

INTRODUCTION TO SHIP

CHAPTER 6 ELIMINATING HEALTH DISPARITIES



Chapter 6

Eliminating Health Disparities

HEALTH DISPARITIES GENERAL OVERVIEW

Healthy People 2010 is designed to achieve two overarching goals (see Chapter 4). The second overarching goal of Healthy People 2010 is to eliminate health disparities. The elimination of health disparities is also a Pennsylvania Department of Health priority.

As it is used in this report, the term **health disparity** refers to statistically significant differences in health status, the delivery of health services, and/or the utilization of health services, which includes, but are not limited to, differences that occur by:

- **Gender**
- **Race and ethnicity**
- **Education and income**
- **Disability**
- **Geographic location**
- **Sexual orientation**

There are some health differences that cannot be avoided— for example, the burden of cervical cancer is only experienced by women because the disease is gender specific. However, there are opportunities to significantly decrease health disparities that are primarily related to factors that can be improved, such as unequal access to quality health care.

There are major challenges in measuring and tracking health disparities among some populations. For example, state-level health data for Asian and Pacific Islander (A/PI) populations in Pennsylvania is largely unavailable. Small A/PI population numbers often prevent the reliable calculation of health-related rates.

There is also limited state-level data for Pennsylvania's **Amish** population. According to the American Religion Data Archive, there were 2,090 Beachy Amish and 25,340 Old Order Amish living in Pennsylvania in 2000. The cost and availability of health care are concerns in the Amish community as members do not prescribe to conventional health insurance, live in rural areas, and have limited transportation resources.¹

Some population groups, such as **migrant farm workers**, face multiple health care barriers and experience complex health problems, including tuberculosis, parasitic diseases, and neonatal problems². Migrant farm workers often live in substandard housing with crowded conditions. Because migrant farm workers move frequently, continuity of care medical care is difficult. Migrant farm workers and their families often face linguistic, financial, immigration and educational barriers to receiving needed health services. The Centers for Disease Control and Prevention estimates that there are 3-5 million migrant and seasonal farm workers who work in the United States each year, with approximately 7% of them being adolescents³. State-level health statistics are not available for migrant farm workers in Pennsylvania.

KEY ISSUES ADDRESSED IN THIS CHAPTER:

WHAT ARE HEALTH
DISPARITIES?

WHAT ARE THE HEALTH
STATUS INDICATORS?

WHAT ARE SOME
HEALTH DISPARITIES
EXPERIENCED BY
DIFFERENT GROUPS IN
PENNSYLVANIA?

WHAT CAN MY
ORGANIZATION DO TO
HELP ADDRESS
HEALTH DISPARITIES?

WHERE CAN I GET
MORE INFORMATION
ON HEALTH
DISPARITIES?



Visit Healthy
People 2010 online at
www.healthypeople.gov
for a full listing of goals
and objectives and
valuable resource links.

Partnerships between public health agencies and justice, education and social service agencies can be forged to help address the health needs of some disparate populations. For example, public health agencies often partner with correctional systems to address health disparities among **correctional populations**. Correctional populations have higher rates of HIV/AIDS, tuberculosis, sexually transmitted diseases and more risk factors for these diseases than the general population⁴. According to the Pennsylvania Department of Corrections, seven out of 10 people committed to the Commonwealth's prisons and jails have used illegal substances, or been involved in substance abuse, prior to their incarceration⁵. In Pennsylvania, the number of inmates incarcerated has increased by 60.8% from 1992 to 2002. The total inmate population was 40,172 in December 2002⁶.

Healthy People 2010 uses different sets of health indicators to monitor progress toward the elimination of health disparities, including the **Health Status Indicators (HIS)** and Leading Health Indicators. Public Health Infrastructure of Healthy People 2010 includes objectives for data and information systems that were developed to ensure the availability of sufficient and accurate data to evaluate Healthy People indicator sets at all geographic levels and for all population groups.

HEALTH DISPARITIES- GENDER

Overview of Health Disparities – Gender

While some health differences are gender specific (e.g., cervical and prostate cancers), there are significant differences in health status between men and women that require greater attention and research.

