HEALTH DISPARITIES AND INEQUITIES IN OHIO

Findings from the **2016 Ohio state health assessment (SHA)**

Urgent need to improve health and wellbeing in Ohio

Ohio is a large and diverse state that faces many health challenges despite a wealth of healthcare resources. Several national scorecards and rankings place Ohio in the bottom quartile of states for health. Even more troubling, Ohio's performance on population health outcomes has steadily declined relative to other states over the past few decades, falling from a rank of 27 in 1990 in America's Health Rankings to 39 in 2015. Ohio also has significant health disparities by race, income and geography, and spends more on health care than most other states.[1]

The Ohio 2016 state health assessment (SHA) is a comprehensive and actionable picture of health and wellbeing in Ohio. The purpose of the SHA is to:
- Inform identification of priorities in the state health improvement plan (SHIP)
- Provide a template for state agencies and local partners, with a uniform set of categories and metrics to use in related assessments

The vision statement guiding the SHA acknowledges the strong two-way relationship between health and economic vitality, while the mission statement emphasizes the importance of achieving health equity. This publication highlights the SHA key findings on health disparities and inequities in Ohio.

SHA key findings: Disparities by race, ethnicity, income level, disability status, geography and other characteristics

There are many population groups in Ohio experiencing health disparities. Information in the SHA on health disparities and factors that contribute to health disparities was gathered on select metrics in the data profiles section of the SHA, as well as through key informant interviews.

Data is not consistently collected or available for all population groups. For example, survey data may not be available for some groups because of small sample sizes. Or, data instruments may not collect any information at all on a particular population. As a result, there is more information on some groups as compared to others (e.g., data is more consistently collected on the African-American/black population than Asian/Pacific Islander).

The findings also serve to highlight gaps in data collection efforts across various population groups. Data collection regarding race, ethnicity, income-level, disability status and across other characteristics is necessary to establish the foundation on which to improve the health of all Ohioans.

SHA vision and mission

Vision	Mission
Ohio is a model of health and economic vitality.	Improve the health of Ohioans by implementing a strategic set of evidence-based population health activities at the scale needed to measurably improve population health outcomes and achieve health equity.

The full **2016 state health assessment** and **2017-2019 SHIP** are available at

www.odh.ohio.gov/sha-ship

Figure 6.4. **Performance on health-related outcomes for racial and ethnic groups of Ohioans compared to the U.S. overall rate**

Metric	White/non-Hispanic white	African-American/black	Asian/Pacific Islander	American Indian/Alaska Native	Hispanic/Latino
Population health metrics					
Premature death	Worse	Worse	Better	Better	Better
Life expectancy at birth	Worse	Worse	Better	No data available	Better
Infant mortality	Better	Worse	No data available	No data available	Worse
Adult smoking	Worse	Worse	No data available	No data available	Worse
Adult obesity	Worse	Worse	No data available	No data available	Better
Adult diabetes	Worse	Worse	No data available	No data available	Worse
Hypertension prevalence	Worse	Worse	No data available	No data available	Better
Low birth weight	Better	Worse	Worse	Better	Better
Child asthma prevalence	Better	Worse	No data available	No data available	Worse
Healthcare system metrics					
Prenatal care	Better	Worse	Worse	No data available	Worse
Female breast cancer early stage diagnosis	Worse	Worse	Better	No data available	Better
Colon and rectal cancer early stage diagnosis	Worse	Worse	Better	No data available	Worse
Cervical cancer early stage diagnosis	Better	Better	Worse	No data available	Worse
Lung and bronchus cancer early stage diagnosis	Worse	Worse	Worse	No data available	Worse
Mortality amenable to healthcare	Worse	Worse	No data available	No data available	Better
Diabetes with long-term complications	Better	Worse	Better	Worse	Worse
Access to healthcare					
Unable to see doctor due to cost	Better	Worse	No data available	No data available	Worse
Unmet dental care needs children*	Better	Worse	No data available	No data available	Worse
Public health and prevention					
HIV prevalence	Better	Worse	Better	Better	Better
Social and economic environment					
Fourth grade reading proficiency	Better	Worse	Better	No data available	Worse
Child poverty	Better	Worse	Better	No data available	Worse
Adverse childhood experiences	Same	Worse	No data available	No data available	Worse

■ Metrics for which Ohio racial or ethic group performs better than U.S. overall rate

□ Metrics for which Ohio racial or ethic group performs the same as U.S. overall rate

■ Metrics for which Ohio racial or ethic group performs worse than U.S. overall rate

*Comparison was made to Ohio rate because data for the U.S. was not available.
Note: Differences between the U.S. rate or Ohio rate and the rates for Ohio racial and ethnic group performance were not tested for statistical significance. A total of 22 metrics were reviewed.

