

Alameda County Public
Health Department

Alameda County Health Status Report 2006



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Comments, questions, and requests for additional copies can be directed to:

Community Assessment, Planning, Education,
and Evaluation (CAPE) Unit

Alameda County Public Health Department
1000 Broadway, Suite 500
Oakland, California 94607
(510) 267-8020
www.acphd.org

Sandra Witt, Dr.P.H.
CAPE Director

Tony Iton, M.D., J.D., MPH
Health Officer

Arnold Perkins, Director
Public Health Department

David Kears, Director
Health Care Services Agency

Cover mural from Santa Fe Elementary School, Oakland California



**ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT**

David J. Kears, Director
Arnold Perkins, Director

1000 Broadway, 5th Floor
Oakland, CA 94607
(510) 267-8000

Anthony B. Iton, M.D., J.D., MPH
County Health Officer

May, 2006

Dear Alameda County Residents,

Welcome to the Alameda County Public Health Department's 2006 County Health Status Report. As you delve into this comprehensive report, you will see that the trends in the data are simultaneously reassuring and alarming. By and large, Alameda County residents are living longer, healthier lives. Rates of death and illness from most all of the major diseases, including heart disease, stroke, and cancer, are on the decline. Rates of most infectious diseases also continue to fall. Life expectancy in Alameda County has increased by about four years during the past decade alone. Life expectancy increases were seen in every race/ethnic group: 4 years for Asian/Pacific Islanders, and roughly 3 years for Whites, African Americans, and Latinos.

Despite these encouraging improvements, we continue to observe large and persistent disparities in health based on race, income, neighborhood, education, and other so-called social determinants. There is even some evidence that these health disparities are worsening. The gaps between Alameda County's *haves* and the *have-nots* increased during the decade of the nineties. We have an increasing concentration of wealth, decreasing affordability of housing, increasing school segregation, and a disproportionate growth in non-living wage jobs. These worsening social inequities have direct and profound consequences on our residents' health. While significant health disparities can be found that afflict almost every racial and ethnic group, the magnitude of racial health disparities in Alameda County is most profound for African-Americans, Latinos, Pacific Islanders, and Native Americans. It is clear that new strategies and solutions are desperately needed.

The root causes of health disparities are complex and closely tied to similar persistent racial and class disparities in education, employment, income, and housing that so thoroughly characterize our society and continue to challenge our deeply held commitment to social justice. It is this relatedness to other social inequities and our recognition of their inherent injustice that leads us to regard them as *health inequities*, rather than health disparities. Eliminating health inequities will require sophisticated and sustained multi-disciplinary interventions. These must simultaneously address both the conditions in our low-income neighborhoods and the inequitable policies that

continue to systematically deprive the residents of these neighborhoods of access to critical social goods such as good schools, better jobs, safe recreational space, clean air, and less crime. We have begun to create such interventions on a small scale and believe that they will soon begin to reap health benefits. We invite your input and guidance.

I am very proud of the hard-working and talented people who labored long hours to put this report together and ensure that it is accurate and relevant to the needs of our community partners. Particular credit must be given to Dr. Sandra Witt, the Director of our Community Assessment, Planning, Education and Evaluation (CAPE) Unit and her dedicated team. Her commitment to high epidemiologic standards and clarity in presentation make this report an extremely valuable tool for our community partners. The enduring vision for this report derives from our Agency Director, Dave Kears, and our Public Health Director, Arnold Perkins. Their commitment to putting the *public* back in public health has driven our efforts to make these reports useable and pertinent to the needs of the residents, community-based organizations, and other stakeholders that make up this wonderful and diverse county.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Tony Iton', is positioned above the typed name.

Tony Iton, M.D., J.D., MPH
Alameda County Health Officer

Acknowledgments

This report was produced by:

The Alameda County Public Health Department, Office of the Director
Community Assessment, Planning, and Education (CAPE) Unit

Director

Sandra Witt

Editor

Jane Martin

Authors

Jane Martin
Matt Beyers
Sangsook Cho
Janet Brown
Elaine Bautista
Neena Murgai
Tony Iton
Liz Maker

Reviewers and Contributors

Kathi Schaff	Sandi Galvez
Kelly Nanney	Sonia Jain
Katie Vu-Ng	Darlene Wong
Mia Luluquisen	Sherri Willis

Other Contributors

Division of Community Health Services

Kimi Watkins-Tart	Jared Fine
Diane Woloshin	Linda Franklin
Brenda Yamashita	Paul Cummings

Division of Communicable Disease Control and Prevention

Barbara Allen	Barbara Green-Ajufo
Gay Calhoun	Alison James
Leslie Greenwood	

Division of Emergency Medical Services

Michael King	Francell Haskins
Mona Mena	Marla Blagg

Division of Family Health Services

Marge Deichman	Jean Hansen
Quamrun Nessa	

Office of AIDS

Ron Person

Tuberculosis Control Program

Sheila Proctor	Bob Benjamin
Kathy Ahoy	

Dedication

This book is dedicated to Arnold Perkins, Director of Alameda County Public Health Department, who will retire this year. It is through Mr. Perkins' vision of monitoring the health status of county residents and examining health inequities that the County Health Status Report has been produced, now for the third time since 1999. His vision, dedication, perseverance, and compassion have compelled the Public Health Department to work in close partnership with our diverse communities to improve health for all. Mr. Perkins is a beloved colleague and mentor to all who work in the Public Health Department, the Health Care Services Agency, and the community.



