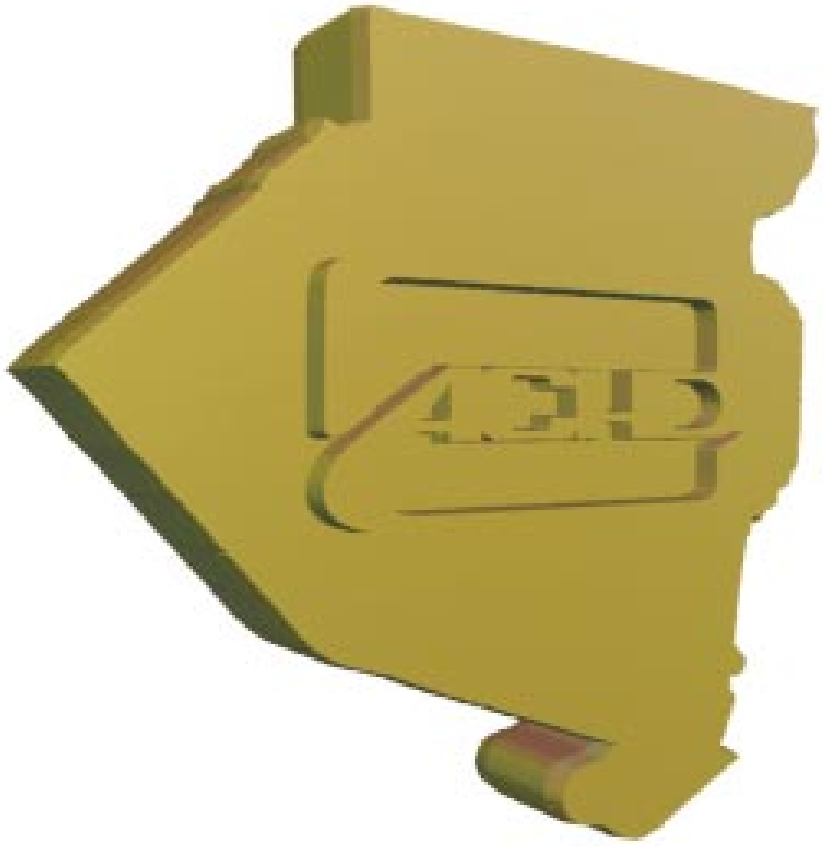
Profile of
ALLEGHENY COUNTY



ALLEGHENY COUNTY HEALTH DEPARTMENT
BUREAU of POLICY DEVELOPMENT and ASSESSMENT

BRUCE W . DIXON, MD, DIRECTOR

New Table of Contents

EXECUTIVE SUMMARY

Improving the health of our community begins with accurate information on its current status and the means of measuring successful control of our health problems. Allegheny County Health Department has prepared this "report card" of key health indicators selected on the basis of three principal criteria:

1. These indicators include the leading causes of death or represent particular health risks for our County.
2. The indicators are included in the Healthy People 2000 priority areas.
3. Accurate local data are available to measure current status and track progress.

Areas studied include chronic diseases, injury, infectious diseases and maternal and child health issues. Based upon the health statistics and our assessment of the health systems in our county, we have developed five recommendations to sustain positive areas and improve areas that are lagging:

SUPPORT AND EXPAND EFFECTIVE PROGRAMS

Liz Schorr, in her book *Within Our Reach*, concluded that we know what works and need to sustain these efforts. Our progress in reducing infant mortality, gonorrhea (STD), unintentional injuries and immunization preventable diseases is encouraging. We must now resist the temptation to dilute successful programs, pulling away staff, resources and funding because the problem has decreased.

This does not mean that the program delivery system is untouchable. Creative strategies to sustain successful programs need to explore institutional change as an effective as well as cost-efficient alternative. Public/private partnerships should continue to be the heart of efforts to sustain gains in health status and to move to the next level.

ENCOURA GE COLLABORATION AMONG HEALTH, SOCIAL SERVICE AND COMMUNITY ORGANIZATIONS TO CHANGE SOCIAL CONDITIONS AND BEHAVIORS THAT LEAD TO POOR HEALTH OUTCOMES

Today more than ever, no one organization can "do it all." Collaboration and cooperation make sense not only in terms of maximizing existing resources but also in terms of planning and implementing programs that meet emerging needs. Prevention, while not glamorous or high tech, works. Effective programs must blend health care, health education, environmental modification and public policy to create a culture supporting a prudent lifestyle. Economic development efforts that bring money into depressed communities, provide jobs with adequate salary and benefits, and support community wide efforts to revitalize areas are equally important contributors to overall health status. Collaborative efforts, with each organization identifying its strength and with citizen input into planning and implementation, bring expertise and insights to the table. All partners can contribute to an environment supporting change in social conditions.

TARGET HEALTH PROMOTION/HEALTHY LIFESTYLE PROGRAMMING TO THE AFRICAN–AMERICAN COMMUNITIES FOCUSING ON HIGH RISK AREAS

One of the goals of Healthy People 2000 is to reduce health disparities between total population and population groups that experience above average incidence of death, disability and disease. In Allegheny County these disparities are most visible in the African-American community, as documented by excess deaths in heart disease, cancer, injuries and stroke. Prevention efforts to close this gap must address behavioral risk factors like diet, smoking and weight, and address utilization of primary health care for early diagnosis and treatment.

David Satcher, MD, Director of the Centers for Disease Control and Prevention, recommends that "prevention efforts to reduce risk factors associated with chronic diseases should be tailored to ...racial and ethnic minorities." Targeted programming must be planned with and by members of the African–American community and should be culturally sensitive. Planning must acknowledge the barriers created by poverty, transportation, concerns about personal safety and conflicting priorities. Partnerships and strategies to sustain programming beyond initial pilot stages are essential.

MOVE COLLABORATIVE VIOLENCE PREVENTION EFFORTS TO THE FOREFRONT

Violence has emerged during this last decade as the leading cause of death in young African–American males. This is a public health problem. The public health model of collection and analysis of data, community-based problem solving that uses data as a starting point and collaborative interventions have potential to come to grips with this deadly plague. This issue must be addressed by community partnerships among many types of organizations and citizens, which will lead to focused and targeted interventions. A solution cannot be imposed by government or law enforcement acting alone. As resources and funding for human services appear to be diminishing, redeploying funds into efforts to reduce violence will be difficult, but this public health problem must move higher on the priority list.

STUDY AND DOCUMENT THE EFFECTS OF POVERTY ON HEALTH STATUS IN WELFARE REFORM

This is a time of proposed change in the structure of government and in the funding of many human service programs. Managed care will have impacts upon families, individuals and health care systems as use of emergency rooms for primary care declines. We need to scrutinize indicators as changes occur in welfare, in health care, in funding patterns and in populations. Data systems must collect useful information to support timely health status monitoring. Findings should be used to influence proposed changes in welfare and health care benefits.