Disparities across racial and ethnic groups

Figure 6.4 summarizes performance on health-related outcomes for different racial and ethnic groups of Ohioans compared to the overall U.S. rate. Disparities exist across all metrics, varying widely by race and ethnicity. Figure 6.4 also demonstrates the lack of data for Asian/Pacific Islander and American Indian/Alaskan Native populations in Ohio – highlighting an additional opportunity to improve data collection efforts across all racial and ethnic groups.
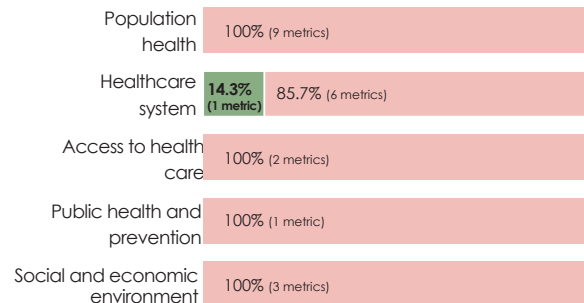
African-American/black

African-American/black Ohioans were much more likely than any other racial and ethnic group to experience poor health outcomes (see Figure 6.4). On 21 of 22 metrics reviewed, African-American/black Ohioans performed worse than the U.S. or Ohio rate when U.S. data was not available (see Figure 6.5). On a number of metrics, the disparity between African-American/black Ohioans and other racial and ethnic groups was particularly striking. For example:

- An African-American child born in Ohio in 2010 could expect to live more than a decade less than children in other racial and ethnic groups.
- The black infant mortality rate was more than two times the rate for white Ohioans in 2014. In addition, black Ohioans were the least likely to receive prenatal care within their first trimester of pregnancy relative to other racial and ethnic groups.
- African-American/black Ohioans were much more likely than any other racial and ethnic group to experience poor outcomes related to obesity, low birth weight, diabetes, hypertension, child asthma and HIV.
- Black Ohioans were the least likely to have colorectal and female breast cancer diagnosed at an early stage compared to other racial and ethnic groups.
- Black Ohioans were 1.8 times more likely to die as a result of untimely and inappropriate health care as compared to white Ohioans.
- African-American/black children in Ohio had the lowest fourth grade reading proficiency rates and were more likely to have two or more adverse childhood experiences compared to other racial and ethnic groups.

During the key informant interviews, when describing the health status of African-Americans/blacks, mental health issues, access to mental health care and diabetes all emerged

Figure 6.5. **Ohio African-American/ black performance compared to U.S. overall rate on metrics included in state health assessment data profile**

BOLD Metrics for which African-American/black Ohioans perform better than U.S. overall rate (n=1)

Metrics for which African-American/black Ohioans perform worse than U.S. overall rate (n=21)

Population health	100% (9 metrics)
Healthcare system	**14.3% (1 metric)** 85.7% (6 metrics)
Access to health care	100% (2 metrics)
Public health and prevention	100% (1 metric)
Social and economic environment	100% (3 metrics)

as common responses. The most frequently mentioned causes of health challenges facing the African-American/black community included:

- Housing issues
- Safety and violence
- Unemployment
- Mental health issues
- Lack of transportation
- Poor access to health care/medical care
- Lack of cultural competence within the healthcare system

