

Utah Health Status Update:

Health Disparities

April 2009

Utah Department of Health

There are many definitions of health disparities. Some people think of them simply as any differences in health between population groups including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, and sexual orientation. Others prefer to focus on differences that are seen as unjust or avoidable. Healthy People 2010, the health agenda for the nation, established two overarching goals: 1) Increase quality and years of healthy life and 2) Eliminate health disparities. In the U.S., much work in this area has focused on racial and ethnic health disparities.

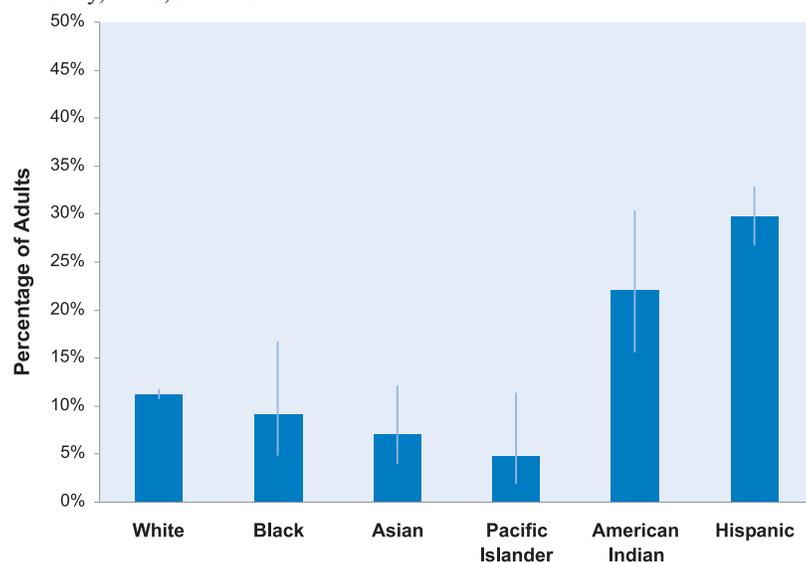
When comparing racial and ethnic populations that are known to have differing age distributions, health measures are typically age standardized. This is because many health measures vary by age group. In addition to age, health measures often differ by socio-economic status including household income and education level, health behaviors such as smoking, and health risks such as being obese. Utah's racial and ethnic populations have differing distributions for these health-related factors, too.

For this report, a question about general health status from Utah's Behavioral Risk Factor Surveillance System (BRFSS) survey was analyzed to illustrate some of the challenges in understanding health disparities. The percentage of adults who report fair or poor health (versus excellent, very good, or good health) increases with age. However, even after adjusting for age, it can be seen that the prevalence of adults who reported fair or poor health varied between racial and ethnic groups in Utah ranging from 7.0% (95% CI 4.0%–12.2%) for Asians up to 29.7% (26.7%–32.9%) for Hispanics (Figure 1).

Thus, the difference in the age distributions alone does not explain this disparity in health status. Further investigation showed that the age-adjusted percentage of adults who reported fair or poor health decreased with increasing income and education, was higher for

Fair or Poor Health by Race and Ethnicity

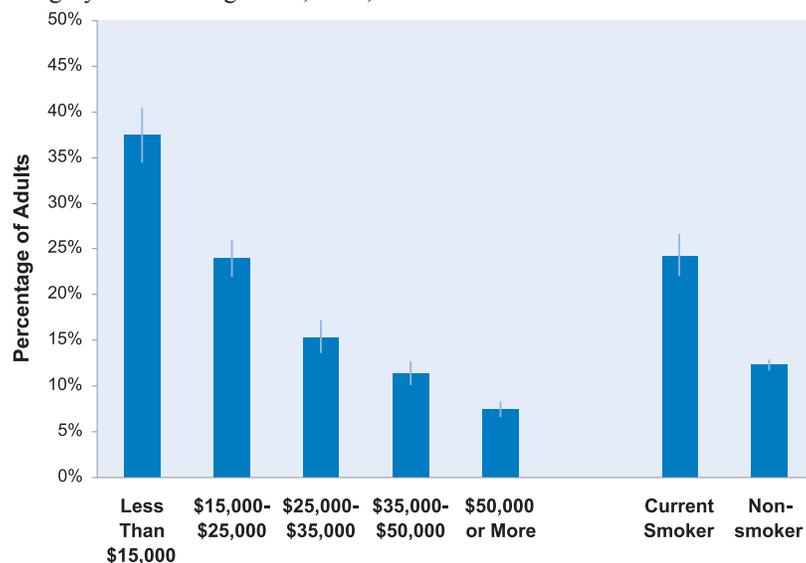
Figure 1. Percentage of adults who reported fair or poor health by race and ethnicity, Utah, 2003–2007



Source: Utah Behavioral Risk Factor Surveillance System (BRFSS)
Age adjusted to U.S. 2000 standard population.

