education, compared with 5% of white residents. Additionally, fewer Hispanics and American Indians have higher education degrees (bachelor’s degrees or higher) compared with other races and ethnicities (Figure 2).
Unemployment is slightly higher among Hispanic residents (11%) than among white (8%). However, Hispanics are more likely to be employed in low-paying jobs in agriculture, construction, manufacturing, and service industries. Industries targeted for business development in Maricopa County include health care/biosciences, aerospace/aviation, emerging technologies, and software. Resources that could help alleviate the current disparities in access to jobs in these industries are limited. Although equal access to educational opportunities could help Hispanic immigrants prepare themselves for a wider array of jobs, the state has reduced funding for community colleges, which have traditionally played an important role in providing advanced skills for many of the county’s Hispanic population because of their affordability and flexibility.

LIMITED ACCESS TO HEALTH AND HEALTH CARE
With limited access to jobs in Maricopa County’s growing industries, Hispanic workers commonly occupy low-paying jobs that often do not offer health insurance, contributing to disparities in access to health care. Indeed, although 18% of Maricopa County residents were uninsured in 2012, 41% of Hispanic residents were uninsured. Hispanic residents were more than four times as likely as white residents and more than twice as likely as any other racial/ethnic group to be uninsured (Figure 3). Because minority groups in Maricopa County frequently lack access to health care coverage, they are less likely to seek medical care. Among Hispanics, 43% have not seen a doctor in the past 12 months, compared with 35% of black, 30% of American Indian, and 17% of white residents.

Key health indicators reflect how disparities in access to care lead to disparities in health outcomes. For example, obesity rates for Hispanic adults and youth are higher than they are for white adults and youth (Figure 4). The 2014 teen birth rate is two to three times higher for several minority groups than it is for white residents. The rate per 1,000 live births for white residents is 15, compared with 48 for Hispanic, 29 for black, and 30 for American Indian/Alaska Native residents.

POLICY BARRIERS TO ACHIEVING HEALTH EQUITY
National, state, and local policies affecting immigrants contribute to unequal health outcomes in Maricopa County.

Maricopa County is home to approximately 190,000 unauthorized immigrants, nearly three-quarters (72%) of the state’s total number of unauthorized immigrants. Ninety-one percent of the county’s immigrants are estimated to be from Mexico or Central America. The large population influx has prompted a backlash in recent years from the Arizona legislature and Maricopa County law enforcement. In 2010, Arizona enacted two laws (Senate Bill 1070 and House Bill 2162) that required state and local law enforcement to check the immigration status of a person involved in a lawful stop, detention, or arrest if they suspected that the person was in the United States illegally, a measure that opponents said would lead to racial profiling. The laws were seen as a way to encourage unauthorized immigrants to leave the country willingly because of intolerable conditions.

Even before the laws were enacted, the Maricopa County Sheriff’s Office under the direction of Sheriff Joseph Arpaio made immigration law enforcement a priority. Beginning in 2006, the office opened an “illegal immigrant hotline” and began conducting “saturation patrols,” in which officers attempted to identify unauthorized immigrants during the course of normal traffic stops. The resulting pattern of discrimination drew widespread criticism and was later challenged in the courts.
In 2013, a federal judge ruled that the Maricopa County Sheriff’s Office had engaged in racial profiling. The court issued an injunction to prevent sheriff’s deputies from contacting federal immigration officers about unauthorized immigrants who are not accused of violating a state law. The court also appointed a monitor to oversee the office’s activities, increased training for sheriff’s office employees, and required comprehensive record keeping. The ruling and injunction were not effective deterrents, however: on May 13, 2016, a federal court found the sheriff’s office in contempt for repeatedly violating court orders to stop racially profiling Hispanic residents as part of unlawful enforcement operations targeting immigrants. The behavior of the sheriff’s office has been characterized as “the sort of open defiance of judicial authority by local law enforcement officials that America hasn’t seen since the massive Southern resistance to desegregation in the 1950s and 1960s.” Maricopa County has suffered significant economic repercussions as a result of these legal battles. For example, in fiscal year 2017 alone, the county will spend more than $13 million to implement the court’s orders in response to the racial profiling lawsuit.

Although more protections now are in place to prevent racial profiling, these policies have created a climate that fosters divisions among racial/ethnic groups and threatens a shared sense of community and social support among residents. Fear resulting from anti-immigrant policies could inhibit Hispanic residents from participating in initiatives geared to promote health and well-being and to undercounting of the population in the U.S. Census. When communities are undercounted, they are shortchanged from their due political representation and their correct proportion of government resources. Child Trends Hispanic Institute and the National Association of Latino Elected and Appointed Officials Educational Fund have estimated that the 2010 Census undercounted approximately 27,000 children younger than age 5 in Maricopa County. This amounts to 85% of the statewide net undercount.

POLICIES AFFECTING ACCESS TO HEALTH CARE

As a result of the Affordable Care Act, the Arizona legislature expanded Medicaid coverage in 2013 to include individuals earning up to 133% of the federal poverty level. As of August 2015, the expansion has provided coverage for an additional 280,000 childless adults since the beginning of 2014. Until recently, Arizona was the only state without a Children’s Health Insurance Program (CHIP) because of the state legislature’s unwillingness to accept federal funding for the program. However, in May 2016, the legislature and governor approved the reinstatement of KidsCare, Arizona’s version of CHIP. KidsCare began enrolling children in August 2016 and active coverage began on September 1. Nearly 9,200 children have enrolled throughout the state since then, but it is estimated that 30,000 children could be eligible.