There is also substantial diversity within the African-American/black population. For example, data on the African-American/black population may mask disparities that are unique to Africans versus African-American or black Ohioans.
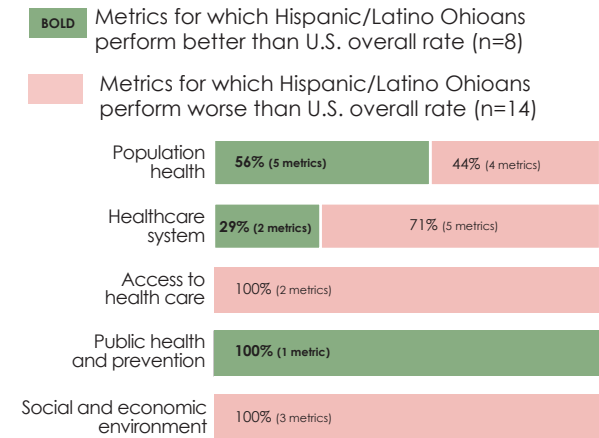
Hispanic/Latino

On 14 of 22 metrics reviewed, Hispanic Ohioans performed worse than the U.S. or Ohio rate when U.S. data was not available (see Figure 6.6).

Disparities for Hispanic Ohioans were widespread across metrics. For example:

- Hispanic Ohioans had the second highest rates of infant mortality, diabetes, child asthma and HIV.
- Only 63 percent of Hispanic women received prenatal care in their first trimester, falling 14 percentage points below white Ohioans in 2014.
- Hispanic Ohioans were the least likely to have cervical cancer diagnosed at an early stage compared to other racial and ethnic groups.

Figure 6.6. **Ohio Hispanic/Latino performance compared to U.S. overall rate on metrics included in state health assessment data profile**

| **BOLD** | Metrics for which Hispanic/Latino Ohioans perform better than U.S. overall rate (n=8) |

| | Metrics for which Hispanic/Latino Ohioans perform worse than U.S. overall rate (n=14) |

Population health: **56% (5 metrics)** | 44% (4 metrics)

Healthcare system: **29% (2 metrics)** | 71% (5 metrics)

Access to health care: 100% (2 metrics)

Public health and prevention: **100% (1 metric)**

Social and economic environment: 100% (3 metrics)

- Children who are Hispanic were more likely to have unmet dental care needs as compared to other racial and ethnic groups.
- Hispanic/Latino children were the most likely to live in a household at or below the poverty threshold in 2014.

When describing the main causes of health challenges facing immigrant and refugee communities, which included Latino communities in northwest and southwest Ohio, the following factors emerged as the most common responses among the interviewees:
- Language and cultural barriers
- Health illiteracy
- Mental health issues
- Lack of transportation
- Lack of cultural competence in the healthcare system
- Housing issues

Asian/Pacific Islander
There was clear underrepresentation of the Asian/Pacific Islander population in the data compiled for the state health assessment. Only 12 of 22 metrics displayed by race and ethnicity had available data on Asian/Pacific Islanders (see Figure 6.4). Of those 12 metrics, Ohioans who are Asian/Pacific Islander performed worse than the U.S or Ohio rate on four metrics (see Figure 6.7). Asian/Pacific Islander Ohioans also had more pronounced disparities across these metrics:
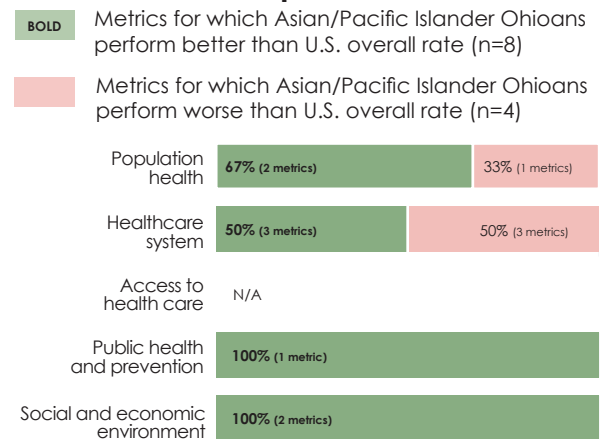- Asian/Pacific Islander Ohioans were the

least likely to have lung/bronchus cancer diagnosed at an early stage and the second least likely to have cervical cancer diagnosed at an early stage compared to other racial groups.
- Babies born to Asian/Pacific Islander Ohioans were the second most likely to have a low birth weight compared to other racial and ethnic groups.

