OHIO MEDICAID ASSESSMENT SURVEY

2012

Taking the pulse of health in Ohio

HEALTH DISPARITIES AMONG ADULTS IN OHIO

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JUNE 2013

OMAS Ohio Medicaid Assessment Survey | Ohio Office of Medical Assistance | MedTAPP | Ohio Colleges of Medicine Government Resource Center | Ohio Department of Health

1. INTRODUCTION

Health disparities have been a focus of the Healthy People program in the United States since the 2000 goals were released. A health disparity is defined as, "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[1] In 2000, one of the two overarching Healthy People goals was to reduce health disparities;[2] in 2010 an overarching goal was to eliminate health disparities.[3] The goal for 2020 is to achieve health equity among all groups.[4]

The focus of this report is on racial/ethnic, income, and geographic location disparities among adults in Ohio. This report has four objectives:

a. To estimate the prevalence of insurance status and Medicaid enrollment by race/ethnicity, income, and county type;
b. To estimate the prevalence of health care utilization and unmet health care needs by race/ethnicity, income, and county type;
c. To estimate health status and the prevalence of chronic diseases by race/ethnicity, income, and county type; and
d. To estimate the prevalence of smoking, binge drinking, and misuse of prescription pain relievers by race/ethnicity, income, and county type.

2. METHODS

Data from the 2012 Ohio Medicaid Assessment Survey (OMAS) were analyzed. Participants were asked to self-report their race with the following question: "Which one or more of the following would you say is your race?" A list of race categories was then given. Ethnicity was asked with the question, "Are you of Hispanic or Latino origin?" The race/ethnicity categories were the following: non-Hispanic White (hereafter referred to as White), non-Hispanic Black / African American (hereafter referred to as Black / African American), Hispanic, Asian, and Other. An imputed value was used in cases where a respondent provided a "don't know" response to the race and ethnicity questions or refused to answer one or more of them. Family income was asked of all participants and, along with the information on family size. The percent of Federal Poverty Level was calculated as the ratio of the family income to the Federal Poverty Level (FPL) for a particular household size, using 2011 self-reported annual income (100% FPL for a family of three was $18,530 in 2011). An imputed value was used in cases where a respondent provided a "don't know" response to income or family size or refused to answer one of the questions. The percent of Federal Poverty Level categories were the following: less than 100%, 101-150%, 151-200%, 201-250%, 251-300%, 301-400%, and 401% or higher. County types were defined using the standard definitions created by the Ohio Family Health Survey team in 1997, with some adjustments given the addition of three counties to Ohio Appalachia. The four categories of county type included: Appalachia (31 counties; note, Mahoning County is defined as a metropolitan county in the OMAS), Rural non-Appalachia (29 counties), Suburban (16 counties), and Metropolitan (12 counties). For each objective, weighted prevalence estimates were examined by race/ethnicity, income, and county type groups.

3. RESULTS

3.1 Objective 1: Prevalence of being uninsured or enrolled in Medicaid by race/ethnicity, income, and county type in Ohio.

As indicated in Table 1, there was a great deal of variability in uninsured rates and Medicaid enrollment. White and Asian adults in Ohio had the lowest prevalence of being uninsured or covered by Medicaid. Hispanics were the most likely to be uninsured, and Black / African Americans were the most likely to be covered by Medicaid. With respect to income, there was a clear decreasing trend between the percent of Federal Poverty Level category and prevalence of being uninsured or covered by Medicaid. Residents in Appalachian counties experienced the highest prevalence of being covered by Medicaid. Suburban residents were least likely to be uninsured or covered by Medicaid.

