

# **A Case for Solidarity**

Common Challenges Involving Health  
and Health Care in the United States

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## Executive Summary

Prior research amply documents the increased risk of poor health among African-Americans, American Indians and Alaska Natives, and groups of Latinos, Asian Americans, and Native Hawaiians and Pacific Islanders. Building on that body of work, Families USA recently commissioned original analysis of national longitudinal data documenting the prevalence of serious health problems and barriers to health care access. To shed light on claims about class, race, and ethnicity that have stoked divisions between communities, we examined selected measures to learn what happens at the intersection of race, ethnicity, class, gender, and place. It came as no surprise to find problems with health status and health care access that affected people of color far more than white people. But we also found startling commonalities across many of these demographic lines as well as important differences, some of which were unexpected.

### **Among both whites and people of color, working-class women are particularly likely to experience serious health problems and to encounter financial barriers that limit access to health care**

For more than a generation, working-class\* women in the United States have experienced serious physical and mental health problems at a high and rapidly rising rate. The disadvantages that face working-class women stand out most clearly in contrast to college-educated men—a comparison that highlights the combined impact of class and gender.

- » In 2011-2013, working-class women were approximately 3.5 times as likely to experience poor physical or mental health for at least 14 days a month, compared with college-educated men.
- » One in 6 working-class women (16.7 percent) experienced prolonged monthly periods of poor physical health, compared with fewer than 1 in 20 college-educated men (4.7 percent).
- » Nearly 1 out of every 5 working-class women (19.1 percent) experienced 14 or more days of poor mental health per month. The same was true for only 1 in 18 college-educated men (5.5 percent).
- » The proportion of working-class women who spent at least 14 days out of the month in poor physical health rose from 12.6 percent in 1999-2001 to 16.7 percent in 2011-2013, a 32 percent relative increase. The prevalence of serious mental health problems grew from 15.1 percent to 19.1 percent, a 27 percent relative increase.
- » Differences between working-class women and college-educated men also widened during this same period. With physical health problems, the gap expanded from an 8.5 percentage-point difference in 1999-2001 to 11.9 percentage points in 2011-2013, a 40 percent relative increase. For mental health problems, the gap grew from 10 to 13.6 percentage points, comprising a 35 percent relative rise.

\* This report classifies adults as “working class” if their education did not go beyond high school.

- » The stark and disturbing difference between the poor health frequently experienced by working-class women and the much better health enjoyed by college-educated men transcends racial and ethnic boundaries. Among both whites and African-Americans, serious physical health problems are more than three times as common for working-class women as for college-educated men. For Latinos, working-class women are more than twice as likely to experience such problems. Similar gaps exist with serious mental health problems.
- » While poor health status typically reflects social and economic conditions more than the receipt of medical care, working-class women also suffer serious disadvantages involving financial access to care. In 2011-2013, working-class women were more than three times as likely to go without doctor visits because of cost as were college-educated men. Fully 27.7 percent of working-class women—more than 1 in 4—encountered this financial barrier. The same was true for only 7.8 percent of college-educated men, or fewer than 1 in 12.

- » In less than 15 years, from 1999-2001 to 2011-2013, the proportion of working-class women who went without doctor visits because of cost rose substantially, with a relative increase that exceeded 50 percent.

These disparities are stark, and their import is clear. Given the well-documented relationship between health status and social and economic circumstances, the serious health problems experienced by working-class women likely reflect underlying life challenges that U.S. public policy has failed to address.

### **With crucial public health priorities, race and ethnicity can overwhelm the effects of class**

- » Working-class status is associated with poor health, but that association is eclipsed by the continuing impact of being a person of color living in the U.S. when it comes to certain critical public health issues. Diabetes rates, for example, are higher for working-class adults than college-educated adults ages 55-64, but African-Americans with a college degree have higher diabetes rates than whites with no more than a high school education (19.4 percent vs. 17.5 percent).

**Given the well-documented relationship between health status and social and economic circumstances, the serious health problems experienced by working-class women likely reflect underlying life challenges that U.S. public policy has failed to address.**

Put simply, regardless of who you are or where you live, you have a heightened risk of living in poor health if your education ended at high school.

- » Similarly, childhood asthma is more prevalent among working-class than college-educated families, but 12.5 percent of African-American children with college-educated parents have asthma—roughly a third more than the 8.6 percent of white children whose parents had a high school education or less.

**Both working-class adults themselves and the serious health problems they experience are highly diverse, transcending boundaries of race, ethnicity, and residence in rural vs. urban areas**

- » Contrary to much popular imagery, the problems experienced by working-class families affect people of color no less than whites, and residents of urban and rural areas alike. Among both whites and African-Americans, and in both rural and urban areas, working-class adults are at least twice as likely as college-educated adults to experience 14 or more days of poor physical or mental health during the month. Put simply, regardless of who you are or where you live, you have a heightened risk of living in poor health if your education ended at high school.
- » Working-class families themselves are remarkably diverse. Defying common stereotypes, fewer than 1 in 8 (12.3 percent) working-class adults are whites living in rural communities. Nearly half (47.4 percent) are

people of color, and most (83.7 percent) live in urban or suburban areas.

**Once the Affordable Care Act took effect, the prevalence of serious health problems among working-class women and men stopped growing and began declining, for both whites and people of color**

Along with serious problems, we find important progress. America's most significant domestic legislation enacted in decades, the Affordable Care Act (ACA), is associated with the reversal of long-standing problematic trends. Once the ACA's major health insurance expansions took effect in 2014, the percentage of working-class women and men with serious physical and mental health problems began to decline, and the yawning gap between working-class women and college-educated men stopped growing and began narrowing. Such gains were widely shared among multiple racial and ethnic groups.

**Rural adults are more likely to experience serious health problems and to encounter financial barriers to care, but nongeographic factors play a far greater role**

- » Serious health problems are more common among residents of rural than urban areas—2.8 percentage points and 1.3 percentage points higher for physical health and mental health problems, respectively. By contrast, serious

physical and mental health problems are 9.2 percentage points and 8.1 percentage points higher, respectively, for working-class than for college-educated adults.

- » While residents of rural areas are 2.0 percentage points more likely than urban residents to go without care because of cost, race and ethnicity have a much stronger association with this measure of financial access barriers. African-Americans are 6.0 percentage points more likely and Latinos 9.8 percentage points more likely than whites to avoid going to the doctor because of cost.

**Even when people of color have greater risks of encountering particular challenges, the largest number of affected people are often white, because most U.S. residents are white**

- » All of us, regardless of race, class, gender, or place, can encounter serious health problems or barriers to care. Even when people of color face greater odds of encountering particular challenges—going without necessary physician care because of cost, for example, or trying to support a family with no more than a high school education—white people comprise the bulk of those affected simply because white people make up the majority of U.S. residents.
- » For example, in rural areas people of color are far more likely than whites to miss doctor visits because of cost, but more than 70 percent of rural residents who encounter this financial barrier to care are white simply because the vast majority of all rural residents are white.

## Implications of This Analysis

The take-home message is clear. Some of our most important health problems, which can signal deeper dysfunctions involving social and economic conditions, transcend racial and ethnic dividing lines, with working-class women of all races and ethnicities experiencing particularly serious disadvantages. Recent gains experienced by working-class women and men, people in rural and urban areas, and both whites and people of color coincided with implementation of the 21st century's largest initiative to address serious daily challenges facing U.S. residents, the ACA. Now is the time for a new round of bold action to address the many common problems still experienced by far too many in our country while redoubling our efforts to combat the long-standing difficulties that uniquely burden particular communities. To continue improving access to health care and to tackle underlying social and economic factors that deeply shape health and well-being, our country needs policies that help families in need, whether they live in the city or the country and regardless of race, ethnicity, and gender.

## Preface: Why This Report Matters Now

Despite our country's considerable progress, racism and xenophobia persist and have become shockingly prominent in recent political discourse. As our nation grows increasingly diverse, it becomes ever more important to grapple with one fundamental, defining question: Are we all in this together? Will we join forces to overcome common challenges, strengthening our country so that all benefit and addressing unmet human needs wherever we find them? Or will we be diverted from solving our shared problems and instead become increasingly pitted against one another along racial and ethnic lines?

Our basic character as a nation, as well as achieving the practical imperatives of promoting social harmony and economic prosperity so all can thrive, depends on moving beyond a short-sighted, racially defined vision of “us versus them.” The truth is far more nuanced than the unidimensional portraits sketched by divisive rhetoric. In reality, surprisingly similar everyday challenges affect people across demographic boundaries.

Our experiences with health and health care provide a prime example of deeply personal struggles that are broadly shared. Regardless of income, education, class, race, ethnicity, gender, sexual orientation, or ZIP code, millions of families contend with a health care system ill-suited to meet many fundamental needs. Moreover, underlying social and economic conditions contribute to serious health problems for people across demographic groups. Yet health and health care have become so politicized in public discourse that these common human experiences often seem to disappear from the conversation.

This report seeks to cut through the politics of division by focusing on the human dimensions of the U.S. health and health care story, elevating our common needs while recognizing nuanced variations among different communities. To that end, we review decades of data involving selected metrics of health and health care, using them as windows through which to view our challenges and progress as a nation. The report goes beyond an oversimplified examination of individual demographic categories to see what happens at the intersection of race, ethnicity, class, place, and gender.

That inquiry yields fact-based conclusions that expose how attempts to exploit the grievances of white, working-class people by pitting them against families of color are not based on reality. The report finds:

1. Among Latinos, African-Americans, and whites alike, in both urban and rural areas, working-class adults—especially working-class women—have experienced high and growing rates of serious physical and mental health problems.
2. Recent gains in health status and access to care experienced since the Affordable Care Act took effect have been broadly shared across lines of race, ethnicity, class, and gender.
3. Race-based disparities, independent of class, remain grave and demand urgent attention, in addition to the important work required to address the problems facing working-class families of all races and ethnicities.
4. All of us, regardless of race, class, gender, or place, are at risk of experiencing serious health problems or encountering major barriers to care.



These findings buttress a national narrative of solidarity rather than division. We live at a critical historical moment. Both our country's prosperity and its basic character hinge on transforming the aspirational promise of *E Pluribus Unum*—the motto on the Great Seal of the United States, which means “out of many, one”—into a lived reality for every human being. This old-but-new narrative affirms that many of our most important day-to-day problems are shared broadly, across racial and ethnic dividing lines, even as some groups face disproportionate burdens. We can appreciate and continue building on our country's extraordinary progress helping families of every race, ethnicity, gender, sexual orientation, and ZIP code without closing our eyes to the communities that have not shared equally in those gains.

Now is the time for a new round of bold action to address the serious problems we share, some of which are reflected in the metrics of health and health care explored in this report. Such action will not succeed, however, unless we simultaneously continue the hard work of dismantling deep, multilayered inequities that continue to undermine many of our communities, work that helps all within our country obtain the resources they need to thrive. Whether it comes to the challenges many of us experience or the solutions we are called as a nation to pursue, truly, we are all in this together.

**—Sinsi Hernández-Cancio, Director of Health Equity, Families USA, and Stan Dorn, Senior Fellow, Families USA**

**Are we all in this together?  
Will we join forces to overcome  
common challenges,  
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## Introduction

Our country's political discourse increasingly features rhetoric that seeks to divide the people of the United States along racial and ethnic lines. Much of that rhetoric is sadly familiar from our country's history. Geography frequently joins the conversation as well, with stark contrasts drawn between people who live in rural and urban areas.

This report brings an empirical lens to the implicit claims undergirding that line of argument. We use specific examples of health status and health care access to analyze whether the distinctions stressed by those who seek to divide us align with reality. It is unsurprising that we find the continued persistence of racial and ethnic inequities. But we also find that many significant health problems and barriers to quality health care extend across demographic and geographic lines.

### Terminology and Technical Limitations

Our methodological appendix, at the end of this report, provides a detailed account of how we analyze the relationship between race, ethnicity, gender, class, and place, on the one hand, and health status and health care access, on the other. Here, we discuss technical limitations and terminological choices that may interest the general reader.

In terms of nomenclature, we define:

**Working-class people** as those with no more than a high school education.

**College-educated people** as those who have received a bachelor's degree, including people who also obtained postgraduate degrees.

**Rural residents** as people who live outside metropolitan statistical areas (MSAs).

**Urban residents** as those who are known to live in core city areas within an MSA.

**Urban and suburban residents** as those who live anywhere inside an MSA.

Our primary data source is the Behavioral Risk Factor Surveillance System (BRFSS), which has operated since 1983 and, "with more than 400,000 adult interviews each year, is the world's largest continuously conducted health survey system."<sup>1</sup> One shortcoming of this otherwise exemplary source of information involves race and ethnicity. In the publicly available, multiyear data we use for our analysis, non-Hispanic respondents are classified as white, black, and "other." The last category combines highly diverse groups, ranging from American Indians and Alaska Natives to immigrants with East Asian, South Asian, or Pacific Islander ancestry. Rather than obscure critically important differences by putting all of those people into a single racial classification, our report's racial and ethnic analyses primarily focus on Hispanics (whom we also refer to as "Latinos"), non-Hispanic blacks (whom we also term "African-Americans"), and non-Hispanic whites ("whites").

A second limitation of BRFSS' publicly available data involves the absence of information about birthplace or citizenship. Our results thus combine immigrants with people born in the United States. This biases our findings and portrays a healthier Latino population than would be shown by limiting the comparison to members of each ethnic group who were born in this country. Immigrants tend to be healthier than native-born Americans, and immigrants comprise a larger proportion of Latinos than of African-Americans or whites. That difference applies at all educational levels, but it is especially pronounced among those with no more than a high school education.<sup>2</sup>

## KEY TERMS

**Working-class people** = received no more than a high school education.

**College-educated people** = received at least a bachelor's degree.

**Rural residents** = people who live outside metropolitan statistical areas (MSAs).

**Urban residents** = people who live in core city areas within an MSA.

**Urban and suburban residents** = people who live anywhere inside an MSA.

**African-Americans** = non-Hispanic blacks.

**Latinos** = Hispanics of any race.

**Whites** = non-Hispanic whites.

A third limitation involves information about our country's lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) population. Considerable research shows that LGBTQ people disproportionately experience many problems involving both health and access to health care. BRFSS did not collect information about LGBTQ status before 2014, and such information is not yet available for all states. We therefore did not include this important population characteristic in our longitudinal analysis of nationwide data. Among other implications, this means that our estimates for gender reflected the simple binary categorization reported by BRFSS, which leaves out a broad spectrum of gender identity.

To enhance clarity and simplicity, most of our analysis of class and place contrasts opposite ends of each spectrum:<sup>3</sup>

- » We often compare people with a high school education or less to those with a college degree or more, setting aside those who attended some college without gaining a bachelor's degree.

- » We often compare people who live in rural areas to those who live in urban areas, not showing the circumstances of those who live in MSAs outside core cities.

Our approach to analyzing multiple years of data frequently averages survey results across three-year periods. That provides greater confidence that changes observed in the data reflect real trends rather than random survey variations. However, the percentage of adults without any college education has steadily declined in recent decades, among both whites and people of color. Differences over time in health status and access to care could thus reflect changes in the characteristics of working-class adults as well as changes in their circumstances.

To keep the report manageable, we focused our discussion of health status and access to care on a single key metric in each area: the percentage of adults under age 65 who experienced 14 or more days of poor physical or mental health the month before

responding to the survey, and the percentage of such adults who went without one or more physician visits during the prior year because of cost. We also concentrated on reporting observed differences, without attempting multivariate regressions.

Follow-up research could overcome many of these limitations and extend the analysis in this report. For example:

- » Other data sources would let us analyze (1) health status and health care access for additional racial and ethnic groups; (2) health status disparities between U.S.-born members of each racial and ethnic group, which would enable more “apples to apples” comparisons by screening out the tendency of immigrants to enjoy better health than native-born residents; and (3) disparities in health status and health care access that affect LGBTQ families, incorporating a broader range of gender identities.<sup>4</sup>
- » State-specific profiles could illustrate important regional and local variations that fill out this report’s national portrait.
- » Broadening and lengthening this report’s core analysis by adding further measures of health status and health care access would increase our account’s comprehensiveness and nuance,<sup>5</sup> and multivariate regressions could add further explanatory power.

Two final comments are important. The first involves the limited nature of this report’s objectives. It does not rigorously analyze causation or propose specific remedies. It neither explores nor attempts to enlarge the considerable body of research linking serious health problems to underlying social and economic conditions. Rather, we analyze selected metrics of health and health care access to gain insights about unmet needs

across diverse demographic groups and the possibility of meaningful progress. We hope this preliminary work can contribute to the identification and enactment of effective solutions in the future.