Healthy People 2010 notes that men have a life expectancy that is 6 years less than that of women and, in Pennsylvania, have higher age-adjusted death rates for 9 of the 10 leading causes of death. In the United States, men are two times more likely than women to die from unintentional injuries and six times more likely than women to die from firearm-related injuries. Nationally, despite overall lower age-adjusted death rates for leading causes of disease, women have shown increased death rates over the past decade in diseases where men have experienced improvements, such as lung cancer. Women also are at greater risk for Alzheimer's disease than men and are twice as likely as men to be affected by major depression.

According to 2003 estimated population statistics released by the Pennsylvania State Data Center at Penn State Harrisburg (the state affiliate of the U.S. Census Bureau), 48.4% of the estimated 12,365,455 persons living in Pennsylvania are male and 51.6% are female.⁷

Health disparities data is also presented for Pennsylvania health priorities, which include the Healthy People 2010 Leading Health Indicators, in the State of the State's Health section of this report.

Table 6-1

Selected HSI Statistics for Pennsylvania by Gender, 2003 ⁸ ; rates per 100,000 population					
Health Status Indicator	HP2010 Target	US	PA	Male	Female
Age-Adjusted Cardiovascular Disease Death Rate	NA	317.4**	323.3*	393.5	272.6
Age-Adjusted Death Rate for Motor Vehicle Accidents	9.2	15.7**	12.6*	18.1	7.5
Age-Adjusted Lung Cancer Death Rate	44.9	54.9**	53.2*	73.5	39.3
Age-Adjusted Intentional Self-Harm (Suicide) Rate	5.0	10.9**	10.5*	18.0	3.8
Age-Adjusted Assault (Homicide) Rate	3.0	6.1**	5.6*	8.8	2.3
Syphilis Incidence Rate	0.2	2.5	1.3**	2.1**	0.5**
AIDS Incidence Rate	NA	15.4	10.7*	15.5	6.3

* 2003 data
 **2002 data
 NA= Not Available
 Sources: National Center for Health Statistics; U.S. Census Bureau; Pennsylvania Department of Health, Bureau of Health Statistics and Research, Bureau of Epidemiology, Bureau of Communicable Diseases, Division of Tuberculosis/Sexually Transmitted Diseases.
 This material was prepared by the Bureau of Health Statistics and Research as a special report received November 4, 2005.

HEALTH DISPARITIES- RACE AND ETHNICITY

Overview of Health Disparities - Race and Ethnicity

Healthy People 2010 presents data on the following racial and ethnic groups:

- American Indian or Alaska Native
- Asian
- Native Hawaiian and other Pacific Islander
- Black or African American
- White
- Hispanic or Latino
- Non-Hispanic Black or African-American
- Non-Hispanic White

The Pennsylvania Department of Health, Bureau of Health Statistics and Research (BHSR) reports Pennsylvania’s progress toward Healthy People 2010 objectives for the racial and ethnic categories in table 6-2 is available and large enough to be statistically reliable.

Race and ethnic disparities are believed to be the result of the complex interaction among environmental factors, specific health behaviors and genetic variations. Current information about the biologic and genetic characteristics of these racial and ethnic groups does not explain the health disparities experienced by them compared with the white, non-Hispanic population.

The U.S. Office of Management and Budget has established five categories for “racial” groups (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White) and two categories for “ethnic” group (Hispanic or Latino and Not Hispanic or Latino). Asian and Native Hawaiian or Other Pacific Islander is often combined with Asian into a single category, Asian/Pacific Islander or API.

While population growth has been minimal over the past decade, the racial and ethnic diversity of the Commonwealth continues to increase. Table 2 shows that the non-White population is approaching 20 percent, comprised mainly of African-Americans. However, the most growth since 2000 is seen in the Asian/ Pacific Islander population.

Table 6-2

Pennsylvania Population Statistics by Race/Ethnicity, 2004					
Population Variable	All Races	White	Black	A/PI	Hispanic
2004 Population	12,528,916	10,793,117	1,373,946	305,698	475,552
Percentage of Population	100.0%	86.1%	11.0%	2.4%	3.8%
Percent Change from 2000	2.0%	2.9%	12.2%	36.9%	20.7%

*Hispanics can be of any race.