HEALTHY PEOPLE 2000
STATUS OF SENTINEL OBJECTIVES

NATIONAL GOAL FOR YEAR 2000	US GOAL MET?	PA GOAL MET?	ALLEGHENY COUNTY GOAL MET?	LOCAL PROGRESS IN RIGHT DIRECTION?
LOWER RATE OF HEART DISEASE DEATHS TO 100 PER 100,000	NO	NO	NO	YES
LOWER RATE OF HEART DISEASE DEATHS IN AFRICAN-AMERICANS TO 115 PER 100,000	NO	NO	NO	YES
LOWER RATE OF CANCER DEATHS TO 130 PER 100,000	NO	NO	NO	NO CHANGE
LOWER RATE OF BREAST CANCER DEATHS TO 20.6 PER 100,000 WOMEN	NO	NO	NO	NO CHANGE
LOWER RATE OF STROKE DEATHS TO 20 PER 100,000	NO	NO	NO	YES
LOWER RATE OF STROKE DEATHS IN AFRICAN-AMERICANS TO 27 PER 100,000	NO	NO	NO	YES
SLOW INCREASE IN COPD DEATH RATE TO 25 PER 100,000	NO	NO	NO	NO
ELIMINATE ALL MEASLES CASES	NO	YES(1993)	NO(1994)	YES
LOWER CASE INCIDENCE OF TUBERCULOSIS TO 3.5 PER 100,000	NO	NO	NO	YES
LOWER CASE INCIDENCE OF SYPHILIS TO 10 PER 100,000	NO	YES	YES	YES
LOWER CASE INCIDENCE OF GONORRHEA TO 225 PER 100,000	YES	YES	YES	YES
CONFINE INCIDENCE OF AIDS TO 35.5 PER 100,000	YES	YES	YES	YES
LOWER HOMICIDE RATE TO 7.2 PER 100,000	NO	YES	NO	NO
LOWER SUICIDE RATE TO 10.5 PER 100,000	NO	NO	NO	NO CHANGE
LOWER MOTOR VEHICLE CRASH DEATH RATE TO 16.8 PER 100,000	YES	YES	YES	YES
DECREASE INFANT MORTALITY RATE TO 7 PER 1,000 LIVE BIRTHS	NO	NO	NO	YES
DECREASE BLACK INFANT MORTALITY RATE TO 11 PER 1,000 LIVE BIRTHS	NO	NO	NO	YES

INTRODUCTION

Improving the health of our community begins with accurate information on its current status and the means of measuring successful control of our particular health problems. Only with reliable baseline data and a set of realistic objectives can we plan a course of action to address these problems. For this reason the Allegheny County Health Department has prepared this Public Health Profile of Allegheny County.

The following reports represent a "report card" of 14 key health indicators selected on the basis of three principal criteria:

1. These indicators include the leading causes of death in Allegheny County or represent particular health risks for our area.
2. The indicators are included in Healthy People 2000's priority areas. Healthy People 2000 is a national strategy for improving the health of the American people over the decade of the 1990's. Through a consensus of national experts, Healthy People 2000 selected 22 priority health issues for the country and established benchmarks for improvement by the year 2000.
3. Accurate local data are available to measure current status and track progress.

The 14 indicators selected for the Profile are listed below in four broad categories. Because some of our most serious health problems are caused by environmental and social conditions, they represent a combination of traditional disease classifications and health risk behaviors.

Chronic Diseases	Infectious Diseases
Heart Disease	Measles
Cancer	Hepatitis B
Breast Cancer	Tuberculosis
Stroke	Sexually Transmitted Diseases
Chronic Obstructive Pulmonary Disease	
Injury	**Maternal and Child Health Issues**
Homicide	Teen Pregnancy and Parenthood
Suicide	Infant Mortality
Motor Vehicle Deaths	

To provide a meaningful evaluation of health status, the Profile compares local status with Pennsylvania and national rates for each of these indicators. The Healthy People 2000 target objectives are also included. In this way the Profile can serve as a baseline document for evaluating health status over time.

The responsibility for improving health status in our county does not fall to the medical community alone. Environmental, social and behavioral complexities of so many of our health problems call for the combined efforts of public officials, social agencies, schools, hospitals and the public health system. It is the intention of the Allegheny County Health Department that the Public Health Profile will serve as a catalyst for convening the community around these health problems and as a planning tool for guiding future collaborative efforts to improve the health of Allegheny County.

BACKGROUND

The population of Allegheny County and the City of Pittsburgh reflects an aging population, with 17% of our population aged 65 and older and 21% less than 18. Our older population groups are increasing at a faster rate than the younger populations. Elderly populations are high consumers of medical care resources. Young populations are vulnerable to injury, sexually transmitted diseases and unplanned pregnancy. Both populations may require assistance or supervision at the extremes of age. Overlaps and gaps in services for both populations exist. Ongoing coordination, cooperation and collaboration to fill gaps and move away from duplicate services will become even more critical in light of potential changes in federal and state funding and service delivery patterns.

Allegheny County compares very favorably to the state and nation when examined as a whole. However, when you begin to examine health indicators by smaller population groups, such as city versus county, a clear difference is apparent. Health indicators generally are less favorable for the City of Pittsburgh than for Allegheny County. The disparity may be explained in part by the higher number of families and individuals, with income below the poverty level, living in the City of Pittsburgh. Improvements in health status have not been uniform and here, as in many other areas, poverty remains a risk factor for poor health.

Poverty remains a risk factor for poor health.

Allegheny County has many health and human service providers, including community clinics, private practices and sophisticated hospitals providing the highest levels of medical care. Access to care issues in this region are generally linked with:

- An inability to pay for services and supplies (*Community Health Centers: Making a Difference*, The Jewish Healthcare Foundation, 1993);
- Lack of health insurance (*Hometown Hunger*, Just Harvest, 1994);
- Transportation barriers (*Healthy Start Comprehensive Plan*, 1989 and Maternal and Child Health Home Visiting Survey, 1994);
- Individuals who do not understand how to access the system or who mistrust the system; and
- Insensitivity of health care providers (*Healthy Start Comprehensive Plan*, 1989).

Impacts of barriers to using the health care system are evident in acute conditions such as cases of preventable communicable diseases as well as in chronic diseases such as heart disease and cancer. Early detection, regular treatment and monitoring can prevent, postpone onset and/or mitigate the development of both infectious and chronic disease.

HEALTH STATUS INDICATORS

Health status can be examined in many ways. This report examines Allegheny County's health status by organizing information and health indicators into four categories:

- Chronic Diseases
- Infectious Diseases
- Injury
- Maternal and Child Health Issues

Each category will look at city, county, state and national health indicators and discuss risk factors and local conditions.