EXECUTIVE SUMMARY

Introduction

The 2006 Alameda County Health Status Report shows sustained improvements in the county population for many health indicators over the past decade. This is good news. And yet while overall health has improved, serious health inequities persist.

The mission of the Alameda County Public Health Department (ACPHD) is to work in partnership with the community to ensure optimal health and well-being of all people. Improving health and well-being calls for active participation from many. We believe that informed public health agencies and their constituencies must be committed to a broad array of activities to change the social, economic, and environmental conditions that will lead to the improved health and well-being of our residents and the elimination of health inequities.

Health inequities are defined as “differences in health that are unnecessary, avoidable, unfair and unjust.”¹ Another definition describes health inequities as “material, social, gender, racial, income, and other social and economic inequalities that are beyond the control of individuals and are therefore considered unfair and unjust.”² Health status and health inequities are shaped by a wide range of factors in the social, economic, natural, built, and political environments.³ Many studies have linked race/ethnicity, income and education with health. Poor people and people of color are more likely to be burdened by substandard housing, poor schools, pollution and public policy decisions that contribute to health risks.⁴⁻⁷

This report describes the health status of county residents by examining a wide range of social, demographic and health indicators including leading causes of death and chronic diseases, maternal and child health, injury and violence, and communicable diseases. Data sources include birth, mortality, hospitalization, cancer and communicable disease incidence, in addition to the census. All health indicators are examined by gender, race/ethnicity, and age. Trends over time and the geographic distribution of selected indicators are also examined. Current health status is compared to California rates and to Healthy People 2010 national objectives⁸ where possible. The report then describes the Department’s current programs and future plans to improve community health.

Two tables detailing the status of Alameda County residents by each health indicator are presented at the end of the executive summary. These are followed by written description of key findings. The first table shows that the county as a whole has met the Healthy People 2010 objectives for three health indicators—coronary heart disease mortality, motor vehicle crash mortality, and early prenatal care. This is up from just one indicator three years ago. However, the majority of Healthy People 2010 objectives have not been met, either at the county level or at the level of individual race/ethnic or gender groups. The second table summarizes trends from 1990 onward for each health indicator. It shows trends for the county overall and for each race/ethnic group. It also shows, in general, whether health

inequities are growing or diminishing.

The Findings

Inequities in income and education level persist in Alameda County. Poverty has changed little since 1990. Approximately 14% of Alameda County children under 18 live in poverty. The income distribution is becoming more skewed than in the past, with the rich having much more income than the poor. While we know that safe, affordable housing is linked to good health, 31% of owner-occupied households in Alameda County spend more than 30% of their income on housing, and 21% of renters spent 50% or more of their income on rent. Crime rates are down since the mid-1990s. Most of the projected growth in jobs will be in those that do not pay a living wage.

African Americans bear the burden of the greatest health inequities. Among Alameda County's race/ethnic groups, African Americans fair the poorest on most key measures of morbidity and mortality examined in this report. They have the highest rate of death from all causes, as well as the highest rates of both death and illness from coronary heart disease, stroke, lung cancer, prostate cancer, asthma, motor vehicle crashes, and homicide/assault. African Americans also have the highest rates of new AIDS cases, diabetes hospitalizations, and deaths from unintentional injury, all cancer, breast cancer, and colorectal cancer. Infant mortality, low birth weight, and low childhood immunization rates also take their greatest toll on African Americans.

Inequities exist for other race/ethnic groups as well. Native Hawaiian/Pacific Islanders have the highest rate of diabetes mortality and the lowest rate of early prenatal care. Latinas have the highest rate of births to teenagers. Asian/Pacific Islanders have the highest rate of tuberculosis. Whites have the highest rates of suicide, all-cancer, breast and colorectal cancer incidence, and hospitalization for both self-inflicted and unintentional injury.

Gender inequities also exist in Alameda County. Males die at an earlier age and have significantly higher rates of illness and death than do females for almost all the indicators examined, most notably coronary heart disease, all cancer, lung cancer, colorectal cancer, childhood asthma and most forms of injury. Females have higher rates of hospitalization due to suicide attempts, as well as higher rates of chlamydia.