Fair or Poor Health by Income and Smoking

Figure 2. Percentage of adults who reported fair or poor health by income category and smoking status, Utah, 2003–2007



Source: Utah Behavioral Risk Factor Surveillance System (BRFSS)
Age adjusted to U.S. 2000 standard population.

individuals who smoked versus those who did not smoke and for adults who were obese versus those who were not obese. Figure 2 illustrates these findings for income and smoking. It has also been observed that there are differences among racial and ethnic populations in Utah in the

percentage of adults who report low household income, low educational attainment, current smoking, and obesity. Figure 3 illustrates these differences for low household income.

An analytical technique that can adjust not only for age but also several other health-related demographic and risk characteristics simultaneously was used in order to determine if disparities in reported fair or poor general health status between racial and ethnic groups persist despite controlling for these differences. This technique uses odds ratios to compare the odds of reporting fair or poor general health between Utah's minority racial and ethnic populations to the referent White majority population. These results are summarized in Figure 4.

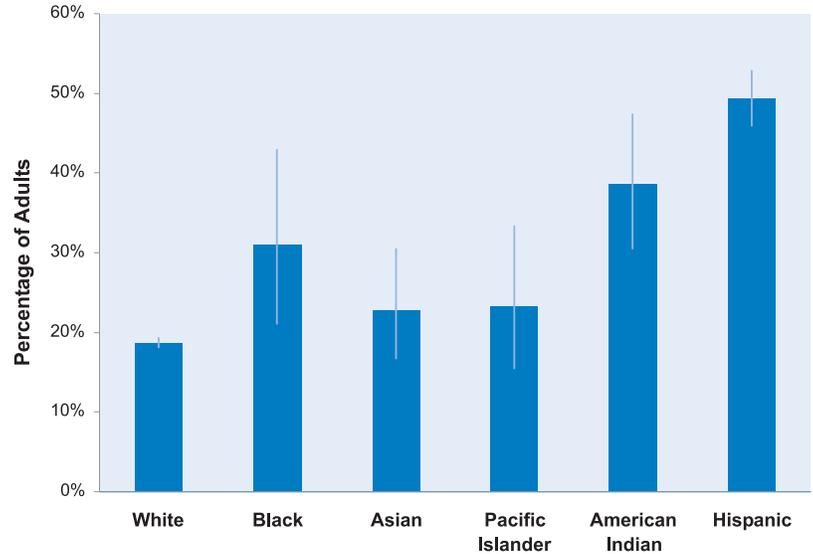
When adjusting for age only, the odds of reporting fair or poor health was greater for American Indians (OR=4.3, 95% CI 3.5–5.1) and Hispanics (OR=3.0, 95% CI 1.8–5.0) when compared to the White population. There were not significant differences in the odds for Blacks, Asians, or Pacific Islanders. When education, income, smoking status, and obesity were also controlled for, the odds were still higher for American Indians (OR=1.8, 95% CI 1.0–3.1) and Hispanics (OR=1.8, 95% CI 1.4–2.2) when compared to Whites, but the magnitude of the odds was substantially smaller.

Controlling for health-related factors in addition to age helped to explain more of the racial/ethnic differences, but disparities did remain for Utah's American Indian and Hispanic adults when compared to Whites. Public health programs that focus on modifiable risk factors among persons with low levels of income or low levels of education could help eliminate racial and ethnic disparities in Utah.

NOTE: Self-identified race/ethnicity included American Indian or Alaska Native only/Non-Hispanic, Asian only/Non-Hispanic, Black or African American only/Non-Hispanic, Hispanic (any race), Native Hawaiians or Pacific Islanders only/Non-Hispanic, and White only/Non-Hispanic.