Source: Pennsylvania State Data Center, November 29, 2005. Special Request.

Black and Hispanic Pennsylvania residents have higher death rates than whites for several causes of death. Figure 6-1 illustrates some of those examples (all rates are per 100,000 population):⁹

- The 2003 age-adjusted death rate for homicide among black residents was 30.9, compared to 2.3 for whites - over 13 times higher.
- The 2003 age-adjusted death rate for HIV/AIDS among black residents was almost 15 times higher than the rate for whites (23.9 vs. 1.6).
- The 2003 age-adjusted death rate of 3.1 for asthma among black residents was 2.6 times higher than the rate of 1.2 for whites.
- The 2003 age-adjusted death rate among Hispanic residents for homicide was almost 5 times higher than the rate for whites (11.4 vs. 2.3).
- The 2002 HIV/AIDS age-adjusted death rate of 14.0 among Hispanic residents was almost 9 times higher than the rate of 1.6 for whites.

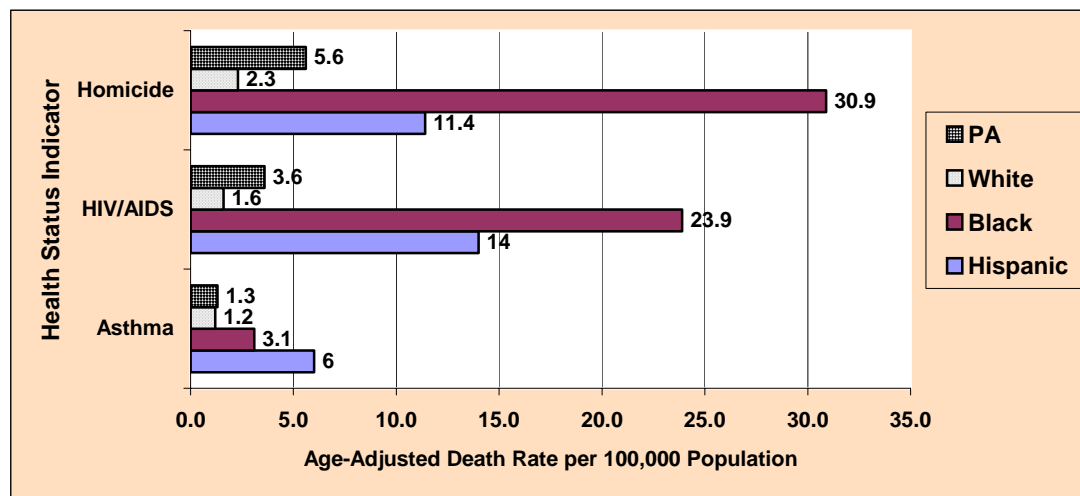


The Bureau of Health Statistics and Research provides minority health reports on its website:
www.health.state.pa.us/stats

Figure 6-1

Homicide, HIV/AIDS and Asthma Health Status Indicators for Pennsylvania by Race/Ethnicity*, 2003

Rates per 100,000 population



*Rates are not calculated for Asian/Pacific Islanders due to small numbers.

Source: Pennsylvania Department of Health, Bureau of Health Statistics and Research

HEALTH DISPARITIES- INCOME AND EDUCATION

Overview of Health Disparities- Income and Education

Inequalities in income and education underlie many health disparities in the United States. In general, population groups that suffer the worst health status also are those that have the highest poverty rates and the least education. According to Healthy People 2010, disparities in income and education levels are associated with differences in the occurrence of illness and death, including heart disease, diabetes, obesity, elevated blood lead level, and low birth weight. Higher incomes permit increased access to medical care, enable people to afford better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors.

According to U.S. Census Bureau data, the median household income for the period 2001—2003 in Pennsylvania was \$43,869, compared to \$43,527 for the United States.

