



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

Community Assessment, Planning, and Education (CAPE) Unit

Alameda County Public Health Department
1000 Broadway, Suite 500
Oakland, California 94607
(510) 267-8020
www.co.alameda.ca.us/publichealth

Sandra Witt, Dr.P.H.
CAPE Director

Robert Benjamin, M.D.
Interim Health Officer

Arnold Perkins, Director
Alameda County Public Health Department

David Kears, Director
Health Care Services Agency



Alameda
County
Health
Status
Report
2003



Alameda
County
Public
Health
Department



Acknowledgements

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
Sangsook Cho
Elaine Bautista
Neena Murgai

Reviewers and Contributors

David Boone	Nobuko Mizoguchi
Liz Maker	Sonia Jain
Janet Brown	Brian Griffiths
Rachel Johns	Maria Hernandez
Mia Luluquisen	Margaret Rivas

Other Contributors

Division of Community Health Services

Jeff Brown	Anaa Reese
Jared Fine	Marla Blagg
Kimi Watkins-Tart	Brenda Yamashita
Paul Cummings	

Division of Communicable Disease Control and Prevention

Barbara Allen	Gay Calhoun
Linda Frank	Barbara Green-Ajufo
Alison James	

Division of Emergency Medical Services

Cindy Abbissinio	Mona Mena
------------------	-----------

Division of Family Health Services

Quamrun Nessa	Julie Garcia
Dani Taylor	

Information Systems

Gary Oliver	Ying-Ling Wang
-------------	----------------

Office of AIDS

Lori Williams	Maria Aguilar
---------------	---------------

Office of the Director

Sherri Willis

Tuberculosis Control Program

Elaine Conley

Photos

Doniphan Blair
Kathy Sloane

Publication underwritten by



Design

Doniphan Blair /

Table of Contents

Executive Summary	1
Summary Table of Health Indicators.....	4
Summary of Key Findings.....	6
Report Overview.....	11
Alameda County Demographic Profile	
Age.....	13
Race and Ethnicity	14
Languages Spoken at Home.....	15
Income.....	15
Housing	18
Unemployment.....	18
Education.....	19
Maternal, Child and Adolescent Health	
Characteristics of Live Births.....	21
Infant Mortality.....	23
Low Birth Weight	26
Prenatal Care	29
Births to Teens.....	31
Childhood Immunization.....	33
Dental Caries.....	35
Death from All Causes	
Rates of Death from All Causes.....	41
Leading Causes of Death.....	44
Leading Causes of Premature Death.....	50
Chronic Diseases	
Asthma.....	55
Diabetes.....	60
Coronary Heart Disease.....	65
Stroke.....	70
All Cancer.....	74
Lung Cancer	77
Breast Cancer	83
Prostate Cancer	87
Injury	
Unintentional Injury.....	95
Motor Vehicle Crash.....	99
Homicide/Assault	103
Suicide/Self-Inflicted Injury	107
Injury Deaths by Mechanism and Intent.....	111
Injury Hospitalizations by Mechanism and Intent	112
Communicable Diseases	
AIDS.....	115
Chlamydia.....	119
Tuberculosis	122
Appendix A: Technical Notes.....	131
Appendix B: Data Tables	139
Map Contents	
Percent of Children Living in Poverty by Census Tract.....	17
Childhood Asthma Hospitalizations by Zip Code.....	58
Diabetes-Related Hospitalizations by Zip Code.....	64
Coronary Heart Disease Deaths by City.....	68
Lung Cancer Deaths by City	80
Tuberculosis Cases Diagnosed 1997-2001.....	124



Executive Summary

The Alameda County Health Status Report 2003 examines the health status of residents in Alameda County. This report also describes the Alameda County Public Health Department's (ACPHD) current programs and future plans to improve community health.

Assessment is a core function of public health.¹ The purpose of this report is to share timely assessment information with partners, agencies, and community residents. This process informs our mission to “work in partnership with the community to ensure optimal health and well-being of all people.” We believe that improving health and well-being calls for active participation from many groups, including government, businesses, non-profits and community residents. Public health agencies and their partners must be committed to a broad array of activities in order to change the conditions that lead to the improved health and well-being of our residents.²

This report presents a select group of indicators that address social and demographic characteristics, maternal and child health, leading causes of death, chronic diseases, injury and violence, and communicable diseases. Data sources include birth, mortality, hospitalization, cancer and communicable disease incidence. The race/ethnicity, sex, and age distribution of the population are examined for each indicator. Trends over time and geographic distribution are presented for select indicators. Current health status is compared to California rates and to Healthy People 2010 national objectives³ where appropriate.