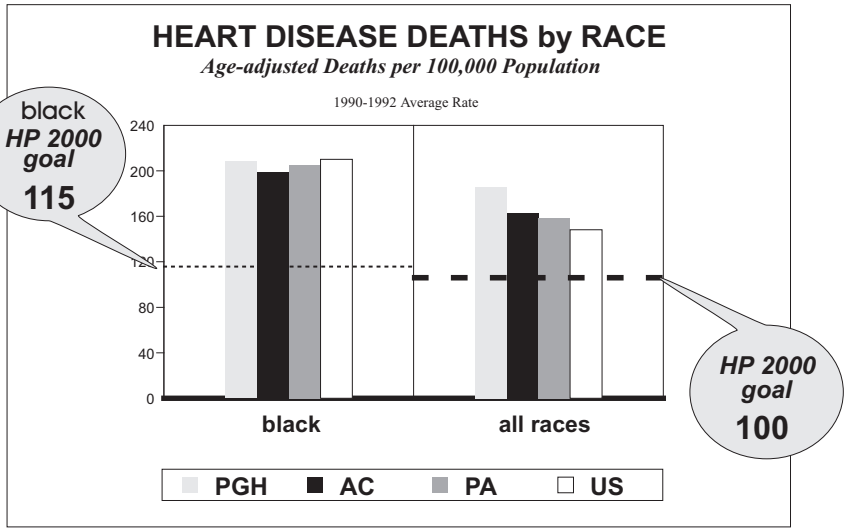
CHRONIC DISEASES

Chronic diseases replaced injuries and communicable diseases as the leading causes of death during this century. In Allegheny County, Pennsylvania and the United States, the four major causes of death are heart disease, cancer, stroke and chronic obstructive pulmonary disease. The incidence of these diseases increases with age. By the time individuals reach age 40, chronic diseases generally are the most frequent causes of death.

Recently health professionals and consumers have become aware of the potential impact that certain health behaviors have on the odds of developing or not developing chronic diseases such as heart disease or cancer. These behaviors include not smoking, eating a low fat/high fiber diet, remaining physically active, maintaining an appropriate weight, using early screening/detection as recommended.

The year 2000 targets include some health behaviors. Measurement of success in these areas is much more difficult than counting numbers of reported events. The standard at this time is a telephone survey conducted by 47 states, including Pennsylvania. Data, uniformly collected, are available for state by state comparison. Allegheny County does not, at this time, collect local data on health risk behaviors.

HEART DISEASE



Heart disease is by far the single most frequent cause of death, responsible for more than a third of all deaths. It is the leading killer of both men and women, and of both whites and blacks. Most victims are elderly when death occurs but have had heart disease for many years.

Do any of us meet the target?

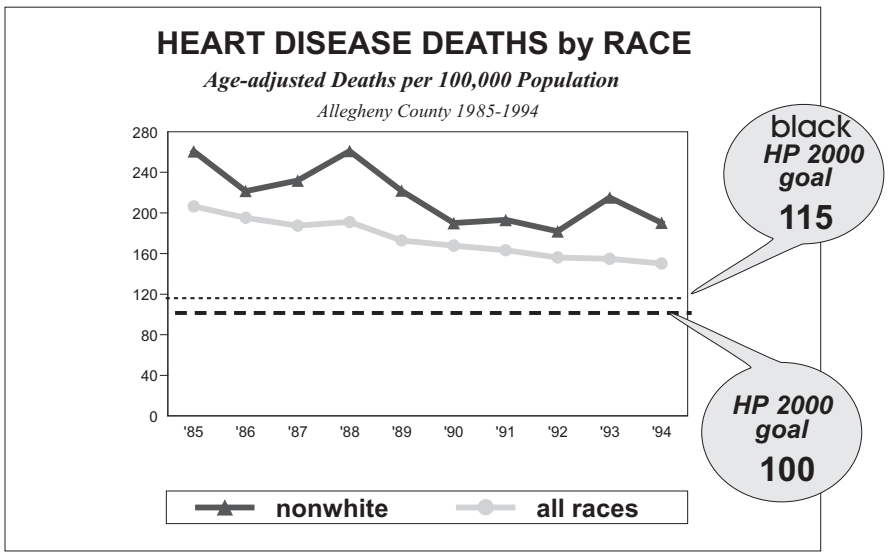
The year 2000 target is 100.0 deaths per 100,000 population. None of us have achieved that goal. The current rates range from 185.7 in Pittsburgh to 148.1 in the United States.

Heart disease is responsible for more than a third of all deaths.

Racial differences persist across all four geographic areas, with rates among blacks consistently higher than rates among whites. Some of this disparity can be attributed to the effects of poverty and lifestyle, but a genetic predisposition toward heart disease may account for part of the gap. The year 2000 race-specific target is 115 deaths per 100,000 black people.

How does local data compare with state and national data?

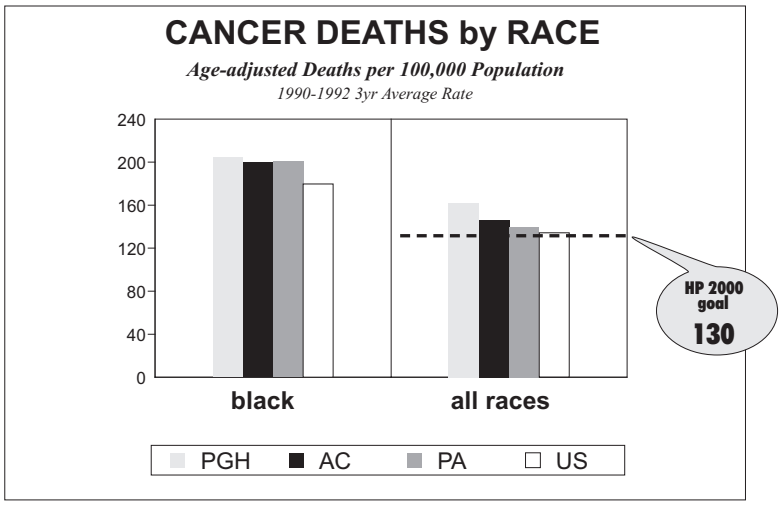
Heart disease death rates are higher here (both in the city and county) than the rates seen statewide and nationwide. Most of the difference is due to the comparatively high rates among our white population, particularly in Pittsburgh. Among our black population, the local rates are similar to those of the state and nation. Differences between the city and county may also reflect the effects of poverty, delayed entry into treatment and risk factor prevalence.



Our newest local data are encouraging. Heart disease deaths have been decreasing steadily for the last five decades. Early detection and ongoing blood pressure control, supplemented by changes in behavior (such as quitting smoking and losing weight), have reduced the number of heart disease related deaths.