The Pennsylvania Department of Health, Bureau of Health Statistics and Research collects some risk factor data on Pennsylvania adults through the Pennsylvania Behavioral Risk Factor Surveillance System (BRFSS) survey. The following 2004 BRFSS statistics related to income and education disparities are age-adjusted:

- Of Pennsylvanians aged 18-64, 15% responded “no” to having any kind of health care coverage in 2004.
- Significantly more young adults (26% of those ages 18-29) reported having no health insurance compared to older adults (13% for ages 30-44 and 10% for ages 45-64).

- Eleven percent of Pennsylvania adults responded that there was an instance where they needed to see a doctor but could not because of cost.
- Adults with less than a high school education recorded a significantly higher percentage with no health care coverage (35%) compared to adults with a high school education or more. Adults with a high school diploma had a significantly higher percentage (18%) compared to adults with a college degree (7%).
- Among Pennsylvania adults in 2004, those without any college education had significantly lower percentages of vigorous or moderate leisure time physical activity compared to those with some college or a college degree.

HEALTH DISPARITIES- DISABILITY

Overview of Health Disparities - Disability

People with disabilities are identified as persons having an activity limitation, who use assistance, or who perceive themselves as having a disability. According to Healthy People 2010, 54 million people in the United States, or roughly 21 percent of the population, had some level of disability in 1994. Although rates of disability are relatively stable or falling slightly for people aged 45 years and older, rates are on the rise among the younger population. People with disabilities tend to report more anxiety, pain, sleeplessness, and days of depression and fewer days of vitality than do people without activity limitations. Many people with disabilities lack access to health services and medical care.

According to the 2004 Pennsylvania Department of Health's Behavioral Risk Factor Surveillance System (BRFSS) statewide sample survey of adults, 18% of Pennsylvania adults reported that they were limited due to physical, mental, or emotional problems. Seven percent of Pennsylvania adults indicated that they had a health problem that required them to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone.

Among those reporting limitations due to physical, mental or emotional problems in the 2004 Pennsylvania BRFSS:

- Pennsylvania adults with a less than a high school education had a significantly higher reported disability percentage (26%) compared to adults with some college education or higher (some college education, 18percent; college degree, 12 percent).
- Adults with household incomes of less than \$15,000 had a significantly higher percentage (35%) compared to adults with household incomes of \$15,000+ (\$15,000-\$24,999, 22 percent; \$25,000-\$49,999, 18 percent; \$50,000-\$74,999, 12 percent; \$75,000+, 9 percent).
- Adults age 45+ had significantly higher percentages of limitations due to physical, mental or emotional health problems (ages 45-64, 22%; age 65+, 26%) compared to adults under age 45 (ages 18-29, 9%; ages 30-44, 13%).

HEALTH DISPARITIES- GEOGRAPHIC LOCATION

Overview of Health Disparities - Geographic Location

Twenty-five percent of Americans live in rural areas, that is, places with fewer than 2,500 residents, as defined by the 1990 census definition of an urbanized area. Injury-related death rates are 40 percent higher in rural populations than in urban populations. Heart disease, cancer, and diabetes rates exceed those for urban areas. People living in rural areas are less likely to use preventive screening services, exercise regularly, or wear safety belts. In 1996, 20 percent of the rural population was uninsured compared with 16 percent of the urban population. Timely access to emergency services and the availability of specialty care are some of the critical public health issues for this population group.

For Census 2000, the United States Census Bureau developed a new definition that classified as “urban” all territory, population, and housing units located within an urbanized area (UA) or an urban cluster (UC). It delineated UA and UC boundaries to encompass densely settled territory, which consists of:

- Core census block groups or blocks that have a population density of at least 1,000 people per square mile and
- Surrounding census blocks that have an overall density of at least 500 people per square mile. In addition, under certain conditions, less densely settled territory might be part of each UA or UC.

The Census Bureau's classification of “rural” consists of all territory, population, and housing units located outside of UAs and UCs. The rural component contains both place and non-place territory. Geographic entities, such as census tracts, counties, metropolitan areas, and the territory outside metropolitan areas, often are “split” between urban and rural territory, and the population and housing units they contain often are partly classified as urban and partly classified as rural. This new definition reduced Pennsylvania's rural population from 3,693,348 in 1990 to 2,819,968 in 2000. This population is almost entirely White.

