Appalachian Health Status in the Cincinnati Area

The health status of white Appalachians[1] in the Cincinnati area has been documented since the 1960s. A study done by Virginia McCoy Watkins in 1978 focused on the gap between the rural experience of Appalachian migrants and the fear and suspicion of health care providers brought with them from the mountains. A similar study conducted by John Friedl in Columbus affirmed Watkins' study and found that migrants had brought with them expectations of "one shot" treatment by physicians without any focus on preventative care. This experience was probably reinforced by the sporadic care migrants received at hospital emergency rooms and neighborhood clinics.

More systematic studies completed in the 1990s found that urban Blacks and Appalachian whites showed similar levels of concern about their risk of heart attack, stroke, emotional or mental illness or serious injury. Two thirds of white Appalachian respondents reported being smokers compared with less than one third of the blacks surveyed (Obermiller and Oldendick). The authors also indicated most white Appalachians believed their health status depended more on God than on behaviors such as exercise and good nutrition. This attitude at the time was strong throughout Appalachian and the rural South. Early research also showed white Appalachians made less use of hospital emergency services than Blacks and a majority of both groups did not seek preventative care such as regular physical checkups. White Appalachians in one survey had fewer physician contacts than the Black cohort. White Appalachians tended to get health information from their families while urban Blacks tended to get such information from their churches. A 1989 study in Lower Price Hill concluded that environmental conditions damaged the health of children and affected their performance in school. These children often had intestinal infectious diseases, viruses and chlamydia, diseases of the central nervous system, diseases of ear and mastoid processes, and acute respiratory infection than other children treated at Children's Hospital. (A broader study found some of these health conditions were even worse in predominantly poor African American zip codes).

A 1998 study confirmed the presence of these health conditions in Lower Price Hill and added that 35% of the children tested had elevated lead poisoning. 80% of the households had one or more smokers and some of the children were smokers.

In the past two decades several regional children's health surveys were completed. These studies continued to find health disparities between Appalachians and other groups. A 2000 study found higher rates of diagnosis of hearing problems among first generation Appalachians than for African American and at a rate much higher than that for second generation Appalachians and non-Appalachian children. The same disparity was found for diagnosis of developmental delay and mental retardation. Second generation white Appalachians faced somewhat worse on indicators of oral health and dental care. On chronic conditions white Appalachians were diagnosed more frequently as having asthma, cancer, lung disease, depression, diabetes, heart trouble or angina, high blood pressure, severe allergies, stroke, high cholesterol or triglycerides. The largest disparities were on diabetes and hypertension or high blood pressure (both 11% difference). The rate of uninsured adults was about the same for Appalachian whites and non-Appalachians (about 15%). Two in ten white Appalachians go without care due to costs; compared to only 13% of non-Appalachian whites. Note: The survey did not compare black Appalachians or non-Appalachians.

[1] Data on Black Appalachians is not provided due to same size and other technical issues involved in collecting such data. We estimate that about 16% of the urban Appalachian population is Black.

Interact for Health 2017 Child Health Survey

The 2017 Child Health Status Survey showed that Appalachians still experienced disparities in their perception of their health conditions as fair or poor. First and second generation Appalachian children do not seem to have higher rates of asthma or diabetes. There is a disparity (89.1 to 83.7) on being diagnosed as having anxiety. Appalachians are less likely to have this diagnosis. Appalachian children were also more likely to see a doctor for preventative care. Appalachian children were more likely to experience delayed or not received health care (7.0 – 12.1%). Most often this was for mental or behavioral health care (4% - 44.6%). The biggest factors are insurance related and availability of services. Most respondents had private insurance. Appalachians seemed to be underutilizing the CHIP program. Only 13.9 used it compared to 29.2% of non-Appalachians. Over 90% of Appalachian respondents felt their children had access to healthy food.

Summary

At the turn of the century local research showed that the rural experience of Appalachians may affect their attitudes and approach to urban health services and that providers needed an understanding of these differences.

More recent studies such as Interact for Health's 2013 Adult Health Status Survey and 2017 Child Health Status Survey show that disparities still exist. White Appalachians were more likely than the general white population to be obese, nearly half (46%) did not eat the recommended daily amounts of fruits and vegetables. There were small differences on availability of healthy food and also on the amount of exercise done. Alcohol consumption was lower among white Appalachians. Three in ten (29%) white Appalachian adults were smokers compared to 24% of white non-Appalachians.

In 2022, the urban Appalachian Community Coalition Research Committee did a study of the general health of Urban Appalachians in Price Hill and Western Riverfront communities of Cincinnati using survey data and focus groups. This study largely confirmed previous studies regarding health conditions and barriers to service and makes recommendations for a more culturally sensitive approach to outreach and service provision to this community. A separate survey of Appalachian experience of the pandemic showed that Cincinnati was slow to set up testing sites in their neighborhoods and that people in these neighborhoods faced difficulties in knowing about and in getting to their appointments. Appointments often required use of the internet. The same difficulties were faced regarding access to vaccinations. Mistrust of government and medical services were listed as causes of resistance to vaccinations by some survey and focus group respondents. Even respondents with good insurance reported difficulty accessing treatment, especially for mental health issues. www.uacvoice.org/research.

References cited are in the files of the Urban Appalachian Community Coalition and listed in an electronic catalog of its library.

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