

Unhealthy Differences: Health Disparities Between Racial and Ethnic Groups in Ohio

SUMMARY

In 2008, over 15% of Ohio's adult (18-64 years) population — more than one million people — self-identified as being of a non-white race or ethnicity. The Health Policy Institute of Ohio (HPIO), looking at data and trends from the 2008 Ohio Family Health Survey (OFHS), found important health disparities associated with these ethnic groups. This data brief more closely examines those disparities and the circumstances surrounding them.

Key findings include:

- Hispanic adults were more than twice as likely as white adults to be uninsured; African-American adults were 80% more likely than white adults to be uninsured
- Hispanic adults were more than two and a half times more likely than white adults to be living at or below 200% of poverty (\$41,304 per year for a family of four)¹
- African-American adults were more likely than white adults to be obese, have high blood pressure, have type 2 diabetes, and have had a stroke
- African-American and Hispanic adults were more likely than white adults to consider themselves to be in poor health

Results presented in this brief highlight key differences (or disparities) found in health behaviors, risk factors, family income, experiences with the health care system, and other key indicators based on race or ethnicity. Policymakers and other decision makers may look to these findings as they shape strategies to build health equity and improve the physical, mental, and social well-being of all populations in Ohio's communities.

INTRODUCTION

Data from studies such as the National Health Interview Survey (NHIS) provides evidence of racial and ethnic disparities in health care and health outcomes on a national level.² In order to examine to what extent such disparities exist in Ohio, the Health Policy Institute of Ohio analyzed data from the 2008 Ohio Family Health Survey. HPIO examined trends in health care, health outcomes, health behaviors, and socioeconomic factors in Ohio's working-age adults (ages 18-64) according to self-reported race and ethnicity. Findings indicated significant differences among groups on the basis of socioeconomic status, health care system experience, health behaviors, and health outcomes. The sections that follow (demographics, health care system, health outcomes, health behaviors and risks, and socioeconomics) further break out the data and describe the findings in ways that provide further tools for policymakers to make informed health policy decisions.

¹ Federal Registrar, effective April 2007-2008.

² Data can be found at the website for the National Center for Health Statistics, Center for Disease Control at <http://www.cdc.gov/nchs/fastats/Default.htm>

Unhealthy Differences: Racial and ethnic health disparities in Ohio

Findings from the Ohio Family Health Survey are divided into four racial and ethnic categories in this brief: African-American, Hispanic, Asian-American, and white.^{3,4} Health disparities also exist among different regions, genders, and age groups; these disparities are covered in accompanying briefs.

What is meant by “health disparities”

Many definitions of *health disparities* exist in the literature and in practice. Olivia Carter-Pokras and Claudia Baquet, two leading scholars in the field of social epidemiology, describe a disparity as a signpost or indicator of something problematic: “If a disparity is identified and described, then the health community, policymakers, and the public can become more aware of it.” (Carter-Pokras and Baquet, *What is a “health disparity”*, 2002)

Inequity and *inequality* are other words with distinct meanings closely related to *disparity*. Many definitions of each of these words also exist and are used to varying degrees by researchers and health policy analysts.

If a disparity is determined to be avoidable, unfair, and actionable, then Carter-Pokras and Baquet consider it to be an “inequity.” What is considered to be avoidable and unjust is a product of what is currently known, they add, and will depend on who is making that decision and how it is made. “Inequality,” by comparison, is considered to be a more observational term; it does not necessarily imply a value statement about the difference.

Briefs written by the Health Policy Institute of Ohio use these definitions because they are clear, concise, and because they fall in line with definitions used by the World Health Organization.

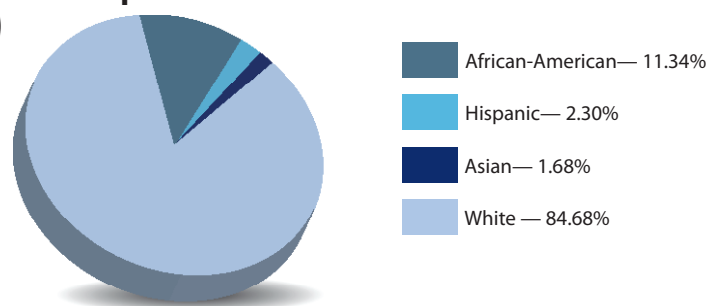
FINDINGS

Demographics

Before looking at health disparities that exist on the basis of race or ethnicity, it is useful to identify Ohio’s racial and ethnic groups. Of approximately 7,164,300 adults aged 18-64, white, non-Hispanics make up the vast majority — about 6.1 million individuals in 2008. African-American adults were the largest minority (about 812,100), followed by Hispanics (nearly 164,800) and Asians (about 120,500). Ohio’s Hispanic population, consistent with the rest of the country, is the fastest-growing minority and is expected to continue to grow rapidly.