African Americans not only have the highest rates on most indicators, but for several of these, the size of the gap has grown over the past decade. In other words, even though rates of morbidity and mortality are improving, they are improving faster for other race/ethnic groups than for African Americans. African American health inequities are growing for overall mortality and for mortality from heart disease, stroke, all cancer, lung cancer, breast cancer, and new AIDS cases. Heart disease, cancer and stroke are the leading causes of death. These diseases kill the largest numbers of people regardless of race, and in Alameda County they kill greater proportions of African Americans than other race/ethnic groups.

An inequity also exists for teen births; the Latina rate has not declined while those in other race/ethnic groups have, leading to an increase in the gap between Latinas and the county overall. For Whites, too, inequities in breast cancer incidence and self-inflicted injury hospitalization have grown.

Mortality and life expectancy have improved more for Whites than for African Americans. In the

mid-1960s African Americans and Whites in Alameda County had roughly the same rates of death from all causes. White death rates have declined more steeply than African American rates, and in 2000 the African American rate of death from all causes was 40% higher than Whites.

It is clear that wealthier people living in the Oakland Hills live longer than poorer people living in the flatlands. It is also clear that the poorer the neighborhood in general, the higher the chances of dying; mortality increases with increasing neighborhood poverty level. This phenomenon is uniformly true for African Americans and Whites for the health outcomes we examined but not always true for Latinos or Asians.

Rates of all-cause mortality and coronary heart disease mortality among both African Americans and Whites increase with each increase in poverty level. However, while African American rates are highest at the lowest poverty level, at the highest poverty level White rates surpass African American rates. Latino mortality rates are constant across poverty levels, a phenomenon seen in state and national data and often referred to as “the Latino paradox.”⁹ A similar pattern is seen for Asians, with one exception; all-cause mortality among Asians increases at the highest poverty level. Patterns of lung cancer incidence reflect a similar social gradient for the different race/ethnic groups except that African American rates remain substantially higher than White rates at all poverty levels.

A clear social gradient is seen for every race/ethnic group when teen birth rates are examined; they increase with every increase in neighborhood poverty level. Most notably, Latina rates jump two-fold between the lowest and highest poverty levels, and White rates jump over ten-fold. The increase among Whites between the two highest poverty levels alone was three-fold, suggesting that teenage Whites living in the poorest neighborhoods are at particularly high risk of early pregnancy.

What Do We Need To Do?

That the poor and people of color fair so much worse on a variety of health measures than those who are White and not poor suggests that Alameda County has not done enough to address the root causes of health inequities. While we continue to provide important services and interventions to address health and disease, we need to do more to affect key policy issues around educational and income inequities to improve health for the poor and people of color. In addition, we must employ community capacity building efforts to support changing those broad health conditions beyond individual behavior or control.

The Alameda County Public Health Department is currently working on several groundbreaking strategies, including community capacity-building, collaboration across agencies, and neighborhood demonstration projects. Community capacity-building involves viewing communities and residents as potential resources for change, rather than as passive recipients of services. Residents possess many skills and strengths that they can use to improve the quality of life in their neighborhoods.¹⁰

In addition, the ACPHD is working internally, and with a variety of outside partners, to incorporate additional community capacity building approaches in their work. Through innovation and sustained active partnerships with residents, we can reduce the health and social inequities in Alameda County and continue health improvements for all.

Key Health Indicator Summary by Race/Ethnicity and Gender, Alameda County

Indicator		Healthy People 2010 Objective	Year(s)	County Rate	Race/Ethnicity										Male
					African American	American Indian	Asian	Native Hawaiian, Pac Islander	Latino	White	Multirace	Female			
All-cause Mortality		X	2001-03	742.2	1,125.4	444.5	451.8	818.2	597.2	790.6	180.9	633.6	884.1		
Coronary Heart Disease		166.0 or less	2001-03	160.3	● 235.5	★	97.4	● 187.2	119.2	● 172.0	40.1	131.4	● 198.2		
Stroke		48.0 or less	2001-03	63.1	● 95.2	★	● 51.4	● 75.0	● 54.4	● 60.6	19.7	● 61.5	● 64.1		
Diabetes		X	2001-03	495.5	842.9	68.6	342.7	381.4	464.1	464.1	X	464.9	534.7		
All Cancer		X	2001-03	22.7	45.9	★	16.9	55.6	32.4	17.9	★	20.5	25.9		
Lung Cancer		X	2001-03	1,129.2	2,164.0	207.4	735.3	1,271.6	938.4	938.4	X	1,110.8	1,154.2		
Female Breast Cancer		159.9 or less	2001-03	178.2	● 258.1	100.1	110.7	● 170.6	126.7	● 199.2	34.5	151.8	● 216.8		
Prostate Cancer		X	2000-02	478.2	504.1	★	308.1	428.0	547.7	547.7	X	436.4	543.0		
Colorectal Cancer		44.9 or less	2001-03	47.4	● 76.1	★	28.3	★	22.9	● 53.8	★	37.3	● 60.9		
Asthma (All ages)		X	2000-02	60.0	85.4	★	37.3	43.6	65.6	65.6	X	48.5	75.8		
Asthma (<5 years)		22.3 or less	2001-03	24.5	● 35.1	★	12.2	★	16.2	● 29.0	★	● 24.5	X		
Asthma (>5 years)		X	2000-02	161.3	146.6	★	105.1	133.7	194.2	194.2	X	161.3	X		
Chronic Disease		28.8 or less	2001-03	30.2	● 66.9	★	11.1	★	21.5	● 30.9	★	X	● 30.2		
Chronic Disease		X	2000-02	167.3	220.3	★	92.9	146.9	178.2	178.2	X	X	167.3		
Chronic Disease		13.9 or less	2001-03	17.9	● 25.8	★	13.8	★	11.2	● 19.2	★	● 15.8	● 20.3		
Chronic Disease		X	2000-02	50.6	51.3	★	45.4	51.0	51.9	51.9	X	42.2	61.4		
Chronic Disease		X	2001-03	1.9	3.3	★	2.5	★	1.4	1.4	★	1.7	2.3		
Chronic Disease		X	2001-03	161.4	417.2	26.5	79.0	120.9	112.3	112.3	X	168.4	150.8		
Chronic Disease		250.0 or less	2001-03	683.2	● 1,573.2	★	● 304.3	● 565.4	● 424.1	● 424.1	X	● 477.7	● 880.8		