Second, as described in the body of this report, we found a notable reduction in the prevalence of serious physical and mental health problems that coincided with the ACA’s main health coverage provisions becoming effective in 2014. In some ways, these findings come as a surprise. Research suggests that, though precise estimates vary, health care is responsible for between 10 percent<sup>6</sup> and 25 percent<sup>7</sup> of a person’s health outcomes. Genetics play a role, but the lion’s share of what determines one’s health are social and economic factors. It is thus remarkable that the ACA’s policy changes, the vast majority of which involved health coverage and access to care, were associated with a demonstrable drop in the prevalence of serious health problems among working-class adults and people of color alike.

On the other hand, emerging research shows that coverage expansions, both before and after the ACA, have significantly increased the detection and treatment of chronic illnesses like diabetes, depression, and (according to some studies) high blood pressure. Research also shows clear improvements in overall health status quickly following coverage expansions.<sup>8</sup> It thus seems highly plausible that the ACA’s increased coverage and improved access to care would reduce the prevalence of serious physical and mental health problems, as some previously uninsured people with untreated conditions received coverage and obtained services that ameliorated those conditions. That said, we are not in a position to test causation as part of this report. Other factors may conceivably have led to the health improvements we observe. Future research could explore the potential causes of the startling recent changes that we report in the sections that follow.

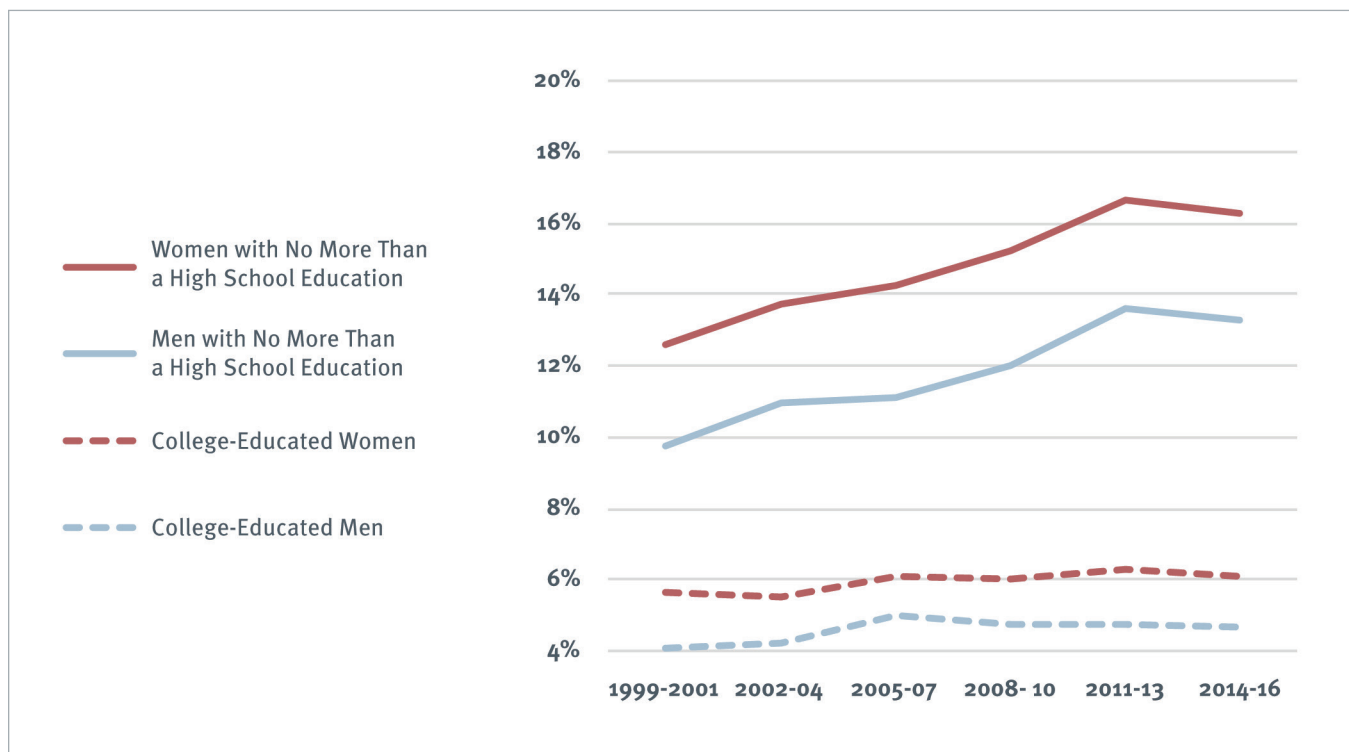
## Health and Health Access Problems Experienced by Working-Class Women

### Serious Physical and Mental Health Problems

Serious physical and mental health problems—which we define as experiencing 14 or more days of poor physical or mental health during the month—are much more common among working-class women than college-educated men (figures 1 and 2). For example, in 2011-2013, serious problems with both physical and mental health were roughly 3.5 times as frequent for working-class women as for college-educated men.

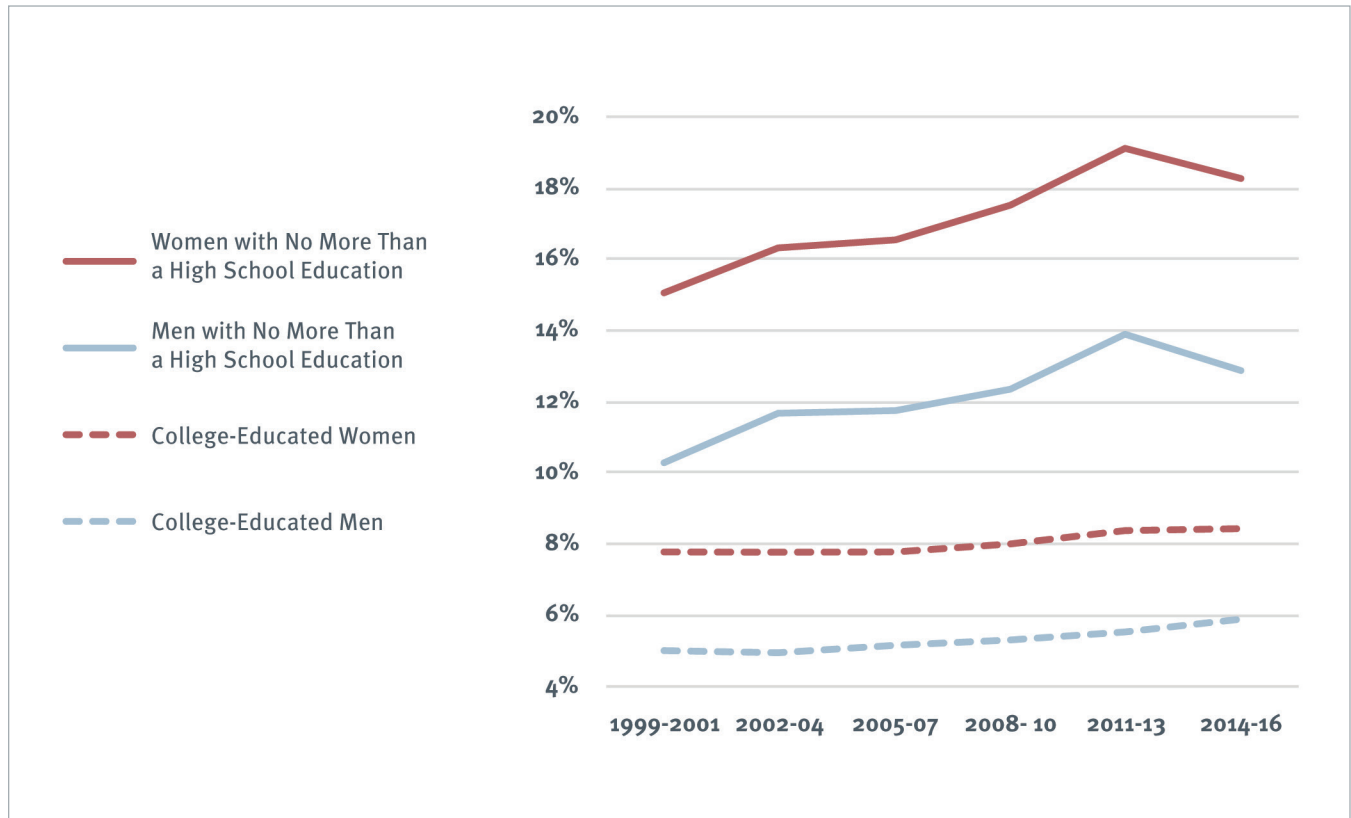
- » One in 6 working-class women (16.7 percent) experienced 14 or more days of poor physical health the previous month. By contrast, those problems were experienced by fewer than 1 in 20 college-educated men (4.7 percent).
- » Nearly 1 out of every 5 working-class women (19.1 percent) experienced 14 or more days of poor mental health the previous month. The same was true for only 1 in 18 college-educated men (5.5 percent).

**Figure 1. The percentage of adults under age 65 with 14 or more days of poor physical health the previous month, by class and gender: 1999-2016**



Source: Families USA-commissioned analysis of Behavioral Risk Factor Surveillance System (BRFSS), 1999-2016.

**Figure 2. The percentage of adults under age 65 with 14 or more days of poor mental health the previous month, by class and gender: 1999-2016**



Source: Families USA-commissioned analysis of BRFSS, 1999-2016.

From 1999 to 2013, prolonged bouts of poor health became increasingly common for working-class women, as the gap between serious health challenges facing such women and the much better health enjoyed by college-educated men grew at an alarming rate:

- » The percentage of working-class women with 14 or more days of poor physical health per month rose from 12.6 percent in 1999-2001 to 16.7 percent in 2011-2013—a 32 percent relative increase. Over that same period, the gap between working-class women and college-educated men increased by 40 percent, from 8.5 percentage points to 11.9 percentage points.

- » The percentage of working-class women with 14 or more days of poor mental health per month grew from 15.1 percent in 1999-2001 to 19.1 percent in 2011-2013—a 27 percent relative rise. Over that same period, the gap between working-class women and college-educated men increased by 35 percent, from 10 percentage points to 13.6 percentage points.<sup>9</sup>

Beginning in 2014—the year the ACA’s major health coverage provisions became effective—trends affecting working-class women changed direction. The prevalence of serious health problems began to decline, and the differences in health status between working-class women and college-educated men began to narrow. For example (Figure 2):

- » After rising steadily from 1999-2001 through 2011-2013, the percentage of working-class women with 14 or more days of poor mental health declined from 19.1 percent in 2011-2013 to 18.2 percent in 2014-2016.
- » The gap between working-class women and college-educated men in the prevalence of serious mental health problems dropped from 13.6 percentage points in 2011-2013 to 12.3 percentage points in 2014-2016.

This correlation does not prove causation. But as noted earlier, much prior research makes it highly plausible that the ACA's major expansion of health insurance coverage reduced the prevalence of serious health problems by letting newly insured families obtain diagnoses and treatment for health conditions that otherwise would have gone unaddressed.

## Women Whose Health Improved Thanks to the ACA

For more than 25 years, Families USA's Storytelling Initiatives Program has given people affected by public policy debates the chance to tell their stories. Here we relay real-world examples of how the ACA has improved women's health.

“

*I have never been able to have insurance until the Obamacare came into play. Since getting insurance, I was able to have a major surgery that I never would have been able to have or even afford before. I also had a mammogram, and my doctors found a lump. Thank goodness it was clear, but I need to have one every year because of a family history of cancer.*

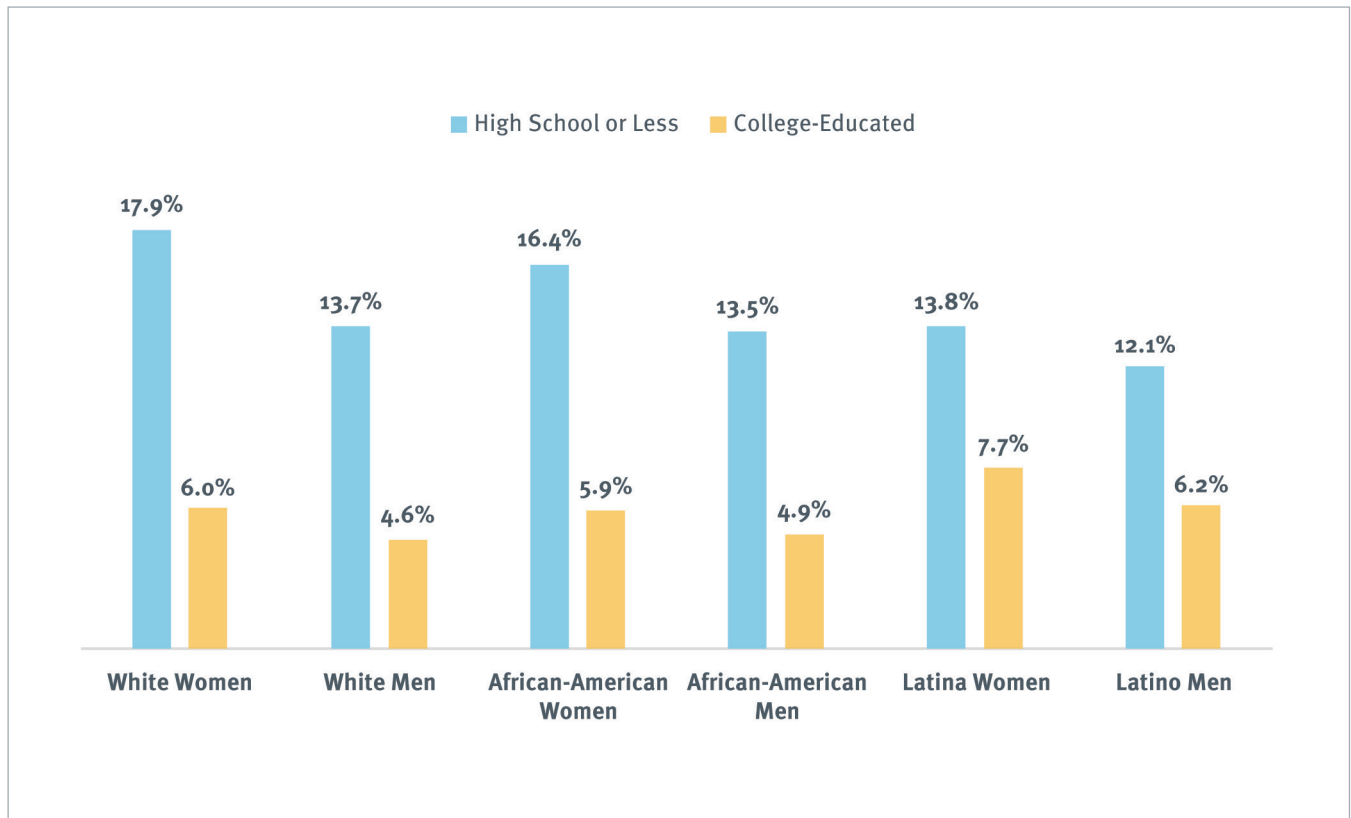
—Barbara from San Mateo, Florida,  
a rural community with fewer than  
2,000 residents

“

*The ACA finally gave me access to insurance. In 2015, I was diagnosed and unable to walk enough to do my own grocery shopping or prepare meals. The ACA exchange policy offered generous physical therapy options, and the physical therapist got me up and walking again in three months. Without that, I'm positive I would still be in a wheelchair today.*

—Lauren from St. Louis, Missouri

**Figure 3. The percentage of adults under age 65 with poor physical health for 14 or more days the previous month, by class, race/ethnicity, and gender: 2014-2016**



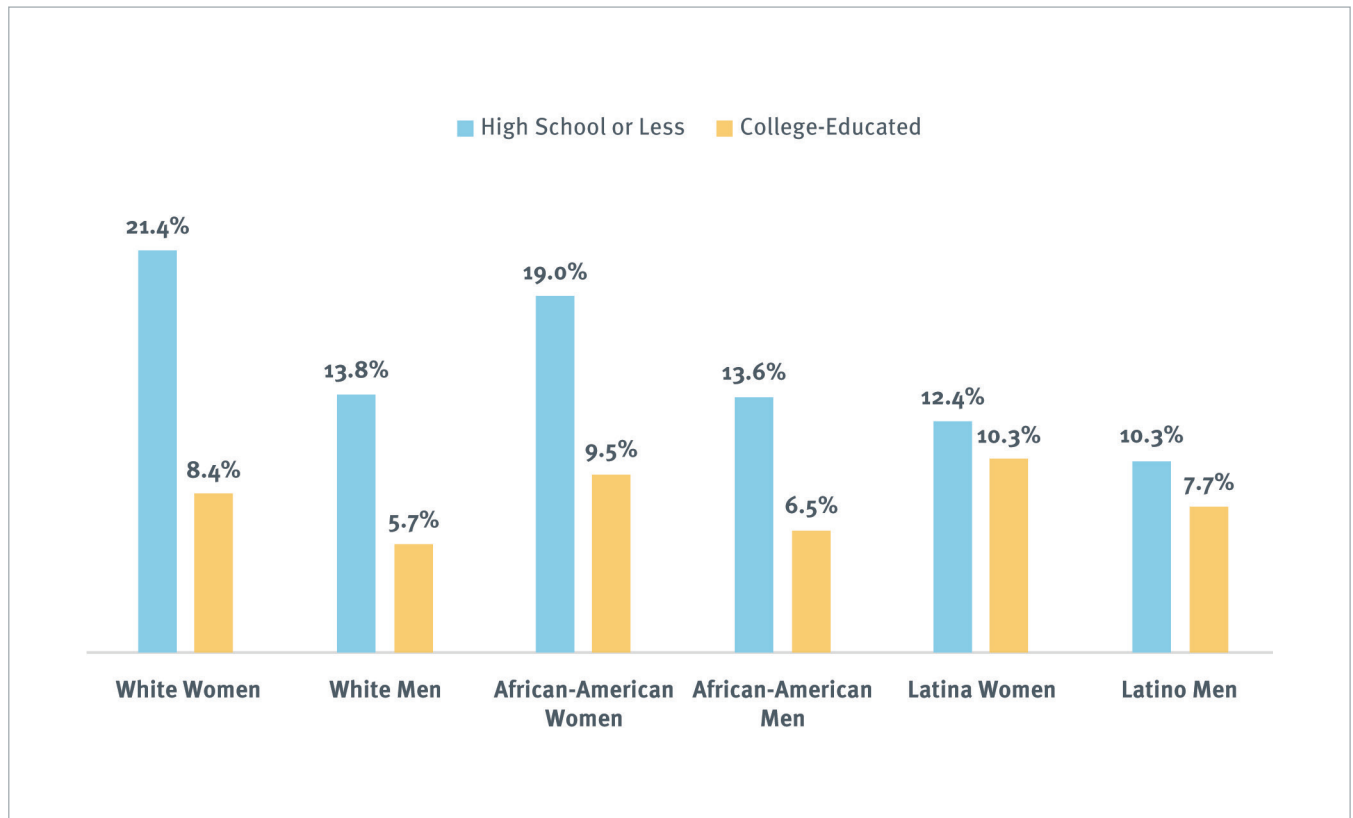
Source: Families USA-commissioned analysis of BRFSS data, 2014-2016. Note: Whites and African-Americans are non-Hispanic whites and blacks, respectively. Latinos are Hispanics of any race.