Health Disparities

The findings of this report demonstrate the persistence of large racial and ethnic health disparities in Alameda County. The National Institutes of Health define health disparities as “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific populations.”⁴

Health status and health disparities (also referred to as health inequities) are shaped by a wide range of factors in the social, economic, natural, built, and political environments.² Many studies have linked race/ethnicity, income and education with health. Poor people and people of color are more likely than others to be burdened by sub-standard housing, poor schools, pollution and public policy decisions that contribute to health risks.⁵

Inequities in income and education level persist in Alameda County. Poverty has changed little during the past decade. Approximately 14% of Alameda County children under 18 live in poverty. While we know that safe, affordable housing is essential for good health, close to one-quarter of renters spent 50% or more of their income on rent. Unemployment is on the rise. Marked disparities exist in the four-year high school dropout rates among school districts in Alameda County, with the Oakland Unified School District dropout rate far exceeding rates in other districts.

As indicated in the summary table that follows,

African-Americans clearly bear a larger burden of disease and death than other racial/ethnic groups for almost all the indicators examined. They have the highest rates of infant mortality, low birth weight, unintentional injury death, homicide, assault, AIDS, chlamydia, asthma, diabetes, coronary heart disease, stroke, lung cancer, and prostate cancer, as well as the lowest rates of immunization. The indicators where groups other than African Americans fare worse are first trimester prenatal care, unintentional injury and self-inflicted injury hospitalizations, tuberculosis, and breast cancer incidence.

Although the Latino population has the highest teen birth rate and a high rate of diabetes, it has the lowest rate of stroke and breast cancer incidence. Asians, as a group, fare better than other racial/ethnic groups in almost all of the indicators examined with the exception of tuberculosis where they have the highest incidence rate by far. For the first time, we are able to monitor the health status of the Native Hawaiian/Other Pacific Islander population for select indicators; this group has the highest rate of death from all causes combined and the lowest rate of first trimester entry into prenatal care. The White population in Alameda County has the highest rate of breast cancer incidence, suicide, unintentional injury hospitalizations, and self-inflicted injury hospitalizations.

Sex disparities also exist in Alameda County. Males die at an earlier age and have significantly higher death rates and hospitalization rates than do females for almost all the indicators examined. Females have higher rates of hospitalization due to suicide attempts, as well as higher rates of chlamydia.

A table detailing the status of Alameda County residents by health indicator is presented at the end of the executive summary. This table is complemented by a list of key findings for each indicator examined.

Commitment to a Healthier Community

The Alameda County Public Health Department is committed to reducing health disparities. In

2002, the ACPHD produced *A Framework for Change: Reducing Health Disparities in Alameda County* to guide our planning.⁶ This document summarizes literature and identifies the most promising strategies that Alameda County can pursue in eliminating health disparities. Recommendations are broad and focus on the following:

- 1) identifying and creating healthful public policy (policies related to education, affordable housing, economic development, transportation, labor, and child care that support population health);
- 2) improving neighborhood living conditions (food, safety and housing);
- 3) implementing population-level disease prevention and health promotion strategies;
- 4) strengthening the public health department's capacity for research and evaluation; and
- 5) strengthening community capacity for reducing health disparities.

To learn more about social, behavioral and environmental determinants of health, the ACPHD will conduct a countywide community health survey in 2003. This information is key for developing effective programs to reduce health disparities.

The ACPHD will continue to collaborate with other government agencies, non-profits, businesses, and community residents to improve health and well-being and to close the gap in health status. Based on the findings in this report and a growing understanding of the social determinants of health, the ACPHD has selected priority health issues and broader determinants of health.

Priority health issues include improving access to health insurance and health care; increasing immunization rates; and reducing violence, the incidence of sexually transmitted diseases, and prevalence of chronic diseases. To make Alameda County a healthier place to live, the ACPHD will also focus on key determinants of health, including nutrition, food access, physical activity, housing, and safety.