Healthy People 2010 Objective		Year(s)	County Rate	African American	American Indian	Asian	Native Hawaiian, Pac Islander	Latino	White	Multirace	Female	Male	
Indicator	Objective												
Maternal and Child Health	Infant Mortality	4.5 or less/ 1,000 live births	● 4.9	● 11.7	4.2	3.5	★	4.3	3.6	★	X	X	
	Low Birth Weight	5.0% or less of live births	● 7.0	● 12.4	● 6.7	● 7.1	● 6.0	● 5.5	● 5.9	● 9.1	X	X	
	First Trimester Prenatal Care	90% or more of live births	90.7	● 88.6	● 85.2	92.0	● 76.8	● 87.5	94.2	● 89.9	X	X	
	Teenage Births (Age 15-19) †	X	31.0	48.8	22.2	8.1	39.1	65.8	12.9	12.4	X	X	
	Childhood Immunization	90% of all children by age 2	● 78.5	● 59.5	★	● 79.3	★	● 70.5	● 78.7	★	★	★	
	Unintentional Injury	Mortality	17.5 or less	● 24.2	● 39.6	★	17.0	★	● 23.0	● 24.7	★	14.9	● 34.8
		Hospitalization	X	396.6	423.2	61.9	171.0		313.6	477.6	X	361.9	414.1
	Motor Vehicle Crash	Mortality	9.2 or less	7.6	● 10.9	★	7.9	★	8.8	6.5	★	4.0	● 11.4
		Hospitalization	X	77.7	100.0	20.7	32.4		66.5	85.6	X	54.1	101.6
	Homicide/ Assault	Mortality	3.0 or less	● 8.2	● 40.0	★	2.5	★	● 5.4	2.1	★	2.7	● 13.6
Hospitalization		X	37.0	116.6	★	8.4		34.7	20.7	X	9.5	64.5	
Suicide/Self-Inflicted Injury	Mortality	5.0 or less	● 8.2	● 5.7	★	3.8	★	4.9	● 12.5	★	3.5	● 14.0	
	Hospitalization	X	26.8	28.9	★	10.8		15.4	40.4	X	33.5	20.5	
AIDS	1.0 or less	2002-04	● 13.0	● 49.0	★	● 1.9	● 11.9	● 8.4	● 8.4	X	● 6.1	● 20.1	
Gonorrhea	X	2002-04	116.9	X	X	X	X	X	X	X	115.9	116.0	
Chlamydia	X	2002-04	324.5	X	X	X	X	X	X	X	492.1	150.1	
TB	1.0 or less	2002-04	● 12.4	● 12.8	★	● 32.2	● 10.3	● 1.9	● 1.9	X	● 10.8	● 14.1	

● HP2010 objective not met; X Data not available or applicable; ★ Rate cannot be calculated due to small numbers; † Rates are per 1,000 females aged 15 to 19.

Note: Unless otherwise stated, rates are per 100,000 population and are annual averages. Rates for chronic disease and injury are age-adjusted by the direct method to US 2000 standard population. Healthy People 2010 Objectives are not available for many indicators. Also, rates for death and birth data show Asians and Native Hawaiian/other Pacific Islanders separately. Rates for all other indicators combine the two groups as Asian/Pacific Islander.