The data reflected in figures 1 and 2 show a promising change in direction, but the disproportionate harm experienced by working-class women remains acute and transcends racial and ethnic lines. For whites, African-Americans, and Latinos alike, the largest differential in the rate of serious physical and mental health problems is between working-class women and college-educated men (figures 3 and 4). For example, serious physical health problems are:

- » For whites, more than three times as frequent with working-class women as with college-educated men (17.9 percent vs. 4.6 percent).
- » More than three times as common for African-American working-class women as for African-American college-educated men (16.4 percent vs. 4.9 percent).
- » Among Latinos, more than twice as frequent among working-class women as among college-educated men (13.8 percent vs. 6.2 percent).

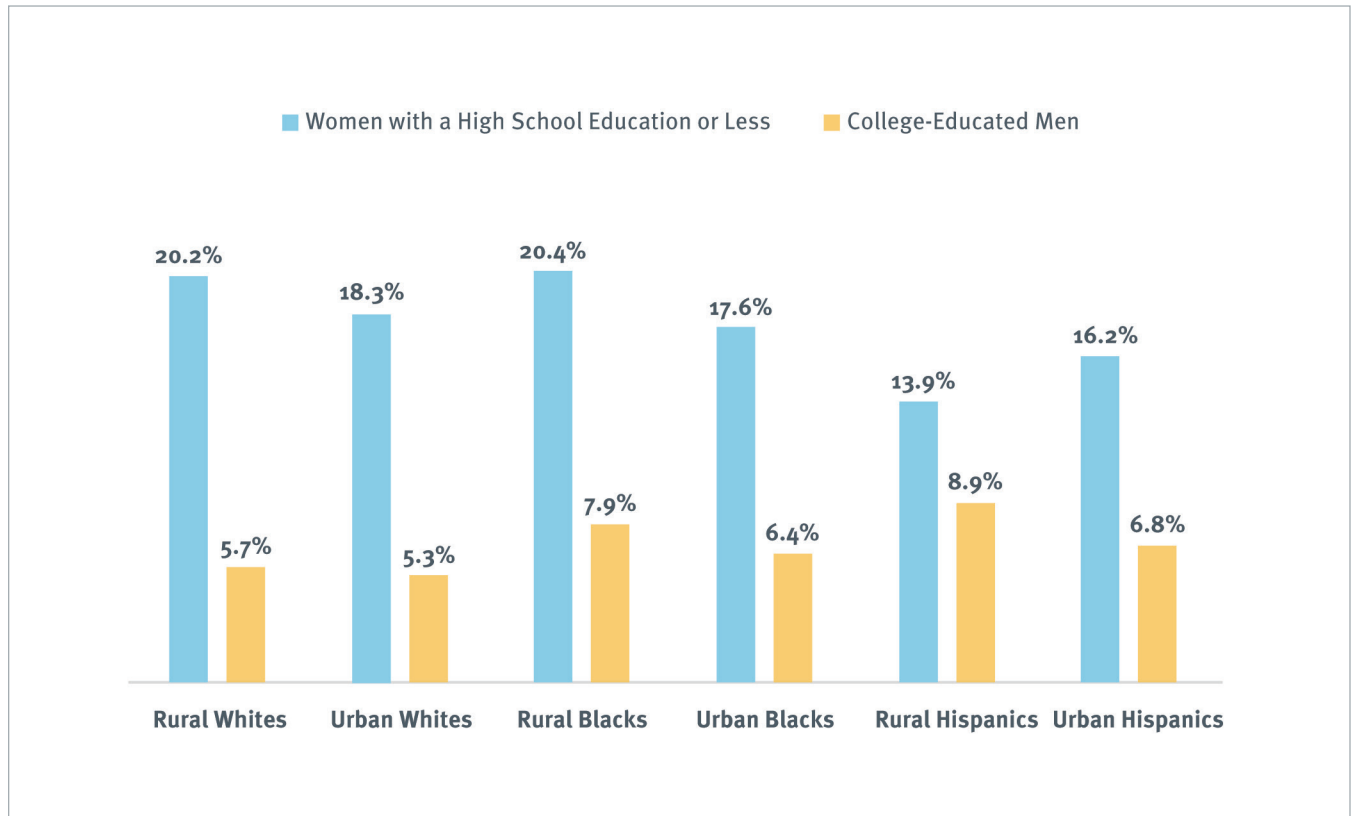


**Figure 4. The percentage of adults under age 65 with poor mental health for 14 or more days the previous month, by class, race/ethnicity, and gender: 2014-2016**



Source: Families USA-commissioned analysis of BRFSS data, 2014-2016. Note: Whites and African-Americans are non-Hispanic whites and blacks, respectively. Latinos are Hispanics of any race.

**Figure 5. The percentage of adults under age 65 with poor physical health for 14 or more days the previous month, by gender, race/ethnicity, and place of residence: 2014-2016**



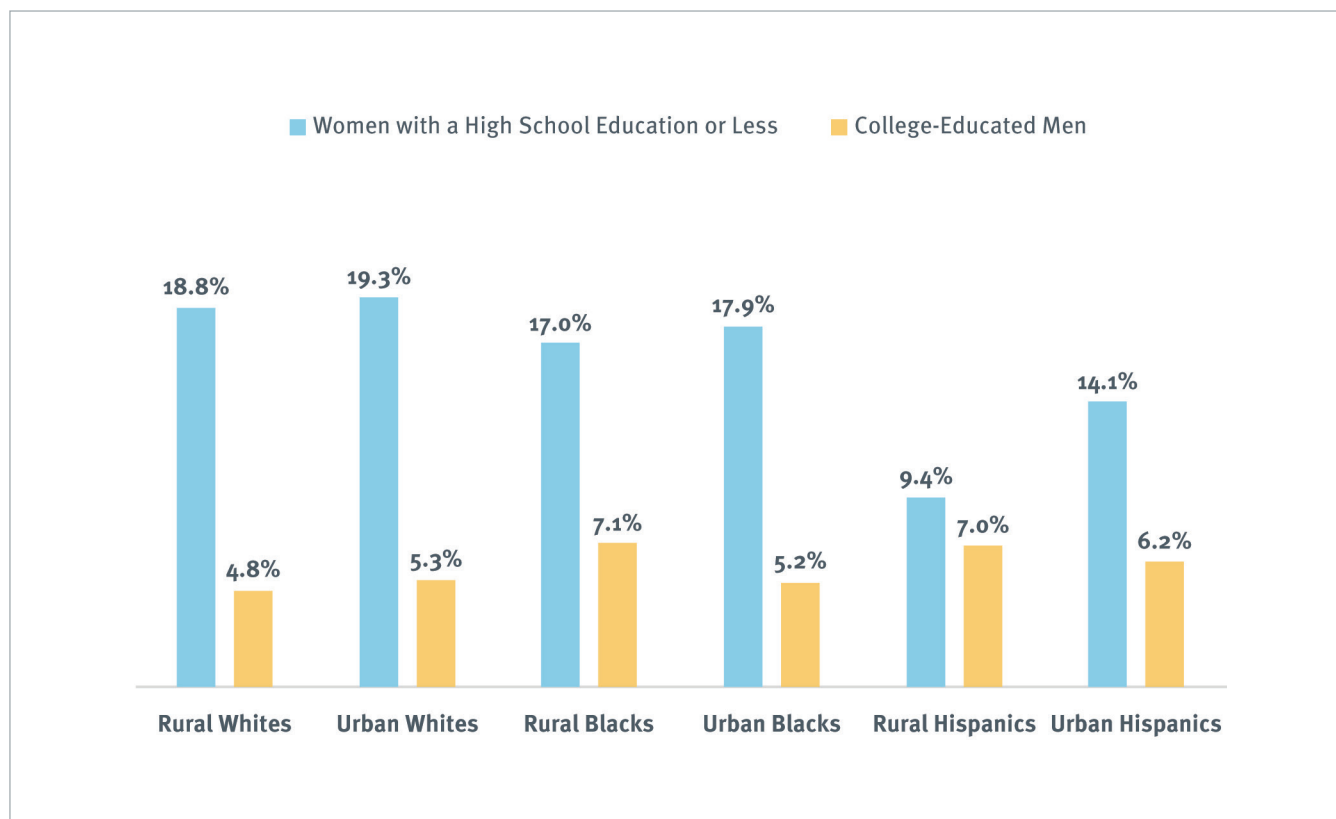
Source: Families USA-commissioned analysis of BRFSS data, 2014-2016. Note: Rural = non-MSA. Urban = central-city MSA. Whites and blacks are non-Hispanics. Hispanics are of any race.

In both rural and urban areas, working-class women are much more likely than college-educated men to experience serious health problems. For example, physical health problems are (Figure 5):

- » Roughly 3.5 times as common for working-class white women as for college-educated white men, in both rural areas (20.2 percent vs. 5.7 percent) and urban areas (18.3 percent vs. 5.3 percent).
- » More than 2.5 times as frequent for working-class black women as for college-educated black men, in both rural areas (20.4 percent vs. 7.9 percent) and urban areas (17.6 percent vs. 6.4 percent).

- » Between 1.5 and 2.4 times more likely for working-class Hispanic women as for college-educated Hispanic men, with a discrepancy of 13.9 percent vs. 8.9 percent in rural areas and 16.2 percent vs. 6.8 percent in urban areas. One likely contributor to this narrower gap among Hispanics is the methodological limitation observed earlier: Working-class Hispanics include many immigrants and so tend to be healthier than similarly situated native-born adults, who comprise a much larger proportion of Hispanics with a college education.

**Figure 6. The percentage of adults under age 65 with poor mental health for 14 or more days the previous month, by gender, race/ethnicity, and place of residence: 2014-2016**



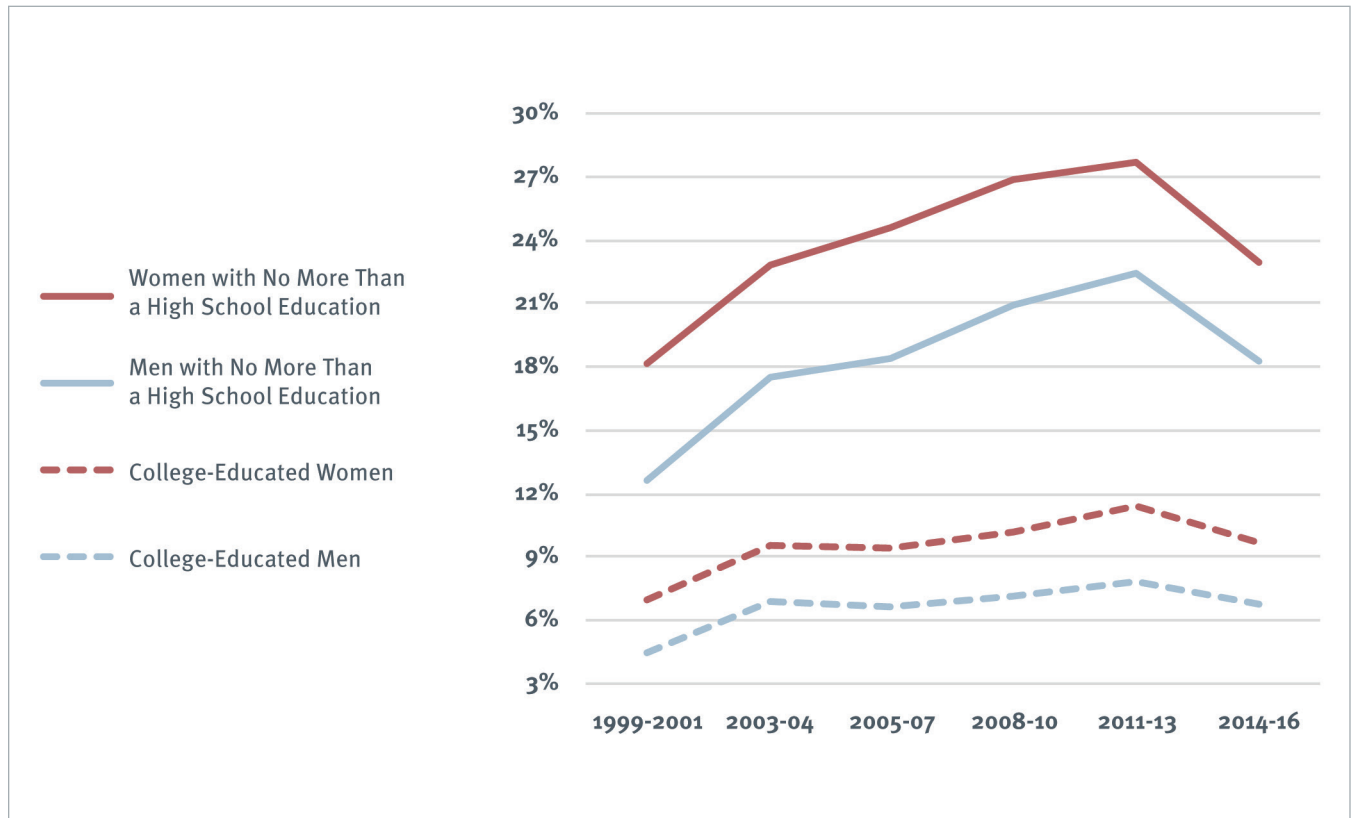
Source: Families USA-commissioned analysis of BRFSS data, 2014-2016. Note: Rural = non-MSA. Urban = central-city MSA. Whites and blacks are non-Hispanics. Hispanics are of any race.

Serious disparities are observed with mental illness as well (Figure 6).

These disparities are stark, and their import is clear. Given the well-documented relationship noted earlier between health status and social and economic circumstances, the serious health problems experienced by working-class women likely reflect underlying life challenges that have long been ignored by U.S. public policy.

**These disparities are stark, and their import is clear. Given the well-documented relationship between health status and social and economic circumstances, the serious health problems experienced by working-class women likely reflect underlying life challenges that have long been ignored by U.S. public policy.**

**Figure 7. The percentage of adults under age 65 who missed one or more physician visits during the year because of cost, by class and gender: 1999-2016**



Source: Families USA-commissioned analysis of BRFSS data, 1999-2016. Note: BRFSS data for this indicator were unavailable for 2002.