Table 1. Uninsured and Medicaid Coverage among Ohio adults ages 19 and older by race/ethnicity, percent of Federal Poverty Level, and county type

	Uninsured Status		Medicaid Coverage	
	Prevalence	90% CI	Prevalence	90% CI
Race/ethnicity				
White	12.4%	(11.8-13.0)	10.5%	(9.9-11.0)
Black/African American	22.2%	(20.2-24.2)	24.9%	(23.1-26.7)
Hispanic	39.8%	(35.0-44.6)	15.8%	(12.7-19.0)
Asian	14.3%	(10.1-18.4)	6.1%	(3.3-8.8)
Other	18.3%	(14.9-21.7)	19.1%	(16.1-22.0)
% Federal Poverty Level				
Less than 100%	29.8%	(27.6-31.9)	40.9%	(38.8-43.0)
101-150%	26.8%	(24.2-29.5)	17.0%	(15.0-18.9)
151-200%	19.2%	(16.7-21.7)	8.6%	(7.0-10.2)
201-250%	14.5%	(12.3-16.8)	3.2%	(2.2-4.2)
251-300%	12.1%	(9.9-14.3)	1.7%	(1.0-2.3)
301-400%	5.2%	(4.0-6.3)	1.8%	(1.2-2.5)
401% or higher	2.8%	(2.2-3.4)	0.9%	(0.6-1.2)
County Type				
Appalachia	16.0%	(14.6-17.5)	14.9%	(13.6-16.1)
Rural, non-App.	14.1%	(12.5-15.7)	10.1%	(8.8-11.3)
Metropolitan	14.8%	(14.0-15.7)	13.1%	(12.4-13.8)
Suburban	10.7%	(9.4-12.0)	8.1%	(7.0-9.2)

3.2 Objective 2: Health care utilization and unmet healthcare needs by race/ethnicity, income, and county type in Ohio.

As indicated in Table 2, the percentage of adults who visited a doctor in the past 12 months ranged from a low of around 80% for Hispanics and Asians to a high of 88-89% among Whites and Black / African Americans in Ohio. In contrast, Asians had the highest prevalence of visiting a dentist within the past year, followed by Whites and Hispanics. Black / African Americans and Other race groups had the lowest, at 61.5% and 57.4%, respectively. There was an increasing trend of visiting a doctor in the past month with income, from a low of 83.9% among adults living under the Federal Poverty Level to a high of 92.2% among adults with the highest incomes. The pattern was similar for visits to the dentist, although the estimates ranged from 51.8% to 85.9%. With respect to county type, adults living in suburban counties had the highest prevalence of visiting a physician and visiting a dentist in the past year.

Table 2. Doctor and dentist visits within the past 12 months among Ohio adults ages 19 and older by race/ethnicity, percent of Federal Poverty Level, and county type

	Doctor Visit Within 12 Months		Dental Visit Within 12 Months	
	Prevalence	90% CI	Prevalence	90% CI
Race/ethnicity				
White	88.3%	(87.7-88.9)	69.9%	(69.1-70.7)
Black/African American	89.4%	(87.8-90.9)	61.5%	(59.4-63.6)
Hispanic	79.6%	(75.5-83.8)	66.1%	(61.5-70.8)
Asian	79.7%	(75.0-84.4)	75.9%	(70.7-81.0)
Other	84.6%	(80.8-88.5)	57.4%	(52.7-62.1)
% Federal Poverty Level				
Less than 100%	83.9%	(82.2-85.7)	51.8%	(49.6-54.1)
101-150%	84.8%	(82.7-87.0)	53.8%	(51.1-56.6)
151-200%	86.3%	(84.2-88.5)	61.2%	(58.4-64.1)
201-250%	87.1%	(85.0-89.3)	66.0%	(63.2-68.8)
251-300%	85.8%	(83.4-88.3)	67.5%	(64.4-70.5)
301-400%	90.4%	(88.7-92.0)	75.3%	(73.1-77.5)
401% or higher	92.2%	(91.3-93.2)	85.9%	(84.8-87.1)
County Type				
Appalachia	87.2%	(85.9-88.6)	61.7%	(59.9-63.4)
Rural, non-App.	86.9%	(85.4-88.5)	67.5%	(65.5-69.5)
Metropolitan	87.8%	(87.1-88.6)	69.9%	(68.9-70.9)
Suburban	90.1%	(88.9-91.4)	74.2%	(72.5-75.9)

The estimates in Table 3 suggest that Black / African Americans and Other race groups had the highest prevalence of at least one hospital stay in the past year, followed by Hispanics and Whites. Asians had a low prevalence of hospital stays in the past year (4.7%). With respect to emergency room (ER) visits, Black / African Americans, Hispanics, and Other race groups were the most likely to have had at least one ER visit in the past 12 months, followed by Whites and Asians, respectively.

