

Ohio Department of Health

2004



Ohio Minority Health Profile

To protect and improve the health of all Ohioans



Ohio
Minority
Health
Profile

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Executive Summary

Background

The Ohio Minority Health Profile 2004 illustrates many of the health disparities that affect the minority population in Ohio. This initial profile is designed to provide measures of mortality, maternal/infant health care (i.e. infant and maternal mortality, low birth weight rates, premature births), health risk factors (i.e. smoking, exercise, alcohol abuse), morbidity (i.e. diabetes, cancer, asthma) and access to health care and health care utilization (insurance coverage, use of preventive care) that exist in Ohio. In the years to come it is our goal to provide comparison data that will be utilized to assess efforts undertaken to reduce and eliminate health disparities in Ohio.

Data Sources

The majority of the data presented in the Minority Health Profile came from one of three sources; year 2000 Census data, the Ohio Department of Health Office of Vital Statistics and the Ohio Behavioral Risk Factor Surveillance System (BRFSS). Wherever possible, we have included every major racial/ethnic group in Ohio; however, in a number of instances the sample size was too small to make sound comparisons between groups.

Census 2000 data provide the necessary background information on racial and ethnic population composition for the United States and Ohio. This information provides a backdrop for the remainder of the Minority Health Profile.

The Vital Statistics data provide detailed information on births and causes of death in Ohio by race and ethnicity. For most of the major causes of death in Ohio (i.e. heart disease, cancer and stroke) black Ohioans died at a higher rate than white Ohioans. In the area of infant mortality, black Ohio infants continue to die at a rate more than double the rate for white infants. The reasons for such disparities are complex and may include access to health care and health risk factors.

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The BRFSS was initiated by the Centers for Disease Control and Prevention in the mid-1980s. Each state participates in the BRFSS telephone survey with the goal of understanding personal health behaviors (i.e. smoking, exercise, use of preventive health care services) that play a major role in premature morbidity and mortality. The survey provides data that allow states to measure health trends and assess chronic disease. Such measures can be utilized to develop awareness programs and guide health policies.

Related Factors

Disparities in educational attainment, employment and income disproportionately affect minorities and affect their health. Poverty can hinder transportation to medical care, increase the likelihood of living in unsanitary conditions and decrease the availability of low-cost fresh foods to name just a few. Employment serves as the gateway to health care for many individuals. Without health care coverage, many people do not obtain preventive health care examinations, accessing health care only when conditions are advanced or critical. Many of the differences presented in this profile would diminish if these disparities were decreased.

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Key Findings

All references to statistical significance refer to the $p < .05$ level.

Demographics

- In 2000, the overwhelming majority of the Ohio population was white (86.4 percent). Blacks represented the largest racial minority group in the state (12 percent), followed by Asian/Pacific Islanders (1.3 percent) and Native American/Alaska Natives (0.3 percent). Ohio's population for persons of Hispanic origin was 1.9 percent in 2000.
- The white population in Ohio increased 3.1 percent from 1990 to 2000, the black population had a 17.7 percent increase, Asian/Pacific Islanders a 62.8 percent increase and American Indian/Alaska Natives a 60.3 percent increase. Persons of Hispanic ethnicity increased 55.4 percent in Ohio from 1990 to 2000.
- In 2000, Hispanic Ohioans had a high school graduation rate of 67.1 percent, followed by Native American/Alaska Natives (73.2 percent), black (73.9 percent), white (84.2 percent) and Asian (86.2 percent) Ohioans.
- In 1999, the unemployment rate for black Ohioans was more than 2.5 times the rate for white Ohioans (11.2 percent versus 4.2 percent), and the rate for Hispanics (7.9 percent) was approximately twice the rate for whites. Asians had the lowest unemployment rate in the state at 3.7 percent.
- In comparison to white Ohioans in 1999, black Ohioans were more than three times more likely to live in poverty (26.5 percent versus 8.2 percent), Hispanic Ohioans more than twice as likely to live in poverty (20.3 percent) and Asian/Pacific Islanders more than 1.5 times more likely to live in poverty (12.9 percent).

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Mortality

Age-adjusted mortality rates use 11 age groups and are standardized to the United States population. Populations used for denominators were the most recent available at the time of analysis. Year 2001 rates reported in this section utilized 2000 populations in the denominator. Age-adjusted rates for Hispanics, Asian/Pacific Islanders and American Indian/Alaska Natives should be used with caution. These rates may be biased for these relatively small populations due to inconsistencies between the numerator and denominator race assignment.

