Franklin County Minority Health Facts: Focus on **Asians, Native Hawaiians, and Pacific Islanders**

Columbus Public Health
Healthier, Safer People

City of Columbus
Michael B. Coleman, Mayor

The Asian alone population was the fastest growing racial/ethnic subpopulation nationally during the period between 2000 and 2010. In Ohio, during the same time, the Asian alone population, which makes up 1.7% of the total population, was the fifth (of nine) fastest growing racial/ethnic subpopulation.

Why is health data important?

Successes in population health are heavily dependent on the type and quality of health and disease information available for analysis and review. For example, public health practitioners use large datasets to predict trends that help policy makers and leaders plan for interventions that slow or stop the development of public health problems, including obesity, smoking, and the spread of infectious diseases.

What kind of health data are available for the Asian, Native Hawaiian, and Pacific Islander populations in Franklin County?

Historically, the most reliable race and ethnicity information for Americans has come from the United States Census. When local and state health departments, and even private organizations such as hospitals, collect race and ethnicity information for health-related purposes, groupings and classifications may be different, thus incomparable. It is important to note that for some data sources, like vital statistics for the state of Ohio, the Asian population is grouped with the Native Hawaiian, and Pacific Islander populations, and for others, like the U.S. census, these populations are separate. There is ongoing effort to eliminate such inconsistancies.

Due to how populations are surveyed or how data are collected, minority populations across the United States tend to be under-sampled and, therefore, under-represented. This means there is not enough information to separate populations (Asians, Native Hawaiians, and Pacific Islanders) into subgroups (Asian women vs. Asian men) for analysis, which would ultimately produce greater knowledge and understanding. Though this deficit in practice does not always translate to negative health outcomes for minority groups and communities, it is in fact a product of systematic inequality.

This health data report attempts to highlight some differences between the Asian, Native Hawaiian, and Pacific Islander population in Franklin County, Ohio and the entire Franklin County population (all races, all ethnicities). However, implications of the data analysis results are limited due to issues related to under-sampling (discussed previously) and the composition of Franklin County (discussed later). Additionally, there are no formal statistical tests of difference done within or between groups. The data presented come from many different sources, and measures were picked based on reliability, relevance, and statistical strength.

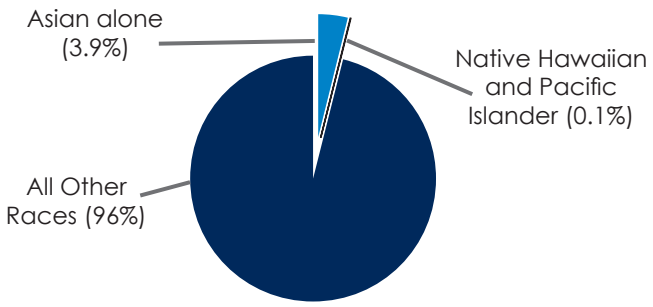
WHAT IS "ASIAN ALONE"?

People who identify themselves racially as Asian only, not Asian and some other race.

ASIAN POPULATIONS IN FRANKLIN COUNTY

In 2010, the total population of Franklin County, Ohio was 1,163,414[1]. At 44,996, the Asian alone population in Franklin County was the largest of all counties in Ohio. Cuyahoga and Hamilton counties had the second and third largest Asian alone populations, respectively.

ASIAN, NATIVE HAWAIIAN AND PACIFIC ISLANDER POPULATION FRANKLIN COUNTY, 2010[1]



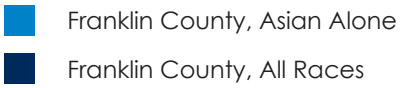
In 2009, people of Asian Indian nationality made up nearly 30% of the Asian alone population of Franklin County, Ohio. Chinese (including Taiwanese) and Cambodian people were the second (20%) and third (9%) largest nationality groups, respectively.