## Inability to Afford Health Care

This section of the report shifts from health status to health care access, focusing on adults who went without one or more physician visits during the year because of cost. Using this specific metric of financial barriers to care, working-class women once again come up short, both overall and for whites, blacks, and Hispanics. Among all U.S. adults under age 65 (Figure 7):

- » In 2011-2013, working-class women were more than three times as likely to go without physician care because of cost, compared with college-

educated men. Fully 27.7 percent of working-class women—more than 1 in 4—encountered this financial barrier. The same was true for only 7.8 percent of college-educated men, or fewer than 1 in 12.

- » From 1999-2001 to 2011-2013, the proportion of working-class women denied physician care because of cost increased by 53 percent, from 18.2 percent to 27.7 percent. At the same time, the gap between such women and college-educated men rose by 45 percent, from 13.7 percentage points to 19.9 percentage points.

## Women with Challenges Involving Health and Health Care

Continuing with examples from Families USA's Storytelling Initiatives Program, here we share the real-world stories of women who face serious challenges with health care affordability as well as underlying health problems.



*I live with an expensive, chronic illness, Type 1 diabetes. The bare-bone cost is currently about \$750 per month for insulin alone. I use a pump, continuous glucose monitoring, etc. My pump supplies for three months is approximately \$2,000 per current insurance contracts. I pay a copay and percentage even when I meet yearly deductibles.*

**—Patricia from Labadie, Missouri, an unincorporated rural community with fewer than 3,000 residents**



*I have fibromyalgia, Sjogren's syndrome, major depressive disorder, and generalized anxiety disorder. It is already difficult for us to pay deductibles and copays for office visits and prescriptions. I put off recommended appointments and procedures because I still haven't paid off the last visits.*

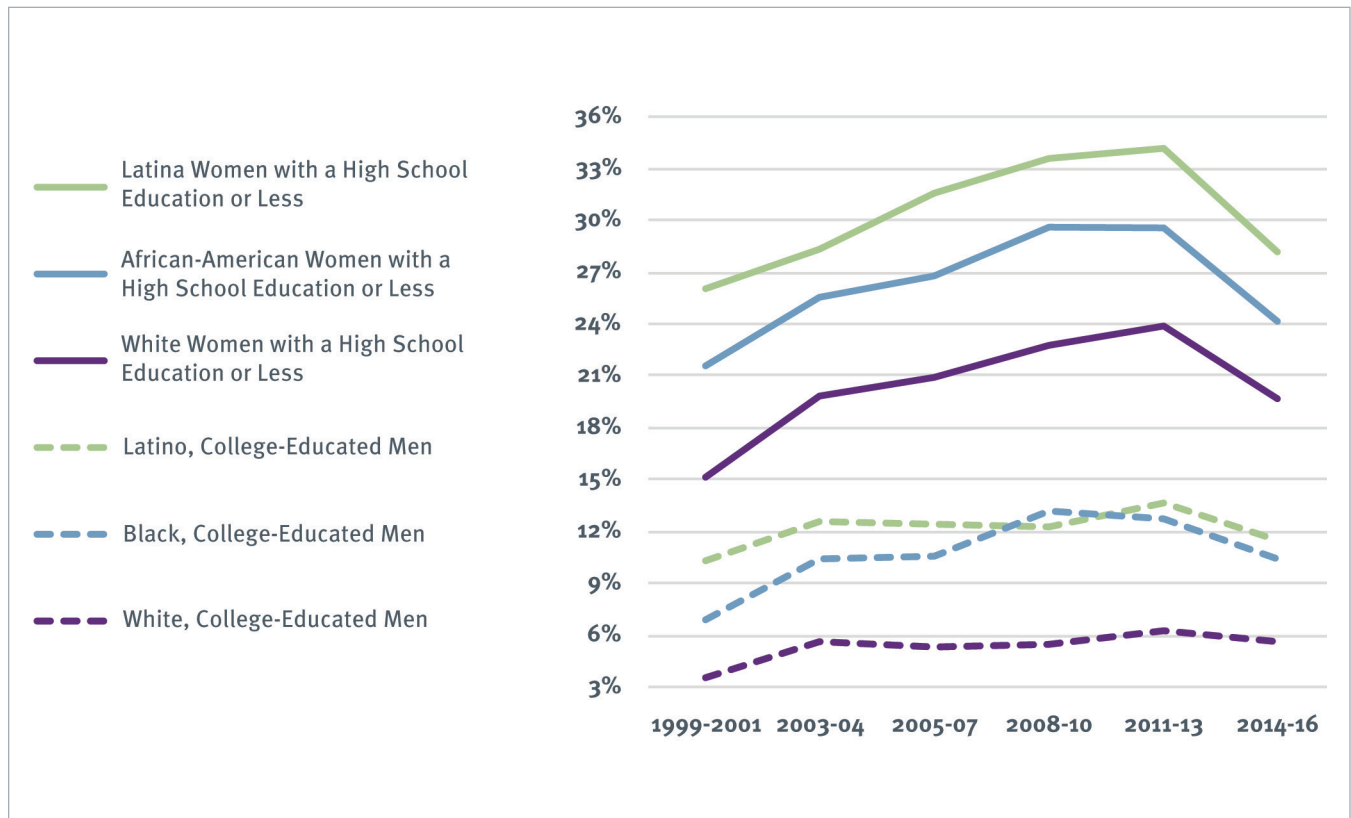
**—April from Nampa, Idaho, the state's second-largest city**



*I am 54 years old and suffer from degenerative disk disease, spinal stenosis, and osteoarthritis. I have bone degeneration in both of my knees and arthritis, and I will need knee replacements. I also have COPD [chronic obstructive pulmonary disease]. I am currently working three days a week but cannot work more than that because I am in constant pain. I have insurance through my employer, but it is a limited plan and only covers preventive care. Four years, \$10,000 in doctors' bills, and I still can't get the care I need. I want to be a productive member of society. I want to work. I have worked for the same company for over 20 years. But I will be in a wheelchair soon if I can't get treatment.*

**—Karen from Gainesville, Georgia, the “poultry plant capital of the world”**

**Figure 8. The percentage of adults under age 65 who missed one or more physician visits during the year because of cost, by race/ethnicity, class, and gender: 1999-2016**



Source: Families USA-commissioned analysis of BRFSS data, 1999-2016. Note: Whites and African-Americans are non-Hispanic whites and blacks, respectively. Latinos are Hispanics of any race. BRFSS data for this indicator were unavailable for 2002.

These financial barriers continue to affect working-class women, in both white families and families of color. In 2014-2016 (Figure 8):

- » For both Latinos and African-Americans, working-class women were more than twice as likely to go without physician care because of cost, compared with college-educated men (28.2 percent vs. 11.6 percent for Latinos and 24.2 percent vs. 10.4 percent for African-Americans).
- » For whites, working-class women were more than three times as likely to go without physician care because of cost, compared with college-educated men (19.7 percent vs. 5.6 percent).

In 2014, the percentage of adults who missed physician visits because of cost began to fall. This drop was sharper than the declining percentage of adults with serious health problems, described above. This is unsurprising, given the ACA's focus on improving health coverage and access to care. These improvements were most evident among working-class women, but men and women of every class, race, and ethnicity analyzed in this report experienced gains.

Note: A later section of the report explores the stark racial and ethnic disparities reflected in these data.

## Ongoing Health Challenges Facing Working-Class Men and Women: Commonalities Across Race, Ethnicity, and Place

### Serious Health Problems of Diverse Groups of Working-Class Adults

In this section of the report, we combine data for men and women to examine the prevalence of serious health problems among working-class adults as a whole. With whites, African-Americans, and Latinos alike, serious physical and mental health problems grew increasingly common for working-class adults

until 2013, after which their rates stabilized or began to decline (figures 9 and 10). For example, the percentage of working-class adults reporting 14 or more days of poor mental health the previous month changed in similar ways across racial and ethnic lines:

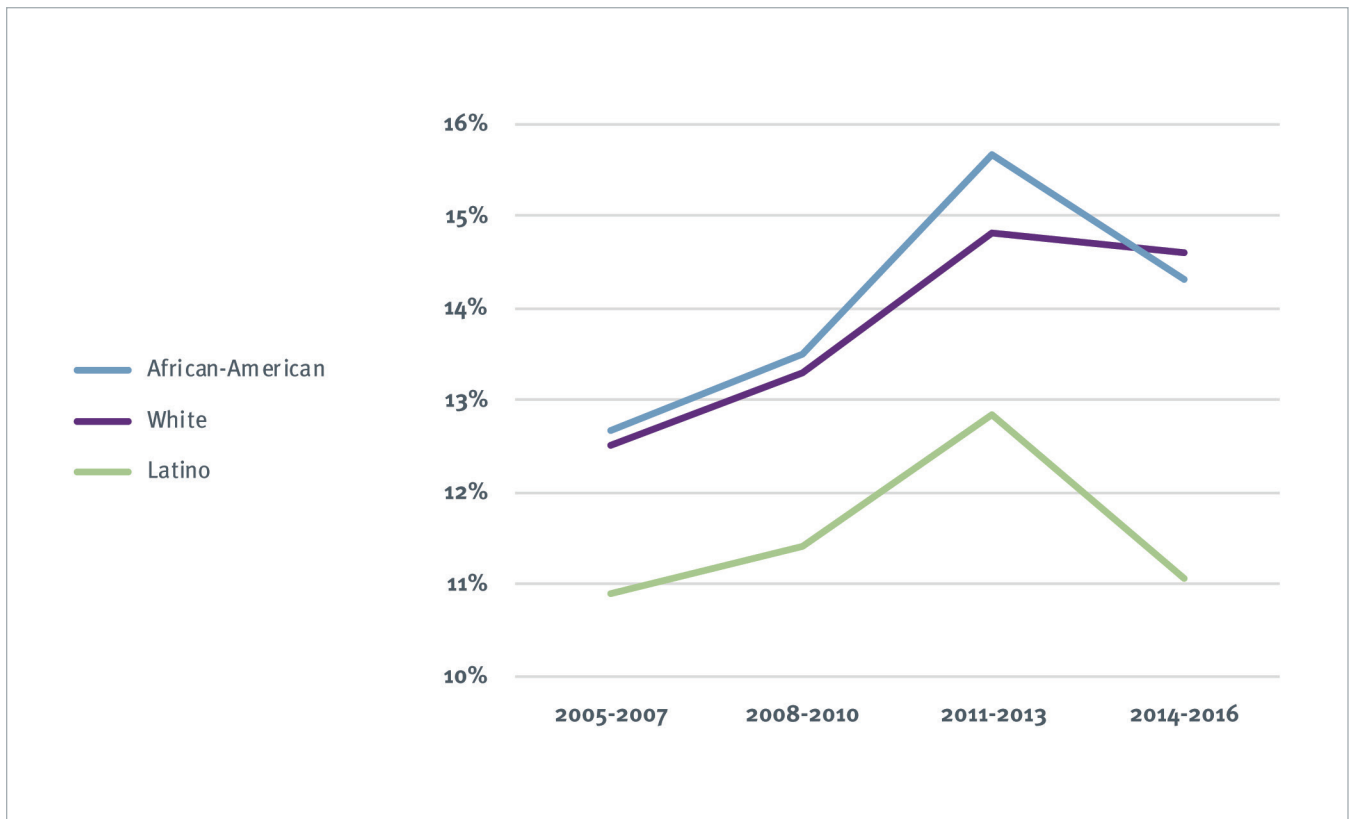
- » For blacks, it rose from 12.7 percent in 2005-2007 to 15.7 percent in 2011-2013, then fell to 14.3 percent in 2014-2016.

**Figure 9. The percentage of working-class adults under age 65 with 14 or more days of poor physical health the previous month, by race/ethnicity: 2005-2016**



Source: Families USA-commissioned analysis of BRFSS data, 2005-2016. Note: “White” refers to non-Hispanic whites. “African-American” refers to non-Hispanic blacks. “Latino” refers to Hispanics of all races. Working-class adults are defined as those with a high school education or less.

**Figure 10. The percentage of working-class adults under age 65 with 14 or more days of poor mental health the previous month, by race/ethnicity: 2005-2016**

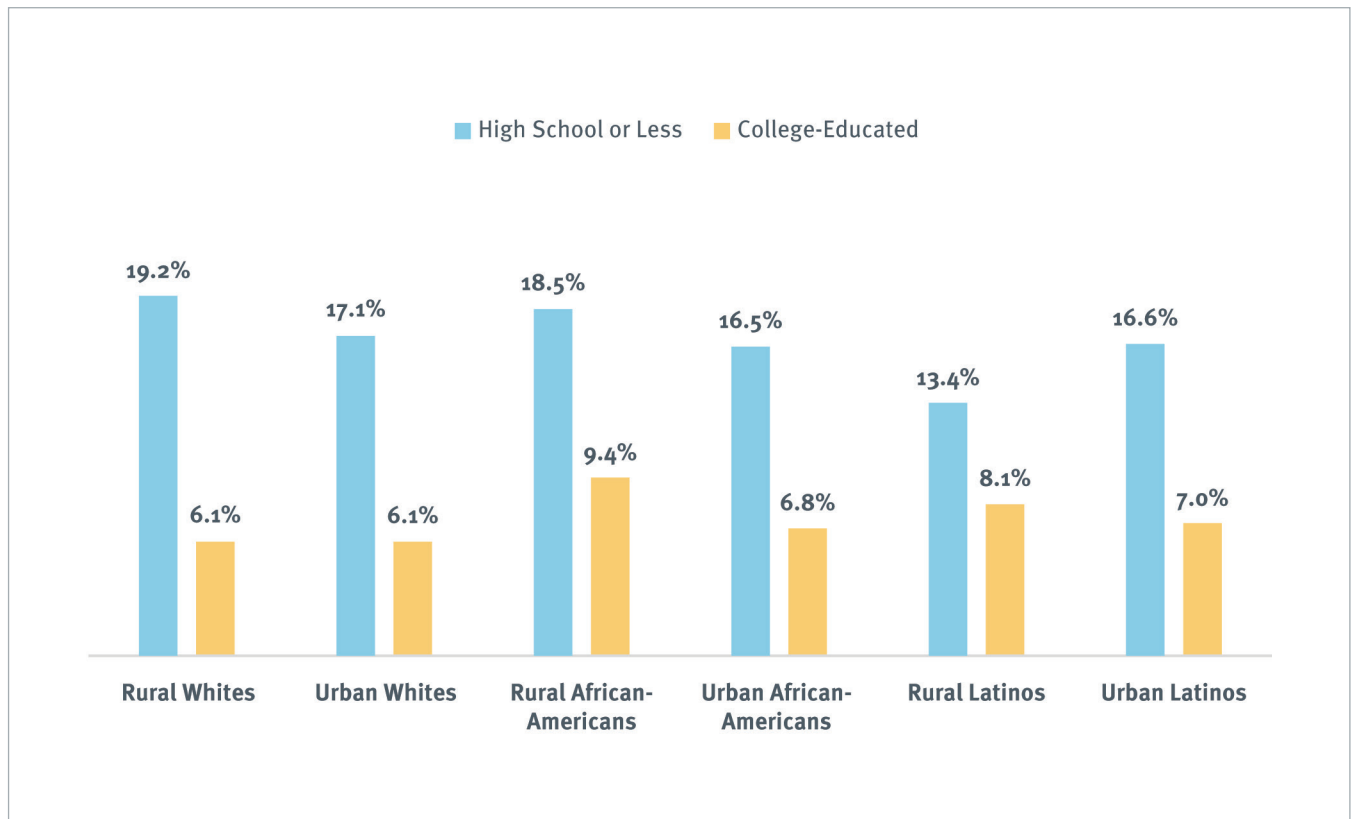


Source: Families USA-commissioned analysis of BRFSS data, 2005-2016. “White” refers to non-Hispanic whites. “African-American” refers to non-Hispanic blacks. “Latino” refers to Hispanics of all races. Working-class adults are defined as those with a high school education or less.

- » Among whites, it increased from 12.5 percent in 2005-2007 to 14.8 percent in 2011-2013, then dropped to 14.6 percent in 2014-2016.
- » For Hispanics, it rose from 10.9 percent in 2005-2007 to 12.8 percent in 2011-2013, then fell to 11.1 percent in 2014-2016.