- According to the Bureau of Health Statistics & Research, many rural counties had 2000-2002 age-adjusted death rates for heart disease that were higher than the state rate.
- In comparing 2000-2002 age-adjusted death rates for stroke by county, the highest rates occurred in mostly rural counties.

The Pennsylvania Office of Rural Health was established at Penn State in 1991. It is a joint effort of the Colleges of Health and Human Development and Penn State Outreach and Penn State Cooperative Extension and is currently administered in the Department of Health Policy and Administration. The office is funded by the Federal Office of Rural Health Policy of the U.S. Department of Health and Human Services, the Pennsylvania Department of Health, and Penn State University.

HEALTH DISPARITIES- SEXUAL ORIENTATION

Overview of Health Disparities - Sexual Orientation

America's lesbian, gay, bisexual, and transgender (LGBT) population comprises a diverse community with varied health issues. Major health concerns for gay men are HIV/AIDS and other sexually transmitted diseases, substance abuse, depression, and suicide. According to Healthy People 2010, gay male adolescents are two to three times more likely than their peers to attempt suicide. Healthy People 2010 notes that some evidence suggests lesbians have higher rates of smoking, overweight, alcohol abuse, and stress than heterosexual women. The issues surrounding personal, family, and social acceptance of sexual orientation can place a significant burden on mental health and personal safety.

Pennsylvania Demographics - Sexual Orientation

According to the U.S. Census Bureau 2000 Census¹⁰:

- There are 2,705,295 households in Pennsylvania occupied by a married or unmarried couple, and of these 21,166 households (0.8 percent) are occupied by same sex couples:
 - 10,492 by male same-sex couples
 - 10,674 by female same-sex couples
- Approximately 32% of same-sex partner households include children under 18 years old:
 - 31.5 percent of male same-sex couple households
 - 33.2 percent of female same-sex couple households
- National increases in syphilis cases recently have observed primarily among men, and several cities have reported syphilis outbreaks among men who have sex with men (MSM).
- Primary and secondary syphilis cases in Pennsylvania increased 30 percent from 108 cases in calendar year 2002 to 155 cases in 2003. Sixty-nine of the 155 cases (44 %) were among MSM.

RECOMMENDATIONS FOR ADDRESSING HEALTH DISPARITIES

Background

The SHIP Health Improvement Planning Committee, which consisted of representatives from SHIP-affiliated community partnerships, state agencies, Department of Health programs, and the SHIP Advisory Board, reviewed national resources on health disparities, including the Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, state reports related to health disparities, and SHIP community-affiliated partnerships' success stories, to develop the list of recommendations presented in this section.

The Health Improvement Planning Committee maintains that a root cause approach focusing on individual behavior, health promotion and disease prevention, and health policy are needed to

effectively address health disparities in the Commonwealth. Thus, recommendations for addressing health disparities are presented under three domains:

- **Health Care Delivery**
- **Health Promotion** (focusing on lifestyle and behavior changes)
- **Health Policy**

Call to Action

The recommendations provided in this section are not prescriptive; rather they are presented as starting points for community partnerships, local and state health agencies, and health care systems to begin examining and addressing health disparities in the communities and populations they serve.

Recommendations should be prioritized and incorporated into organizations' programs and practices based on the needs of the populations they serve and resources available for implementing, sustaining and evaluating the impact of adopted recommendations. Resources for translating these recommendations into action steps are provided in this chapter. Federally and state funded health programs are also taking action to address health disparities throughout the Commonwealth.