The Asian/Pacific Islander population performs well on a number of metrics relative to the U.S. rate and other racial and ethnic groups. However, there is great diversity within this population that is not typically reflected in available data sources. Aggregated statistics on the Asian/Pacific Islander community can mask health disparities, particularly between subpopulations, such as Southeast Asians and new immigrant or refugee groups. For example, a 2014 study found that Bhutanese refugees in Ohio experienced high rates of alcohol and tobacco use, mental health issues and suicide.[2]

Figure 6.7. **Ohio Asian/Pacific Islander performance compared to U.S. overall rate on metrics included in state health assessment data profile**

| **BOLD** | Metrics for which Asian/Pacific Islander Ohioans perform better than U.S. overall rate (n=8) |

| | Metrics for which Asian/Pacific Islander Ohioans perform worse than U.S. overall rate (n=4) |

Population health: **67% (2 metrics)** | 33% (1 metrics)

Healthcare system: **50% (3 metrics)** | 50% (3 metrics)

Access to health care: N/A

Public health and prevention: **100% (1 metric)**

Social and economic environment: **100% (2 metrics)**

To learn more about Ohio's Asian/Pacific Islander population, please see the **Ohio Asian American Pacific Islander Advisory Council** reports including:
- **2014 Annual Report**
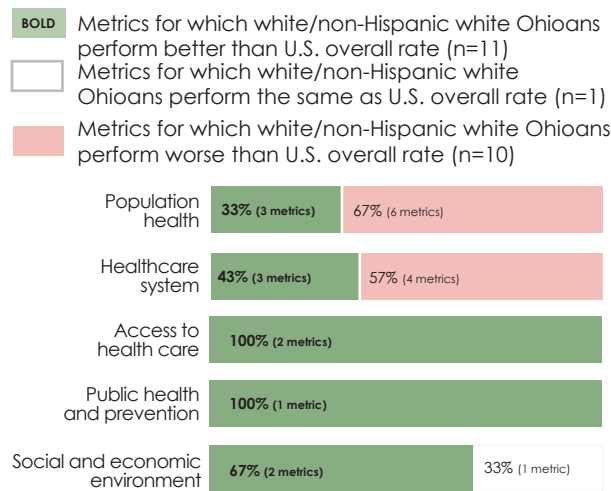- **A Report on the State of Asian Americans and Pacific Islanders in Ohio, March 2013**

American Indian/Alaskan Native

Very few of the metrics reviewed had information available on American Indian/Alaskan Native Ohioans (see Figure 6.4). As a result, it was difficult to assess the nature and burden of health disparities for the American Indian/Alaskan Native population in Ohio, which comprised only 0.1 percent of the Ohio population in 2014 (see Figure 2.a.4 in the full SHA). Medicare data reviewed in the data profiles did demonstrate particularly strong disparities for Ohioans who are American Indian/Alaskan Native around admissions for diabetes with long-term complications and Medicare spending for those with chronic disease.

White

White Ohioans performed relatively well compared to other racial and ethnic groups in Ohio. However, compared to the U.S. rate, white Ohioans performed poorly on metrics related to population health and healthcare system (see Figure 6.8).

Figure 6.8. **Ohio white/non-Hispanic white performance compared to U.S. overall rate on metrics included in state health assessment data profile**

BOLD Metrics for which white/non-Hispanic white Ohioans perform better than U.S. overall rate (n=11)
☐ Metrics for which white/non-Hispanic white Ohioans perform the same as U.S. overall rate (n=1)
■ Metrics for which white/non-Hispanic white Ohioans perform worse than U.S. overall rate (n=10)

Population health: **33% (3 metrics)** 67% (6 metrics)
Healthcare system: **43% (3 metrics)** 57% (4 metrics)
Access to health care: **100% (2 metrics)**
Public health and prevention: **100% (1 metric)**
Social and economic environment: **67% (2 metrics)** 33% (1 metric)

Disparities across income and education level

Higher income was generally associated with better health outcomes. Compared to the U.S. rate, a slightly higher proportion of Ohioans had a low household income (less than $24,999) and a lower proportion of Ohioans had a higher household income ($75,000 or more) (see Figure 2.a.7 in the full SHA).

Diabetes, obesity, hypertension and tobacco use were all more common among lower-income Ohioans (those with household incomes less than $25,000) than among Ohioans with household incomes at $50,000 or more. There was a particularly strong relationship between income level and adult diabetes and smoking. Ohioans in the lowest income group were more than twice as likely to report having diabetes and three times as likely to be a current smoker compared to those in the highest income group. Notably, disparities for obesity and hypertension were less pronounced.

