

OREGON PUBLIC HEALTH DIVISION • OREGON HEALTH AUTHORITY

RACIAL AND ETHNIC HEALTH DISPARITIES IN OREGON

Medical providers know that patients who eat well, stay active, don't smoke, get recommended immunizations and screening tests, and seek appropriate care when they are sick tend to be healthier overall than those who don't. While individual choices are important for health, health status is also determined by access to social and economic opportunities, the quality of our schooling, the safety of our workplaces, and the nature of our social interactions and relationships. The conditions in which we live — the so-called "social determinants of health" — help explain why some Oregonians are healthier than others.

The health of people in different Oregon communities is affected by the conditions in which they are born, live, learn, work, play, and age. This *CD Summary* examines health disparities among racial and ethnic populations, including differences in mortality, health behaviors, chronic diseases, and maternal and child health.

**OREGON'S DEMOGRAPHICS**

The need to address racial and ethnic health disparities is essential, given Oregon's changing demographics. From 1995 to 2025, Oregon is expected to gain 197,000 people through immigration.<sup>1</sup> The Latino population has almost doubled in the past 10 years — from 275,000 in 2000 to more than 400,000 in 2010 — and is now the largest minority population in the state. Likewise, the Asian American population in Oregon continues to grow, now numbering more than 130,000.

Because it is important to monitor the health of populations, the State of Oregon collects data on health disparities by race and ethnicity. However, reporting by race and ethnicity is a tricky business and requires that some assumptions be made. Racial and ethnic categories reflect social constructs that are not necessarily based on biology, anthropology, or genetics. Broad categories used for data collection may

obscure, rather than illuminate, important health disparities. For example, the racial category of "Black or African American" does not distinguish between an African American with roots in the U.S. dating back hundreds of years and a recent refugee from Africa. Similarly, the racial category of "White" includes individuals from culturally diverse ethnic communities, such as Eastern European and Middle Eastern. Data on racial and ethnic health disparities, or lack thereof, should be interpreted thoughtfully due to these inherent limitations.

**DISPARITIES IN MORTALITY**

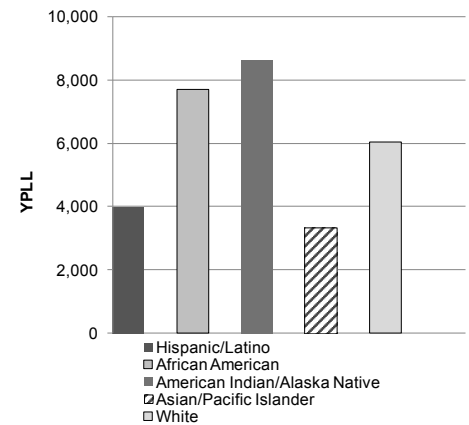
The estimation of years of potential life lost (YPLL) is a handy tool for quantifying the burden of early death. YPLL measures the number of years between age at death and the age at a specific standard lifespan. For instance, if the standard expected lifespan is set at 75 years, a death at age 21 results in 54 years of potential life lost. YPLL calculations show that some groups of Oregonians die earlier than others. The African American and American Indian/Alaska Native communities in Oregon are disproportionately burdened by premature death compared to non-Latino whites (Figure 1).

**DISPARITIES IN HEALTH BEHAVIORS**

The root causes of chronic diseases include smoking, lack of physical activity, obesity, and chronic stress. Among adults, African Americans and American Indians/Alaska Natives are more likely than other populations to smoke (table, *verso*). Disparities are similar among Oregon youth: 15% of African American and 17% of American Indian/Alaska Native 8<sup>th</sup> graders smoke, compared to 10% of white 8<sup>th</sup> graders.

Obesity rates also vary across communities. The prevalence of adult obesity is very high among Latinos, African Americans, and American Indians/Alaska Natives, while the prevalence of obesity among Asian/Pacific Island-

Figure 1. Years of potential life lost (YPLL) before age 75 per 100,000, Oregon, 2009\*



Source: Oregon Vital Statistics and National Center for Health Statistics

\*Age-adjusted to U.S. standard population, 2000

ers is relatively low (table, *verso*).

**DISPARITIES IN CHRONIC CONDITIONS**

Prevalence of chronic conditions also varies by race and ethnicity in Oregon (table, *verso*). African Americans have the highest prevalence of asthma, diabetes, and hypertension — conditions that can dramatically affect quality of life. American Indians/Alaska Natives have a higher prevalence of asthma and diabetes than do non-Latino whites, and Latinos have a higher prevalence of diabetes. In addition, the rates of new HIV/AIDS diagnoses in Oregon are higher among Latinos and African Americans than non-Latino whites, with case rates of 9.8/100,000 for Latinos, 17.5 for Black/African Americans, and 5.4 among non-Latino whites.

**DISPARITIES IN MATERNAL AND CHILD HEALTH**

Early health and risk assessments, obstetric care, and education improve health outcomes for both mother and infant. In 2009, Latino (62%), African American (63%), and American Indians/Alaska Native (60%) women in Oregon were less likely to have begun prenatal care in the first trimester compared to non-Latino white women (74%).