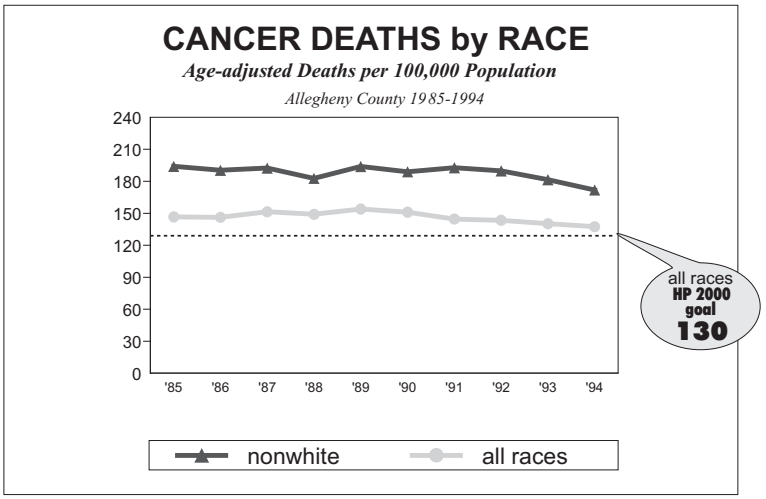
CANCER

Cancer is not one disease, but many. Taken as a group, cancers are the second leading cause of death, responsible for about one-fourth of all deaths. Some cancers are linked with known risk factors (such as smoking with lung cancer) but others (such as prostate cancer) are not currently linked with any specific risk factors. Age is the only common thread—the majority of cancer cases are detected during and after the sixth decade of life. Many cancers take years to develop following environmental exposures (smoking, sunburns), explaining the higher incidence in later life.



Do any of us meet the target?

The year 2000 target is 130.0 deaths per 100,000 population. The United States has essentially met that goal, and Pennsylvania is not far from it. At 146.3 and 162.2, Allegheny County and Pittsburgh, respectively, have a longer way to go.

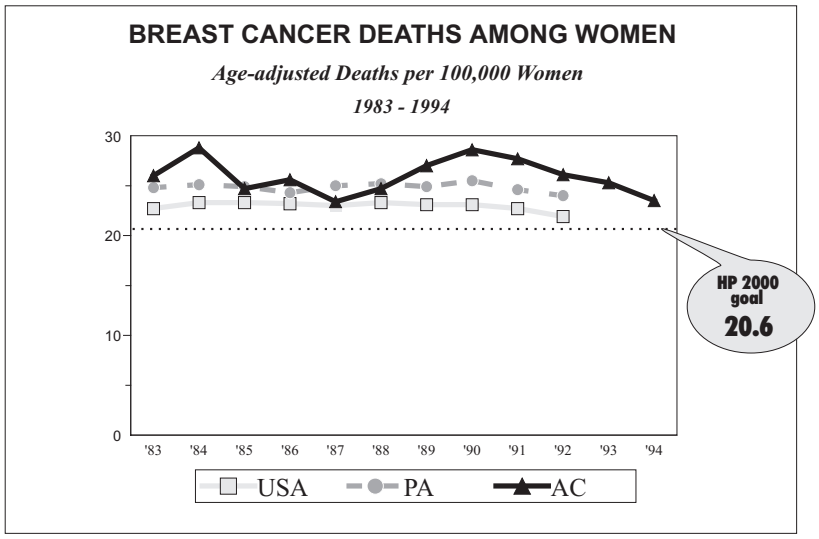


As was the case for heart disease, racial differences persist across all four geographic areas. The rates among blacks are consistently higher than rates among whites. Some of this disparity may be the result of delayed entry into treatment, lack of access to primary health care, exposures to carcinogenic substances and health risk behaviors.

How does local data compare with state and national data?

Cancer death rates are higher here (both in the city and county) than the rates seen statewide and nationwide. We have comparatively higher rates among both our white and our black populations, particularly in Pittsburgh. The higher rates in Pittsburgh may also reflect the effects of poverty.

Our newest local data are encouraging. The 1994 rates are among the lowest on record. While the local death rates have been fairly stable over the past 15 years, slight improvements have been noted among men. Because cancer may take years to manifest itself, the effects of improved health behaviors today may not be reflected in the death rates for many years.



BREAST CANCER

Breast cancer is the most frequently diagnosed form of cancer in women. One woman in every 9 will develop it during her life. Early detection and treatment can greatly increase the odds of survival. While there are some known risk factors (i.e., history of breast cancer in the family, fibrocystic disease, obesity, high fat diet), in 70% to 80% of all cases the woman has none of these risk factors.

Do any of us meet the target?

The year 2000 target is 20.6 deaths per 100,000 women. None of us have met that goal.

How does local data compare with state and national data?

Breast cancer death rates are higher here than the rates seen statewide and nationwide. Little change has occurred during the past 25 years. Although the rates fluctuate from year to year, the overall trend has been flat.

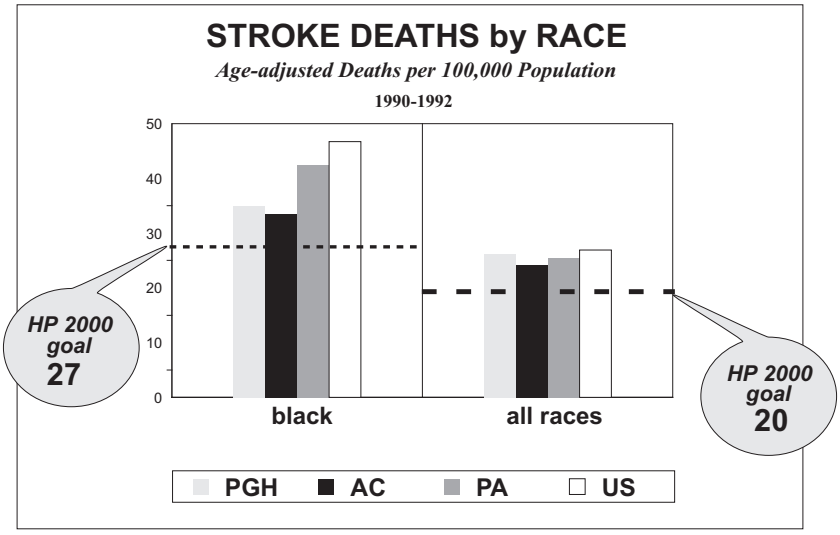
The Mammogram Voucher Program makes it possible for women to get a mammogram.

Clinical breast examination and mammography offer women the best chance for early detection of breast cancer and survival. Insurance plans and Social Security generally provide mammography coverage for women over age 50 and 65, respectively. Cost remains a barrier for uninsured women or women advised to get a screening mammogram more frequently than their insurance coverage allows. The Mammogram Voucher Program is a local partnership that makes it possible for women to obtain a needed mammogram. The American Cancer Society screens eligible women and manages the voucher program. The National Council of Jewish Women's Race for the Cure provides funding and outreach support for the voucher program. Area hospitals and imaging centers agree to accept the dollar amount of the voucher as payment and agree to work with their staff and others for needed follow-up.