**Figure 11. The percentage of adults under age 65 with 14 or more days of poor physical health the previous month, by race/ethnicity, class, and place of residence: 2014-2016**

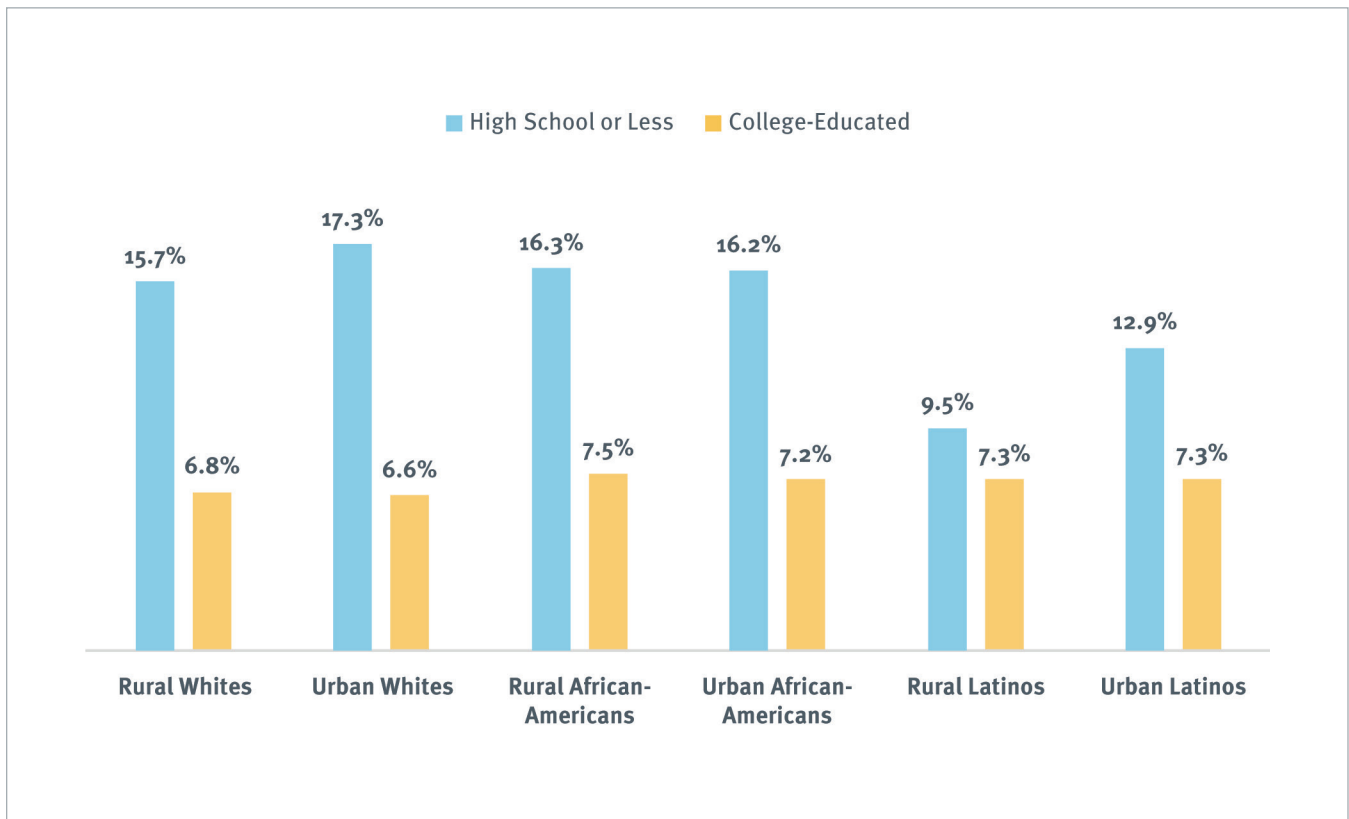


Source: Families USA-commissioned analysis of BRFSS data, 2014-2016. Note: Rural = non-MSA. Urban = central-city MSA. Whites and African-Americans are non-Hispanic whites and blacks, respectively. Latinos are Hispanics of any race.

Notwithstanding recent progress, serious physical and mental health problems remain much more common for working-class people than those with a college education, whether they are white adults, people of color, urban residents, or those who live in rural areas. For example, in rural areas, the percentage of adults with 14 or more days of poor physical health the previous month is (Figure 11):

- » More than three times as high for working-class whites as for college-educated whites (19.2 percent vs. 6.1 percent).
- » Almost twice as high for working-class African-Americans as for college-educated African-Americans (18.5 percent vs. 9.4 percent).
- » More than 65 percent higher for working-class Latinos than for college-educated Latinos (13.4 percent vs. 8.1 percent).

**Figure 12. The percentage of adults under age 65 with 14 or more days of poor mental health the previous month, by race/ethnicity, class, and place of residence: 2014-2016**



Source: Families USA-commissioned analysis of BRFSS data, 2014-2016. Note: Rural = non-MSA. Urban = central-city MSA. Whites and African-Americans are non-Hispanic whites and blacks, respectively. Latinos are Hispanics of any race.

In urban areas, the percentage of adults with 14 or more days of poor mental health the previous month is (Figure 12):

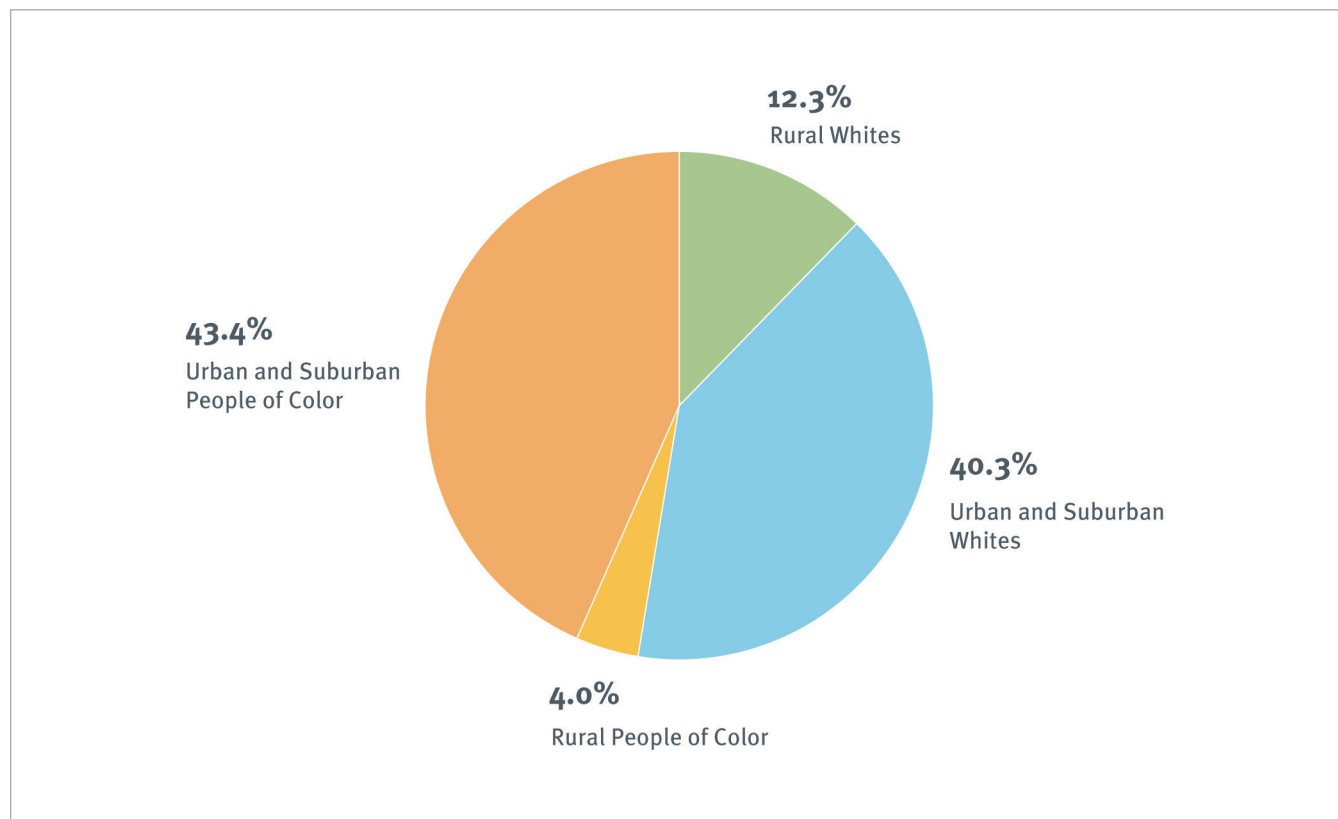
- » Among both whites and African-Americans, more than twice as high for working-class adults as for college-educated adults (17.3 percent vs. 6.6 percent for whites and 16.2 percent vs. 7.2 percent for African-Americans).
- » For Latinos, more than 77 percent higher for working-class adults than for college-educated adults (12.9 percent vs. 7.3 percent).

#### Adults in different racial and ethnic groups benefit from a college degree, but some benefit more than others

For example, in urban areas, a college education reduces the odds of serious mental health problems by:

- » 62 percent for whites.<sup>10</sup>
- » 55 percent for African-Americans.
- » 43 percent for Latinos.

**Figure 13. Adults under age 65 with a high school education or less, by race/ethnicity and place of residence: 2016**



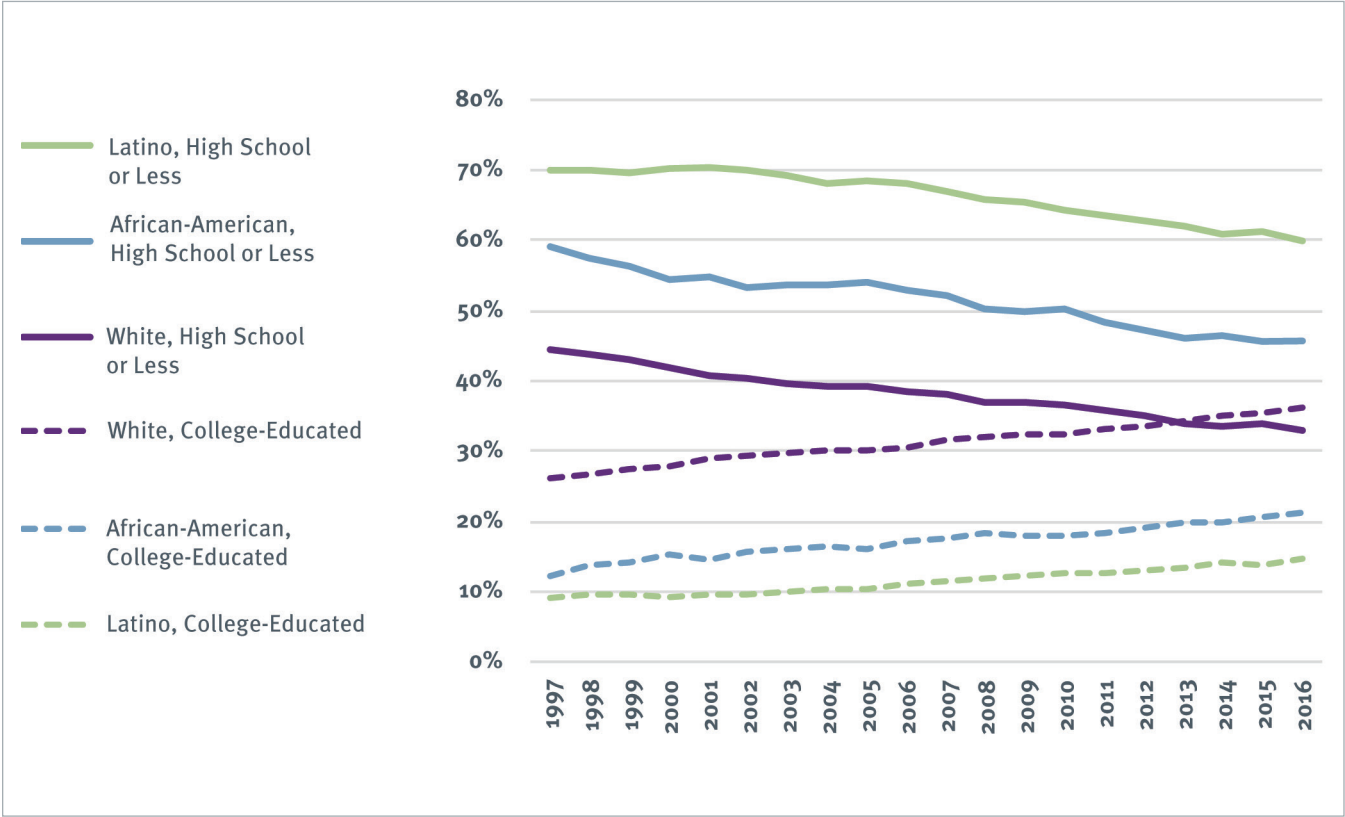
Source: Families USA analysis of Current Population Survey – Annual Social and Economic Supplement (CPS-ASEC) 2017. Note: “Rural” refers to non-MSA areas. “Urban and suburban” refers to MSA areas. “Whites” refers to non-Hispanic whites. “People of color” includes all races and ethnicities, other than non-Hispanic whites.

## Working-Class Families’ Underlying Demographic Diversity

In this section of the report, we change our focus from the prevalence of health problems to the demographics of working-class families. Nearly half of working-class adults (47.4 percent) are people of color, and most (83.7 percent) live in urban and suburban areas (Figure 13). Defying common stereotypes, fewer than 1 in 8 working-class adults (12.3 percent) are whites who live in rural areas.

Nearly half of working-class adults (47.4 percent) are people of color, and most (83.7 percent) live in urban and suburban areas. Defying common stereotypes, fewer than 1 in 8 working-class adults (12.3 percent) are whites who live in rural areas.

**Figure 14. The percentage of adults under age 65 with different levels of education, by race/ethnicity: 1997-2016**



Source: Families USA analysis of CPS-ASEC data, 1998-2017. Note: “White” refers to non-Hispanic whites. “African-American” refers to non-Hispanic blacks. “Latino” refers to Hispanics of any race.

Although whites make up slightly more than half of working-class adults, people of color are far more likely than whites to be in the working class. That educational and economic inequity has persisted over time, even as the proportion of working-class people has fallen within each demographic group.

Among white people, adults with a college degree began to outnumber those with a high school education in 2013, but for Latinos and African-

Americans, adults with no more than a high school degree continue to outnumber adults who finished college (Figure 14). For example, in 2016, 60 percent of Latino adults had a high school education or less, while only 15 percent had a college degree. For African-Americans, those proportions were 46 percent and 21 percent, respectively. Among white adults, just 33 percent had no more than a high school education, and fully 36 percent were college graduates.

## Race and Ethnicity Eclipsing Class in Their Association with Widespread and Serious Chronic Diseases

The previous discussion of class and gender should not obscure the profound and continuing impact of race and ethnicity on health and well-being. Here, we provide examples that involve some of the country's most pressing public health problems: adult diabetes and childhood asthma.