References

1. Institute of Medicine, National Association of Sciences. The Future of Public Health. Washington D.C., National Academy Press. 1988.
2. Institute of Medicine, National Association of Sciences. The Future Of The Public's Health In The 21st Century. Washington D.C., National Academy Press. November 2002.
3. U.S. Department of Health and Human Services. Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.
4. NIH definition of health disparities: <http://healthdisparities.nih.gov/whatare.html>.
5. National Association of County and City Health Officials. NACCHO Exchange. Volume 1 No 4: Winter 2003.
6. Brown E. A Framework for Change: Reducing Health Disparities in Alameda County. Alameda County Public Health Department. October 2002.

Selected Indicators, Alameda County with Status Comparison to Healthy People 2010 Objectives

Indicator		Healthy People 2010 Objective ¹	County		African American	American Indian	Asian	Native Hawaiian & Pacific Islander	Latino	White	Two or More Races	Female	Male	
			Year	Rate ¹										
Maternal & Child Health	Infant Mortality	4.5 or less/ 1,000 live births	2000	●4.6	●8.5	*	*	*	4.0	3.7	*	x	x	
	Low Birth Weight	5.0% or less of live births	2000-01	●6.9	●12.4	*	●7.2	*	●5.5	●5.3	●8.3	x	x	
	First Trimester Prenatal Care	90% or more of live births	2000-01	●88.9	●86.9	●87.7	90.3	●73.3	●84.8	93.6	●86.1	x	x	
	Teenage Births (Age 15-19) ²	x	2000-01	36.3	63.8	*	12.7	*	73.8	13.8	18.2	x	x	
	Childhood Immunization	90% of all children by age 2	2002 survey	●73.6	●55.0	*	●86.7		●65.5	●78.7	x	x	x	
Injury	Unintentional Injury	Death	99-00	●23.5	●32.7	*	●19.0	*	●21.7	●23.1	*	15.8	●31.8	
		Hospitalization	98-00	439.8	431.4	*	201.8		305.0	499.8	x	400.8	459.3	
	Motor Vehicle Crash	Death	99-00	◆7.3	*	*	9.2	*	9.2	6.6	*	4.3	●10.6	
		Hospitalization	98-00	94.2	103.0	*	43.1		70.1	97.3	x	70.4	118.5	
	Homicide/ Assault	Death	99-00	●7.2	●34.1	*	*	*	*	*	*	*	*	●11.8
		Hospitalization	98-00	45.7	130.5	*	9.8		40.8	23.4	x	14.1	77.2	
	Suicide/Self-Inflicted Injury	Death	99-00	●7.8	*	*	*	*	*	●9.7	*	3.2	●13.0	
		Hospitalization	98-00	29.5	27.4	*	15.6		20.9	35.7	x	36.1	23.2	
Communicable Disease	AIDS	Incidence	99-01	●15.4	●56.1	*	●2.7		●12.8	●8.8	x	●6.6	●24.5	
	Chlamydia	Incidence ³	99-01	341.4	x	x	x		x	x	x	517.7	147.4	
	TB	Incidence ³	99-01	●16.4	●21.9	*	●43.2		●12.3	●2.4	x	●13.9	●19.0	