Fig. 1

Ethnic Breakdown of Ohio’s Population (Adults 18-64: n=7.16 million)



Source: 2008 Ohio Family Health Survey

Health Care System

Ethnic disparities appear when looking at data pertaining to Ohioans’ experiences with the health care system. In the 2008 OFHS, 17% of Ohio’s adults — over 1.2 million people — reported that they did not have health insurance.⁵ Hispanic adults were more than two and half times more likely than

3 Because no group is homogeneous, disaggregation of racial and ethnic groups may provide further insight on how health issues are addressed in different population sub-groups. Groups have been aggregated for the sake of statistical strength.

4 For the purposes of this brief, African-American refers to black African immigrants as well as indigenous African-Americans; Hispanic refers to anyone of Latino/Latina origin, regardless of immigrant or indigenous status; Asian-American refers to Asian immigrants as well as indigenous Asian-Americans; white refers to those self-identified as non-Hispanic white or Caucasian origin

5 This percentage refers to adults with general health insurance coverage; the reported figure is based on the response of insurance status in the week prior to being surveyed.

Unhealthy Differences: Racial and ethnic health disparities in Ohio

white adults to be **uninsured** and African-American adults were 80% more likely to lack general health coverage. There was no significant difference in coverage between Asian-Americans and whites.⁶

Respondents were asked to rate the **quality** of the health care that they received in the last year on a scale of zero to ten, with zero representing the worst quality, and ten the best. Nearly 4% of Ohio adults rated their health care quality as 'poor' — a value of zero through four. African-American adults were more than twice as likely as white adults to rate the quality of their care as 'poor.' There was no significant difference in reported health care quality between white, Asian-American, or Hispanic adults.

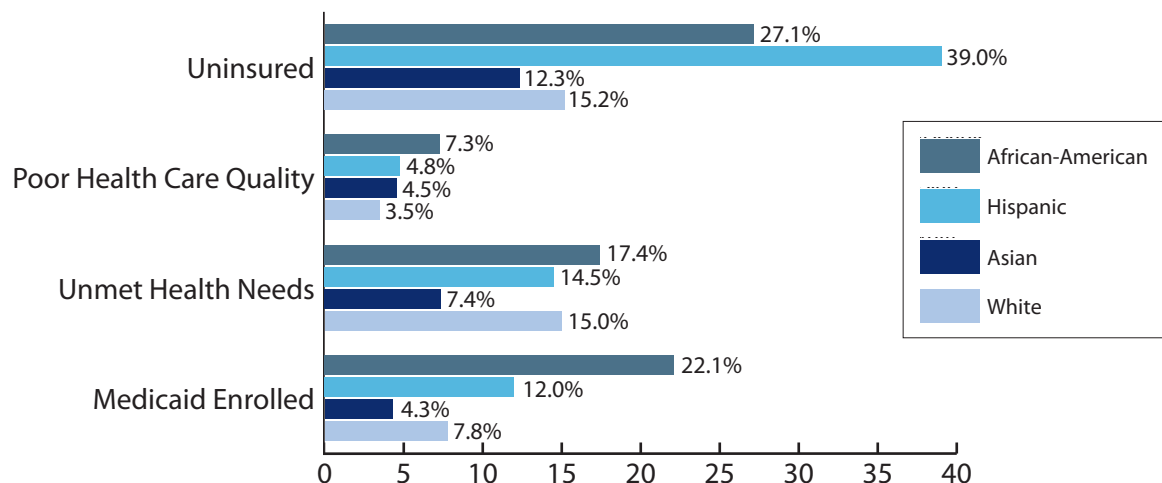
African-American adults were also more likely than white adults to report having **unmet health needs**. Over 17% of African-Americans reported having unmet needs, compared to the state average of 15%. Asian-Americans were 50% less likely to indicate that they had unmet health needs. There was no significant difference in unmet health needs between white and Hispanic adults.