Table 3. Hospital stay and emergency room (ER) visit in the past 12 months among Ohio adults ages 19 and older by race/ethnicity, percent of Federal Poverty Level, and county type

	One or More Hospital Stays		One or More ER Visits	
	Prevalence	90% CI	Prevalence	90% CI
Race/ethnicity				
White	14.5%	(13.9-15.0)	23.3%	(22.6-24.0)
Black/African American	20.5%	(18.8-22.2)	30.3%	(28.3-32.2)
Hispanic	15.7%	(12.2-19.2)	31.0%	(26.6-35.4)
Asian	4.7%	(2.3-7.0)	8.6%	(5.5-11.7)
Other	19.2%	(15.5-22.9)	29.8%	(25.5-34.1)
% Federal Poverty Level				
Less than 100%	21.2%	(19.5-22.9)	39.5%	(37.3-41.6)
101-150%	21.4%	(19.2-23.6)	31.4%	(28.9-34.0)
151-200%	17.0%	(15.0-19.1)	27.3%	(24.7-29.9)
201-250%	12.7%	(10.9-14.6)	21.9%	(19.5-24.4)
251-300%	11.6%	(9.7-13.5)	21.7%	(19.1-24.3)
301-400%	10.8%	(9.4-12.3)	16.2%	(14.4-18.0)
401% or higher	9.9%	(9.0-10.8)	14.5%	(13.4-15.6)
County Type				
Appalachia	15.2%	(14.0-16.4)	26.4%	(24.8-28.0)
Rural, non-App.	13.8%	(12.4-15.2)	22.0%	(20.3-23.8)
Metropolitan	15.9%	(15.1-16.6)	24.4%	(23.5-25.3)
Suburban	12.6%	(11.4-13.9)	21.6%	(20.0-23.2)

In Table 4, the prevalence of having any unmet health care need is presented. Unmet health care needs included dental care, prescriptions, vision care, mental health care or counseling services, or any other health care during the past 12 month. As indicated in the table, almost half of Black / African Americans and Other race groups had an unmet health care need in the past 12 months, followed by Hispanics at 43.4%. Less than one-third of Whites and about 1 in 5 Asians experienced an unmet need. There was a clear pattern between income and unmet needs, with higher income adults experiencing less unmet care. Appalachian and Metropolitan County residents experienced the highest prevalence of unmet needs, with over one-third of adults having at least one unmet need in the past 12 months.

Table 4. Unmet health care needs* among Ohio adults ages 19 and older by race/ethnicity percent of Federal Poverty Level, and county type

	Unmet Needs	
	Prevalence	90% CI
Race/ethnicity		
White	30.7%	(29.9-31.5)
Black/African American	49.3%	(47.2-51.4)
Hispanic	43.4%	(38.8-48.0)
Asian	19.7%	(15.4-24.1)
Other	47.3%	(42.3-52.3)
% Federal Poverty Level		
Less than 100%	54.4%	(52.2-56.6)
101-150%	50.8%	(48.1-53.5)
151-200%	44.8%	(41.9-47.7)
201-250%	37.6%	(34.8-40.4)
251-300%	31.3%	(28.3-34.2)
301-400%	24.9%	(22.8-27.0)
401% or higher	17.0%	(15.8-18.2)
County Type		
Appalachia	35.3%	(33.6-37.0)
Rural, non-App.	28.1%	(26.2-30.1)
Metropolitan	34.8%	(33.8-35.8)
Suburban	28.0%	(26.2-29.8)

**Unmet health care needs was measured by using questions about unmet needs of dental care, filling a prescription, vision care, mental health care or counseling services, or any other health care during the past 12 months. The prevalence reported in the table is the prevalence of having any unmet need.*

3.3 Objective 3: Prevalence of fair/poor self-rated health status and chronic diseases by race/ethnicity, income, and county type in Ohio

The estimates in Table 5 suggest that Black / African Americans, Hispanics, and Other race groups had worse self-ratings of their overall health, as well as the health of their teeth/gums and vision, compared to Whites and Asians. There was also a clear pattern between the self-rated health measures and income, with lower income groups having a greater prevalence of fair or poor self-rated health. Residents of Appalachian counties had the highest prevalence of fair or poor self-rated health, with approximately one-quarter of all adults self-rating their overall health as fair or poor. Similarly, Appalachian residents experienced the highest prevalence of fair or poor self-rated health of teeth/gums and vision.