Low Income by Race and Ethnicity

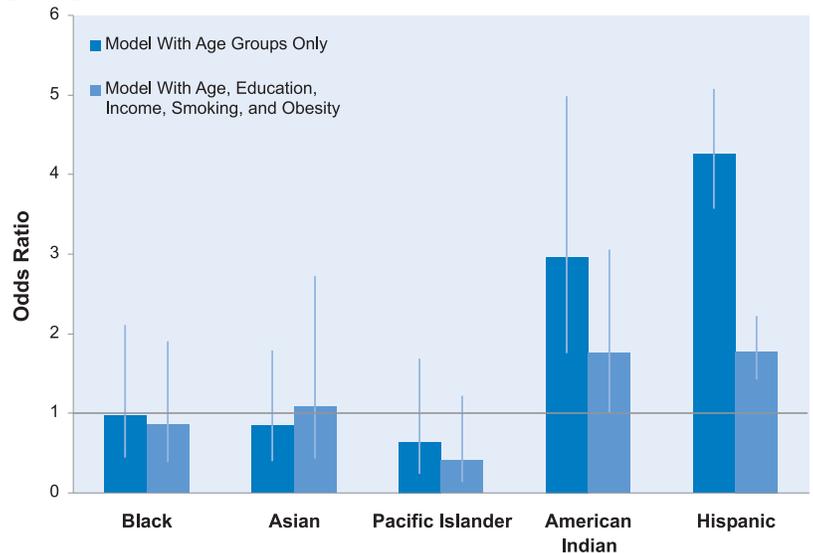
Figure 3. Percentage of adults who reported annual household incomes less than \$25,000, Utah, 2003–2007



Source: Utah Behavioral Risk Factor Surveillance System (BRFSS)
Age adjusted to U.S. 2000 standard population.

Odds Ratios for Fair or Poor Health

Figure 4. Odds ratios of reporting fair or poor health for adults in Utah's racial/ethnic minority groups versus the White majority population, Utah, 2003–2007



Source: Utah Behavioral Risk Factor Surveillance System (BRFSS)

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For additional information about this topic, contact the Office of Public Health Assessment, Utah Department of Health, Box 142101, Salt Lake City, UT 84114-2101, (801) 538-6108, FAX (801) 538-9346, email: chdata@utah.gov

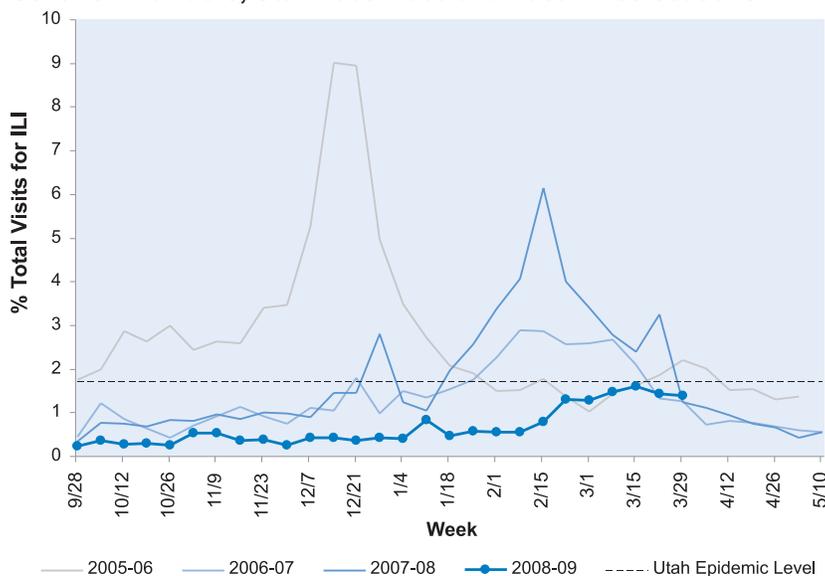
Breaking News, March 2009

Utah's 2008–2009 Influenza Season

To date, 163 influenza-associated hospitalizations have been reported in Utah for the 2008–2009 influenza season, compared to 373 at this time last year. 85% have been type A, 8% have been type B, and 8% have been undifferentiated. Roughly 50% of all hospitalizations have been in children under 5 years of age. Influenza-like illness activity in Utah has been low compared to previous years. For the past 6 weeks, activity has remained stable just under the Utah epidemic threshold. It is likely that influenza-like illness activity has peaked for the season in Utah. While the season was slow to start nationally, influenza appears much more active outside of Utah, with national influenza-like illness levels elevated above the national baseline.