More than 675,000 adults (9.4%) were enrolled in the Medicaid program at the time of the 2008 OFHS, primarily ethnic minorities.⁷ African-American adults were nearly three times more likely than their white peers to be enrolled in Medicaid. Hispanic adults were 50% more likely than white adults to be enrolled in Medicaid, and Asian-American adults were 40% less likely than white adults to be enrolled.

Fig. 2

Health Care System Factors by Ethnicity

Adults 18-64



Source: 2008 Ohio Family Health Survey

Health Behaviors and Risks

In population surveys such as the Ohio Family Health Survey, considerations such as health behaviors are typically treated as personal choices and are addressed on an individual level. The 2008 OFHS findings illustrate that there are significant differences in health behaviors and health risk factors among racial and ethnic groups.

Nearly two million adults (27.7%) reported **smoking** at least one cigarette per day, most or everyday. More than one and a half million (21%) reported at least one incidence of **binge drinking** in the thirty

6 When looking at only those Ohioans living at or below 200% of poverty, racial/ethnic disparities still existed, though the magnitude was reduced as compared to disparities for all income groups.

7 Medicaid is Ohio's largest health and long-term care program that provides a broad range of health services each year to 2.2 million low-income working families, children, seniors, and people with disabilities. (HPIO, 2009 Ohio Medicaid Basics)

Unhealthy Differences: Racial and ethnic health disparities in Ohio

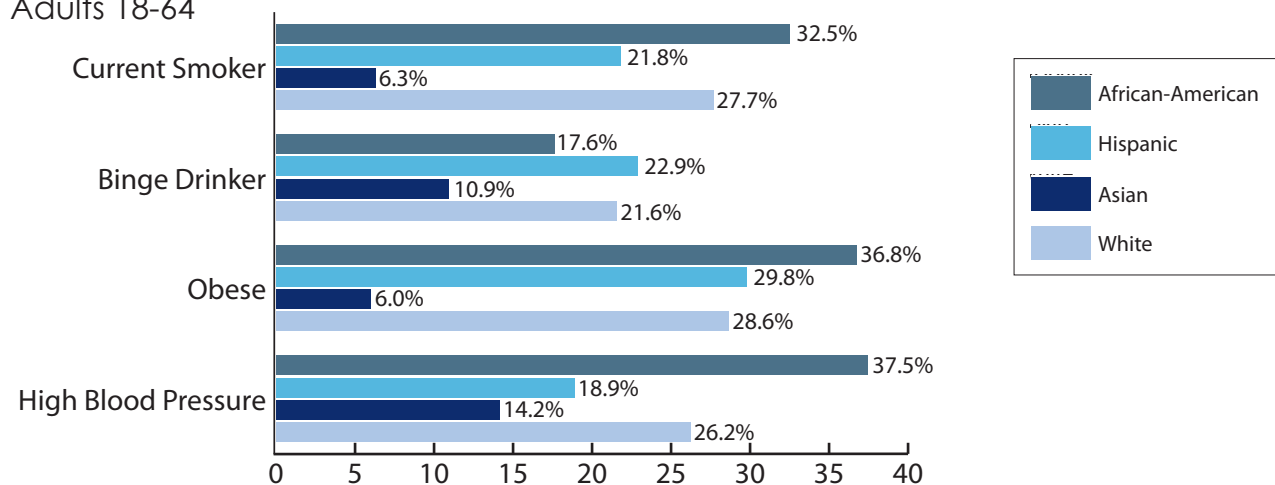
days prior to being surveyed.⁸ African-Americans were 20% more likely than whites to be smokers, but 20% less likely to engage in binge drinking. Asian-Americans were 80% and 50% less likely to smoke or binge drink, respectively. While Hispanic adults were 10% more likely to report that they had incidences of binge drinking, they were 20% less likely than white adults to be regular smokers.