Table 5. Prevalence of fair or poor self-rated health, fair or poor teeth or gums, and fair or poor vision condition among Ohio adults ages 19 and older by race/ethnicity, percent of Federal Poverty Level, county type

	Fair/Poor Self-Rated Health		Fair/Poor Self-Rated Health of Teeth/Gums		Fair/Poor Self-Rated Vision	
	Prevalence	90% CI	Prevalence	90% CI	Prevalence	90% CI
Race/ethnicity						
White	20.1%	(19.5-20.8)	22.4%	(21.7-23.1)	15.2%	(14.6-15.8)
Black/African American	30.7%	(28.8-32.6)	34.8%	(32.8-36.8)	24.4%	(22.7-26.2)
Hispanic	36.8%	(32.2-41.4)	39.0%	(34.4-43.6)	25.5%	(21.4-29.7)
Asian	9.7%	(6.6-12.8)	17.2%	(13.2-21.2)	10.4%	(7.3-13.6)
Other	28.1%	(24.6-31.6)	35.1%	(30.9-39.3)	22.4%	(18.9-26.0)
% Federal Poverty Level						
Less than 100%	42.1%	(40.0-44.3)	45.8%	(43.6-48.0)	28.7%	(26.8-30.7)
101-150%	32.2%	(29.8-34.7)	38.2%	(35.5-40.8)	25.4%	(23.2-27.7)
151-200%	22.9%	(20.6-25.1)	28.9%	(26.3-31.5)	17.2%	(15.1-19.3)
201-250%	18.4%	(16.3-20.5)	24.3%	(21.8-26.7)	15.5%	(13.6-17.5)
251-300%	17.0%	(14.7-19.3)	20.7%	(18.1-23.2)	12.1%	(10.0-14.1)
301-400%	11.8%	(10.4-13.3)	15.1%	(13.4-16.8)	9.6%	(8.2-10.9)
401% or higher	7.8%	(7.0-8.6)	8.7%	(7.8-9.6)	6.2%	(5.5-7.0)
County Type						
Appalachia	25.8%	(24.3-27.3)	28.1%	(26.5-29.7)	21.6%	(20.1-23.0)
Rural, non-App.	20.4%	(18.7-22.0)	23.9%	(22.1-25.7)	15.2%	(13.7-16.7)
Metropolitan	21.8%	(21.0-22.6)	24.7%	(23.8-25.6)	16.3%	(15.5-17.0)
Suburban	17.2%	(15.8-18.6)	18.5%	(17.0-20.0)	13.0%	(11.8-14.3)

Table 6 contains the prevalence estimates for the cardiovascular diseases that were included on the 2012 OMAS questionnaire. Black / African Americans had the highest prevalence of heart disease and hypertension and were nearly tied with Other race groups for stroke prevalence. Asians were the least likely to have one of the three conditions. For each condition, there was a relationship with income, with lower income groups experiencing a higher prevalence of each condition. Residents in Appalachia experienced the greatest burden of heart disease. For the other two conditions, stroke and hypertension, there was not a clear difference between county types, with stroke ranging from 3.5-4.5% and hypertension from 35.6-38.8%.

Table 6. Heart disease, stroke, and hypertension prevalence among Ohio adults ages 19 and older by race/ethnicity, percent of Federal Poverty Level, and county type