Indicator		Healthy People 2010 Objective ¹	County		African American	American Indian	Asian	Native Hawaiian & Pacific Islander	Latino	White	Two or More Races	Female	Male	
			Year	Rate ¹										
Chronic Disease	Asthma (All ages)	Death	x	99-00	2.5	*	*	*	*	*	*	*	*	
		Hospitalization	x	98-00	189.5	458.1	*	116.0	123.1	115.0	x	195.3	180.2	
	Childhood Asthma (0-14 years)	Hospitalization	x	98-00	420.2	1072.7	*	197.9	266.7	194.9	x	317.5	518.3	
	Diabetes	Death	x	99-00	22.8	49.3	*	16.5	*	34.6	16.7	*	20.2	26.3
		Hospitalization	x	98-00	1201.3	2249.1	509.7	847.1	1171.1	963.6	x	1204.3	1205.2	
	Coronary Heart Disease	Death	166.0 or less	99-00	●188.5	●266.4	*	99.1	*	156.0	●199.7	*	156.0	●230.0
		Hospitalization	x	98-00	1522.8	1762.7	491.3	1011.2	1021.1	1614.9	x	1220.9	1913.3	
	Stroke	Death	48.0 or less	99-00	●70.5	●103.9	*	●65.7	*	●56.1	●68.6	*	●67.6	●75.1
		Hospitalization	x	98-00	580.2	874.3	*	439.7	324.0	560.0	x	553.5	617.2	
	All Cancer	Death	159.9 or less	99-00	●190.4	●259.4	*	132.9	*	140.4	●213.0	*	●167.7	●228.3
	Lung Cancer	Death	44.9 or less	99-00	●50.9	●70.9	*	31.1	*	33.0	●59.0	*	42.7	●63.6
		Incidence	x	97-99	62.0	74.4	*	37.0	39.4	67.7	x	53.9	73.9	
	Female Breast Cancer	Death	22.3 or less	99-00	●26.9	●34.7	*	*	*	●34.5	*	26.9	x	
		Incidence	x	97-99	165.0	131.6	*	119.6	108.4	186.6	x	165.0	x	
Prostate Cancer	Death	28.8 or less	99-00	●30.2	●73.6	*	*	*	●27.4	*	x	30.2		
	Incidence	x	97-99	152.1	188.8	*	84.3	94.1	146.5	x	x	152.1		

◆ Has met HP objective ● HP objective not met

x Data not available or applicable. * Rate cannot be calculated due to small number.

¹ Unless otherwise stated, rates are per 100,000 population and are annual averages. Rates for injury and chronic diseases are age-adjusted to US 2000 standard population.

² Rates are per 1,000 females aged 15 to 19. ³ Excludes City of Berkeley cases.

Note that Healthy People 2010 Objectives are not available for many indicators. Also, note that the rates for deaths and maternal child health indicators among Asian and Native Hawaiian and other Pacific Islanders are separated between these racial/ethnic groups, while the rates for hospitalization, cancer incidence and communicable disease indicators are grouped together because of data availability. Note that death rates by race/ethnicity are based on year 2000.

Summary of Key Findings

Social/Demographic

- According to Census 2000, the Alameda County population is racially and ethnically diverse. No group comprises a majority.
- There has been little change in the poverty rate since 1989. Approximately 14% of children under 18 live in poverty.
- The unemployment rate in Alameda County has been increasing since 2000, reaching 6% in the first half of 2002.
- Marked disparities exist in the four-year high school dropout rates among school districts in Alameda County, ranging from 20% in Oakland Unified School District to 0% in Piedmont City Unified School District.

Maternal, Child, and Adolescent Health

Live Births

- The birth rate in Alameda County remained stable in 2001 at 15.2 births per 1000 population.
- Latinos and Native Hawaiian/Other Pacific Islanders had birth rates in 2000-2001 that were substantially higher than those among other race/ethnic groups.
- Over 7% of births were to mothers 19 years and under.

Infant Mortality

- The infant mortality rate in Alameda County decreased significantly from 8.9 deaths per 1000 live births in 1990 to 4.6 in 2000. Such declines have been observed for all racial-ethnic groups.
- African Americans did not meet the Healthy People 2010 national objective of no more than 4.5 infant deaths per 1,000 live births. In fact, their infant death rate was 8.5 per 1,000

live births compared to 4.0 for Latinas and 3.7 for Whites.

Low Birth Weight

- Overall, 6.9% of all births in Alameda County were low birth weight. This percentage exceeds the Healthy People 2010 national objective of no more than 5.0%.
- African Americans and teenagers were more likely to have low birth weight babies when compared to other racial/ethnic and age groups.

Prenatal Care

- Overall, 88.9% of pregnant women in Alameda County began prenatal care during the first trimester. This percentage is very close to the Healthy People 2010 national objective of 90.0%.
- Rates of first trimester prenatal care have increased over time for all racial/ethnic groups. However, only 73% of Native Hawaiians/Other Pacific Islanders (a newly monitored racial group) entered prenatal care early.

Births to Teens

- The average rate of birth to teens 15-19 years of age in Alameda County was 36.3 per 1,000 females, a rate lower than the state average of 50.3 per 1,000.
- Teen birth rates among Latinas and African Americans were three to five times higher than teen birth rates among Asians, Whites and those of two or more races.