African American women also are



If you need this material in an alternate format, call us at 971-673-1111.

IF YOU WOULD PREFER to have your *CD Summary* delivered by e-mail, zap your request to [cd.summary@state.or.us](mailto:cd.summary@state.or.us). Please include your full name and mailing address (not just your e-mail address), so that we can purge you from our print mailing list, thereby saving trees, taxpayer dollars, postal worker injuries, etc.

**Table. Prevalence of select chronic conditions among adult Oregonians by race and ethnicity**

	Non-Latino				Latino
	African American	American Indian/Alaska Native	Asian/Pacific-Islanders	White	
Smoking	30%	38%	10%	20%	14%
Obesity	29%	30%	15%	24%	31%
Diabetes	13.4%	12.2%	7.2%	6.2%	9.6%
Hypertension	41.4%	29.5%	18.9%	25.3%	19.2%
Asthma	16.5%	15.3%	6.4%	10.1%	4.9%

Source: Oregon Behavioral Risk Factor Surveillance System, race oversample 2004–2005  
 All estimates have been age adjusted to the U.S. standard population, 2000

more likely (10%) to have infants of low birth weight than are women of other races and ethnicities (6–7%). Compared to infants of normal weight, low-birth-weight infants are at higher risk for impaired development and death during infancy.

Receipt of recommended vaccinations in early childhood is often used as a proxy for measuring the quality of well-child care. In comparison to non-Latino whites (73%), vaccination rates\* are slightly higher among Latinos (80%) and Asian Americans (76%), while the rate among Pacific Islanders (61%) is lower.†

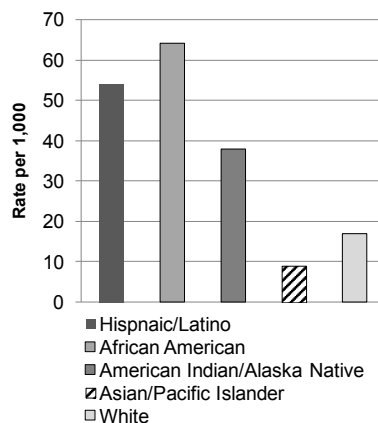
Racial and ethnic disparities also exist in rates of teen pregnancy. In Oregon, Latinos, African Americans,

and American Indians/Alaska Natives have teen pregnancy rates that are 2–3 times higher than non-Latino whites (Figure 2).

**RECOMMENDATIONS**

Health disparities must be addressed at a population level, but it is helpful for clinicians to be aware of the impact that social and economic conditions have on the health of individual

**Figure 2. Teen pregnancy rate per 1,000 women aged 15–17 years, Oregon, 2009**



\* Reported for the 4:3:1:3:3:1 immunization series — i.e., 4 doses of DTaP, 3 doses of IPV, 1 dose of MMR, 3 doses of Hib, 3 doses of HepB, and 1 dose of Varicella.

† This is an example of how analyzing data by the more specific categories of Asian American and Pacific Islander sheds light on a disparity.

patients. The Oregon Public Health Division is joining the U.S. Department of Health & Human Services<sup>2</sup> and the World Health Organization<sup>3</sup> in addressing the social determinants of health by working to achieve the Healthy People 2020 goal of “Creating social and physical environments that promote good health for all.” Tools being used include health-impact assessments to review needed, proposed, and existing social policies for their likely effects on health<sup>4</sup>; and application of a “health-in-all-policies” strategy, which introduces improved health for all and the closing of health gaps as goals to be shared across all areas of government.<sup>5</sup>

**REFERENCES**

1. Campbell PR, 1996, Population Projections for States, by Age, Sex, Race and Hispanic Origin: 1995 to 2025, Report PPL-47, U.S. Bureau of the Census, Population Division.
2. Secretary’s Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020. Healthy People 2020: An opportunity to address the societal determinants of health in the United States. July 26, 2010. Available from: [www.healthypeople.gov/2010/hp2020/advisory/SocietalDeterminantsHealth.htm](http://www.healthypeople.gov/2010/hp2020/advisory/SocietalDeterminantsHealth.htm)
3. World Health Organization, Commission on Social Determinants of Health. Closing the gap in a generation: Health equity through action on the social determinants of health. Available from: [www.who.int/social\\_determinants/en](http://www.who.int/social_determinants/en)
4. Health Impact Assessment: A tool to help policy makers understand health beyond health care. Annual Review of Public Health 2007;28:393–412. Retrieved 26 October 2010. Available from: [www.annualreviews.org/doi/abs/10.1146/annurev.publhealth.28.083006.131942](http://www.annualreviews.org/doi/abs/10.1146/annurev.publhealth.28.083006.131942)
5. European Observatory on Health Systems and Policies. Health in All Policies: Prospects and potentials, 2006. Accessed 16 June 2011. Available from: [www.euro.who.int/\\_data/assets/pdf\\_file/0003/109146/E89260.pdf](http://www.euro.who.int/_data/assets/pdf_file/0003/109146/E89260.pdf)