	Heart Disease		Stroke		Hypertension	
	Prev.	90% CI	Prev.	90% CI	Prev.	90% CI
Race/ethnicity						
White	10.3%	(9.9-10.7)	3.7%	(3.4-4.0)	37.0%	(36.2-37.8)
Black/African American	12.0%	(10.8-13.2)	5.8%	(5.0-6.7)	47.5%	(45.4-49.6)
Hispanic	9.4%	(6.6-12.2)	3.2%	(1.7-4.8)	24.3%	(20.7-28.0)
Asian	2.4%	(1.2-3.7)	0.7%	(0.2-1.2)	13.8%	(10.5-17.1)
Other	9.5%	(7.4-11.7)	6.0%	(4.2-7.8)	33.8%	(29.7-37.9)
% Federal Poverty Level						
Less than 100%	13.8%	(12.5-15.2)	5.8%	(5.0-6.7)	40.8%	(38.7-42.9)
101-150%	14.5%	(12.8-16.2)	6.3%	(5.2-7.4)	43.6%	(41.0-46.3)
151-200%	12.1%	(10.5-13.7)	4.6%	(3.6-5.6)	38.3%	(35.6-41.1)
201-250%	9.6%	(8.1-11.0)	2.9%	(2.1-3.7)	37.2%	(34.5-39.8)
251-300%	8.6%	(7.1-10.2)	3.0%	(2.1-3.9)	35.7%	(32.8-38.6)
301-400%	7.5%	(6.4-8.5)	1.8%	(1.3-2.4)	31.2%	(29.0-33.3)
401% or higher	6.2%	(5.6-6.8)	1.6%	(1.3-1.9)	32.1%	(30.7-33.5)
County Type						
Appalachia	12.4%	(11.4-13.5)	4.5%	(3.9-5.1)	38.8%	(37.1-40.4)
Rural, non-App.	10.1%	(9.1-11.2)	4.2%	(3.4-4.9)	35.6%	(33.7-37.5)
Metropolitan	9.9%	(9.4-10.4)	3.7%	(3.4-4.1)	37.3%	(36.3-38.2)
Suburban	9.6%	(8.6-10.6)	3.5%	(2.9-4.1)	37.4%	(35.6-39.2)

The other adult chronic conditions examined in the 2012 OMAS were cancer, diabetes, and obesity. As indicated in Table 7, Whites, followed by Other race groups, had the highest prevalence of cancer. Black / African Americans adults, however, experienced the highest prevalence of diabetes and obesity. Asians were the least likely to experience one of these three conditions. The relationship between cancer and income was not as clear as the relationship between income and other conditions. While the reported prevalence was slightly higher for the lower income groups compared to the two highest income groups, the differences were small. Diabetes and obesity, however, were clearly more common among the lower income groups compared to the higher income groups. There was little variability in prevalence of cancer, diabetes, and obesity among the various county types.

Table 7. Cancer, diabetes, and obesity prevalence among Ohio adults ages 19 and older by race/ethnicity, percent of Federal Poverty Level, and county type

	Cancer		Diabetes		Obesity	
	Prev.	90% CI	Prev.	90% CI	Prev.	90% CI
Race/ethnicity						
White	11.7%	(11.3-12.2)	13.4%	(12.9-13.9)	32.7%	(32.0-33.5)
Black/African American	7.4%	(6.4-8.4)	18.1%	(16.6-19.5)	38.9%	(36.9-40.9)
Hispanic	5.2%	(3.2-7.1)	14.8%	(11.8-17.8)	29.5%	(25.5-33.5)
Asian	1.1%	(0.4-1.8)	6.0%	(3.8-8.2)	10.3%	(7.1-13.6)
Other	9.9%	(7.3-12.6)	12.5%	(10-15.1)	33.9%	(30.1-37.7)
% Federal Poverty Level						
Less than 100%	10.8%	(9.5-12.0)	17.6%	(16.0-19.1)	37.5%	(35.4-39.6)
101-150%	11.7%	(10.2-13.2)	19.7%	(17.8-21.7)	36.6%	(34.0-39.2)
151-200%	12.1%	(10.4-13.8)	14.2%	(12.3-16.0)	36.6%	(33.8-39.5)
201-250%	10.9%	(9.4-12.4)	12.5%	(10.9-14.1)	33.3%	(30.6-36.0)
251-300%	10.8%	(9.1-12.4)	12.3%	(10.5-14.2)	31.3%	(28.4-34.2)
301-400%	9.0%	(7.8-10.2)	11.8%	(10.4-13.2)	32.7%	(30.4-35.0)
401% or higher	9.2%	(8.4-10.0)	9.8%	(8.9-10.6)	29.0%	(27.6-30.4)
County Type						
Appalachia	12.1%	(11.0-13.1)	15.1%	(14.0-16.2)	35.4%	(33.7-37.1)
Rural, non-App.	9.8%	(8.8-10.8)	13.2%	(12.0-14.5)	33.0%	(31.1-35.0)
Metropolitan	10.6%	(10.0-11.1)	13.6%	(12.9-14.2)	31.8%	(30.8-32.8)
Suburban	11.2%	(10.2-12.3)	13.7%	(12.5-14.9)	33.7%	(31.8-35.5)