Recommendations – Health Care Delivery

- Educate health professionals in your organization or community on understanding cultural diversity and patient motivation; openly discuss perceptual differences across groups.
- Raise cultural competence and diversity training as a continuous quality improvement (CQI) issue in your organization.
- Support state and local efforts to recruit racial and ethnic minorities into the health professions.
- Include financiers, health insurance representatives, and third-party payers in your organization's planning around identifying and addressing health disparities.
- Develop policies, training, and health care provider prompts and tools to help eliminate differential treatment of Medicare and Medical Assistance Access patients.
- Document the effectiveness of your organizations interventions with particular disparity groups, and share success stories with partners.
- Develop policies, training and tools that encourage health professionals to consider their perceptions of risk (i.e., to address the issue of certain segments of the population not being asked important health questions because they or their health professionals do not consider them at risk).
- Contribute to the improvement of local health status and economy by supporting the development of the community laid worker infrastructure through the provision of technical assistance, health services training or other contributions.
- Connect with community partnerships to stay abreast of community health resources that are available, accessible and appropriate for different segments of the population your organization serves.

- Participate in, and support the expansion of, exemplary medical volunteer models such as Kids Smiles in Philadelphia and Centre for Volunteers in Medicine in State College.

Recommendations - Health Promotion

- In promoting healthy lifestyles:
 - Use educational programs and the media to better target disparity populations.
 - Take interventions to where the people are— address health issues at multiple points in the community beyond traditional health care settings (e.g., beauty/barber shops, grocery stores, mobile services).
 - Reinforce simple, consistent health messages.
 - Expand evidence-based, faith-based initiatives, such as the parish/church nurse model program.
 - Use local celebrities to reach target audiences.
 - Recruit disease survivors to serve as community lay workers.
 - Identify and encourage healthy activities that are appropriate and feasible at any age.
- Local and state groups should positively exploit national media attention by providing timely comment and linking national health issues and trends to local health issues and trends.
- Serve on school health councils and participate in other school meetings and health initiatives to raise awareness among local school boards about the role of their decision-making in influencing healthy behaviors in school children; emphasize that healthy behaviors begin at an early age; and support a comprehensive approach to health that includes vision and eye health.
- Understand and use the role of technology in informing and educating patients (e.g., use of bilingual kiosks in targeted areas to simplify message and delivery and maintain user anonymity).

Communities can partner with local colleges and universities to conduct community health research and to collect community-level health data that can be used to direct and enhance program services.

Recommendations – Health Policy

- Structure marketing campaigns and material to both raise awareness of health risks and disease prevention and control issues in the general public and increase knowledge around these issues among targeted groups (e.g., disparate populations, legislators, health care professionals).
- Improve and enhance data collection and information systems to include more health data for:
 - Children and youth
 - Small population groups, including Asian/Pacific Islander
 - Various socio-economic variables

Innovative Activity

Convene house parties. Though a house party may focus on a single health issue, a variety of health issues can be covered. Provide time and space for guests to browse through health resources after the party.

- Hamilton Health Care, Inc.

- Morbidity measures
- Collaborate with partners and examine technology to link major health data sources and databases.
- Identify the limitations of current data sources and collection methods to ensure that health inequities are not overlooked or misinterpreted.
- Educate community-based programs on ways to collect local data that are meaningful and accurate.

Pennsylvania Public Health Efforts

The Center for Rural Pennsylvania: <http://www.ruralpa.org>

Pennsylvania Department of Health: <http://www.health.state.pa.us>

PennsylvaniaPowerPort: <http://www.state.pa.us> Provides links to all state agencies, including the Governor's Advisory Commission on African American Affairs, Governor's Advisory Commission on Asian American Affairs, and Governor's Advisory Commission on Latino Affairs.

While this resource list is not exhaustive, it provides some credible starting points for statistics, best practices, and toolkits related to health disparities

Other State Agency and National Resources

The Center for Minority Health at the Graduate School of Public Health, University of Pittsburgh: <http://www.cmh.pitt.edu>

The Commonwealth Fund: <http://www.cmwf.org>

Kaiser Family Foundation: <http://www.kff.org>

Public Health Foundation: <http://www.phf.org>

The Robert Wood Johnson Foundation: <http://www.rwjf.org>

Administration on Aging: <http://www.aoa.gov>

Agency for Healthcare Research and Quality: <http://www.ahrq.gov>

Centers for Disease Control and Prevention: <http://www.cdc.gov>

Department of Health and Human Services (DHHS): <http://www.hhs.gov>

DHHS Office of Minority Health: <http://www.omhrc.gov>

Office of Minority Health Resource Center
 Department of Health and Human Services
 1101 Wootton Parkway, Suite 650
 Rockville, MD 20852
 1-800-444-6472