Income disparities across the social factors that impact health were also striking. Fourth graders who were not economically disadvantaged were more than twice as likely to be proficient in reading compared to lower-income children. In addition, more than 40 percent of children living below the federal poverty level had experienced two or more adverse childhood experiences, compared to only eight percent of children in the highest income group.

In regards to education level, women in Ohio who had higher levels of education were more likely to receive prenatal care within their first trimester of pregnancy as compared to those with lower levels of education.

Unemployment, poor nutrition/access to healthy foods, transportation, housing, health illiteracy, coverage and affordability, and access to health care were all identified as main causes of health challenges facing low-income individuals during the key informant interviews.

Disparities across age and gender

The data profiles demonstrate that health disparities exist and vary across age and gender. For example:

• Obesity rates were highest for adults of ages 45-64.
• Diabetes and hypertension prevalence increased with age, greatly impacting those of ages 65 and older.
• Suicide rates varied by age and sex, with middle-aged Ohioans (ages 45-54) and males being most at risk.
• HIV prevalence rates were four times higher among males than females in 2014.
• Asthma prevalence is higher for children in Ohio as compared to adults. However, asthma prevalence rates for both children and adults in Ohio are higher than U.S. rates.

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As Ohio's "baby boom" generation ages, Ohio will have a larger proportion of older adults (ages 60+) in 2030 than it did in 2010. These changing demographics will have a substantial impact on the burden of disparities across Ohio's population, particularly as it relates to the long-term effects of chronic disease.

Disparities across other population groups
Disability status
People with disabilities are a community of individuals who share a unique culture and collective lived experiences that cut across the boundaries of race, ethnicity, age, gender and income-level.

Data on people with disabilities is not systematically collected for all metrics, particularly for the social, economic and physical environment factors that impact health. As a result, it is difficult to assess the nature and burden of health disparities for people with disabilities in Ohio. Ignoring and/or excluding disability status, a critical factor with a significant impact on the health of all racial and ethnic groups, does a disservice to the many people who live at the intersection of this double burden.

In 2014, the percentage of adults in Ohio who had any disability was 23.3 percent, slightly higher than the U.S. rate at 22.5 percent (includes U.S. territories).[3] People with disabilities experience disparities for many metrics – with substantial disparities across metrics related to health outcomes and accessing health care. For example, when compared to individuals without a disability, adults with a disability:
• Were two times more likely to smoke cigarettes
• Had higher rates of hypertension
• Were almost four times as likely to report ever having depression
• Were more than three times as likely to forgo seeing a doctor due to cost

During the key informant interviews, lack of transportation and inadequate health insurance coverage and healthcare affordability were the most common responses for the main causes of health challenges facing people with disabilities.

Lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) individuals
Sexual orientation and gender identity questions are not asked on many national and state surveys, making it very difficult to assess the health needs of the LGBTQ community in Ohio. Often, available data is limited to information on the LGBT population, excluding data on individuals who identify as queer or questioning. All seven objectives related to LGBT health from Healthy People 2020 focus on increasing the number of population-based data systems collecting data on LGBT populations.[4]

Limited national data on the LGBT community indicates LGBT individuals face severe barriers to accessing health care, including stigma, discrimination, workplace policies and violence, and as a result, are more likely to experience poorer health outcomes.[5]

Amish
Ohio has a large Amish community, particularly in Holmes County. However, there is very little data on the Amish — regarding population size as well as overall health outcomes — making it difficult to assess the burden of health disparities within this community.

Disparities by geography
Economic vitality varies widely across the state. The unemployment rate in 2014, for example, varied from a low of 3.8 percent in Mercer County to a high of 10.8 percent in Monroe County. Similarly, child poverty ranged from five percent in Delaware to 38 percent in Gallia

in 2014. Population growth is also uneven; Delaware County was projected to grow by 20.9 percent from 2010 to 2020, while Crawford County was projected to shrink by 6.6 percent.