Childhood Immunization

- According to California's annual Kindergarten Retrospective Survey, the percentage of kindergarteners fully up-to-date on immunizations by two years of age steadily improved from 60.0% in 1998 to 73.6% in 2002.
- African American and Latino children have the

lowest immunization rates compared to other racial/ethnic groups.

Dental Caries

- As many as 44,500 children 2 to 8 years of age in Alameda County may have untreated tooth decay. The highest prevalence of untreated tooth decay is found among ethnic minorities.

Death from All Causes & Leading Causes of Death

- The rate of death from all causes declined from 916.0 deaths per 100,000 in 1990 to 789.2 per 100,000 in 2000.
- Males had higher death rates in every age group than females.
- The three leading causes of death in Alameda County were diseases of the heart, cancer, and stroke. These accounted for 62% of all deaths.
- The three leading causes of premature death in Alameda County were cancer, diseases of the heart, and unintentional injuries. These accounted for 54% of all years of potential life lost annually.

Chronic Diseases

Asthma

- Asthma death rates among those 35-64 and 65 and over in Alameda County exceeded the Healthy People 2010 national objectives.
- The age-adjusted rate of asthma hospitalization among children under 15 years of age was 420.2 per 100,000, more than twice the California rate of 195.5.
- African American males under age 15 were hospitalized at a rate four times higher than Latino males and five times higher than White or Asian males.

Diabetes

- The diabetes death rate in Alameda County

was 22.8 per 100,000, higher than in neighboring counties or the state as a whole.

- Diabetes death rates increased from 1990 to 1995, and leveled off in the latter half of the decade. Rates of diabetes-related hospitalization increased significantly from 1995 to 1999 and leveled off in 2000.
- Rates of diabetes death were higher among African Americans and Latinos compared to other racial/ethnic groups. African American males and females had diabetes hospitalization rates that were twice the rates in other groups.
- Males died from diabetes at a higher rate than females. However, African American and Latino females were hospitalized for diabetes-related illnesses at higher rates than their male counterparts.

Coronary Heart Disease

- Alameda County's rate of death from coronary heart disease (CHD) was 188.5 per 100,000, a rate that exceeds the Healthy People 2010 national objective of no more than 166 deaths per 100,000.
- Rates of death from CHD declined during the 1990s while rates of hospitalization for related illnesses remained stable.
- Overall, males died from CHD at a rate nearly 50% higher than the female rate. The CHD death rate was substantially higher among African Americans than among other racial/ethnic groups.
- African Americans of both sexes were hospitalized for CHD at rates second only to White males.

Stroke

- Alameda County's rate of death from stroke was 70.5 per 100,000, a rate that exceeds California's rate as well as the Healthy People 2010 national objective of no more than 48 deaths per 100,000.

- Rates of death from stroke remained stable in the latter half of the 1990s. Rates of stroke death as well as hospitalization were higher among males than females.
- Compared to other racial/ethnic groups, African Americans were substantially more likely to die of stroke or be hospitalized for it.

All Cancers

- Although the death rate from all cancers has declined over the past decade, Alameda County has not yet met the Healthy People 2010 national objective of no more than 159.9 per 100,000.
- Alameda County's death rate from all cancers was 190.4 per 100,000, a rate higher than in neighboring counties and the state as a whole.
- The death rate for all cancers among males was 36% higher than the rate for females.
- African Americans had a significantly higher cancer death rate than Asians, Latinos, or Whites.

Lung Cancer

- Although the lung cancer death rate has been declining since 1993, Alameda County, with a rate of 50.9 per 100,000, has not met the Healthy People 2010 national objective of no more than 44.9 per 100,000. Lung cancer incidence has been stable since 1996.
- The male lung cancer death rate was approximately 50% higher than the female rate. The male lung cancer incidence rate was 37% higher than the female rate.
- African Americans had significantly higher death and incidence rates of lung cancer compared to Whites, Asians, or Latinos.

Female Breast Cancer

- Alameda County's female breast cancer death rate was 26.9 per 100,000. This rate exceeds the Healthy people 2010 national objective of no more than 22.3 per 100,000 females.

- Breast cancer incidence rates have increased in Alameda County in the last decade, a pattern that can be explained in part by an increase in screening practices and diagnosis at earlier stages of the disease.
- White females had a significantly higher breast cancer incidence rate than African Americans, Asians, or Latinos.