The Guide to Community Preventative Services: <http://www.thecommunityguide.org>

Healthy People 2010: <http://www.healthypeople.gov>

Healthfinder: <http://www.healthfinder.gov>

HRSA Bureau of Primary Health Care: <http://www.bphc.hrsa.gov>

HRSA Office of Rural Health Policy: <http://www.ruralhealth.hrsa.gov>

Indian Health Service: <http://www.ihs.gov>

National Center for Minority Health Disparities: <http://www.ncmhd.nih.gov>

National Institutes of Health: <http://www.nih.gov>

Office of the Surgeon General: <http://www.surgeongeneral.gov/index.html>

Office on Women's Health: <http://www.4woman.gov>

Health Status Indicators

The Health Status of a community is measured by key Health Status Indicators (HSI). Together with demographic and socio-economic data, Health Status Indicators provide a profile of the community and are a foundation for defining the community Health needs. Health Status Indicators identify the mortality and morbidity rates of the Commonwealth. Please see table on the following page.

Table 6-3 presents Health Status Indicator data for those populations for which data are available. The comparisons are divided into three categories: U.S and P.A. rates and Healthy People 2010 targets, gender, and race and ethnicity. Although some individual populations appear to have met some Healthy People 2010 targets, the goal is to meet or exceed those targets for all populations.

Table 6-3 Health Status Indicators Data for the United States, Related Healthy People 2010 Targets, and Pennsylvania by Gender and Race/Ethnicity, 2003¹¹;
Death and Disease Rates per 100,000 persons, Infant Mortality per 1,000 Live Births

Health Status Indicator*	HP2010 Target	US	PA	Male	Female	White	Black	Hispanic	API
Age-Adjusted Death Rate for All Causes	NA	845.3**	869.8	1067.5	728.9	850.9	1146.8	639.0	382.0
Age-Adjusted Cardiovascular Disease Death Rate	NA	317.4**	323.3	393.5	272.6	318.8	402.4	201.7	141.2
Age-Adjusted Coronary Heart Disease Death Rate	166.0	180.0**	177.0	231.3	138.5	175.7	209.5	104.5	67.3
Age-Adjusted Stroke Death Rate	48.0	56.2**	53.7	54.3	52.5	52.0	77.5	47.6	39.2
Age-Adjusted Death Rate for Motor Vehicle Accidents	9.2	15.7**	12.6	18.1	7.5	13.2	10.2	13.0	4.7
Age-Adjusted Lung Cancer Death Rate	44.9	54.9**	53.2	73.5	39.3	52.6	66.9	23.6	20.7
Age-Adjusted Female Breast Cancer Death Rate	22.3	25.6**	27.1	NA	27.1	26.7	34.3	21.9	10.4
Age-Adjusted Intentional Self-Harm (Suicide) Rate	5.0	10.9**	10.5	18.0	3.8	11.0	7.6	6.6	4.7
Age-Adjusted Assault (Homicide) Rate	3.0	6.1**	5.6	8.8	2.3	2.3	30.9	11.4	3.4
Work-Related Injury Death Rate	NA	1.9	1.7	3.2	0.3	1.6	1.5	2.4	DSU
Infant Death Rate	4.5	7.0**	7.3	8.1	6.4	6.2	16.1	7.7	2.8
Syphilis Incidence Rate	0.2	2.5	1.3**	2.1**	0.5**	0.6**	6.2**	DSU**	DSU**
AIDS Incidence Rate	NA	15.4	10.7	15.5	6.3	3.5	59.3	41.3	4.0
Tuberculosis Incidence Rate	1.0	5.2	2.7	2.9	2.5	1.3	7.6	13.7	37.5
Measles Incidence Rate	0.0	0.02	DSU	DSU	DSU	DSU	DSU	DSU	DSU
Percent Low Birth Weight	5.0	7.9	8.1	7.4	8.8	6.9	14.2	8.9	7.8
Percent of Births with Mother Not Obtaining Prenatal Care in First Trimester	10.0	15.9	18.1	NA	NA	14.7	35.0	30.8	22.2
Percent of Births to Mothers Less than 18 Years of Age	NA	3.4	3.2	NA	NA	2.0	8.4	8.2	0.8
Percent of Children 5-17 Years Old Living in Poverty	NA	15.3**	12.8**	NA	NA	NA	NA	NA	NA
Percent of Persons Living in Counties Exceeding EPA Air Quality Standards (Ozone)	0.0	41.0***	81.4	NA	NA	NA	NA	NA	NA