- In 2001, black Ohioans had a higher age-adjusted mortality rate for all causes than white, Asian/Pacific Islanders and Hispanic Ohioans. Blacks had higher age-adjusted mortality rates than whites for heart disease, cancer, stroke, diabetes, nephritis, nephritic syndrome and nephrosis (kidney disease), septicemia (blood poisoning), homicide, perinatal conditions, accidents/unintentional injuries and HIV disease; and a significantly lower rate than whites for chronic lower respiratory disease and suicide. When examining trends from 1993-2001, blacks had age-adjusted mortality rates that increased for diabetes, kidney disease and blood poisoning. In contrast, from 1993-2001 the age-adjusted mortality rates for blacks decreased by nearly two-thirds for HIV disease, and nearly half for homicide with smaller decreases for heart disease and cancer.
- Hispanics had significantly lower age-adjusted mortality rates for all causes than whites in 2001 and specifically for heart disease, cancer, stroke and suicide. Trend data from 1993-2001 for Hispanics indicated age-adjusted mortality rates that increased somewhat for heart disease, cancer, diabetes and accidents/unintentional injuries and decreased for age-adjusted mortality rates from homicide and perinatal conditions. Although Hispanics consistently had an age-adjusted mortality rate from HIV disease significantly higher than whites, the rate did drop by more than half during the 1993-2001 time period.

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- Asian Americans and Pacific Islanders had the lowest mortality rate for all causes in 2001. The 2001 age-adjusted mortality rates for Asians/Pacific Islanders were significantly lower than whites for heart disease, cancer, stroke and accidents/unintentional injuries. Trend data from 1993-2001 for Asians/Pacific Islanders indicated age-adjusted mortality rates that increased somewhat for cancer, stroke and accidents/unintentional injuries. Trend data from 1993-2001 showed a decrease in the age-adjusted mortality rate for Asians/Pacific Islanders.
- Mortality rates for American Indian/Alaska Natives were analyzed to a very limited degree due to insufficient numbers to calculate stable rates. When examined for three-year time periods, American Indian/Alaska Natives had significantly lower age-adjusted mortality rates for heart disease and cancer. Rates of diabetes and early death from accidental injuries, violence and respiratory infections among American Indians and Alaska Natives are known to be higher than those in the general population, but we were unable to report on those areas due to insufficient numbers to calculate stable rates for Ohio.

Maternal/Infant Health

- During the 1999-2001 time period, black infants in Ohio died at rates more than double those for whites, Hispanics and Asian/Pacific Islanders. Black women had the highest percent of preterm births, low birth weight babies and lack of first trimester prenatal care from 1999-2001. During this same time period, black women were less likely to smoke during pregnancy compared to their white and American Indian/Alaska Native counterparts. When examining trends from 1993-2001, there was a decrease in black infant mortality and sudden infant death syndrome among blacks. Preterm births, low birth weight, lack of first trimester prenatal care and smoking during pregnancy also decreased among black women. However, the maternal mortality rates for black women increased by more than 25 percent from the 1990-1995 to the 1996-2001 time period.

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- Hispanics had the greatest decrease in infant mortality from the 1993-1995 to the 1999-2001 time period among all racial/ethnic groups in Ohio. Trend analysis showed that the percent of preterm births, low birth weight infants, and lack of first trimester prenatal care remained relatively stable for Hispanic women from the 1993-2001 time period, while smoking during pregnancy for the same time period decreased.
- Asian/Pacific Islanders had the lowest percent of smoking during pregnancy in Ohio among all racial/ethnic groups from 1993-2001, and the lowest rate of infant mortality from 1996-2001. During the 1999-2001 time period, Asian/Pacific Islanders had the lowest percent of preterm births.
- American Indian/Alaska Native Ohio women consistently had the highest percent of smoking during pregnancy (more than 30 percent), more than 10 percent greater than white women who had the second-highest smoking rate during pregnancy. American Indian/Alaska Native women had the second-highest percent of preterm births and low birth weight babies during the 1999-2001 time period. Trend data indicated an 18.4 percent drop from the 1993-1995 to the 1999-2001 time period for American Indian/Alaska Native women who did not receive first trimester prenatal care.