Trends for Key Health Indicators, Alameda County

Indicator		Trend Overall	Health Inequity ¹	African American	Asian/API	Latino	White
All-cause Mortality		→	←	→	→	↔	→
Coronary Heart Disease	Mortality	→	←	→	→	↔	→
	Hospitalization	→	→	↔	↔	↔	→
Stroke	Mortality	→	←	↔	→	↔	→
	Hospitalization	→	←	↔	↔	↔	→
Diabetes	Mortality ²	↔	↔	←	↔	←	↔
	Hospitalization	←	↔	↔	↔	←	←
All Cancer	Mortality	→	←	→	→	→	→
	Incidence ³	→	←	→	→	→	→
Lung Cancer	Mortality	→	←	↔	↔	↔	→
	Incidence	→	↔	→	→	→	→
Colorectal Cancer	Mortality	→	↔	→	↔	→	→
	Incidence ³	→	↔	→	↔	↔	→
Female Breast Cancer	Mortality	→	←	↔	→	↔	→
	Incidence ³	↔	←	↔	↔	↔	←
Prostate Cancer	Mortality	→	↔	↔	→	↔	→
	Incidence	↔	↔	→	↔	↔	↔
Asthma Hospitalization (All Ages)		→	↔	→	→	→	→
Asthma Hospitalization (<5 years)		↔	↔	↔	→	↔	↔

Chronic Disease

Indicator		Trend Overall	Health Inequity ¹	African American	Asian/API	Latino	White	
Maternal and Child Health	Infant Mortality	➔	↔	➔	➔	➔	➔	
	Low Birth Weight	↔	➔	➔	➔	↔	➔	
	First Trimester Prenatal Care ²	➔	➔	➔	➔	➔	➔	
	Teenage Births (Age 15-19) ⁴	➔	➔	➔	➔	↔	➔	
Injury	Unintentional Injury	Mortality	↔	↔	↔	↔	↔	
		Hospitalization ³	➔	➔	➔	➔	➔	
	Motor Vehicle Crash Mortality	Mortality	➔	↔	➔	↔	↔	➔
		Hospitalization	➔	↔	➔	➔	↔	➔
	Homicide ⁵ /Assault	Mortality	➔	↔	➔	➔	➔	➔
		Hospitalization	➔	➔	➔	➔	➔	➔
	Suicide/Self-Inflicted Injury	Mortality ³	➔	↔	↔	↔	↔	➔
		Hospitalization ³	➔	➔	➔	➔	↔	↔
Communicable Disease	AIDS	➔	➔	➔	➔	➔	➔	
	Gonorrhea	↔						
	Chlamydia	➔						
	TB	➔						

➔ increasing (upward) trend; ➔ declining (downward) trend (or improving ➔ trend); ↔ inconclusive; variable; no clear trend

Notes: American Indians are not presented because of small numbers. 1. Health inequity is measured by the gap between the group with the highest rate and the Alameda County rate. Unless otherwise stated, African Americans were the group with the highest rates; 2. NHOPIs had the highest rate; however, since the group is not shown here, health inequity measurement is based on the group with the second highest rate; 3. Rates highest among Whites; 4. Rate highest among Latinas; 5. Recent increases since 2000, despite downward trends.

Summary of Key Findings

Demographics

- The number of Whites has declined since 1970 and is predicted to continue declining. Latinos and APIs will continue to increase.
- While 11% of all persons in Alameda County lived in poverty in 1999, 21.2% of African Americans lived in poverty. Only 5.9% of Whites lived in poverty.
- In the county, 82.4% of all persons 25 years and over had a high school degree or equivalent. The figure decreases to only 55.9% for Latinos.

Health Inequities

- While mortality rates overall have declined in the past 40 years, the inequity in mortality between Whites and African Americans has grown larger.
- In the early 1960s, African Americans in Alameda County had a mortality rate similar to Whites. By 2000, the African American rate was 42% higher than the White rate.
- Except for Latinos, the mortality rate for each race/ethnicity increases with neighborhood poverty level.
- In the lowest poverty neighborhoods, African Americans have a far higher mortality rate than other groups. In the highest poverty neighborhoods, Whites are the highest.

Death From All Causes

- About 9,600 residents die each year in Alameda County. Nearly 60% of these die from three causes: heart disease, cancer, and stroke. These three leading causes of death were the same for both males and females.
- Heart disease, cancer, and stroke are the three leading causes of death for all race/ethnic groups except American Indians and Asians. For American Indians, the leading causes of death are cancer, heart disease, liver cirrhosis, diabetes, and chronic lower respiratory diseases. For Asians, they are cancer, heart disease, and stroke.
- Unintentional injury is the leading cause of death among young people 1-14 years of age and among adults 25-44 years of age. Among 15-24 year-olds, homicide is the leading cause of death followed by unintentional injury.
- Cancer is the leading cause of death among 45-64 year-olds and accounts for over one-third of all deaths. Among those over age 65 the leading cause of death is heart disease, which accounts for 31% of all deaths.
- The leading causes of premature death include cancer, heart disease, unintentional injuries and homicide.
- Life expectancy in Alameda County continues to increase, by about four years during the past decade alone. The improvement in life expectancy at birth was seen in every race/ethnic group: 4.2 years for Asian/Pacific Islanders, 3.3 years for Whites, 3.1 years for African Americans, and 3.0

years for Latinos.