Prostate Cancer

- Alameda County has experienced a decline in the prostate cancer death rate since 1993. However, the County rate of 30.2 per 100,000 males exceeds the Healthy People 2010 national objective of no more than 28.8 per 100,000 males.
- African Americans had a prostate cancer death rate 2.7 times the rate for Whites. The incidence of prostate cancer was the highest among African Americans compared to other racial/ethnic groups.
- Prostate cancer incidence rates increased in the late 1990s, which is consistent with increases in screening practices and early diagnosis among older men in recent years.

Injury

Unintentional Injuries

- The death rate from unintentional injury in Alameda County was 23.5 per 100,000, a rate that exceeds the Healthy People 2010 national objective of no more than 17.5 unintentional injury deaths per 100,000 people.
- The rate of unintentional injury death was substantially higher among African Americans compared to other racial/ethnic groups.
- Males were twice as likely to die from injuries as females. They were also more likely to be hospitalized for injuries.

Motor Vehicle Crashes

- Alameda County has met the national Healthy People 2010 objective of no more than 9.2

motor vehicle crash deaths per 100,000. The County's rate was 7.3 per 100,000.

- The death rate from motor vehicle crashes among Alameda County residents declined throughout the 1990s.
- The motor vehicle crash death rate was two times higher among males than females.
- African American males had the highest rates of hospitalization for motor vehicle crashes, followed by White and Latino males. Asians of both sexes had the lowest rates.

Homicide

- Alameda County ranks 6th among California's 58 counties in deaths due to homicide. The County's homicide rate was 7.2 per 100,000, a rate that exceeds the Healthy People 2010 national objective of no more than 3 homicide deaths per 100,000.
- The homicide rate declined throughout the 1990s and leveled off in 2000. While no data are shown, rates appeared to begin climbing again in 2001 and 2002.
- The male homicide rate was nearly five times higher than the female rate. The same is true of hospitalizations for assault.
- African Americans were ten times more likely to die as a result of a homicide than all other racial and ethnic groups combined. Nearly two-thirds of all homicide victims are African American.

Suicide

- Alameda County's suicide rate is 7.8 per 100,000, a rate that exceeds the Healthy People 2010 national objective of no more than 5 suicide deaths per 100,000.
- Over three-quarters of suicide victims were male. In contrast, the majority of those hospitalized for self-inflicted injury were female.

Communicable Diseases

AIDS

- In 2001, Alameda County reported 191 new

AIDS cases, the lowest case count since 1985. AIDS mortality in Alameda County decreased to 71 deaths in 2001.

- The distribution of AIDS by race/ethnicity has shifted from affecting mostly Whites in the early part of the epidemic, to Latinos and African Americans more recently. In 2001, the case rate among African Americans was eight times that of Whites and nearly four times that of Latinos.
- Exposure to HIV by heterosexual contact has increased markedly over the past five years and accounted for about one-third of cases in 2001. Men-who-have-sex-with-men (MSM) continues to be the predominant exposure mode for HIV infection.

Chlamydia

- There were 4,675 cases of chlamydia in Alameda County in 2001. Chlamydia accounts for over 75% of the reported sexually transmitted diseases each year.
- The highest rates of chlamydia are seen among adolescents, young adults, and African Americans.
- Over three quarters of the reported chlamydia cases in Alameda County were female. This is largely attributed to expanded screening efforts targeting women.

Tuberculosis

- The case rate in Alameda County was 16.4 per 100,000 residents, the third highest case rate among California's 58 counties. Alameda County reported 196 cases of tuberculosis in 2001.
- The majority of Alameda County's tuberculosis cases have occurred among ethnic minorities. The Asian/Pacific Islander community has been disproportionately affected by TB.
- Over 80% of new TB cases were among individuals born outside the United States.
- Over 85% of new TB cases were among adults aged 25 years and older, with the greatest number being in the 25-44 age group.

Report Overview

Structure of Report

The Alameda County Health Status Report 2003 presents the health status of the residents of Alameda County. It includes six main sections:

1. Social/demographic profile
2. Maternal, child, and adolescent health
3. Death from all causes and leading causes of death
4. Chronic diseases
5. Injury
6. Communicable diseases.