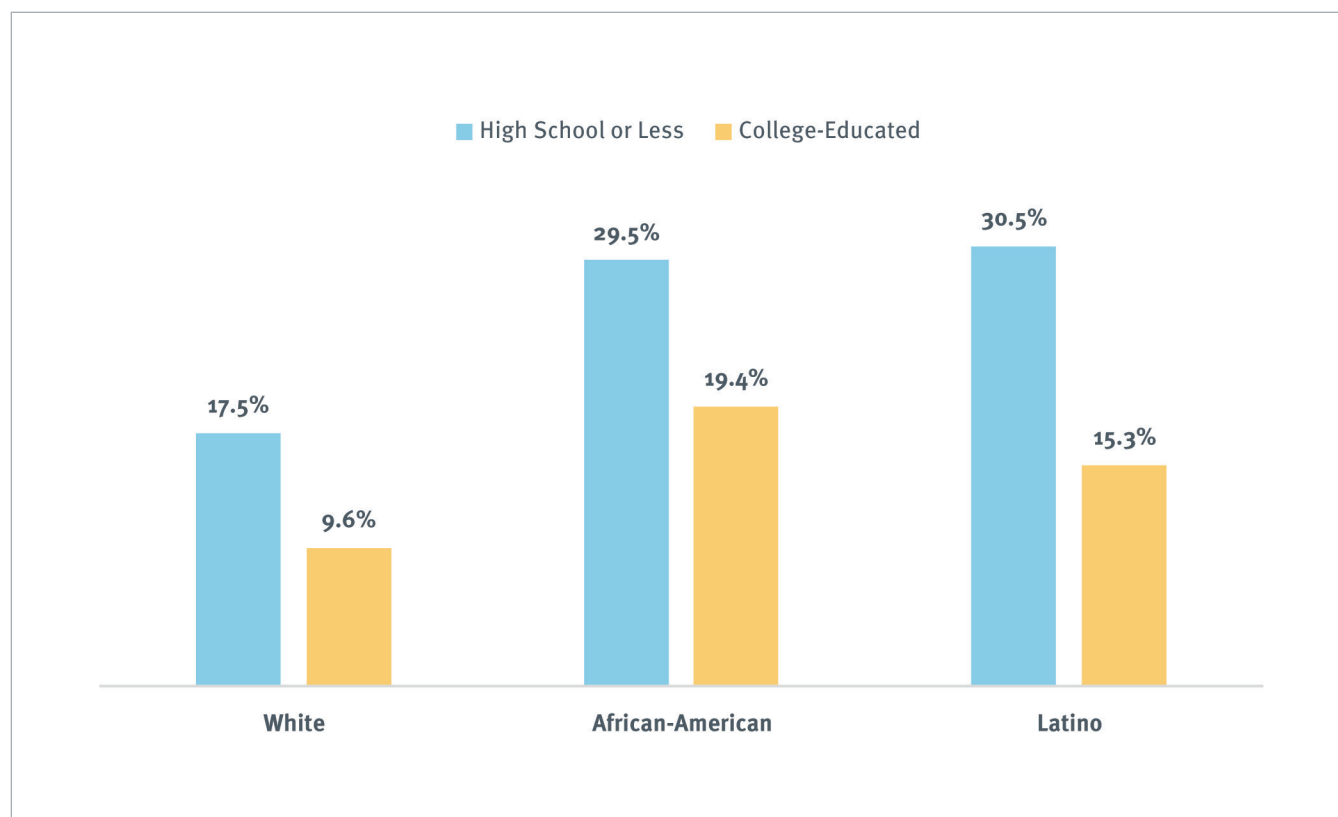
### Diabetes Rates Among Adults Ages 55-64

Older adults without any education beyond high school are more likely to have diabetes, whether they are whites or people of color. But college-educated people of color have diabetes rates comparable to or even higher than those of whites with no more than a high

school education. For example, among adults ages 55-64 (Figure 15):

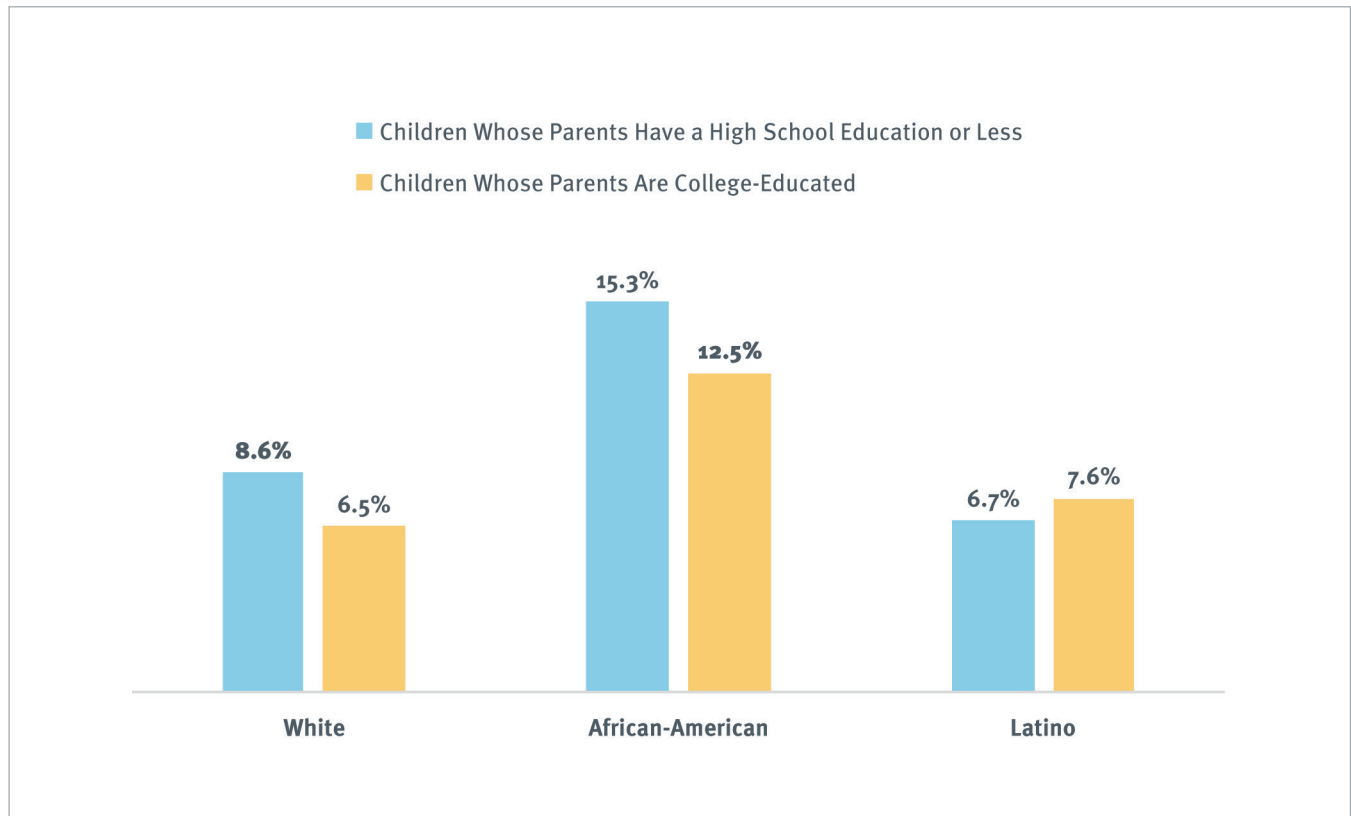
- » Nearly 1 in 3 working-class African-Americans (29.5 percent) have diabetes, far more than the roughly 1 in 5 African-Americans with a college degree (19.4 percent) who were diagnosed with the disease.
- » Whites with a college education are far less likely to have diabetes than those with a high school degree or less (17.5 percent vs. 9.6 percent).
- » **Diabetes rates are higher for African-Americans with a college degree than for whites with a high school education or less (19.4 percent vs. 17.5 percent).**

**Figure 15. The percentage of adults ages 55-64 with diabetes, by race/ethnicity and class: 2014-2016**



Source: Families USA-commissioned analysis of BRFSS data, 2014-2016. Note: Whites and African-Americans are non-Hispanic whites and blacks, respectively. Latinos are Hispanics of any race.

**Figure 16. The percentage of children diagnosed with asthma, by race/ethnicity and class of parents: 2014-2016**



Source: Families USA-commissioned analysis of BRFSS data, 2014-2016. Note: Whites and African-Americans are non-Hispanic whites and blacks, respectively. Latinos are Hispanics of any race.

## Childhood Asthma

Similar key facts emerge from an analysis of race, ethnicity, class, and childhood asthma rates (Figure 16):

- » Asthma is more prevalent among children in working-class families than among the children of college-educated parents, among both whites and African-Americans.
- » **Asthma affects 12.5 percent of African-American children with college-educated parents—roughly a third more than the 8.6 percent of white children whose parents' education never went beyond high school.<sup>11</sup>**

Even as our country's leaders craft and enact policies that benefit working-class families—especially working-class women—across lines of race and ethnicity, it remains essential to continue pursuing a distinct agenda that addresses the considerable challenges that uniquely face people of color.

## Rural Residence Associated with Poorer Health and More Limited Financial Access to Care, but Much Less Important Than Nongeographic Factors

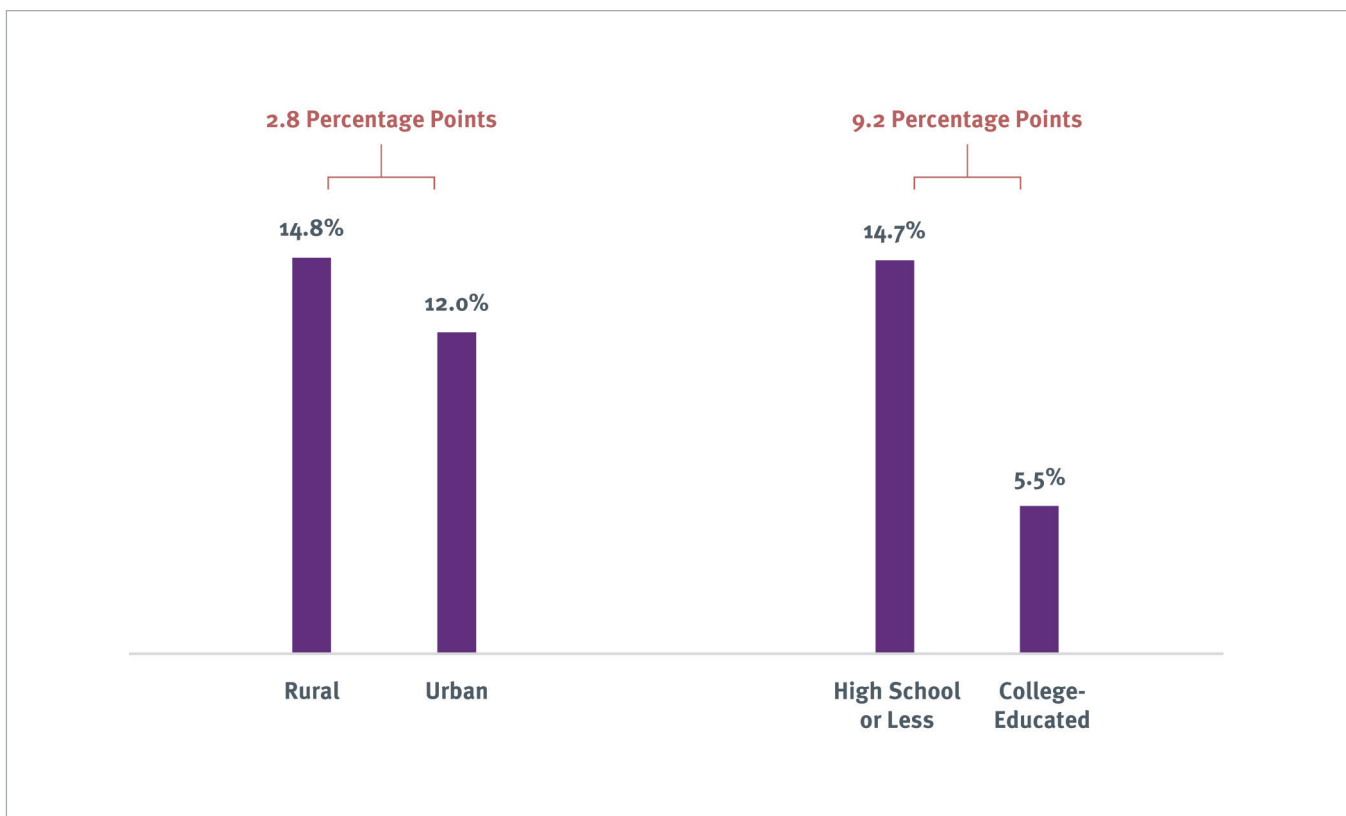
Adults who live in rural areas are more likely than those who live in cities to experience serious physical and mental health problems and to go without physician visits because of cost. However, factors other than rural residence matter more.

### Serious Health Problems

Among all adults under age 65, those living in rural areas have a 2.8 percentage-point greater likelihood, compared with city residents, of experiencing 14

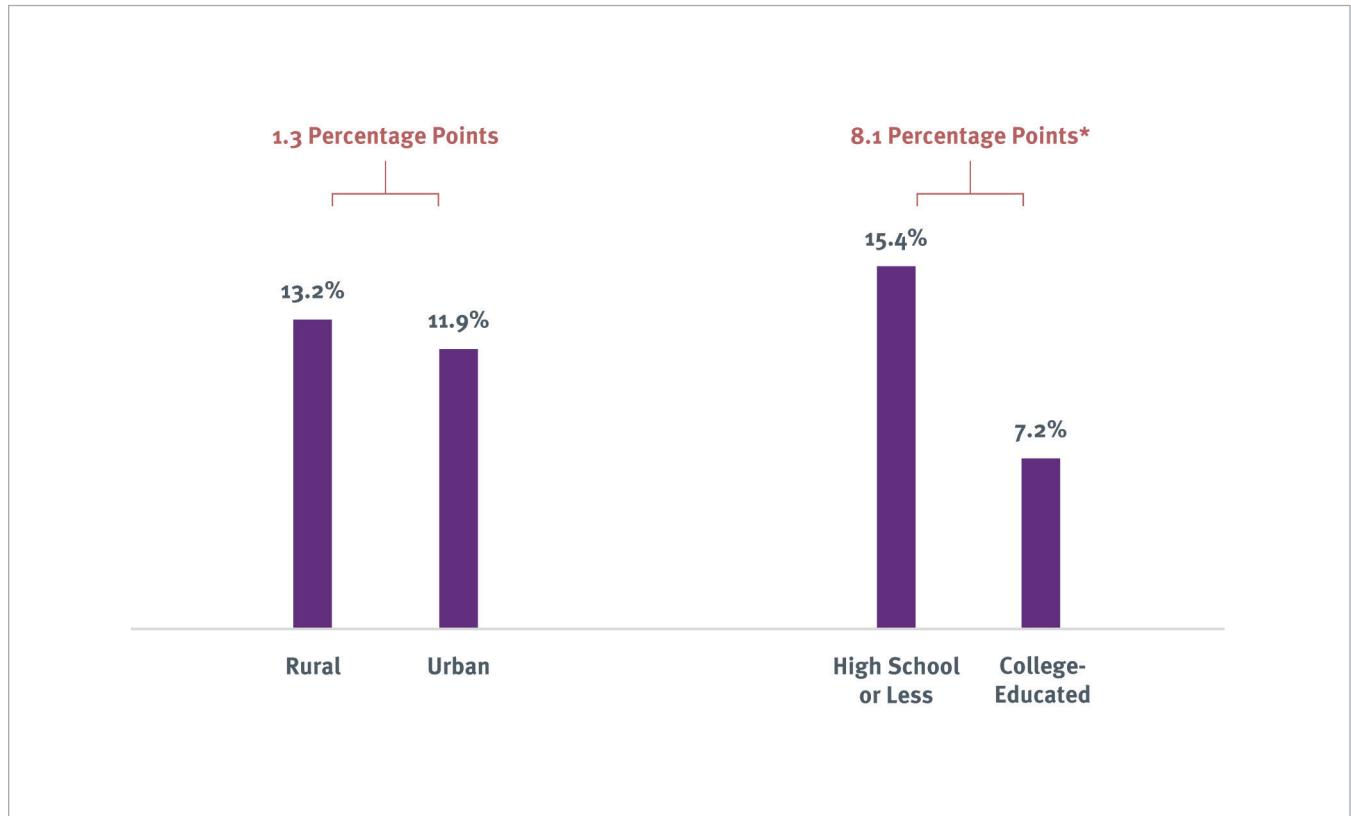
or more days of poor physical health the previous month (Figure 17). Serious mental health problems are 1.3 percentage points more common in rural than in urban areas (Figure 18). By contrast, working-class status, compared with having a college education, increases the likelihood of serious health problems by 9.2 percentage points for physical health and 8.1 percentage points for mental health.<sup>12</sup> Put simply, when it comes to the prevalence of serious health problems, rural residence matters, but class appears far more consequential.

**Figure 17. Adults under age 65 with 14 or more days of poor physical health the previous month: Differences between rural and urban adults and between working-class and college-educated adults: 2014-2016**



Source: Families USA-commissioned analysis of BRFSS data, 2014-2016. Note: Rural = non-MSA. Urban = central-city MSA.

**Figure 18. Adults under age 65 with 14 or more days of poor mental health the previous month: Differences between rural and urban adults and between working-class and college-educated adults: 2014-2016**



Source: Families USA-commissioned analysis of BRFSS data, 2014-2016. Note: Rural = non-MSA. Urban = central-city MSA.