Additional education about the need for mammography, the recommended frequency, the procedure and the resources to help pay for the test are keys to increasing the use of existing mammogram facilities.

STROKE

Stroke has been the third leading cause of death for many years, responsible for about 7% of all deaths. Similar to heart disease, the risk factors for stroke include high blood pressure, smoking, obesity and a genetic predisposition.



Do any of us meet the target?

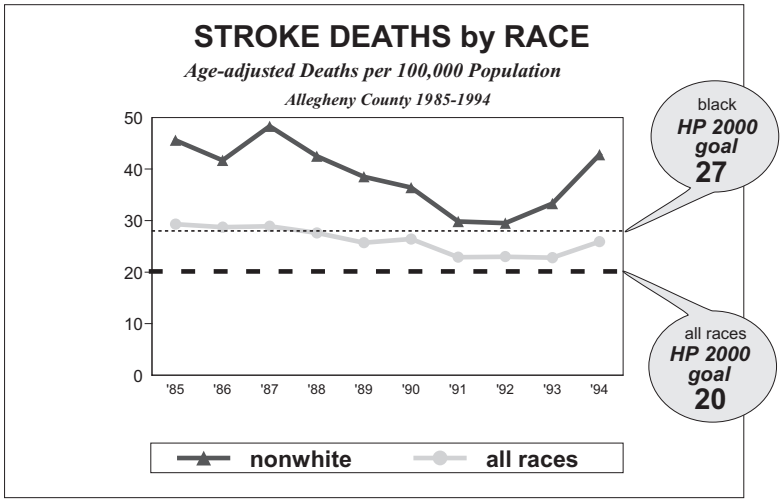
The year 2000 target is 20.0 deaths per 100,000 population. None of us have met that goal. All of us have similar rates, ranging from 26.9 in the United States to 24.2 in Allegheny County.

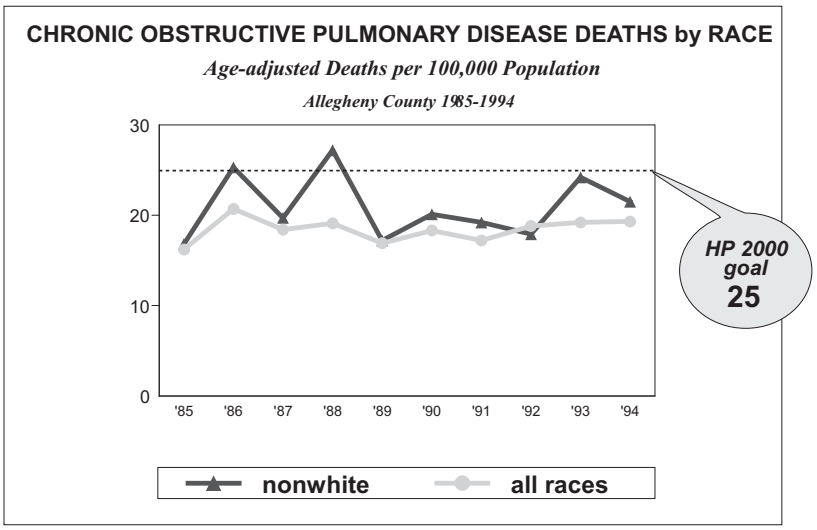
As was the case for heart disease and cancer, racial differences persist across all four geographic areas. The rates among blacks are strikingly higher than rates among whites. Again, some of this disparity may be the result of higher prevalence of risk factors in the black population.

How does local data compare with state and national data?

Our local rates are remarkably similar to the state and national rates, overall and for whites. However, a clear difference can be seen in our black rates—ours are much lower. The United States and state rates are 46.7 and 42.5, respectively. The county and city rate only 33.5 and 34.9, respectively. The reason for this local advantage is not known although higher cancer and heart disease mortality may have taken more black lives at a younger age.

There has been a clear decline in stroke deaths over the past 30 years. The improvement is likely due to advances in blood pressure treatment and early detection.





CHRONIC OBSTRUCTIVE PULMONARY DISEASE

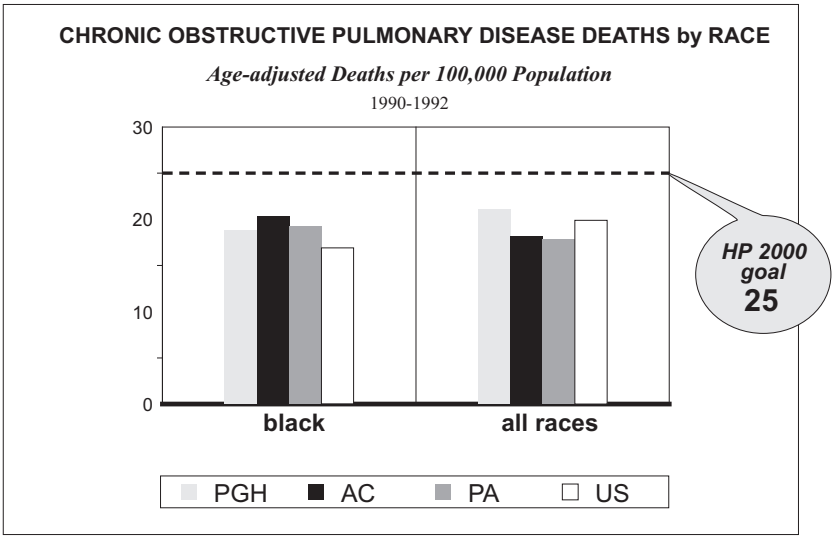
Chronic obstructive pulmonary disease (COPD, which includes emphysema, asthma and bronchitis) is the fourth leading cause of death, responsible for about 4% of all deaths. For individuals with COPD, a bout with the flu or pneumonia can be life threatening. This risk factor has been reduced by local flu and pneumonia immunization campaigns targeted to the elderly and chronically ill. Other risk factors for COPD include smoking and occupational exposures.

Do any of us meet the target?

The year 2000 target is 25.0 deaths per 100,000 population. At this point, all four areas are below the target. However, COPD is rising, and the battle will be to remain below that target.

Unlike the previously examined causes of death, there is no racial difference for COPD. The rates for both race groups are similar and are increasing.

How does local data compare with state and national data?



Our local COPD death rates are similar to the state and national rates, both overall and racially.

Our newest local data are discouraging. There continues to be a clear increasing trend in COPD deaths, particularly among women. Fifteen years ago there was a large gender gap. Today that gap is almost closed, with the rates seen among women rapidly approaching the high levels seen among men.