According to the information presented in Table 8, Black / African Americans clearly experienced the greatest burden of chronic disease in Ohio. Over half of Black / African American adults experienced at least one of the chronic conditions measured in the 2012 OMAS, and one-quarter experienced at least two. Asians were the least likely to have a chronic disease. The burden of chronic diseases was also greater among lower income groups, compared to the higher income groups. Finally, residents of Appalachia had the highest prevalence of one or more and two or more chronic diseases. Half of Appalachian residents reported at least one chronic disease and nearly one-quarter reported two or more chronic conditions.

Table 8. Prevalence of one or more chronic disease and two or more chronic diseases among Ohio adults ages 19 and older by race/ethnicity, percent of Federal Poverty Level, and county type

	One or More Chronic Disease		Two or More Chronic Diseases	
	Prevalence	90% CI	Prevalence	90% CI
Race/ethnicity				
White	47.3%	(46.5-48.1)	20.0%	(19.4-20.6)
Black/African American	53.6%	(51.5-55.8)	25.9%	(24.2-27.6)
Hispanic	34.9%	(30.7-39.2)	14.2%	(11.4-17.1)
Asian	17.8%	(14.1-21.4)	4.8%	(2.9-6.6)
Other	45.4%	(41.0-49.8)	17.8%	(14.8-20.7)
% Federal Poverty Level				
Less than 100%	51.3%	(49.1-53.6)	24.4%	(22.7-26.1)
101-150%	54.7%	(51.9-57.5)	28.2%	(25.9-30.4)
151-200%	50.0%	(47.1-53.0)	21.2%	(19.1-23.3)
201-250%	45.8%	(42.9-48.6)	20.5%	(18.5-22.5)
251-300%	44.7%	(41.7-47.8)	18.4%	(16.3-20.6)
301-400%	39.1%	(36.7-41.4)	16.0%	(14.5-17.6)
401% or higher	41.7%	(40.2-43.2)	13.4%	(12.5-14.4)
County Type				
Appalachia	50.0%	(48.2-51.8)	22.5%	(21.2-23.8)
Rural, non-App.	45.3%	(43.2-47.3)	19.6%	(18.2-21.0)
Metropolitan	46.6%	(45.6-47.6)	19.8%	(19.1-20.5)
Suburban	46.8%	(44.9-48.7)	19.6%	(18.2-21.0)

**Overall chronic disease status defined as reporting any type of chronic disease (including coronary heart disease, heart attack, congestive heart disease, hypertension, stroke, cancer, and diabetes).*

3.4 Objective 4: Prevalence of smoking, binge drinking, and misuse of prescription pain relievers by race/ethnicity, income, and county type in Ohio

Current smoking, defined as currently smoking every day or some days, was most prevalent among Other race groups, followed by Black / African Americans (Table 9). Binge drinking, defined as consuming 5 or more drinks on one occasion for men or 4 or more drinks on one occasion for women at least once in the past month, was most prevalent among Hispanics. In the 2012 OMAS, misuse of prescription pain medication was defined as using a prescription pain reliever in a way not prescribed by the doctor or using someone else's prescription pain reliever in the past year. This behavior was most prevalent among Other race groups and least prevalent among Asians. Current smoking and misuse of prescription pain relievers were behaviors that were more prevalent among lower income groups. However, binge drinking was more prevalent among higher income groups. While smoking was more prevalent among adults in Appalachia, there was little variability in the other behaviors by county type.