Obesity and **hypertension** are important predictors of poor medical outcomes. Statewide, 29.2% of adults (more than two million) had a body mass index (BMI) of at least 30 kg/m² (qualifies as obese) and 27.1% (nearly two million) had been told that s/he had high blood pressure (hypertension). African-Americans have increased risk — 30% more likely than white adults to be obese and 40% more likely to have hypertension. Asian-Americans were respectively 80% and 50% less likely than whites to be obese or have high blood pressure. Hispanic adults were 30% less likely to have high blood pressure than white adults; there was no significant difference in obesity between Hispanic and white adults.

Fig. 3

Health Risks by Ethnicity

Adults 18-64



Source: 2008 Ohio Family Health Survey

An important, yet unmeasured variable that operates both as a risk factor and as an outcome is stress. While it is accepted that all individuals feel stress to some degree, and that stress can take a positive or a negative form, the lack of an appropriate measure prevents public health officials from being able to quantify stress as a population-level outcome. If stress can lead to serious mental, emotional, and physiological problems for an individual, so too may the chronic stress of being an ethnic minority adversely affect minority health. Consideration of stress as a health outcome is important in work on health disparities, as well as in public health in general.

Health Outcomes

When asked to rate their own **health status** as *poor*, *fair*, *good*, *very good*, or *excellent*, 16.5% of Ohio's adults (nearly 1.2 million) considered themselves to be in only poor or fair health. The 2008 OFHS gathered data on a number of health outcomes that, for many people, may contribute to their self-perception of being unhealthy. Statewide, 3.3% of adults reported having ever had a **heart attack**, 2.2% reported having ever had a **stroke**, 6.2% had ever been diagnosed with **cancer**, 3.8% had ever been diagnosed with heart disease, and 9.6% had ever been diagnosed with **type 2 diabetes** (diabetes mellitus).

⁸ Respondent reported drinking at least five (men)/ four (women) alcoholic beverages in one sitting in the thirty days prior to being surveyed.

Unhealthy Differences: Racial and ethnic health disparities in Ohio

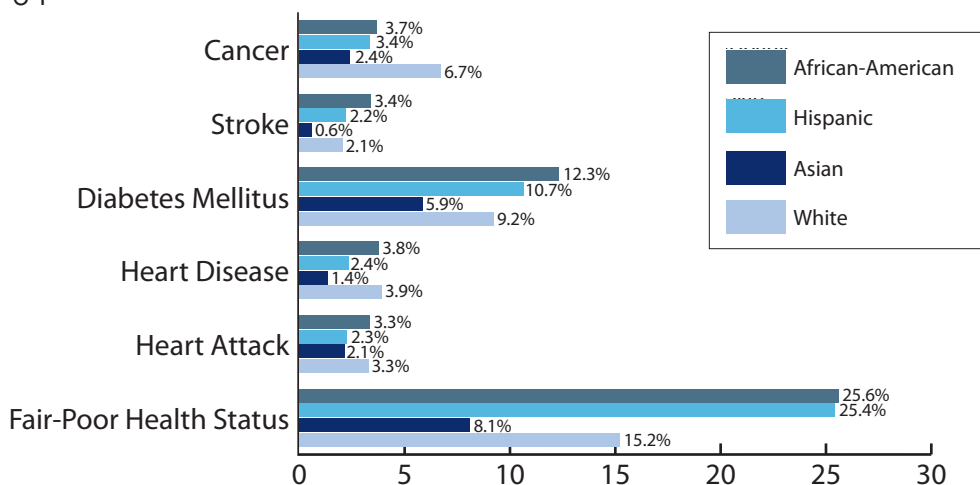
When broken down by ethnicity, these data show that both African-American and Hispanic adults were 70% more likely than white adults to rate their health status as fair or poor. African-American adults were 70% more likely than their white peers to have had a stroke and 30% more likely to have been diagnosed with type 2 diabetes. Hispanic adults were 40% less likely than white adults to have been diagnosed with heart disease. Asian-Americans, who were 50% less likely to consider themselves in fair or poor health than white adults, were also 70% less likely than their white peers to have been diagnosed with heart disease and 40% less likely to have been diagnosed with type 2 diabetes.⁹ White Ohioans were more likely to have ever been diagnosed with cancer: African-American, Hispanic, and Asian-American adults were respectively 40%, 50%, and 60% less likely to have ever been diagnosed with cancer than white adults.