Coronary Heart Disease

- Alameda County, as well as its neighboring counties, has met the HP2010 national objective of 166 or fewer CHD deaths per 100,000 people.
- Both African American males and females experienced higher coronary heart disease (CHD) mortality than any other race/ethnic group. Among African Americans, both male and female rates were more than twice the corresponding rates for Asians and Latinos.
- Rates of death from CHD have declined significantly during the last decade for every race/ethnic group except Latinos. Declines were greatest among Whites and APIs.
- Disparities in rates between African Americans and other race/ethnic groups have increased over the past decade. In 1990-91 the African American rate was 16% higher than the county rate; in 2002-03 it was 50% higher.

Stroke

- African American males experienced about 70-90% higher stroke mortality than any other race/ethnic group.
- Neither males nor females of any race/ethnic group has met the HP2010 objective; however, rates for Asian and Latino females were close to approaching the HP2010 objective of no more than 48 deaths per 100,000 people.
- Stroke mortality has declined over the past decade, mostly due to declines among Whites and APIs. The rates for African Americans have been consistently higher than any other race/ethnic group throughout the past decade.
- Disparities in rates between African Americans and other race/ethnic groups have increased over the decade. In 1990-91 the African American rate was 27% higher than the county rate; in 2002-03 it was 58% higher. Relative to Latinos, the gap increased from 57% in 1990-91 to 100% in 2002-03.

Diabetes

- For both males and females, the highest diabetes death rate was observed among African Americans, followed by Latinos. Although the rates for Asian males and females were lower than those for any other race/ethnic groups, the male death rate among Asians was 60% higher than the female rate. No gender difference in diabetes mortality was observed for Latinos.
- Mortality rate from diabetes increased sharply until 1996. The mortality rate from diabetes among African Americans has been consistently higher than any other race/ethnic group throughout the decade. The disparity in rates between African Americans and other race/ethnic group except Latinos has remained steady. Due to increasing rates, Latinos are the only group to be closing the gap with African Americans.

Asthma

- Asthma hospitalization rates in Alameda County exceed California rates as well as the HP2010 national objectives in all three age groups, most notably among children under five years of age.

The rate for the under five group is 2.7 times the HP2010 objective and the rate for those over age 65 is 2 times the objective.

- Rates were very high among African American males under five years of age: five times higher than for APIs and three to four times higher than for Whites and Latinos. A similar pattern was observed for females.
- Over the decade the African American rate has been consistently 2.2 to 2.5 times the county rate.
- Children under five years of age, especially boys, are vulnerable to asthma attacks serious enough to warrant hospitalization.

All Cancer

- The highest rate of cancer mortality was seen among African American males, followed by White males.
- Asians of both genders, Latinas, and Pacific Islander males were the only race/ethnic groups that met the HP2010 objective of no more than 159.9 cancer deaths per 100,000.
- Mortality from all cancers has declined significantly during the last decade for every race/ethnic group. African American cancer mortality has been consistently higher than that for any other race/ethnic group throughout the decade. The disparity in rates between African Americans and the county widened during this time from 30% in 1990-91 to 49% in 2002-03.
- The incidence of new cancer cases was higher among males than females in all race/ethnic groups. Males were also more likely to die of cancer than females in all race/ethnic groups with the exception of Pacific Islanders.
- There was a significant decline in cancer incidence and mortality in the past decade. The decline in incidence was the greatest among African Americans and APIs, and decline in mortality was the steepest among APIs.

Lung Cancer

- Males had substantially higher lung cancer incidence and mortality than females in all race/ethnic groups. African Americans were two to three times more likely to die of lung cancer than Asians or Latinos.
- Asians and Latinos of both genders were the only race/ethnic groups that met the HP2010 objective of 44.9 or fewer lung cancer deaths per 100,000.
- Both incidence of new cases and mortality from lung cancer declined significantly in the last decade for the population as a whole.
- Mortality declined significantly among Whites and incidence declined significantly among Latinos and APIs in the past decade.
- African Americans consistently had higher incidence and mortality than the county and the race/ethnic inequity in lung cancer mortality widened over time.

Colorectal Cancer

- Colorectal cancer death rates among African Americans, both males and females, were higher than any other race/ethnic group. Asian females and Latinas were the only groups that met the HP2010 objective of no more than 13.9 colorectal cancer deaths per 100,000 people.
- There was a significant decline in colorectal cancer incidence and mortality in the county over the last decade. African Americans and Whites had the steepest declines in incidence.
- African Americans had consistently higher mortality than the county. There was a narrowing of race/ethnic disparities in colorectal cancer incidence.