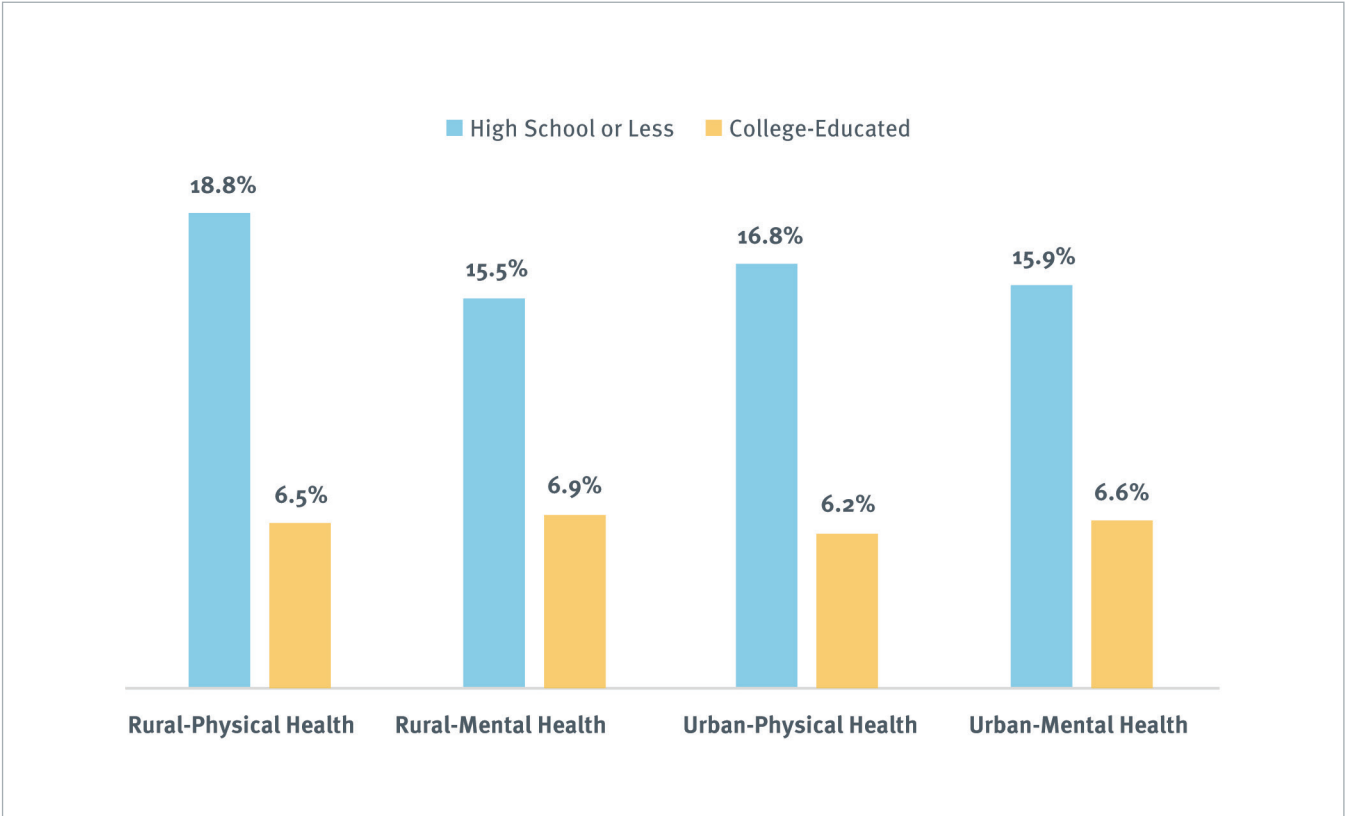
\*Due to rounding, the difference between the two groups may not equal the percentage-point difference shown.

The relative importance of class and place remains clear when one examines the prevalence of serious health problems among adults with intersecting characteristics. Compared to college-educated adults (Figure 19):

- » In rural areas, working-class adults are nearly three times as likely to experience serious physical health problems (18.8 percent vs. 6.5 percent) and more than twice as likely to experience serious mental health problems (15.5 percent vs. 6.9 percent).
- » In cities, working-class adults are more than twice as likely to experience either serious physical health problems (16.8 percent vs. 6.2 percent) or serious mental health problems (15.9 percent vs. 6.6 percent).

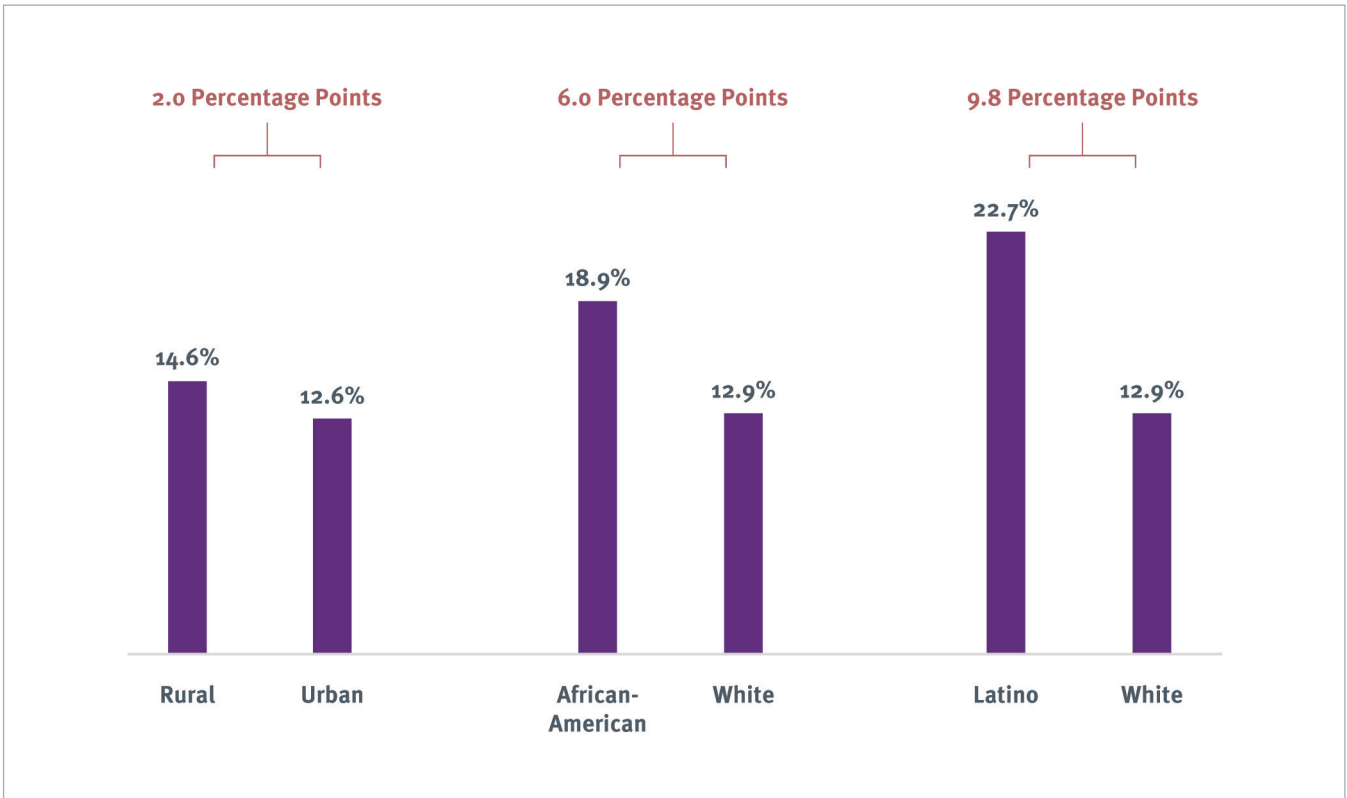


**Figure 19. Adults under age 65 with 14 or more days of poor health the previous month, by class, place of residence, and physical vs. mental health: 2014-2016**



Source: Families USA-commissioned analysis of BRFSS data, 2014-2016. Note: Rural = non-MSA. Urban = central-city MSA.

**Figure 20. Adults under age 65 who missed one or more physician visits per year because of cost: Percentage-point differences between rural and urban adults and between whites and people of color: 2014-2016**



Source: Families USA-commissioned analysis of BRFSS data, 2014-2016. Note: Rural = non-MSA. Urban = central-city MSA. Whites and African-Americans are non-Hispanic whites and blacks, respectively. Latinos are Hispanics of any race. The data used to produce the estimates in this figure do not include survey respondents whose MSA status is unknown.

### Missing Physician Visits Because of Cost

People in rural areas are more likely than those in cities to go without doctor visits because of cost. However, race and ethnicity have a much stronger association with this financial barrier to care. Residents of rural areas are 2.0 percentage points more likely than urban residents to go without care because of cost (Figure 20). But in comparison to white adults, African-Americans are 6.0 percentage points more likely and Latinos 9.8 percentage points more likely to encounter this financial access barrier.<sup>13</sup>

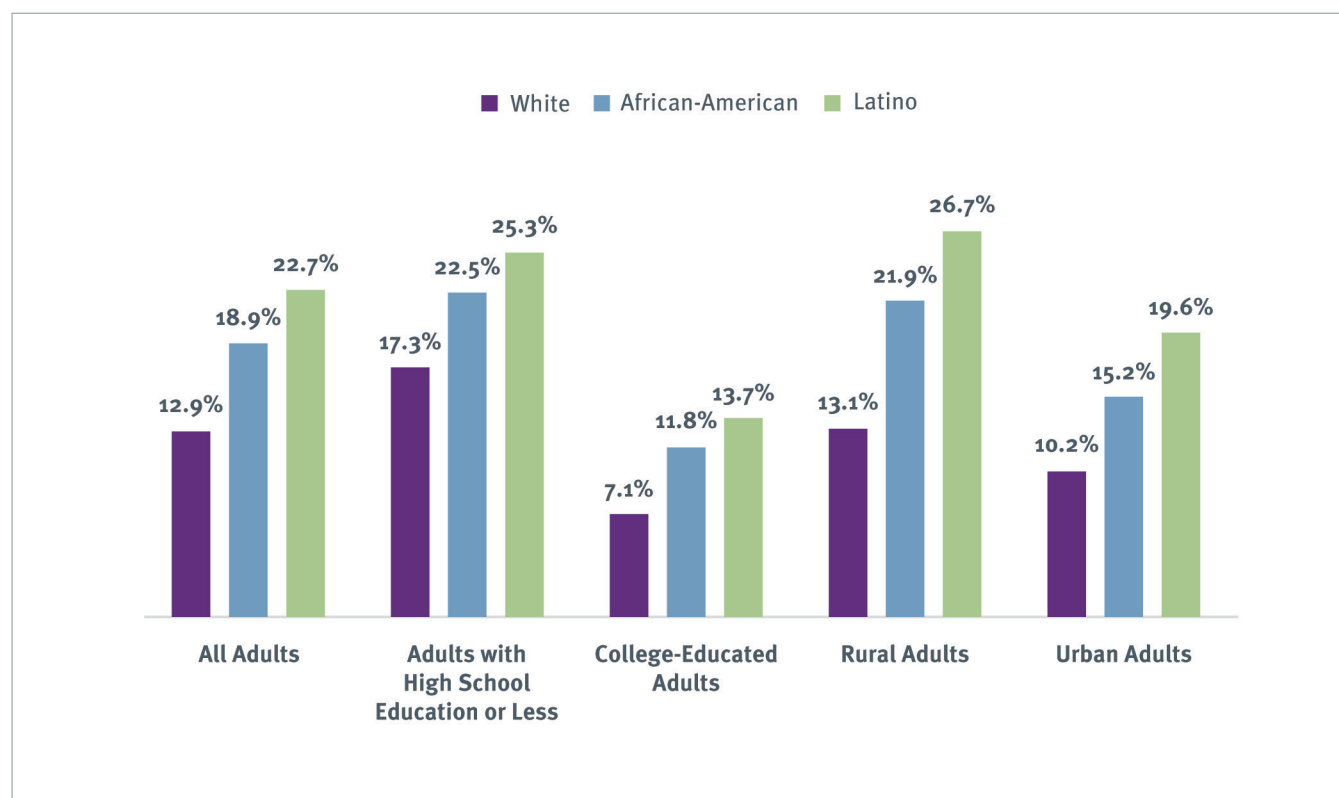
## People of Color More Likely to Face Challenges and Barriers, Even as Whites Comprise the Largest Affected Group

We explained earlier that, although the majority of working-class adults in the U.S. are white, working-class status is more likely for people of color than for whites. A similar trend is observed with people who miss one or more doctor visits during the year because of cost. People of color are much more likely than white people to encounter this access barrier, whether they are working-class or college-educated, and whether they live in urban or rural areas (Figure 21).

Taking residents of rural areas as an example, adults who went without physician visits because of cost comprised:

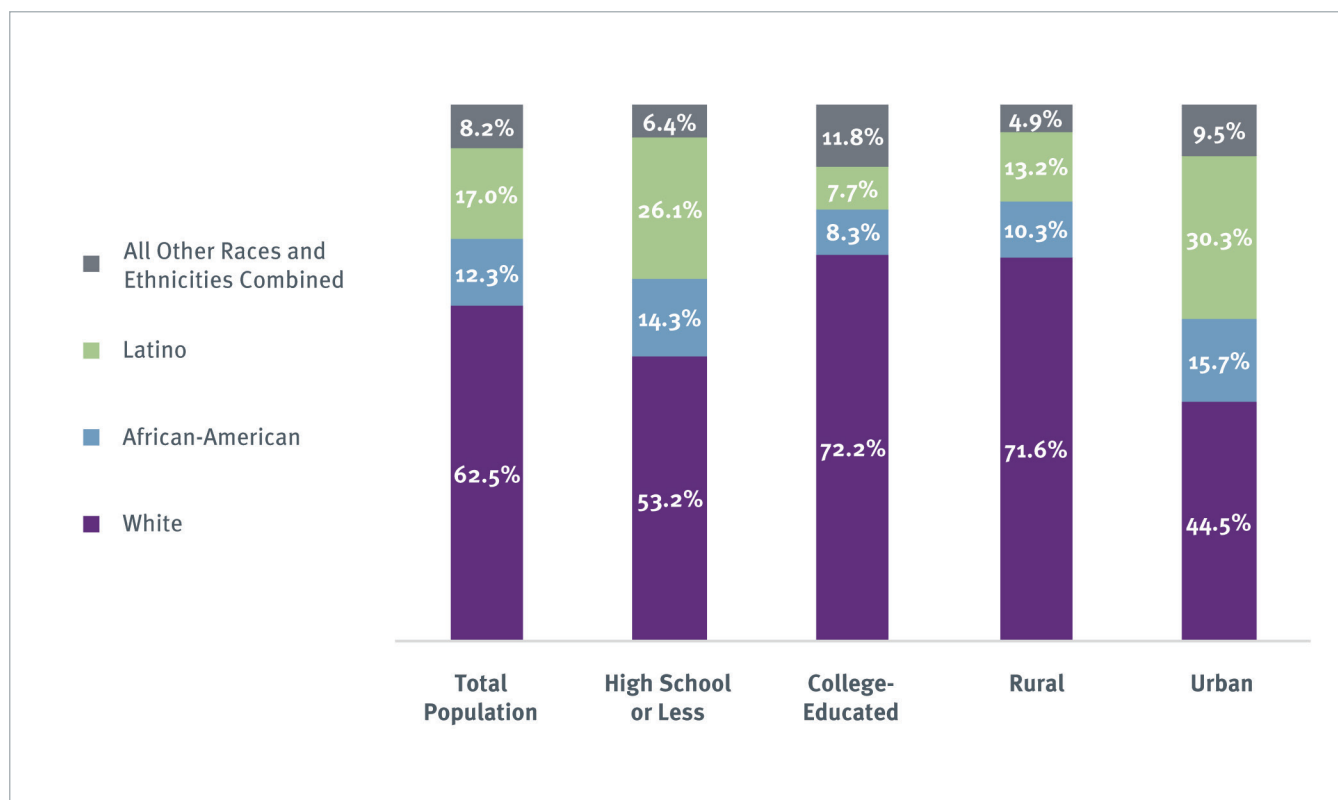
- » More than 1 in 8 whites (13.1 percent).
- » More than 1 in 5 African-Americans (21.9 percent).
- » More than 1 in 4 Latinos (26.7 percent).

**Figure 21. The percentage of adults under age 65 missing one or more doctor visits during the year because of cost, by race/ethnicity, class, and place of residence: 2014-2016**



Source: Families USA-commissioned analysis of BRFSS data, 2014-2016. Note: Rural = non-MSA. Urban = central-city MSA. Whites and African-Americans are non-Hispanic whites and blacks, respectively. Latinos are Hispanics of any race.