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Health Risk Factors

- Black respondents reported significantly worse general health status than white respondents. Blacks were significantly more likely to report either “fair” or “poor” health when compared to white respondents. In contrast, white respondents were significantly more likely than black respondents to report that their general health was either “very good” or “excellent.” There were no significant differences between white, black and Hispanic respondents in their reports of quality of life being limited due to physical, mental or emotional problems.
- A significantly higher percentage of black (33.2 percent) and Hispanic (38.6 percent) respondents than white respondents (24.8 percent) were classified as obese. There were no significant differences between white (37.5 percent) and black (38.0 percent) respondents in the overweight category. Hispanic respondents not classified as overweight or obese (32.2 percent) were not significantly different than white respondents (37.7 percent). Nearly half of white, black and Hispanic respondents indicated that they were currently trying to lose weight.
- Black respondents (67.5 percent) reported significantly less participation in physical activities than white respondents (75.2 percent). There were no significant differences between white and Hispanic respondents in participation in physical activities.
- Approximately one out of four white and black respondents indicated that they were current smokers. There were no significant differences between whites, blacks and Hispanics who did not currently smoke. Nearly half (46.1 percent) of white smokers indicated that they had tried to quit smoking at least once in the last 12 months, while more than half (56.2 percent) of black respondents indicated that they had tried to do so.

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- Black respondents (48.6 percent) were significantly more likely than white respondents (42.7 percent) to report abstinence from alcoholic beverages during the previous month. There were no significant differences between white and Hispanic respondents who had abstained from alcohol consumption in the previous month. Of those black and white respondents who reported alcohol use in the last month, there were no significant differences in the average number of drinks consumed at one time or the number of times five or more alcoholic beverages were consumed.
- Black respondents were significantly less likely to report that they always used their seatbelt (66.4 percent) compared to white respondents (77.4 percent). There was no significant difference in the percentage of Hispanic respondents and white respondents who indicated that they always used their seatbelt.

Morbidity

- Black respondents were significantly more likely than white respondents to report that they had been diagnosed with diabetes. Nearly 10 percent of black respondents indicated that they had been informed by a doctor that they had diabetes compared to 7 percent of white and 7.5 percent of Hispanic respondents.
- A significantly higher percentage of black (38.5 percent) respondents than white respondents (26.1 percent) had been told by a health care professional that they had high blood pressure. Just over 20 percent of Hispanic respondents reported they had been told by a health care professional that they had high blood pressure. The percentage difference in high blood pressure between white and Hispanic respondents was not significantly different.
- Black Ohioans had higher average annual cancer incidence rates for all sites/types of cancer combined compared to white Ohioans. Black Ohioans had higher rates of lung, prostate and colorectal cancer compared to white Ohioans. White females in Ohio had higher rates of breast cancer than black females.

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- Black respondents were significantly more likely than white respondents to report that they had been informed they had asthma. Nearly one out of five black respondents indicated that they had been informed they had asthma, compared to one out of 10 white respondents.
- The HIV/AIDS prevalence rate (rate of reported persons living with HIV/AIDS per 100,000 population) among black Ohioans (404.2) is six times higher than the rate among white Ohioans (68.0). The rate among Hispanic Ohioans (280.0) is four times higher than the rate among white Ohioans (68.0). Half of the persons living with HIV/AIDS in Ohio are white, 42 percent are black and 5 percent are Hispanic.

Access to Care and Health Care Utilization

- Black respondents were significantly more likely than white respondents to report that they lacked health care coverage (including health insurance, prepaid plans such as HMOs or government plans such as Medicare). Approximately 19 percent of black respondents reported that they were without health care coverage versus 10.5 percent of white respondents and 12.7 percent of Hispanic respondents.
- Black respondents were approximately five times more likely than white respondents to report a clinic or health center, hospital outpatient department or emergency room as their usual source of care. They were approximately four times more likely than white respondents to report a hospital outpatient department as a usual source (6 percent versus 1.6 percent) and three times more likely to report an emergency room as a usual source (11.9 percent versus 3.6 percent).
- Black respondents were more than twice as likely as white respondents to report having problems obtaining medical care in the past 12 months. Nine percent of black respondents reported having problems obtaining medical care versus 4.2 percent of white respondents.

Executive Summary

- Black and Hispanic respondents were significantly less likely than white respondents to report a dental visit or cleaning within the past year. White respondents (76.4 percent) were most likely to report a dental visit or cleaning, followed by black (71.5 percent) and Hispanic (59.4 percent) respondents.
- Black and Hispanic women were significantly more likely than white women to have had their last Pap smear within the past year (75.4 percent and 79.9 percent, respectively, versus 67.1 percent).
- Black respondents were most likely to report that they had ever had a sigmoidoscopy or colonoscopy exam (53.1 percent), followed by white (46.9 percent) and Hispanic (39.7 percent) respondents. Black respondents were significantly more likely than white respondents to have had their last exam within the past year (approximately 48 percent versus 33 percent, respectively). Black females were significantly more likely than white females to have ever had a sigmoidoscopy or colonoscopy exam. Approximately 61 percent of black females have had an exam versus 47.8 percent of white females.
- Black respondents were significantly more likely than white respondents to indicate that they had been tested for HIV. They were most likely to report that they had been tested for HIV (64.4 percent), followed by Hispanic (44.9 percent) and white (35.3 percent) respondents. Black males were significantly more likely than white males to have been tested for HIV (69.2 percent and 34.8 percent, respectively). Black and Hispanic females were significantly more likely than white females to have been tested for HIV (60.2 percent and 56.8 percent, respectively, versus 35.9 percent).