There were no significant differences among ethnic groups for heart attack. There were also no significant differences between African-American and white adults in terms of heart disease, or between Hispanic and white adults for type 2 diabetes. There was no statistically significant difference in stroke outcome between white and Asian-American adults.

Fig. 4

Health Outcomes by Ethnicity

Adults 18-64



Source: 2008 Ohio Family Health Survey

Socioeconomics

When examining the issues of health disparities, it is essential to keep in mind that there are structural and social factors that affect how individuals and populations manage their health and interact with the health care system. The circumstances in which people are born, grow, live, work and age, as well as how they interact with a very complex health care system, are referred to by researchers as *social determinants of health*.¹⁰ The OFHS gathered data on one of the most influential social determinants of health – socioeconomic status.

⁹ There are several explanations for evidence suggesting disparities in outcomes, including lack of universal insurance coverage (Williams JM, et al. Differences in control of cardiovascular disease and diabetes by race, ethnicity, and education: US trends from 1999 to 2006 and effects of Medicare coverage. *Annals of Internal Medicine*, 2009;150:505-515.) and less access to specialists and diagnosis of disease (Cook NL, et al. Differences in specialist consultations for cardiovascular disease by race, ethnicity, gender, insurance status, and site of primary care. *Circulation*, 2009;119:2463-2470.).

¹⁰ Whitehead M. The concepts and principles of equity and health. Copenhagen: WHO/EURO; 1991.

Unhealthy Differences: Racial and ethnic health disparities in Ohio

What is meant by “social determinants of health”

The World Health Organization defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity,” (WHO Constitution, 1946) implying that characteristics outside of the biological realm impact human health.

To that end, the World Health Organization, its affiliates, and the CDC have recognized and adopted twelve contributing factors that describe “social determinants of health”:

| | |
|-----------------------------------|---|
| Income and social status | Health services |
| Social support networks | Personal health practices and coping skills |
| Education and literacy | Healthy child development |
| Employment and working conditions | Biology and genetic endowment |
| Social environments | Culture |
| Physical environments | Gender |

Socioeconomic status (SES) is a complex concept. It includes factors that directly or indirectly relate to an individual's financial solvency, stability, and growth potential. In the 2008 Ohio Family Health Survey, these factors included annual income, educational attainment, and employment. Although not measured by the 2008 OFHS, other SES components traditionally include wealth, assets, family size, parental occupation, home ownership, and group associations. Income, education, and employment are considered separately in the sections that follow. The evidence suggests that Hispanics and African-American adults in Ohio do not share the same socioeconomic status as white and Asian-American adults.

Income was evaluated by comparing federal poverty guidelines with 2008 OFHS data (which captured a survey respondent's annual gross income for calendar year 2007). The following table details 2007-2008 Federal Poverty Guidelines (FPL).¹¹

| Federal Poverty Guidelines* | | | |
|--|----------|----------|----------|
| Annual Gross Income as Percent of the Federal Poverty Line | | | |
| Family Size | 100% FPL | 200% FPL | 300% FPL |
| 1 | \$10,212 | \$20,424 | \$30,636 |
| 2 | \$13,692 | \$27,384 | \$41,706 |
| 3 | \$17,172 | \$34,344 | \$51,516 |
| 4 | \$20,652 | \$41,304 | \$61,956 |

*Federal Register, effective April 2007-2008

HPIO found that 34%, or over 2.4 million adults, were living at or below 200% of poverty. Considerable disparity in income existed among ethnic groups:

- Hispanic adults were twice as likely as white adults to live at or below 200% of poverty
- African-American adults were nearly twice as white adults as likely to live at or below 200% of poverty
- Asian- American adults were 20% less likely than white adults to live at or below 200% of poverty

While the 2008 OFHS did not collect data on wealth and assets (two additional measures of SES), annual income is an easily quantified financial measure that provides insight into whether adults are covered by other government assistance programs (such as Medicaid, Food Stamps, and Welfare-to-Work) that may impact health status and health behaviors.