Last season, CDC detected a growing number of influenza A (H1N1) isolates resistant to the antiviral drug oseltamivir (Tamiflu). This season, nearly all influenza A (H1N1) isolates tested at CDC have been resistant to oseltamivir, although resistance has not been seen in influenza A (H3N2) and influenza B isolates. In Utah, 85% of influenza isolates tested at the Utah Public Health Laboratory have been influenza A (H1), 1% have been influenza A (H3), and 14% have been influenza B. The growing resistance to antiviral medications underscores the importance of preventing influenza infection through vaccination.

Percentage of Visits for Influenza-Like Illness (ILI) Reported by Sentinel Providers, Utah 2008–2009 and Past Three Seasons



Community Health Indicators Spotlight, March 2009

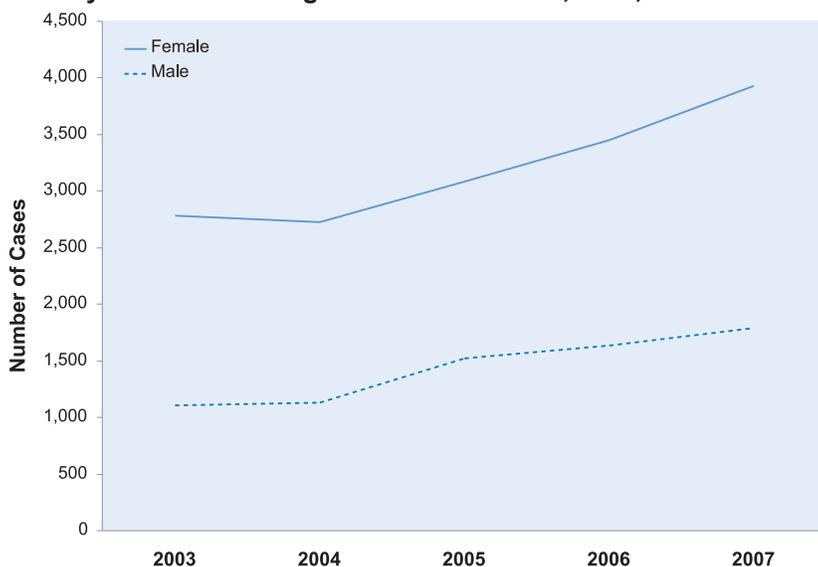
Chlamydia in Utah

During 2003–2007, chlamydia cases in Utah increased almost 50% (from 3,894 cases to 5,721 cases). Of the 23,166 cases reported during this time period, 15,973 (69%) were females and 7,193 (31%) were males.

This increase follows national trends and is partly due to increased testing and use of increasingly accurate tests. More cases are reported in females than males because testing is more often performed among females.

Chlamydia usually causes no or nonspecific symptoms, but untreated chlamydia infection can cause serious reproductive and other health problems. In women, untreated infections can spread into the uterus or fallopian tubes causing pelvic inflammatory disease (PID) leading to infertility, chronic pelvic pain, and ectopic pregnancy (pregnancy outside the uterus).

Chlamydia Cases Among Males and Females, Utah, 2003–2007



Source: Utah Department of Health, Bureau of Communicable Disease Control, Sexually Transmitted Disease Surveillance Program

Monthly Health Indicators Report

(Data Through February 2009)

Monthly Report of Notifiable Diseases, February 2009	Current Month # Cases	Current Month # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
Campylobacteriosis (Campylobacter)	8	13	25	29	0.9
Enterotoxigenic Escherichia coli (E. coli)	1	2	5	5	1.0
Hepatitis A (infectious hepatitis)	2	2	2	3	0.6
Hepatitis B (serum hepatitis)	2	1	2	3	0.6
Influenza†	Weekly updates at http://health.utah.gov/epi/diseases/flu				
Measles (Rubeola, Hard Measles)	0	0	0	0	--
Meningococcal Diseases	1	2	1	3	0.4
Norovirus	0	0	4	3	1.3
Pertussis (Whooping Cough)	18	36	33	61	0.5
Salmonellosis (Salmonella)	19	17	46	31	1.5
Shigellosis (Shigella)	0	4	1	6	0.2
Varicella (Chickenpox)	42	82	92	166	0.6
Viral Meningitis	2	4	4	8	0.5