INFECTIOUS DISEASES

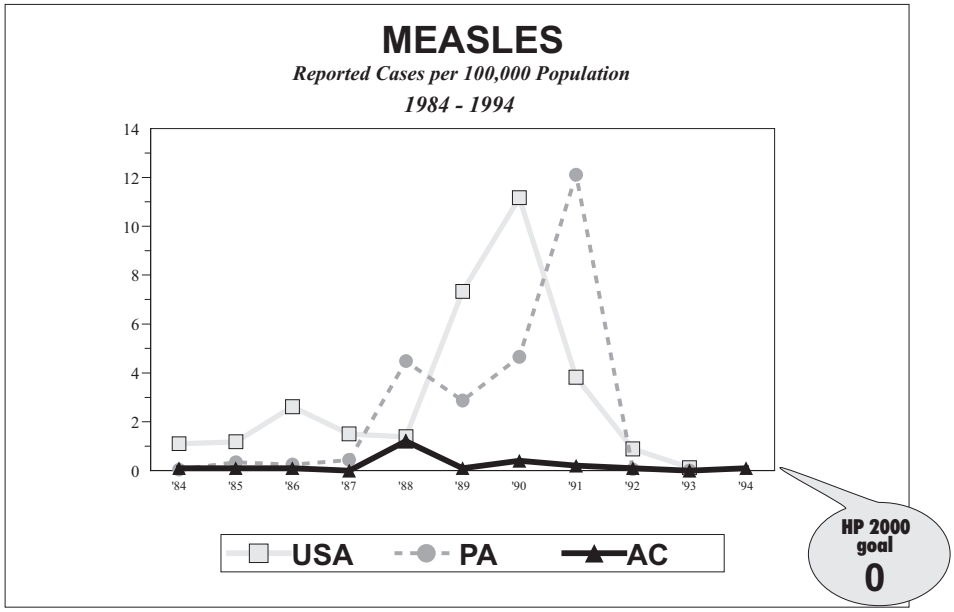
Despite predictions that infectious diseases would be eliminated during this century as a public health problem, they remain a leading cause of death worldwide. AIDS and Lyme Disease are examples of infectious diseases that have emerged during the last decade. Tuberculosis (TB), a disease we once thought controlled, has reemerged, striking vulnerable populations.

MEASLES

Measles is a highly contagious viral infection characterized by a high fever, cough and red blotchy rash. More severe in infants and adults than school-aged children, measles can result in otitis media, pneumonia and encephalitis.

Do any of us meet the target?

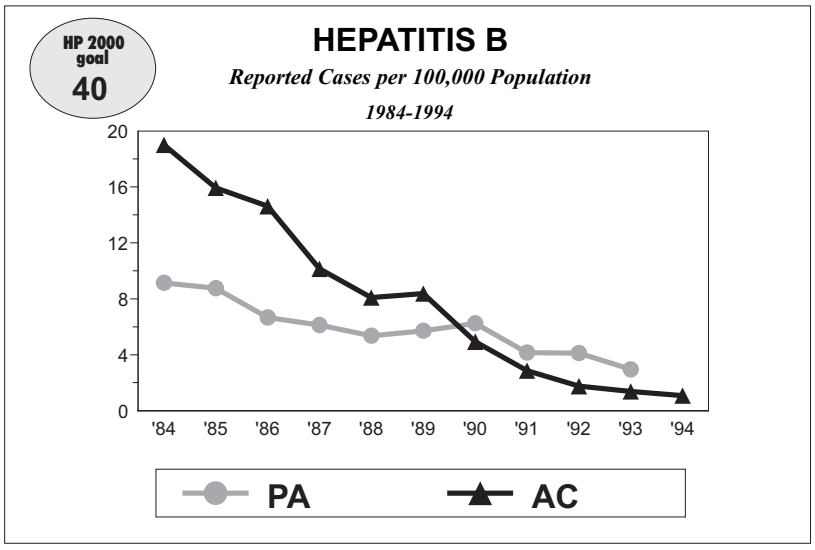
The year 2000 goal is zero cases of measles. Following peaks in 1990 for the United States and 1991 for Pennsylvania, all areas are close to reaching the goal. In Allegheny County and Pennsylvania all parents of children entering school must document that they have received a measles immunization. Our measles rate has remained low during this decade and Allegheny County has not had a locally contracted and laboratory confirmed case of measles since 1991. All cases of measles are deemed vaccine-preventable.



HEPATITIS B

Hepatitis B is a blood borne viral disease characterized by lack of appetite, abdominal discomfort, nausea, vomiting and jaundice. Severity of the disease ranges from no apparent symptoms to liver disease resulting in death. Risk of contracting Hepatitis B increases for people whose livelihood brings them in contact with blood (health care workers, emergency responders) and for people who engage in high risk behaviors such as injecting drugs.

Universal immunization of children for Hepatitis B is now a recommendation of the American Academy of Pediatrics and the Centers for Disease Control's (CDC) Immunization Practices Advisory Committee. In Allegheny County infants born after 1991 are generally immunized for Hepatitis B during the first 6 months of life. Older children and most adults have not been immunized.



Perinatal transmission of Hepatitis B from mother to child can be prevented if the child receives a complete Hepatitis B vaccine series. To ensure that each child born to an infected mother is fully immunized the Department formed a network with physicians and key personnel in hospitals with obstetrical units. Reinforcing relatively new professional standards, we encouraged obstetricians to screen all pregnant women for Hepatitis B. Hospital staff voluntarily notify us when an infected woman delivers and provide us with confirmation that the child received the first vaccine in the series. Our staff, working with other health care providers, monitor the family to be sure that the child completes the three-shot Hepatitis B series. Since this program's inception all children identified have either completed their vaccine series or are currently being immunized.

How does local data compare with state and national data?

Reported acute cases of Hepatitis B in Allegheny County have trended downward since 1984. Statewide the trend downward has not been as steep; however, Pennsylvania's incidence is lower than the United States'.