Breast Cancer

- Breast cancer mortality among African Americans was higher than other race/ethnic groups, about three times that of Asians and two times that of Latinas. Asians and Latinas were the only groups that met the HP2010 objective of no more than 22.3 breast cancer deaths per 100,000 women.
- Breast cancer mortality declined significantly in the past decade, overall, and among Whites and APIs. An increasing proportion of women are diagnosed at early stages of the disease.
- The African American breast cancer mortality rate was 53% higher than the county rate in 2002-03, up from 11% in 1990-91. The rate of new breast cancer cases in Alameda County changed very little between 1990 and 2002. However, the rate among White women increased significantly by about 1% per year.
- While White women consistently had the highest rates of new breast cancer cases in the county, African American women had higher rates of death from breast cancer. The disparity in breast cancer incidence between White women and the county increased over the decade.

Prostate Cancer

- Prostate cancer mortality among African Americans was higher than other race/ethnic groups, about six times that of Asians, three times that of Latinos, and two times that of Whites. Asians and Latinos were the only groups that met the HP2010 objective of no more than 28.8 prostate cancer deaths per 100,000 men.
- Prostate cancer mortality in Alameda County declined significantly over the past decade, most notably for Whites and APIs.
- Prostate cancer incidence decreased steadily among African American men in the past decade. Over this time, an increasing proportion of men were diagnosed at an early stage of disease.

Unintentional Injury

- Male unintentional injury death rates were about two to three times higher than those for females in every race/ethnic group.
- The rate for African American males was almost three times the rate of Asians and more than 1.5 times the rates of Latinos and Whites.
- Over the past decade, unintentional injury deaths in Alameda County have declined. Hospitaliza-

tions for unintentional injury have declined among every race/ethnic group except Latinos.

Motor Vehicle Crashes

- Deaths due to motor vehicle crashes were highest among males, especially, teens, young adults, and 65 and older age groups.
- African American motor vehicle crash death rates have been higher than any other race/ethnic group throughout the past decade. The gap between African Americans and the county as a whole increased from 20% in 1990-91 to 69% in 1998-99. Recent trends suggest the gap may be closing.

Homicide

- For both African American men and women, homicide rates were significantly higher than any other race/ethnic group. The male rate for African Americans was more than twenty times the rates for Asians and Whites, and eight times the rate of Latinos. The female rate for African Americans was five to eight times the rates for Asians and Whites.
- Rates were highest among teen and young adult males, approximately six times higher than among females of the same ages.
- Homicide rates declined for every race/ethnic group in Alameda County until 2000 when they began to climb again among African Americans and Latinos.

Suicide

- The highest suicide rates were among the oldest males, especially among White males.
- Over the past decade, the White suicide rate has been 30%-50% higher than the county rate.
- The county suicide rate declined over the past decade, largely due to a decline among Whites. However, increases were seen for all but APIs in the most recent 2002-2003 period.
- Rates of self-inflicted injury hospitalization declined over the past decade for every race/ethnic group except Whites, who showed a slight increase.

Injury Deaths by Mechanism and Intent

- More than half of injury deaths from 2001 to 2003 were unintentional (57.2%); 21.2% were from homicide and 19.6% from suicide.
- The five leading mechanisms of injury death accounted for 81% of all injury deaths in Alameda County: Firearm (25.1%), transport-related (19.7%), poisoning (19.4%), falls (10.4%), and suffocation (7.7%).

Live Births

- The birth rate has decreased from 18.3 per 1000 people in 1990 to 14.4 in 2003.
- Native Hawaiians/Other Pacific Islanders (NHOPI) had the highest birth rate (22.4 per 1,000 people) followed closely by Latinos (21.1).
- In 2003, over half (52%) of the births were to foreign-born mothers. Ninety percent of Asian mothers were foreign born, 71% of Latina mothers, 57% of NHOPI mothers, 18% of White mothers and 9% of African American mothers.

Infant Mortality

- The infant mortality rate has declined over the last decade in Alameda County as it has in California.
- The infant mortality rate among African Americans remains two to three times higher than among other race/ethnic groups and the county as a whole.

Low Birth Weight

- During the last decade, the percentage of low birth weight babies in Alameda County has remained approximately 7%, higher than the HP2010 objective of 5% or less
- African Americans in Alameda County had the highest rate of LBW (12.4%), almost two times the county average.

Prenatal Care

- During the past decade, the percentage of women seeking early prenatal care has increased among every race/ethnic group in Alameda County.
- Ninety-one percent of pregnant women in Alameda County began prenatal care during their first trimester of pregnancy meeting the HP2010 objective of at least 90%.
- NHOPIs still have notably low rates of early prenatal care (77%).

Teenage births

- The teen birth rate in Alameda County was 31 per 1,000 females aged 15-19 years. This rate was higher than those in neighboring counties but substantially lower than California's rate of 41.1.
- The teen birth rate in Alameda County has declined steadily since 1990. The decline among African Americans has been dramatic, while for Latinas it was minimal.
- The current Latina teen birth rate is eight times higher than the Asian rate and five times higher than rates among Whites.

Childhood Immunization

- Seventy three percent of Alameda County children were fully up-to-date on their immunizations by two years of age which is well below the HP2010 objective of at least 90%.
- The percentage of fully immunized children varied across racial/ethnic groups. While only 60% of African American children were immunized, almost 80% of Asian children were.