NATIONALITY OF ASIAN ALONE POPULATION FRANKLIN COUNTY, 2009[2]

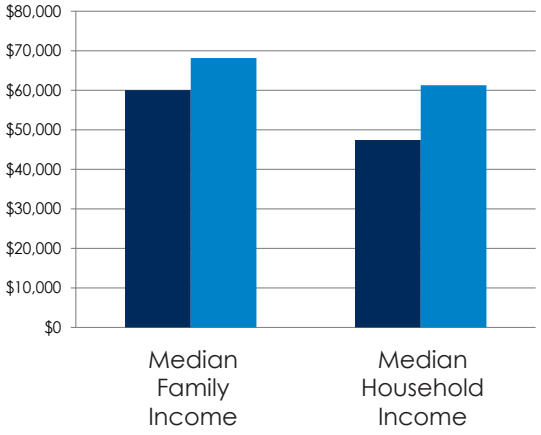
Nationality	Percentage of Total Asian Alone Population
Asian Indian	29.7%
Chinese (including Taiwanese)	19.5%
Cambodian	9.3%
Vietnamese	8.9%
Korean	8.1%
Filipino	6.1%
Other Asian	18.5%

Other Asian includes: Sri Lankan, Japanese, Laotian, and Pakistani

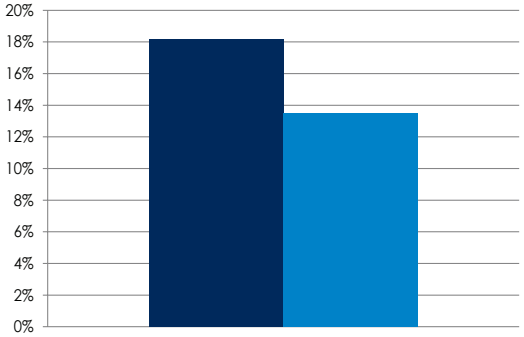
INCOME, POVERTY AND HEALTH INSURANCE COVERAGE



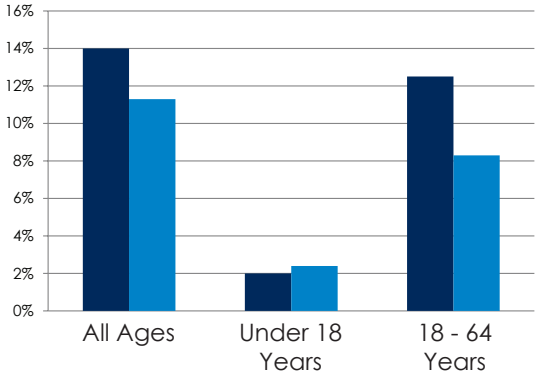
MEDIAN FAMILY AND HOUSEHOLD INCOME, 2009[2]



PERCENTAGE OF POPULATION WITH AN INCOME BELOW POVERTY LEVEL, 2009[2]