** This is 2002 data. NA = Not Available. DSU = Data Statistically Unreliable (<10 events)

Note: Death rates (all causes and cause-specific) are per 100,000 population (except for female breast cancer, which is per 100,000 females) and are age-adjusted to the 2000 U.S. standard million population (except for work-related injury, which is a crude rate per 100,000 population). Infant death rates are per 1,000 live births. All disease incidence rates are per 100,000 population. AIDS incidence reported as of 12/31/04.

Sources: National Center for Health Statistics; U.S. Census Bureau; Census of Fatal Occupational Injuries as conducted by the U.S. Department of Labor; Pennsylvania Department of Health, Bureau of Health Statistics and Research, Bureau of Epidemiology, Bureau of Communicable Diseases, Division of Tuberculosis/Sexually Transmitted Diseases; Pennsylvania Department of Environmental Protection, Bureau of Air Quality. Prepared as a special report by the PA DoH Bureau of Health Statistics and Research for this Plan and received on November 4, 2005.

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- 1 American Religion Data Archive. www.thearda.com. Internet; accessed December 14, 2005. The American Religion Data Archive (ARDA) is a project funded by the Lilly Endowment, Inc. and acts to preserve quantitative data on American religion, to improve access to this data, to increase the use of the data, and to allow comparisons across data files. The ARDA collection includes data on churches and church membership, religious professionals, and religious groups (individuals, congregations and denominations). The Beachy Amish separated from the Old Order Amish in the 1920s.
 - 2 Centers for Disease Control and Prevention. Prevention and control of tuberculosis in migrant farm workers: Recommendations of the Advisory Council for the Elimination of Tuberculosis. Atlanta, Georgia, 1992. MMWR 1992: 41.
 - 3 CDC, Office of Minority Health, Farm worker Health: www.cdc.gov/omh/AMH/farmworker.htm
 - 4 National Alliance of State and Territorial Aids Directors, NASTAD HIV Prevention Fact Sheet: www.nastad.org.
 - 5 Pennsylvania Department of Health, PA Health Department kicks off conference on drug abuse, addiction (press release). September 27, 2004.
 - 6 Pennsylvania Department of Corrections, The Office of Planning, Research, Statistics and Grants. 2002 Annual Statistical Report.
 - 7 Pennsylvania State Data Center, Penn State Harrisburg, Pennsylvania Facts 2005, http://pasdc.hbg.psu.edu/pasdc/whats_new/2005FactsBrochure.pdf accessed on December 9, 2005
 - 8 PA DOH, Bureau of Health Statistics and Research. Part of a special report received November 4, 2005. Sources include: National Center for Health Statistics; U.S. Census Bureau; Pennsylvania Department of Health, Bureau of Health Statistics and Research, Bureau of Epidemiology, Bureau of Communicable Diseases, Division of Tuberculosis/Sexually Transmitted Diseases.
 - 9 BHSR. Epidemiologic Query and Mapping System (EpiQMS) report. The EpiQMS system may be found on-line at app2.health.state.pa.us/epiqms/Asp/ChooseDataset.asp. Internet; accessed December 15, 2005.
 - 10 U.S. Census Bureau, Census 2000 Special Reports, "Married-Couple and Unmarried Couple Households: 2000." This publication is available online at www.census.gov/prod/2003pubs/censr-5.pdf.
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