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

Indicator definition — *What is it?*

A brief background — *Why is it important?*

Health data — *What is Alameda County's status?*

Program activities — *What are we doing?*

Recommendations for future action —
What else do we need to do?

In addition to the core health indicators examined previously in the Alameda County Health Status Report, 2000, the current report includes several new measures of illness or morbidity: hospitalization for asthma, diabetes, coronary heart disease, stroke, unintentional injury, motor vehicle crash, assault, and self-inflicted harm. Also new are cancer incidence data for lung, breast and prostate cancer.

Important Changes In This Report

There are four major changes in this report that make it different from, and therefore not comparable to, the previous Alameda County Health Status Report (2000):

1. Change in disease classification system. Cause of death data has been coded using the International Classification of Diseases, 10th Revision (ICD-10).¹ Every decade or two, the

World Health Organization revises the international disease classification system. The current system was implemented for recording cause of death in 1999. Hospitals in California continue to use ICD-9 codes.²

2. New categories of race introduced in Census 2000. The Census 2000 form allowed for people to identify with more than one racial group and separated Native Hawaiians/Other Pacific Islanders (NHOPI) from Asians and placed them into their own group. These changes allow for representation of our increasingly diverse population. However, in the presentation of health information, the new, smaller groups (NHOPI and those of two or more races) may not have a sufficient number of events (i.e., <20) on which to base rates. In addition, the old racial groups may no longer be comparable to the new racial groups.

3. Change in standard population. Age-adjusted rates presented in this report are based on the 2000 projected United States population,³ also referred to as the 2000 standard population. This standard reflects an estimate of the age structure of the U.S. population in 2000. Use of age-adjusted rates in disease reporting allows us to express the burden of disease in different groups, racial groups for instance, in units that are comparable even though the age composition of the groups may differ. The 2000 standard population is older than the previous 1940 standard. Thus rates of disease, especially the chronic diseases like cancer and heart disease, will be higher using this new standard.

4. New National Health Objectives. In 2000, The Department of Health and Human Services issued Healthy People 2010,⁴ a comprehensive set of 467 health objectives in 28 focus areas. This expanded and updated set of health objectives is based on targets that reflect 1) progress made toward the Year 2000 health objectives and 2) the age structure of the U.S. population in the year 2000. The new targets are based on the 2000 projected U.S. population. The Healthy People 2000 national objectives were based on the 1940 standard population.

Taken together, these four changes alter counts of the major causes of death, the racial groups that

we consider when looking at rates of mortality and morbidity, the standard population we use to compare them, and the national targets toward which we aim. Therefore, this lack of comparability over time means that we must start with a new baseline of health measures. Rates and trends we monitored previously alerted us to health disparities we need to address. However, it would be misleading to draw direct comparisons with data that the Alameda County Public Health Department has presented in the past.

Using the Report

Age-adjusted rates are used to report chronic disease and injury mortality and morbidity. 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. For the most part, these rates are taken from the California Department of Health Services publication, *County Health Status Profiles, 2002*.⁵ Due to small differences in counts and choice of population denominator, they may not correspond directly to the overall Alameda County rate presented in the summary indicator table or the tabular appendices. Such discrepancies are unavoidable and do not affect the conclusions that might be drawn from the data.

Throughout the report, the term Latino is used to describe people of Hispanic or Latino origin. All data (case/numerator and population/denominator) is processed so that Hispanic or Latino origin is classified as such, regardless of race. 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.

Included at the back 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. The Tabular Appendix includes a set of tables for most of the data shown graphically in the report. The tables include counts (usually average annual number of events), rates, and 95% confidence intervals. Tables are not included for State-level data or for Census data.

References

1. World Health Organization. *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision*. Geneva: World Health Organization. 1992.
2. World Health Organization. *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death, Ninth Revision: Volume 1*. Geneva: World Health Organization. 1977.
3. Klein RJ, Schoenborn CA. Age adjustment using the 2000 projected U.S. population. *Healthy People Statistical Notes*, no. 20. Hyattsville, Maryland: National Center for Health Statistics. January 2001.
4. U.S. Department of Health and Human Services. *Healthy People 2010*. 2nd ed. With *Understanding and Improving Health and Objectives for Improving Health*. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.
5. California Department of Health Services. *County Health Status Profiles, 2002*.