These expansions in health insurance coverage offer limited help to immigrant residents. Authorized immigrants who are not U.S. citizens are not eligible for a majority of services under the Affordable Care Act until they have satisfied a 5-year waiting period. Although pregnant women and children can be eligible for Medicaid and CHIP during this waiting period, their ability to receive services depends on whether a state has chosen to extend coverage under the Children’s Health Insurance Program Reauthorization Act of 2009. Arizona has chosen not to extend coverage.

Unauthorized immigrants are eligible only for emergency Medicaid.

LIMITED PUBLIC HEALTH RESOURCES

In Arizona, county boards of health only have advisory authority, so they have little influence on county public health budgets. In Maricopa County, the health department’s relatively scarce resources limit its ability to comprehensively address residents’ health needs. Several factors contribute to the lack of public health resources in Maricopa County.

Having been hit more severely by the Great Recession than the rest of the nation, Arizona took many months longer to recover. During this time, health departments across the state were affected by reductions in county revenue, such as property and sales tax collections. In Maricopa County, the Department of Public Health receives less than $3 per person from local tax revenue, making it “among the least resourced local health departments for a large jurisdiction in the United States” (p. 877).

Additionally, Arizona ranked 49th on per capita public health funding in the United Health Foundation’s 2015 America’s Health Rankings. Such funding includes state dollars dedicated to public health and federal dollars directed to states by the Centers for Disease Control and Prevention and the Health Resources and Services Administration. Arizona’s ranking is in part a result of the state’s historical lack of commitment to public health funding (for example, Arizona ranked 44th in public health funding in 2005) and recurrent state budget cuts since 2009, affecting general funds designated for counties and targeted funds designated specifically for county health departments.

At $11.75, the Maricopa County Department of Public Health’s per capita funding is less than one-fifth of the national level ($64.74) and less than one-sixth of urban health departments ($76.72).

The Maricopa County health department has been able to make up for some of these budget cuts through state and federal grants, including funds from the American Recovery and Reinvestment Act of 2009. However, grant funds are often temporary and tied to specific programs, limiting the health department’s ability to engage in long-term strategic planning that assumes a consistent availability of non-earmarked funds.

Bridging Resource Gaps Through Collaboration

To overcome its lack of dependable financial resources, Maricopa County’s health department strategically fosters collaboration among individuals and organizations and helps coordinate initiatives. This approach was emphasized as part of the 2012 Maricopa County Community Health Assessment.

The assessment identified several public health priorities, including obesity, diabetes, cardiovascular disease, lung cancer, and access
to health care. The assessment also noted that “as our population continuously grows in numbers and diversity, the Department will not be able to meet its needs alone, but through partnerships and collaboration” (p. 1).³

COORDINATING ACROSS SECTORS TO PROMOTE HEALTHY LIVING

In response to the assessment’s call for collaboration, the health department and others formed the Health Improvement Partnership of Maricopa County, a collaborative effort of more than 105 public and private organizations across four sectors: community, worksite, education, and health care.³²,³⁸,³⁹ Established to address priorities through the 2012-2017 Community Health Improvement Plan, the partnership received funding from the Robert Wood Johnson Foundation via the Institute for Healthcare Improvement as part of the SCALE (Spreading Community Accelerators through Learning and Evaluation) initiative to accelerate health improvement practices for targeted populations.

For example, Esperança is a community organization that provides nutrition and physical activity education to families without insurance coverage, particularly Hispanic families, which have high rates of obesity.⁴⁰ FitPHX is a worksite initiative that encourages partnerships among businesses, nonprofits, and government agencies to help residents lead healthier lifestyles.⁴¹ As part of its effort to promote and support collaborative efforts, the health department plays a central role in this partnership, providing administrative, evaluation, and epidemiological support.

Maricopa County’s health department further offsets its lack of resources by effectively spearheading other collaborative initiatives that support preventive measures to benefit residents. The Preventive Health Collaborative, for example, works to streamline preventive health...
services and care for children from birth to age 5 and their families. The collaborative has more than 70 partners in Phoenix, with plans to expand to include other Maricopa County communities. Table 1 presents examples of other key active collaborative initiatives in Maricopa County demonstrating work that encompasses a wide range of topics with a variety of population groups.

### Capitalizing on Creative Collaborations

Maricopa County’s health department is leveraging its limited resources by mobilizing people and organizations to create robust partnerships and providing high-level coordination services such as strategic planning, networking opportunities, and other forms of technical assistance. Nevertheless, the department faces significant limitations due to the lack of funding for public health. It also faces the challenge of addressing racial and ethnic disparities within a political environment fraught with anti-immigrant sentiment and other policies that affect access to health services for the largely Hispanic immigrant population.

Additional surveillance, data and information gathering, analysis, and reporting will examine the following questions in further detail:

- To what extent, and for what population groups, have cross-sector collaborations improved the health and well-being of the county residents? For example, how has the 2012–2017 Community Health Improvement Plan progressed in addressing the five health assessment priorities: obesity, diabetes, cardiovascular disease, lung cancer, and access to health care?

- Which factors have facilitated or inhibited the collaborative atmosphere in Maricopa County? How have individuals and organizations sought to overcome obstacles?

- In what ways have budgetary limitations affected the health department’s efforts to foster cross-sector collaborations to improve public health?

- To what extent are community leaders working in a coordinated manner to improve the public health infrastructure?

- What types of agencies have formed to address gaps in access to services among vulnerable populations, especially among unauthorized immigrants who are unable to receive most government-provided services?

- How are various sectors of the community (e.g., education, health, business) working together to address socio-economic disparities?

- In what ways are leaders in Maricopa County working to incorporate underrepresented minority groups into the public discussion on health and well-being?
References