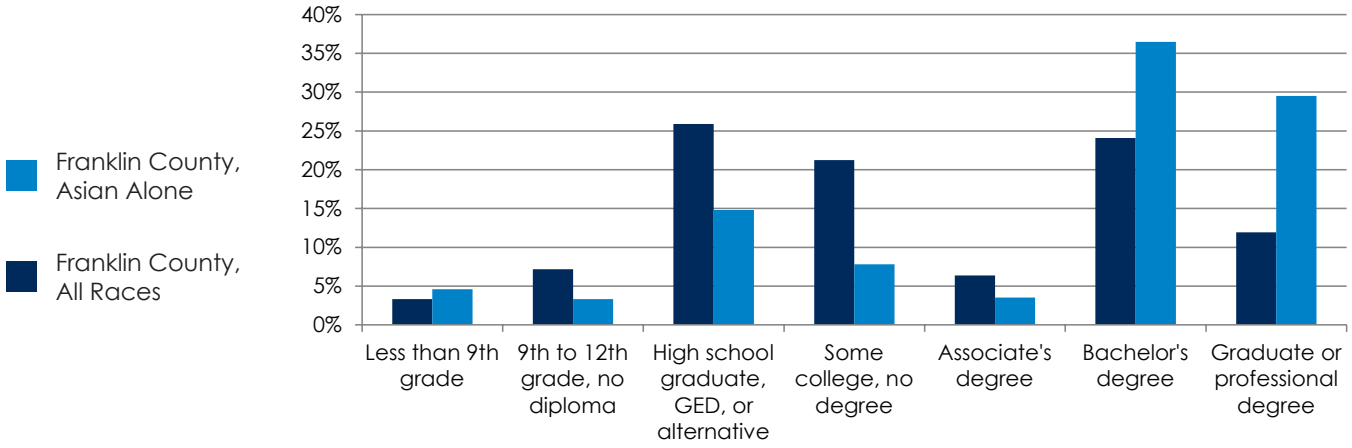


PERCENTAGE OF POPULATION WITH NO HEALTH INSURANCE COVERAGE, 2009[2]



For adults ages 25 years and over, 66% of the Asian alone population had a college degree or higher while 36% of the all-races Franklin County population achieved the same level of education.

EDUCATIONAL ATTAINMENT FOR ADULTS 25 YEARS AND OVER, FRANKLIN COUNTY, 2009[2]



MATERNAL AND CHILD HEALTH

Vital Statistics for 2006-2008 show that several key maternal and child health indicators for the Franklin County, Ohio Asian/Pacific Islander population are better (more "healthy") than those for all-races.

MATERNAL AND CHILD HEALTH INDICATORS FRANKLIN COUNTY, 2006 - 2008[3]

Category	Asian/ Pacific Islander	All Races
Infant Mortality Rate (deaths per 1,000 live births)	3.8	8.7
Teen Birth Rate (15 - 19 years old)*	16.8	47.8
Preterm Birth (less than 37 wks)	9.7%	13.4%
Low Birth Weight (less than 5.5 lbs)	8.5%	9.6%
Mothers with Late Prenatal Care (after third month)**	8.7%	10.7%

* Per 1,000 women in specialized age and race group
** Data from 2003 - 2005; Includes "No Prenatal Care"

BEHAVIORAL RISK FACTORS

Each year, the Ohio Department of Health conducts the Behavioral Risk Factor Surveillance System, a telephone survey of approximately 10,000 people throughout Ohio. The survey generates information about health risk behaviors, clinical preventive practices, and health care access. From 2006 to 2010, a total of 49,657 Ohio adults were surveyed, of which only 342 were of Asian racial background. For the self-reported questions on general health status, exercising during the past month, and having ever smoked, the Franklin County Asian population percentages were more positive than the general population.

GENERAL HEALTH STATUS AND RISK FACTORS FOR ADULTS (18 YEARS AND OLDER), OHIO, 2006 - 2010[4]

	Asian/ Pacific Islander	All Races
General Health Status		
Poor or Fair	7.1%	19.7%
Exercise During the Past Month		
Yes	78.4%	71%
Ever Smoked		
Yes	26.8%	48.2%

LEADING CAUSES OF DEATH

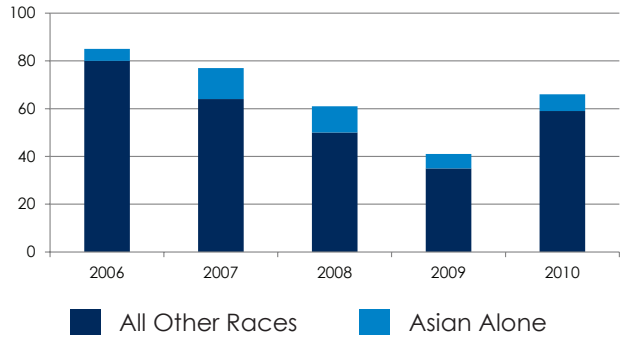
MORTALITY RANKINGS BASED ON NUMBER OF DEATHS FRANKLIN COUNTY, 2006 - 2008[3]

Top Five Causes of Death	Asian/ Pacific Islander	All Races
All Cancers	#1	#1
Heart Disease	#2	#2
Stroke	#3	#5
Diabetes	#4	#6
Accidents and Unintentional Injuries	#5	#4

TUBERCULOSIS

From 2006 to 2010, 13% of all new Franklin County active tuberculosis cases were diagnosed among Asian people. The most common country of birth for Asian, foreign-born cases was India.