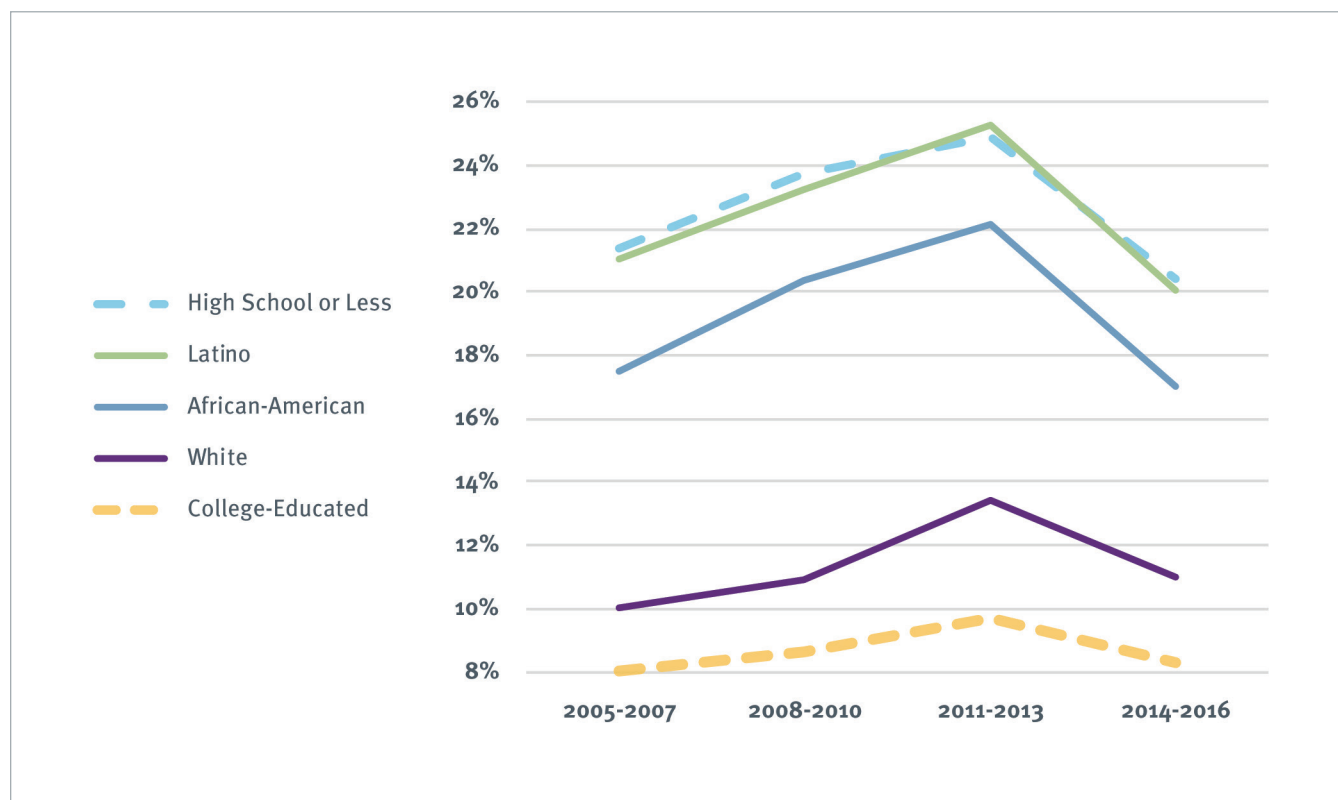
**Figure 22. Adults under age 65 missing one or more doctor visits during the year because of cost, by race/ethnicity, class, and place of residence: 2014-2016**



Source: Families USA-commissioned analysis of BRFSS data, 2014-2016, and Families USA analysis of 2017 CPS-ASEC data showing population characteristics in 2016. Note: Rural = non-MSA. Urban = central-city MSA. Whites and African-Americans are non-Hispanic whites and blacks, respectively. Latinos are Hispanics of any race. All other races and ethnicities combined are non-Hispanic adults who describe their race as something other than white or black.

Nevertheless, the largest group of people who go without physicians' services because of cost are white, regardless of class and place of residence, simply because whites are by far the country's largest demographic group. Even as African-Americans and Latinos in rural areas are substantially more likely than whites to miss physician visits because of cost, more than 7 in 10 adults (71.6 percent) who live in rural areas and encounter this access barrier are white (Figure 22).

**Figure 23. Percentage of adults under age 65 missing one or more doctor visits during the year because of cost, by race/ethnicity and class: 2005-2016**



Source: Families USA-commissioned analysis of BRFSS data, 2005-2016. Note: Whites and African-Americans are non-Hispanic whites and blacks, respectively. Latinos are Hispanics of any race.

Over time, the upward and downward trends in the likelihood of encountering financial barriers to care, as measured by this metric of financial access to care, are similar for many different demographic groups. From 2005-2007 to 2011-2013, the proportion of adults going without physician visits because of cost rose for whites and people of color, and for working-class and college-educated adults alike, until the ACA's main coverage provisions went into effect, after which fewer adults in each demographic category encountered this barrier (Figure 23).

## Conclusion

Few issues are as personal and consequential as health. Almost every family has members who experience serious health problems or encounter obstacles to obtaining necessary health care services. Even though these basic challenges are nearly universal, the U.S. health care system still struggles to provide high-quality, affordable, and equitable health care for all. Families throughout the country continue to grapple with difficult economic and social conditions that undermine rather than promote health and wellness.

Despite its responsibility for addressing these common challenges, our political system has failed to come together around core values of improving health and health care for all. Instead, political infighting and fractious rhetoric have forced the health and well-being of countless families to take a back seat in the national conversation. The racial components of this rhetoric misrepresent who our current system is failing, who benefits when economic and social conditions improve in ways that promote health and well-being, and who gains ground from more accessible, more affordable, higher-quality systems of coverage and care.

When it comes to health and health care, we are truly in this together, often facing common challenges that require common solutions. However, the relationships between health and health care, on the one hand, and race, place, class, and gender, on the other, are complex and multifaceted. As with racial and ethnic health inequities, the health problems of working-class adults, including the particularly severe problems encountered by working-class women, reflect a wide variety of social and economic determinants, apart from the access and quality of health care. Nevertheless, many strikingly diverse people across

the United States share common challenges when it comes to trying to navigate a health care system that, in many ways, is not designed to meet their needs.

Several years ago, our nation enacted its most important social solidarity legislation in decades, the ACA. Focused primarily on increasing health insurance coverage and, as a result, improving access to care, the law was associated with immediate improvements, not just in fewer financial barriers to care, but also in reversing the long-term growth in the prevalence of serious health problems. These improvements serve as a powerful reminder that meaningful progress is possible in addressing major national problems, but the remaining inequities show the need for further bold action, encompassing but also going far beyond improvements to health coverage and care.

Many of the health problems discussed in this report that grew steadily before 2014, that stabilized or receded after that, and that continue to persist (albeit at a slightly reduced level) have been widely shared across lines of ethnicity, class, place, and gender. Some people are more likely to be affected than others, but no demographic group is immune from challenges involving health and health care.

With both health care and the broader economic and social conditions that profoundly shape health and well-being, it is imperative for policymakers to take two paths at once: continuing our country's ongoing work to eliminate the serious racial, ethnic, and other health inequities that harm far too many people each and every day; while taking significant and broadly targeted steps that help families in need, wherever they live, however they work, and whoever they are.

## Acknowledgements

Families USA thanks Nicole L. Novak, Ph.D., for her tireless labors to analyze the data presented in this report. After receiving master's degrees from Oxford University in global health science and medical anthropology, she earned her doctorate in epidemiologic science from the University of Michigan-Ann Arbor. Dr. Novak currently works as a postdoctoral scholar at the Prevention Research Center of the University of Iowa. These institutions are listed for background information purposes only and had no role in the research undertaken by Dr. Novak, who did her work as an individual consultant.

Families USA also thanks The California Endowment for its support for the research described in this report. The California Endowment's mission is to expand access to affordable, quality health care for underserved individuals and communities and to promote fundamental improvements in the health status of all Californians. Neither Dr. Novak nor The California Endowment are responsible for the opinions expressed in this report, which are the author's.

## Methodological Appendix

Nicole L. Novak, Ph.D.

The data used to generate most figures in this report come from the Behavioral Risk Factor Surveillance Survey (BRFSS), an annual cross-sectional health survey sponsored by the Centers for Disease Control and Prevention (CDC) and other state and federal agencies. Extensive documentation of BRFSS is available on the CDC website. What follows is a brief overview of the data and analytic methods used for this report.

## Data

BRFSS is a state-based survey, so some aspects of the sampling design vary according to state priorities. Generally, BRFSS uses random-digit dialing to conduct hundreds of thousands of health surveys each year. The sampling frame draws from telephone numbers in each of the 50 U.S. states as well as the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands.

Sampling weights applied during analysis make estimates more representative of the total U.S. population. Prior to 2011, post-stratification weights were applied based on age, race and ethnicity, sex, and geographic region within a state. Beginning in 2011, BRFSS switched to a different weighting method, iterative proportional fitting, which uses age, sex, categories of ethnicity, geographic regions within states, marital status, education level, homeownership, and type of phone ownership. This new method of weighting accommodated the inclusion of participants with mobile phone numbers in addition to the traditional landline-based sampling.

## Variables Used

This report used information on participants' age, sex, race and ethnicity, and education. Data collection on race and ethnicity has changed multiple times over BRFSS' 34-year history. Because this report tracks trends over 20 years (1997-2016), we limit this analysis of racial/ethnic categories to those consistently classified over this period: non-Hispanic white, non-Hispanic black, and Hispanic. Participants also reported the highest grade or year of school they completed. Education was classified into three categories that were consistently available across the study period: high school or less (up to grade 12 or general equivalency diploma), some college or technical school (less than four years of college), and college graduate (four years or more of college).

All health outcomes variables were collected consistently over the study period. Every BRFSS survey asked respondents to report poor physical and mental health over the past 30 days using the following questions:

- » “Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?”
- » “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?”

These measures have been validated against other measures of health-related quality of life and have been shown to have good measurement properties across multiple populations and settings.<sup>14</sup> A cutpoint of 14 days was used to dichotomize responses to these questions, a cutpoint that has been used in numerous previous studies.<sup>15</sup>

Other variables included whether the participant was ever diagnosed with diabetes (except during pregnancy), whether a randomly selected child in the home had been diagnosed with asthma, and whether in the past 12 months the participant had been unable to see a doctor because of cost.

### **Analytic Approach**

Statistical analyses were conducted using Stata 15. Weighted means of each outcome variable were calculated for the total sample, and by subgroups of race/ethnicity, education, and by race/ethnicity groups within each education category. Weighted means were also calculated according to rural/urban status, and the intersection of rural/urban status with race/ethnicity and education.

### **Limitations**

The BRFSS survey has several strengths, including its consistency across time periods and a sampling strategy designed to generate estimates that are representative of the U.S. population. However, limitations do exist.

Any comparison of cross-sectional data over a 20-year period is vulnerable to some changes in data collection, which may limit comparisons between years. The changes in BRFSS sampling design in 2011 mean we should use caution in interpreting comparisons of outcomes before and after this year and should corroborate these findings with data from other population-based samples. Furthermore, although BRFSS consistently produced variables classifying participants as non-Hispanic white, non-Hispanic black, or Hispanic, changes in the way race/ethnicity questions were asked or changes in public understanding of these categories may limit comparisons between years.

Self-reported data on diabetes and asthma are also vulnerable to diagnostic bias. Individuals with lower levels of health care access or health care literacy may be less likely to report being diagnosed with a chronic condition on a health survey.

For some respondents, BRFSS data show age, gender, race, and ethnicity, but do not show whether they reside in a central city of a metropolitan statistical area (MSA), a noncentral city of an MSA, or outside all MSAs. We included these records in developing estimates involving age, gender, race, and ethnicity without regard to place of residence. In developing estimates for groups defined by place of residence, we used only records where place of residence was known.



## Endnotes

<sup>1</sup> Centers for Disease Control and Prevention. (2014, May 16). Behavioral Risk Factor Surveillance System. Retrieved October 4, 2018, from <https://www.cdc.gov/brfss/about/index.htm>.

<sup>2</sup> Based on Families USA analysis of data from the Current Population Survey – Annual Social and Economic Supplement (CPS-ASEC), among college-educated adults under age 65 in 2016, 93 percent of non-Hispanic whites, 81 percent of non-Hispanic blacks, and 55 percent of Hispanics were born in the U.S.; and among those with no more than a high school education, adults born in the U.S. comprised 96 percent of non-Hispanic whites, 89 percent of non-Hispanic Blacks, and 38 percent of Hispanics.

<sup>3</sup> Additional tabulations are available upon request.

<sup>4</sup> Our most likely data source for the first two topics would be the National Health Interview Survey (NHIS). Although NHIS makes data separately available for multiple ethnic categories and provides information about nativity and citizenship, it does not show residence by MSA status. For information about the impact of LGBTQ status on health and access to care, we could potentially use BRFSS data from the states that collect this information.

<sup>5</sup> The report's discussion of diabetes and childhood asthma, as measures of health status showing how serious health problems are sometimes more closely associated with race than class, illustrates how widening the metrics under examination can help paint a more complete picture. To illustrate the potential usefulness of adding other access measures, as well as the in-depth analytic work that would be required to provide solid explanations, our preliminary analysis of BRFSS and NHIS data found that the percentage of working-class adults without a regular source of care has risen and fallen several times in recent decades, rather than having risen steadily through 2013; and for both working-class and college-educated adults, African-Americans are less likely than whites and Latinos to go without a checkup for at least two years and, among women, more likely to have a mammogram after age 50.

<sup>6</sup> McGinnis, J.M., Williams-Russo, P., & Knickman, J.R. (2002). The case for more active policy attention to health promotion. *Health Affairs* 21(2), 78-93. <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.21.2.78>.

<sup>7</sup> New Local Government Network. (2012, May). *Healthy places: Councils leading on public health*. London: Kuznetsova, D. Retrieved October 3, 2018, from [http://www.nlgn.org.uk/public/wp-content/uploads/Healthy-Places\\_FINAL.pdf](http://www.nlgn.org.uk/public/wp-content/uploads/Healthy-Places_FINAL.pdf).

<sup>8</sup> Sommers, B.D., Gawande, A.A., & Baicker, K. (2017, August 10). Health insurance coverage and health—What the recent evidence tells us. *New England Journal of Medicine* 377, 586-593.

<sup>9</sup> Because of rounding, products reported in the text may differ from the result of multiplying factors stated in the text. Similar rounding effects affect other arithmetic operations.

<sup>10</sup> To illustrate how we derived these proportions from Figure 12, consider the bars for urban whites. Reducing 17.3 percent by 62 percent yields 6.6 percent ( $0.173 - (0.173 \times 0.62) = 0.066$ ).

<sup>11</sup> Asthma rates are roughly comparable for the children of college-educated Latinos (7.6 percent) and working-class whites (8.6 percent). While asthma rates for Latino children as a whole are only moderately higher than among whites, Puerto Rican children in particular fare much worse, with a prevalence rate 80 percent higher than for white children (Centers for Disease Control and Prevention. (2018, May 15). Most recent asthma data. Retrieved October 3, 2018, from [https://www.cdc.gov/asthma/most\\_recent\\_data.htm](https://www.cdc.gov/asthma/most_recent_data.htm)) and nearly quadruple the death rate (Akinbami, L. (2010, April 06). Asthma prevalence, health care use and mortality: United States, 2003-05. National Center for Health Statistics, Centers for Disease Control and Prevention. Retrieved October 3, 2018, from <https://www.cdc.gov/nchs/data/hestat/asthma03-05/asthma03-05.htm>). Our data source for rates of childhood asthma as shown in the text, BRFSS, did not allow for this level of disaggregation by racial and ethnic subgroup.

<sup>12</sup> In terms of relative proportions, the difference in magnitude becomes even starker. Serious physical health problems were reported by 11.9 percent of center-city residents and 13.2 percent of people living outside MSAs. The second figure is 1.3 percentage points higher, as noted in the text, but 11 percent higher, in relative terms. Serious physical health problems are reported by 7.2 percent of college graduates and 15.4 percent of people with a high school education or less. The latter figure is 8.1 percentage points higher, as stated in the text, but in relative terms it is 112 percent higher. The proportions reporting serious mental health problems are 12.0 percent in urban and 14.8 percent in rural areas, which is a 2.8 percentage-point difference (noted in the text) and a 23 percent relative difference. By contrast, those problems are experienced by 5.5 percent of college-educated adults and 14.7 percent of those with a high school education or less, which amounts to a 9.2 percentage-point difference but a 169 percent relative difference.

<sup>13</sup> The stronger association with race and ethnicity becomes even more apparent when one makes comparisons in relative rather than percentage-point terms. The proportion of adults going without one or more physician visits due to cost was 12.6 percent in urban and 14.6 percent in rural areas—a 2.0 percentage-point difference, as noted in the text, but a 16 percent relative difference. Among non-Hispanic whites, non-Hispanic blacks, and Hispanics, the proportions reporting this access barrier were 12.9 percent, 18.9 percent, and 22.7 percent, respectively. Accordingly,

the proportion was 6.0 percentage points higher among non-Hispanic blacks than non-Hispanic whites, amounting to a 47 percent relative difference. The proportion among Hispanics was 9.8 percentage points higher than among non-Hispanic whites, amounting to a 76 percent relative difference.

<sup>14</sup> Moriarty, D.G., Zack, M.M., & Kobau, R. (2003, September 2) The Centers for Disease Control and Prevention's Healthy Days Measures – Population tracking of perceived physical and mental health over time. *Health and Quality of Life Outcomes* 1, 37.

<sup>15</sup> Bensley, L., Van Eenwyk, J., & Simmons, K.W. (2003, July). Childhood family violence history and women's risk for intimate partner violence and poor health. *American Journal of Preventive Medicine* 25(1), 38-44; Hassan, M.K., Joshi, A.V., Madhavan, S.S., & Amonkar, M.M. (2003, October) Obesity and health-related quality of life: A cross-sectional analysis of the US population. *International Journal of Obesity* 27(10), 1227-1232.





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