¹¹ For these analyses, the 200% FPL cutoff is used for three key reasons: 1) The US Census Bureau's most recent poverty threshold for the state of Ohio was identified as 200% FPL. 2) The Economic Policy Institute, a national economic think-tank, indexed the 2007 national family budget as \$48,778 for a family of four, a number more than twice the value of the federal poverty line. This family budget estimation includes funds for food, housing and utilities, non-recreational transportation, health care, child care, taxes and necessary household items. 3) The 200% FPL cutoff has been proposed as the new income level for adult Medicaid eligibility.

Unhealthy Differences: Racial and ethnic health disparities in Ohio

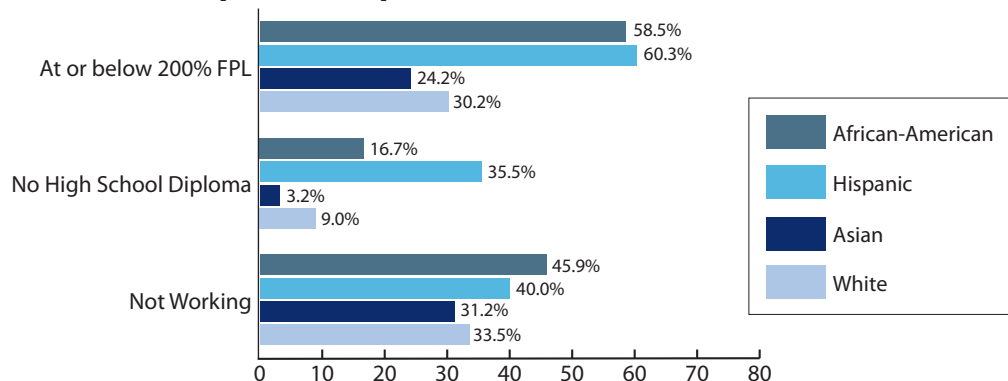
Educational attainment considered whether or not the respondent had received his/her high school diploma or equivalent at the time of the survey. Statewide, nearly 750,000 adults (10.4%) did not have a high school diploma, with significant differences in educational attainment by ethnicity. Hispanic adults were nearly four times as likely as their white peers not to have a diploma; African-American adults were nearly twice as likely. Asian-American adults were less than half as likely as white adults not to have a high school diploma.

Official **unemployment** numbers, as compiled by the U.S. Bureau of Labor Statistics, are complex. They include information on length of time spent looking for work, type of work, and other details. The OFHS focused on factors associated with employment (income, insurance, etc.) rather than the reasons an individual may or may not be working. Therefore, employment was recorded by whether or not the respondent was working (full- or part-time) in the week prior to being surveyed. By this simple measure, 35% of adults (just over 2.5 million) were not working at the time of the 2008 OFHS. Again, significant ethnic disparities were evident. African-American and Hispanic adults were 40% and 20% more likely, respectively, not to be working than their white peers. There was no significant difference in rates of not working between white and Asian-American adults.

Fig. 5

Socioeconomic Factors by Ethnicity

Adults 18-64



Source: 2008 Ohio Family Health Survey

CONCLUSION

Data from the 2008 OFHS indicate that ethnic minorities varied from Ohio's white majority on many measures of individual health, health care coverage, access to health care, and use of health care. Hispanic and African-American adults were more likely than their white peers to be uninsured, more likely to live in poverty, and more likely to consider themselves in poor health. Asian-Americans were less likely to experience poor health outcomes. These results provide evidence for community actors to shape their understanding of health and health care needs of different populations. Additionally, the data may inform strategies for reaching these populations in communities and improving their health. Concrete data on health disparities contributes to dialogue where policymakers and decision makers think meaningfully about healthy equity, equality, and social determinants of health.

Health disparities in Ohio also will be the focus of future work by HPIO in the coming months, including included the publication of policy briefs on gender-related disparities and regional disparities. Disparities also will be a central topic in a 2008 OFHS data brief on children, and will contribute to the development of future editions of the OFHS.

The Health Policy Institute of Ohio is an independent, nonpartisan organization that forecasts health trends, analyzes key health issues, and communicates current research to Ohio policymakers, legislators, and others.



ABOUT HPIO

The Health Policy Institute of Ohio is an independent, nonpartisan organization that forecasts health trends, analyzes key health issues, and communicates current research to Ohio policymakers, legislators, and others. For additional copies of this publication visit www.healthpolicyohio.org or call (614) 224-4950.

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