Introduction

At the beginning of the new millennium, the racial and ethnic composition of the United States and Ohio continued to change. In 2000, the overwhelming majority of the Ohio population was white (86.4 percent). Blacks represented the largest racial minority group in the state (12 percent), followed by Asian/Pacific Islanders (1.3 percent) and Native American/Alaska Natives (0.3 percent). Ohio's Hispanic population was 1.9 percent in 2000. Both the United States and Ohio populations became increasingly diverse from 1990 to 2000. In Ohio, the white population increased 3.1 percent from 1990 to 2000, the black population had a 17.7 percent increase, Asian/Pacific Islanders a 62.8 percent increase and American Indian/Alaska Natives a 60.3 percent increase. The Hispanic population increased 55.4 percent in Ohio from 1990 to 2000.

Poverty, unemployment and educational attainment are all areas in Ohio that continue to disproportionately affect minorities. Census 2000 data show that 26.5 percent of Ohioans living in poverty are black, 20.3 percent are Hispanic, 12.9 percent are Asian/Pacific Islanders and 8.2 percent are white. In 1999, blacks had the highest unemployment rate in Ohio at 11.2 percent, while Hispanics had a rate of 7.9 percent, followed by whites (4.2 percent) and Asians (3.7 percent). Hispanic Ohioans had a high school graduation rate of 67.1 percent, followed by Native American/Alaska Natives (73.2 percent), black (73.9 percent), white (84.2 percent) and Asian (86.2 percent) Ohioans. All of these areas directly and indirectly affect health care conditions and outcomes. Employment serves as the gateway to health care for many individuals. Without health care coverage, many people do not obtain preventive health care examinations and access health care only when conditions are advanced or critical. Poverty can hinder transportation to medical care, increase the likelihood of living in unsanitary conditions and decrease the availability of low-cost fresh foods to name just a few disparities.

Introduction

The Ohio Minority Health Profile 2004 illustrates many of the health disparities that affect the minority population in Ohio. This initial profile is designed to provide measures of mortality, maternal/infant health care (i.e. infant and maternal mortality, low birth weight rates, premature births), health risk factors (i.e. smoking, exercise, alcohol abuse) morbidity (i.e. diabetes, cancer, asthma) and access to health care and health care utilization (insurance coverage, use of preventive care) that exist in Ohio. In the years to come, it is our goal to provide comparison data that will be utilized to measure our progress in reducing and eliminating health disparities in Ohio.

The majority of the data presented in the Minority Health Profile came from one of three sources; year 2000 Census data, the Ohio Department of Health Office of Vital Statistics and the Ohio Behavioral Risk Factor Surveillance System (BRFSS). Wherever possible, we have included every major racial/ethnic group in Ohio; however, in a number of instances the sample size was too small to make sound comparisons between groups.

Census 2000 data provide the necessary background information on racial and ethnic population composition for the United States and Ohio. This information provides a backdrop for the health disparities section of the Minority Health Profile.

The Vital Statistics data provide detailed information on births and causes of death in Ohio by race and ethnicity. For most of the major causes of death in Ohio (i.e. heart disease, cancer and stroke) black Ohioans died at a higher rate than white Ohioans. In the area of infant mortality, black Ohio infants continue to die at a rate more than double the rate for white infants. The reasons for such disparities are complex and may include access to health care and health risk factors.

The Behavioral Risk Factor Surveillance System (BRFSS) was initiated by the Centers for Disease Control and Prevention in the mid-1980s. Each state participates in the BRFSS telephone survey with the goal of understanding personal health behaviors (i.e. smoking, exercise, use of preventive health care services) that play a major role in premature morbidity

Introduction

and mortality. The survey provides data that allow states to measure health trends and assess chronic disease. Such measures can be utilized to develop awareness programs and guide health policies.

The health of minorities in Ohio is worse than that of whites for many conditions and important health indicators. Despite the increase in medical technology and scientific advancements in health care, minorities often do not fully benefit from what the health care system can provide. Access to care, including health care insurance and communication with health care professionals, is crucial to good health outcomes. Improved educational and employment opportunities for minorities, along with safer housing and neighborhoods, will likely lead to improved health and a narrowing of disparities. It remains critical that health care professionals, researchers and policy makers identify and transform the delivery of health care in a manner that reduces and eliminates health care disparities in Ohio and the United States.