Notifiable Diseases Reported Quarterly, 4th Qtr 2008	Current Quarter # Cases	Current Quarter # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
HIV	34	24	106	84	1.3
AIDS	9	14	34	51	0.7
Chlamydia	1,459	1,306	5,910	4,633	1.3
Gonorrhea	83	199	473	690	0.7
Tuberculosis	9	8	27	35	0.8

Program Enrollment for the Month of February 2009	Current Month	Previous Month	% Change ^s From Previous Month	1 Year Ago	% Change ^s From 1 Year Ago
Medicaid	178,646	177,149	+0.8%	159,338	+12.1%
PCN (Primary Care Network)	14,964	15,762	-5.1%	19,164	-21.9%
CHIP (Children's Health Ins. Plan)	36,607	36,231	+1.0%	31,760	+15.3%

Medicaid Expenditures (in Millions) for the Month of February 2009	Current Month	Expected/Budgeted for Month	Fiscal YTD	Budgeted Fiscal YTD	Variance - over (under) budget
Capitated Mental Health	\$ 8.1	\$ 8.5	\$ 63.5	\$ 67.8	(\$ 4.3)
Inpatient Hospital	\$ 19.4	\$ 15.9	\$ 142.6	\$ 129.9	\$ 12.7
Outpatient Hospital	\$ 8.2	\$ 6.9	\$ 57.5	\$ 55.6	\$ 1.9
Long Term Care	\$ 14.5	\$ 15.4	\$ 117.5	\$ 121.9	(\$ 4.4)
Pharmacy	\$ 9.5	\$ 10.8	\$ 82.7	\$ 95.3	(\$ 12.6)
Physician/Osteo Services‡	\$ 7.4	\$ 5.5	\$ 48.9	\$ 44.1	\$ 4.8
TOTAL HCF MEDICAID	\$ 151.4	\$ 143.7	\$ 971.5	\$ 973.5	(\$ 2.0)

Health Care System Measures	Number of Events	Rate per 100 Population	% Change ^s From Previous Year	Total Charges in Millions	% Change ^s From Previous Year
Overall Hospitalizations (2007)	278,952	9.7%	-0.7%	\$ 4,265.9	+10.1%
Non-maternity Hospitalizations (2007)	164,659	5.6%	-0.9%	\$ 3,554.6	+9.9%
Emergency Department Encounters (2007)	682,122	24.0%	-1.3%	\$ 781.0	+17.1%
Outpatient Surgery (2006)	304,511	11.3%	-3.1%	\$ 1,020.9	+7.7%

Annual Community Health Measures	Current Data Year	Population at Risk	Number Affected	Percent/Rate	% Change ^s From Previous Year
Overweight and Obesity (Adults 18+)	2008	1,924,274	1,119,500	58.2%	+0.5%
Cigarette Smoking (Adults 18+)	2008	1,924,274	179,200	9.3%	-20.4%
Influenza Immunization (Adults 65+)	2008	237,275	173,900	73.3%	-3.8%
Health Insurance Coverage (Uninsured)	2008	2,781,954	298,200	10.7%	+0.7%
Motor Vehicle Crash Injury Deaths	2007	2,699,554	269	10.0 / 100,000	-12.0%
Suicide Deaths	2007	2,699,554	368	13.6 / 100,000	-0.1%
Diabetes Prevalence	2008	2,781,954	129,500	4.7%	-1.0%
Coronary Heart Disease Deaths	2007	2,699,554	1,531	56.7 / 100,000	-5.1%
All Cancer Deaths	2007	2,699,554	2,547	94.3 / 100,000	-5.1%
Births to Adolescents (Ages 15-17)	2007	61,060	1,133	18.6 / 1,000	+13.5%
Early Prenatal Care	2007	55,063	43,728	79.4%	+0.5%
Infant Mortality	2007	55,063	284	5.2 / 1,000	+2.5%
Childhood Immunization (4:3:1:3:3:1)	2007	51,449	40,200	78.1%	+14.7%

† Influenza activity is local in Utah. Influenza-like illness activity is below baseline statewide. As of March 18, 2009, 163 influenza-associated hospitalizations have been reported to the UDOH. More information can be found at <http://health.utah.gov/epi/diseases/flu>.

§ % Change could be due to random variation.

‡ Medicaid payments reported under Physician/Osteo Services do not include enhanced physician payments.

Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance for West Nile virus has ended until the 2009 season.