Table 9. Prevalence of current smoking, binge drinking in past month, and misuse of prescription pain relievers in past year among Ohio adults ages 19 and older by race/ethnicity, percent of Federal Poverty Level, and county type

	Current Smoking		Binge Drinking in Past Month		Misuse of Prescription Pain Reliever in Past Year	
	Prev.	90% CI	Prev.	90% CI	Prev.	90% CI
Race/ethnicity						
White	25.6%	(24.8-26.3)	18.3%	(17.6-19.0)	3.7%	(3.4-4.1)
Black/African American	29.0%	(27.1-31.0)	18.5%	(16.7-20.4)	4.9%	(3.9-5.9)
Hispanic	21.2%	(17.4-25.0)	27.4%	(23.1-31.8)	4.8%	(2.7-6.8)
Asian	10.9%	(7.1-14.6)	13.7%	(9.4-18.1)	1.7%	(0.1-3.3)
Other	36.7%	(32.2-41.1)	22.4%	(18.3-26.5)	9.8%	(6.4-13.3)
% Federal Poverty Level						
Less than 100%	40.3%	(38.7-42.0)	17.4%	(16.1-18.8)	4.8%	(4.0-5.6)
101-150%	30.5%	(28.4-32.7)	14.3%	(12.6-16.1)	4.7%	(3.6-5.7)
151-200%	29.3%	(26.8-31.7)	15.0%	(13.0-17.1)	3.7%	(2.7-4.8)
201-250%	24.1%	(21.8-26.4)	19.7%	(17.4-21.9)	4.0%	(3.0-5.1)
251-300%	20.2%	(17.9-22.6)	19.6%	(17.1-22.1)	3.4%	(2.4-4.5)
301-400%	19.9%	(18.1-21.7)	20.5%	(18.6-22.4)	3.4%	(2.5-4.2)
401% or higher	14.8%	(13.7-15.8)	20.4%	(19.2-21.6)	3.1%	(2.6-3.6)
County Type						
Appalachia	32.7%	(31.0-34.5)	18.4%	(16.8-19.9)	4.1%	(3.3-4.8)
Rural, non-App.	23.7%	(21.9-25.5)	18.5%	(16.8-20.3)	3.5%	(2.6-4.3)
Metropolitan	24.6%	(23.7-25.5)	18.7%	(17.8-19.6)	4.2%	(3.7-4.6)
Suburban	23.1%	(21.4-24.9)	17.6%	(16.0-19.2)	3.0%	(2.3-3.6)

4. KEY CONSIDERATIONS

•In 2002, the Institute of Medicine published their landmark report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care."[5] A key recommendation was to raise the awareness of such disparities among the public, health stakeholders, and health providers. It is therefore important for the OMAS to continue to collect information that will allow us to track the presence of racial/ethnic, income, and geographic disparities in Ohio over time.

•Under the Patient Protection and Affordable Care Act, there are several provisions that have been designed to reduce health disparities in the United States. First, incentives are included to increase the diversity of the health care professional pool and cultural competency training will be extended to all providers. This provision should serve to improve health care encounters among racial and ethnic minority groups. Second, there will be incentives to increase the number of primary care providers, particularly those in underserved communities. Appalachian and other rural counties in Ohio, as well as inner-city urban areas, should benefit from this provision. Finally, with respect to chronic disease prevention, the Affordable Care Act calls for an expansion of screening programs and regular check-ups, which should serve to benefit disadvantaged individuals who currently may not have insurance that covers such services. As Ohio moves to full implementation of the Affordable Care Act, it will be important to track how well these provisions are implemented in the State, and evaluate the impact they have on health disparities.

•The proposed Medicaid expansion, outlined in the Affordable Care Act, could also help to reduce health disparities. As indicated in this report, there are clear and strong associations between income and most of the chronic conditions, health risk behaviors, and unmet health care needs. Providing Medicaid to a greater number of low-income adults could help to reduce this burden, as it would allow individuals to have greater access to the health care system.

•It is important to recognize that improving access to care may not eliminate the health disparities that exist in Ohio. Other factors, most important of which are the social determinants of health, also need to be considered at some level. Social determinants of health are those community-level factors that influence health and include, among others, transportation, educational systems, segregation, social norms, access to healthy foods, exposure to crime, and poverty.[6] For the first time, the Healthy People 2020 initiative included the social determinants of health in their topic areas. Policymakers may wish to consider how policies in these particular areas may impact health outcomes in disadvantaged groups.

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