TUBERCULOSIS CASES IN FRANKLIN COUNTY, 2006 - 2010[6]



CANCER RATES AND MORTALITY

AVERAGE ANNUAL AGE-ADJUSTED CANCER INCIDENCE RATES AND NUMBER OF NEW INVASIVE CANCER CASES, OHIO, 2003 - 2007[5]

Sites/Types	Asian/Pacific Islander		All Races	
	Rate	Number of Cases	Rate	Number of Cases
All Sites/Types	233.3	283	470.0	58,136
Female Breast*	61.3	47	119.9	8,073
Prostate*	50.3	36	145.5	6,370
Lung and Bronchus	35.2	35	75.0	9,295
Colon and Rectum	31.7	25	51.1	7,961

AGE-ADJUSTED CANCER MORTALITY RATES AND NUMBER CANCER DEATHS, FRANKLIN COUNTY, 2006 - 2008[3]

Sites/Types	Asian/Pacific Islander		All Races	
	Rate	Number of Deaths	Rate	Number of Deaths
All Sites/Types	88.5	59	196.6	5,607
Female Breast*	22.4	8	28.4	480
Lung and Bronchus	17.1	9	62.0	1,746
Liver and Bile Ducts	11.0	7	5.2	153
Colon and Rectum	4.4	5	17.6	496

Rates are per 100,000 population; Age-adjusted to the 2000 standard population
* Sex-specific

HEPATITIS B

The Centers for Disease Control and Prevention reports that, though Asians and Pacific Islanders only make up roughly 5% of the total United States population, they account for more than 50% of Americans living with chronic Hepatitis B. Lack of screening for infection, misconceptions and lack of education about the disease, language barriers, and immigration from countries where the disease is more common are some documented contributors to this significant health disparity. Of course, some aspects of the virus itself, including its infectiousness and ability for symptoms to remain dormant for up to 20 to 30 years, make disease control and prevention particularly difficult.

The Ohio Disease Reporting System documents all types of Hepatitis B infections (perinatal, acute, and chronic), but race and ethnicity information is not recorded consistently. Excluding perinatal cases, race information is not available for anywhere from 22% to 55% of Hepatitis B cases in Franklin County. Therefore, it is difficult to determine how many people from each race category are actually affected.

TOTAL NUMBER OF NEW HEPATITIS B CASES, FRANKLIN COUNTY, 2006 - AUGUST 20, 2011[7]

Infection or Transmission Type	Asian/ Pacific Islander	All Races
Hepatitis B, Acute	4	366
Hepatitis B, Perinatal	159	731
Hepatitis B, Chronic	298	3697

In Franklin County, Asian/Pacific Islanders make up almost 22% of perinatal Hepatitis B cases.

Preliminary results from recent studies conducted by Asian-American Community Services of Central Ohio, in partnership with other organizations, in the Franklin County area have shown the prevalence of chronic Hepatitis B virus infection to be close to 11% among some Asian-American subgroups, in particular Cambodian and Vietnamese.

SEXUALLY TRANSMITTED INFECTIONS

Though chlamydia, gonorrhea, and syphilis are all reportable sexually transmitted infections in Franklin County and Ohio, there is little information for Asians, Native Hawaiians, and Pacific Islanders. This is due to a combination of factors, including low number of cases among the population and missing race and ethnicity information for cases. Only chlamydia had strong enough numbers to provide useful information. In 2010, there were 103 cases of chlamydia for every 100,000 population among Franklin County Asian, Native Hawaiian, and Pacific Islanders. In comparison, for the same sub-population, Ohio had a rate of 51 cases for every 1000,000 in 2010.

What are some challenges associated with using health data for the Asian, Native Hawaiian, and Pacific Islander populations in Franklin County?

1. Small Numbers

One of the main challenges associated with health data for Asian, Native Hawaiian, and Pacific Islander populations is small numbers. There simply is not enough information for public health practitioners and researchers alike to describe population health and disease, as well as certain health promoting and high risk characteristics, in a reliable and valid way.