These conditions affect regional patterns in health outcomes. Appalachian counties in southern and eastern Ohio tend to have poorer health outcomes, such as higher rates of premature death, although there are counties with significant health challenges in all areas of the state. Northeast Ohio also faces some unique challenges, such as poorer outdoor air quality and high rates of black/white residential segregation and child lead poisoning in Cleveland. Finally, HIV prevalence is highest in Cleveland and Columbus.[6]

Conclusions

Ohio is a large and diverse state that faces many health challenges despite a wealth of healthcare resources. Ohio also has significant health disparities by race, income, disability status and geography, and spends more on health care than most other states.[7] The SHA underscores the urgent need to improve health and wellbeing in Ohio.

Key findings from the SHA are outlined below:
Key finding #1. Many opportunities exist to improve health outcomes, especially in terms of mental health, addiction, chronic disease, maternal and infant health and health behaviors.

Key finding #2. Many opportunities exist to decrease health disparities by race, ethnicity, income and education-level, disability status and other characteristics.

Key finding #3. Access to health care has improved, but challenges remain especially related to disparities in accessing care, provider distribution and capacity particularly for behavioral health services and dental care, and the affordability of health insurance coverage and care.

Key finding #4. Social determinants of health present cross-cutting challenges. Social determinants of health that drive disparities in health outcomes include:
• Employment, poverty, income and education
• Social support
• Violence, trauma and toxic stress, including the

high prevalence of intimate partner violence (rape, physical abuse, stalking) and adverse childhood experiences (such as having a parent who has died or been incarcerated)
• Physical environment, including transportation, housing, residential segregation, lead poisoning and air and water quality

Key finding #5. Opportunities exist to address health challenges across the life course. Many health problems are rooted in behaviors and conditions developed early in life, as well as other childhood experiences. Also, Ohio will have a much larger proportion of older adults in the coming decades. Efforts to address Ohio's health challenges must therefore include strategies at every stage of life, as well as strategies designed to improve short-term and long-term outcomes.

Key finding #6. Improved data collection efforts are needed to assess health issues at the local level and for specific groups of Ohioans. Both the nation and our state need a more coordinated approach to population health data collection and reporting that makes data available for a wider range of metrics at the county-level and by race, ethnicity, disability status and other characteristics.

Greater pooling of data collection resources could also increase the efficiency and quality of data available for state and local-level assessments and evaluation. In addition, increased data sharing between health care and public health could greatly improve the timeliness and usefulness of existing health information.

Key finding #7. Widespread agreement on health issues identified at local, regional and state levels can be an impetus for greater collaboration. The interconnectedness of Ohio's greatest health challenges, along with the overall consistency of health priorities identified in this assessment, indicates many opportunities for collaboration between a wide variety of partners at and between the state and local level, including physical and behavioral health organizations and sectors beyond health.

Key finding #8. Sustainable healthcare spending remains a concern in Ohio, especially since comparatively high spending has not translated into improved population health outcomes.

Current public and private efforts focused on addressing this concern through payment reform provide the opportunity to invest resources strategically so that outcomes are improved. Evidence-based strategies can also be implemented or accelerated in Ohio to address both high healthcare spending and Ohio's performance on health outcomes.

Due to several recent changes in the policy landscape (including the expansion of health coverage, public and private sector value-based payment reform and legislative attention to mental health, addiction and infant mortality), as well as strong public- and private-sector leadership and a desire to collaborate at the state and local level, Ohio is now poised to leverage its resources in a more strategic way to achieve measurable improvements in population health outcomes, health equity and healthcare spending. The SHA provides the data needed to inform the next steps in Ohio's journey to improved health and wellbeing through the state health improvement plan.

Notes

1. Health Policy Institute of Ohio. "2014 Health Value Dashboard." December 16, 2014.
2. "Epidemiology of Mental Health, Suicide and Post-Traumatic Stress Disorders among Bhutanese Refugees in Ohio, 2014" Ohio Department of Mental Health and Addiction Services.
3. Behavioral Risk Factor Surveillance System, 2014. National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention.
4. Office of Disease Prevention and Health Promotion, Healthy People 2020.
5. "Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S." Ranji U., Beamesderfer, A., Kates, J et. al Kaiser Family Foundation (April 2015)
6. Due to high prevalence rates, Columbus and Cleveland are the only cities in Ohio that are eligible for Ryan White Part A funding for HIV/AIDS-related services. http://hab.hrsa.gov/abouthab/parta.html
7. Health Policy Institute of Ohio. "2014 Health Value Dashboard." December 16, 2014.