Dental Health

- Overall, 69% of Alameda County third graders have had dental disease, either treated or untreated. This figure is 64% higher than the HP2010 objective of 42% or lower.
- Only 34% of third graders had dental sealants on at least one molar while the HP2010 objective is 50% or more.
- As school poverty level goes up so does the proportion of children with untreated tooth decay. Conversely, the proportion of Alameda County third graders with protective dental sealants decreases as school poverty level increases.

Tuberculosis

- Although TB cases and case rates have decreased over the past five years in Alameda County, with an average annual rate of 12.4 per 100,000 population for 2002-2004, the rate is 1.5 times greater than the state rate.
- 77% of TB cases occurred among persons born outside of the U.S., particularly from countries with higher rates of TB. Persons of Asian/Pacific Islander descent made up the majority of foreign-born cases, while African Americans comprise the greatest portion of cases born in the U.S.

HIV/AIDS

- Alameda County's AIDS case rate of 13.0 per 100,000 exceeds the state rate and is second highest in the Bay Area, following San Francisco.
- AIDS cases, case rates, and deaths have declined for all racial/ethnic groups. However, African Americans of both genders continue to have rates several times greater than other race/ethnic groups.
- Although men-who-have-sex-with-men (MSM) continues to be the predominant exposure mode, cases attributed to heterosexual exposure have increased substantially over the past decade.

Sexually Transmitted Diseases

- Chlamydia and Gonorrhea rates in Alameda County were higher than the state and other Bay Area counties, with the exception of San Francisco.
- Chlamydia cases and case rates were greater for females than males for all race/ethnic groups.
- Gonorrhea rates overall were the same for males and females; however, the rate among females aged 15-19 years was nearly three times the male rate.

Overview of Report

The Alameda County Health Status Report 2006 presents the health status of the residents of Alameda County. It includes six chapters:

1. Demographic and Social Profile
2. Health Inequities
3. Death from All Causes
4. Chronic Disease
5. Injury
6. Maternal, Child, and Adolescent Health
7. Communicable Disease

Each section contains several health indicators. For each indicator, we address:

What is it?	Indicator definition
Why is it important?	A brief background
What is Alameda County's status?	Health data
What are we doing?	Program activities
What else do we need to do?	Recommendations for future action

Using the Report

Age-adjusted rates are used to report data on death and illness from chronic disease and injury. Crude, or unadjusted, rates are used to report communicable diseases. For reporting maternal and child health indicators, age-specific rates, as well as rates based on number of live births, are used.

Most sections open with a bar chart showing the Alameda County rate compared to rates in neighboring counties and the state, in addition to a Healthy People 2010 objective where one exists.¹¹ For the most part, rates for neighboring counties and the state are taken from the California Department of Health Services publication, County Health Status Profiles, 2005.¹² Where our own Alameda County rates differ from those published in the state report (due to small differences in counts and choice of population denominator) we report the rate we have calculated in order to maintain consistency with the remainder of the report. Any differences between the Alameda County rates published here and those published by the State are very small and do not affect the conclusions drawn from the data.

Mortality trends presented in this report reflect cause of death based on the ICD-9 classification system from 1990 to 1998 and based on ICD-10 from 1999 to 2003. The change in coding cause of death has meant that trends for pre-1999 data are not directly comparable to those for post-1999 data. However, for the major causes of death covered in this report, data from the two periods, pre- and post-1999, are reasonably comparable (that is, within one or two percent).¹³

Throughout the report, the term Latino is used to describe people of Hispanic or Latino origin. In the classification of race/ethnicity, Hispanic origin was determined first, regardless of race, and the race categories for remaining non-Hispanics were determined second. Also in this report, the term American Indian is used inclusively to refer to Native Americans and Alaska Natives and the term African American is used to refer to those who are black or African American.

Finally, birth and death figures showing a three-year average rate for the period 2001-2003 present Asians and Native Hawaiians/other Pacific Islanders (abbreviated as NHOPI or PacIsl in this report) separately. For many health indicators, NHOPI figures are not shown due to small numbers. Figures showing trends, 1990-2003, in this report group Asians with NHOPI. This combined group is shown as API, for Asian/Pacific Islander. The combined group is shown in order to be consistent with racial classifications used prior to Census 2000 when NHOPI was first offered as a separate racial group. Other data sources, such as hospitalization, cancer incidence, and communicable diseases present the combined API group in all figures.

Included at the end of the report are two appendices, the Technical Appendix and the Tabular Appendix. The Technical Appendix documents data sources, limitations, definitions, and some statistical terms and methods. The Tabular Appendix includes a set of tables for most of the data shown graphically in the report. The tables include counts (as a three-year total number of events), three-year average rates, and 95% confidence intervals. Tables showing annual counts and rates are also presented for 1990 to 2003 for most indicators. Tables are not included for State-level data or for Census data.

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