2. Generalization

The Asian, Native Hawaiian, and Pacific Islander population in the United States, and Ohio, is diverse with respect to country of origin, language, culture, medical and/or health practices, and many other aspects of identity. Additionally, within specific subpopulations, level of acculturation and time of residence in the U.S. may create differences in health status. In terms of health data, diversity within a population implies that general statistics do not represent smaller groups of people. Therefore, while it is useful to know, for example, that infant mortality is lower for the Asian, Native Hawaiian, and Pacific Islander population in Franklin County, Ohio when compared to the all races population, we cannot be certain that this is the case for the Cambodian population specifically.

What is the role of local government and community-based organizations in assuring and promoting data quality and availability?

1. Advise legislation:

Within the past year (February 2011) a bill (AB 1088) was introduced and passed in the California state assembly, requiring every state agency, board, and committee to expand the number of Asian/Pacific Islander subgroups it counts from 11 to 21. Some new subgroups include Indonesian, Thai, Hmong, and Malaysian. These agencies will also be required to post and annually update demographic information on their websites. All changes must be enacted by July 1, 2012. In Ohio, because the makeup of minority populations is different and less diverse than in California, there is less of a need for accounting of multiple subgroups. However, there is still a lot of value in taking steps to ensure that lawmakers understand how important it is to count and know their constituents.

2. Educate Community Members:

Educated and informed community members who can advocate for community driven priorities are important for any kind of social change. When it comes to health data, awareness of gaps in quality and availability is usually a first step to more unified efforts for data collection.

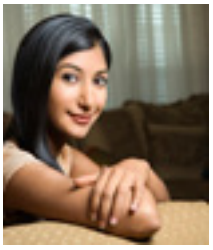
3. Collect and Monitor Data for Constituents by Race, Ethnicity, and Primary Language:

Though basic demographics have become standard among many survey instruments, race and ethnicity information remain extraneous and unnecessary for a lot of organizations and groups. Simply keeping track of the kinds of information available by race and ethnicity requires time and resources. But, if improving data quality and availability are formal goals for local government and community-based organizations, there needs to be sustained support for data collection.

4. Address Challenges to Data Collection and Monitoring (adapted from the Institute of Medicine):

Ethical, logistical, and fiscal concerns present challenges to data collection and monitoring. These include the need to protect patient privacy, the costs of data collection, and resistance from healthcare providers, institutions, health insurance plans and patients. However, these challenges need to be addressed, because the costs of failing may outweigh new burdens imposed by data collection and analysis efforts.






Sources

1. U.S. Census Bureau, 2010 Census
2. U.S. Census Bureau, American Community Survey, 2009
3. Ohio Department of Health, Vital Statistics
4. Ohio Behavioral Risk Factor Surveillance System, 2006 - 2010
5. Ohio Cancer Facts and Figures, 2010
6. Ben Franklin Tuberculosis Control Program, Columbus Public Health
7. Ohio Disease Reporting System

About the Columbus Office of Minority Health:

The mission of the Columbus Office of Minority Health (COMH) is to provide leadership to reduce health inequities in minority communities of Columbus and its surrounding areas. We have an important role in activating efforts to educate citizens and professionals on imperative health care issues. Such roles are to improve minority community health at the community, family and individual levels and, to seek ways to increase capacity of community groups to establish health and well being priorities of those communities.

Additionally, the COMH maintains active participation in health policy forums such as on social determinants of health, health plans, task forces, workgroups / committees. Our efforts are supported by the Minority Health Advisory Committee, which is comprised of dedicated individuals from many of the minority communities we serve in Columbus. We also partner with CPH's Office of Assessment & Surveillance to monitor and report on the health status of various minority populations in our service area. The local office works to recognize and support programs by providing technical assistance for program planning and evaluation. This briefing is provided as a free resource to the community.

What do we mean by "health disparity" and "equity?"

Health Disparities are the differences in rates of disease, health outcomes and access to healthcare found between different groups of people.

Healthcare Disparities are the differences in the quality of care received by different groups.

Health Equity is a basic principle of public health - that all people have a right to health.

Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when other factors are the same, such as insurance and income.