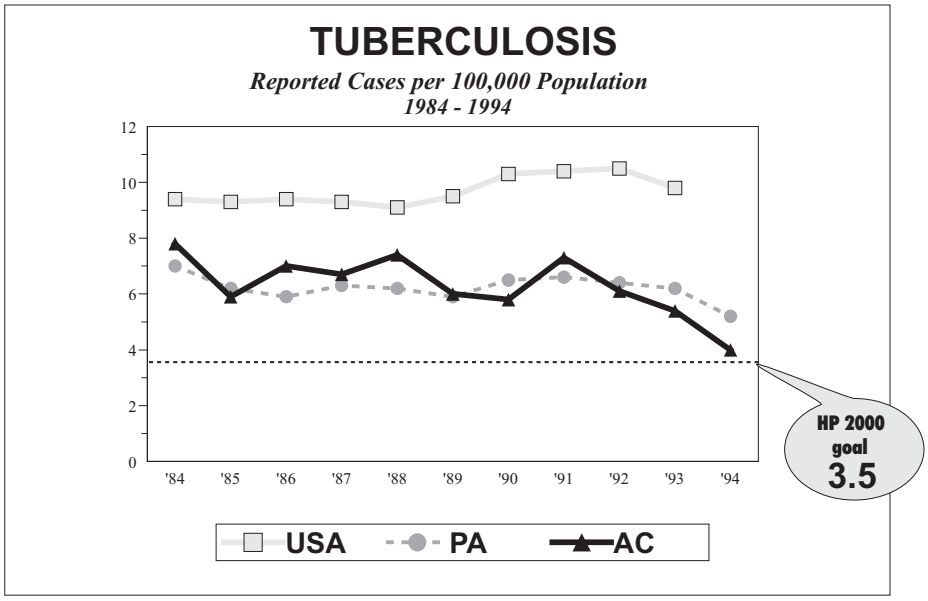
TUBERCULOSIS

Tuberculosis, once thought to be a conquered disease, has reemerged during the last decade. A bacterial disease transmitted by air borne droplets, TB is found most frequently among individuals who are immuno-compromised (HIV infected or taking anti-rejection transplant drugs), live in overcrowded conditions or are poor. In more than 90% of new cases the infection enters a latency period without symptoms. Reactivation of the infection, which can be triggered by decline in general health status, can lead to fever, fatigue, weight loss, cough, chest pain and death.

Tuberculosis has reemerged during the last decade.

Do any of us meet the target?

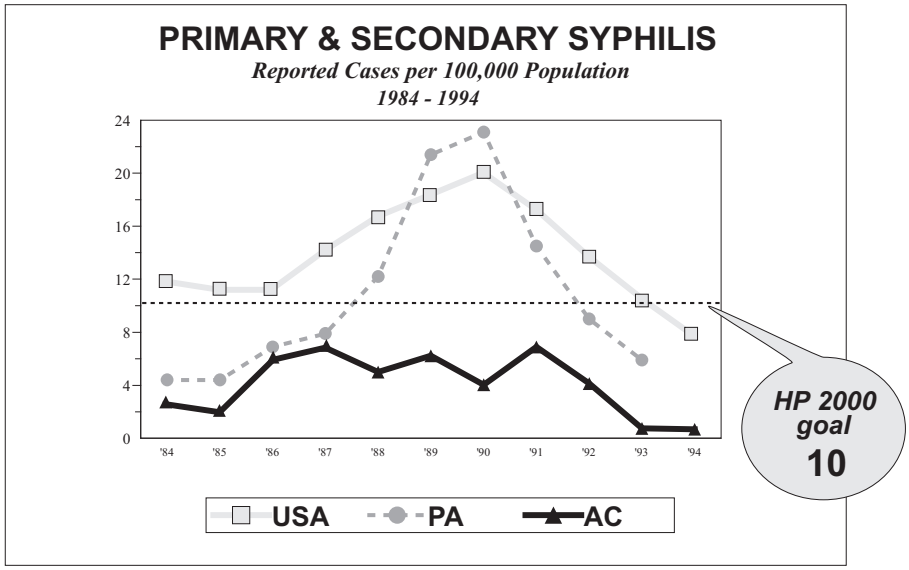
None of the three geographic areas have met the year 2000 target of 3.5 cases per 100,000. During the last 10 years our local case rate has declined from 7.8 per 100,000 in 1984 to 4.0 in 1994. Pennsylvania and the United States have remained relatively stable.



SEXUALLY TRANSMITTED DISEASES

Sexually transmitted diseases are preventable through abstinence and by use of barrier protection methods, monogamous relationships and partner notification to prevent further transmission. This report examines three reportable diseases: syphilis, gonorrhea and AIDS. Chlamydia, which was not included, has been a reportable disease for about 2 ½ years and insufficient data are available to make comparisons.

SYPHILIS



Syphilis is characterized by three stages. Primary syphilis generally presents as a painless lesion where the bacteria entered the body; symptoms of secondary syphilis involve a rash often on the soles of the hands and feet. Syphilis is curable at this point. If not detected and cured syphilis enters a latent period, which can last for months or years. In the final stage syphilis causes irreparable damage to the victim. The infection can be cured at this point but damages generally are not treatable. Transmitted primarily by sexual contact with an infected person during the early stages, syphilis can also be transmitted to a baby during pregnancy.

Do any of us meet the target?

Syphilis began to increase nationally in 1986. Following a peak in 1990 and 1991 the rates have begun to decrease in all geographic areas. Both Allegheny County and Pennsylvania have met the year 2000 goal of 10 cases per 100,000 population. The United States has met this goal for 1993.

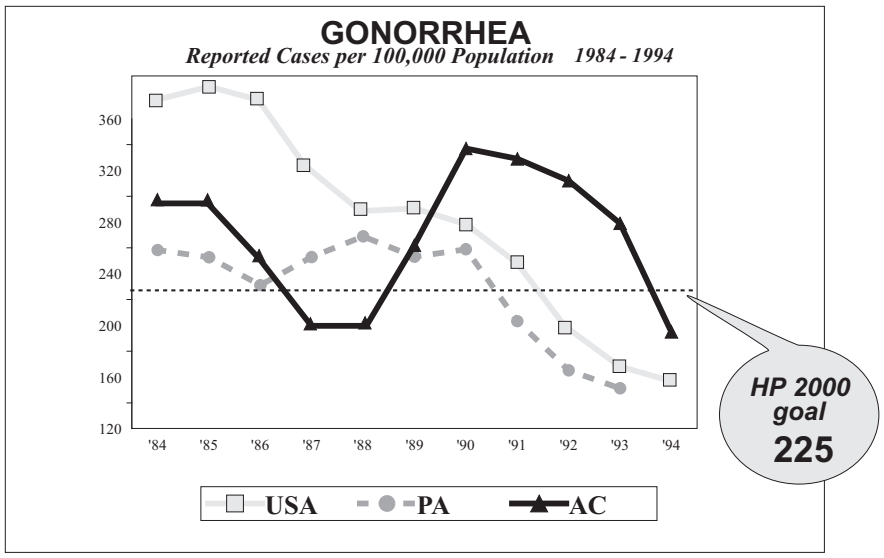
GONORRHEA

Gonorrhea is often viewed as an indicator of high risk sexual behavior including multiple sexual partners and unprotected sexual activity. Transmitted by sexual contact, gonorrhea produces painful urination among men within 2 to 7 days of infection. Women, who generally do not have warning symptoms, face the risk of scarring of the fallopian tubes and subsequent infertility if untreated. Primarily found in adolescents and young adults, gonorrhea tends to be more prevalent in urban than rural areas.

Do any of us meet the target?

Allegheny County's incidence, 195 cases per 100,000 population, fell below the national target of 225 per 100,000 in 1994. It is still higher than the national average of 153 per 100,000. The underlying reasons for declining morbidity, nationally and locally, are not completely understood. Certainly HIV education and outreach in high risk communities have contributed to the reduction in gonorrhea. Our local decrease in gonorrhea can also be attributed in part to the partnership between Family Health Council and Healthy Start. Using funding from Healthy Start, outreach workers provided condoms to women in communities with high infant mortality rates. The condoms not only assist women in spacing births but also greatly reduce the risk of getting a sexually transmitted disease.

The partnership between Family Health Council and Healthy Start contributed to a decrease in gonorrhea.

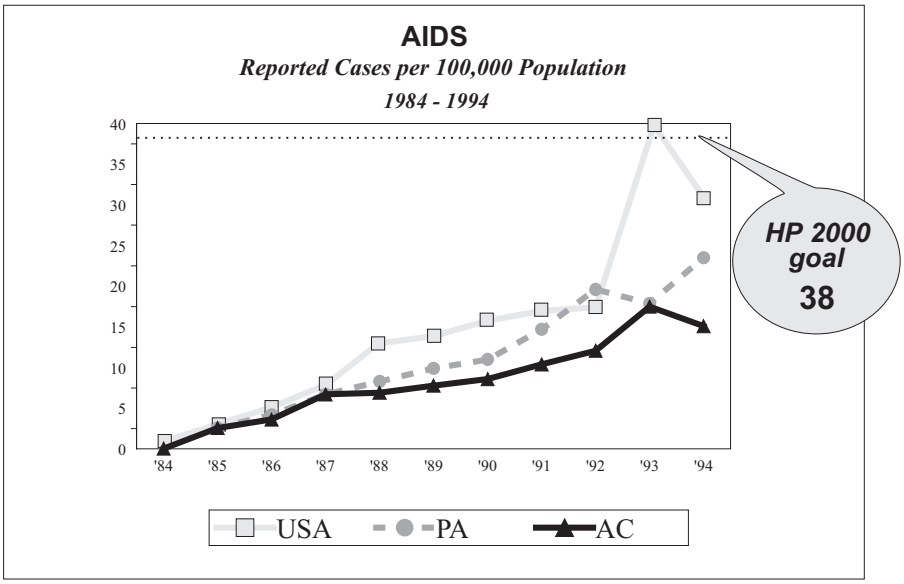


AIDS

HIV infection is transmitted by unprotected sex with an infected person, by blood exposure and by infected mothers to their unborn child. Following an incubation period that varies in length, HIV begins to attack the victim's immune system. As the disease progresses, infected individuals are susceptible to many opportunistic diseases that a normally functioning immune system could fight off. AIDS is the clinical stage of the infection when the immune system impairment begins to affect health.

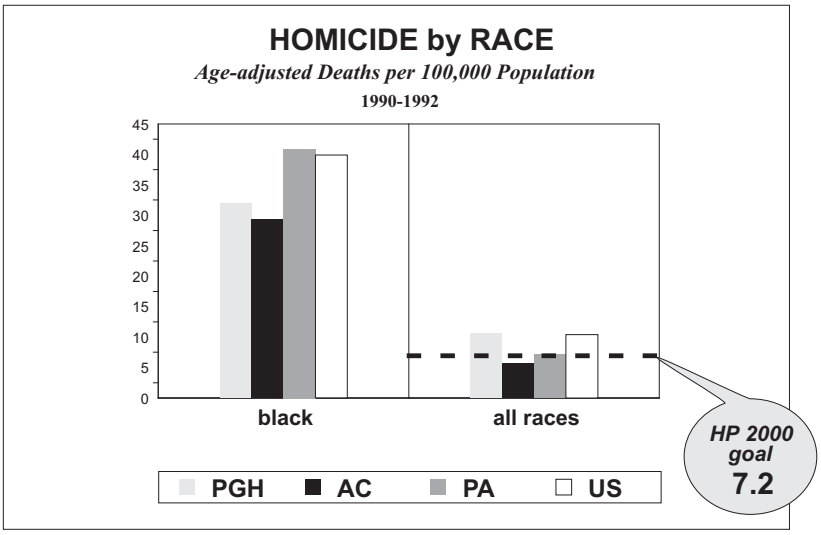
Do any of us meet the target?

AIDS cases have followed an upward trend since first recognized in 1984. The sharp upswing in 1990 reflects an expansion of the case definition by CDC. AIDS rates in Allegheny County have consistently been lower than both the state and the nation. At this time all three geographic areas are below the year 2000 goal of 38 cases per 100,000. Both Allegheny County and the United States reflect a decline from 1993 to 1994. This decline may be due to incomplete reporting for 1994.



INJURY

Injury is generally studied in two categories: intentional injuries including homicide and suicide and unintentional injuries including traffic accidents, falls, burns. Injuries, both fatal and nonfatal, tend to cluster in the younger ages. All these deaths are deemed preventable.



HOMICIDE

Locally, homicide is the leading cause of death among African–American teenagers. During the past 5 years there has been an alarming escalation in homicides, particularly among black men between the ages of 15–24. Strategies to reduce these premature deaths have focused on reducing access to handguns, gang mediation and teaching nonviolent conflict resolution skills.

Homicide is the leading cause of death among African-American teenagers.

Do any of us meet the target?

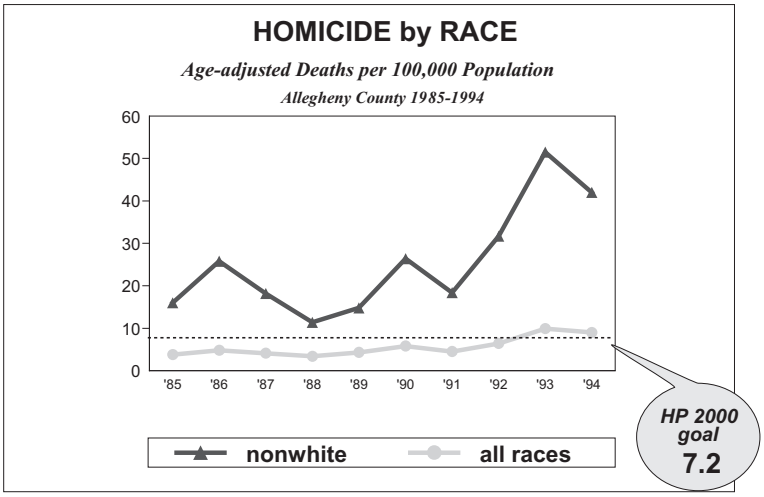
The year 2000 target is 7.2 homicides per 100,000 population. Allegheny County and Pennsylvania have met that goal (5.6 and 7.1, respectively). Pittsburgh and the United States are still above it (10.6 and 10.4, respectively).

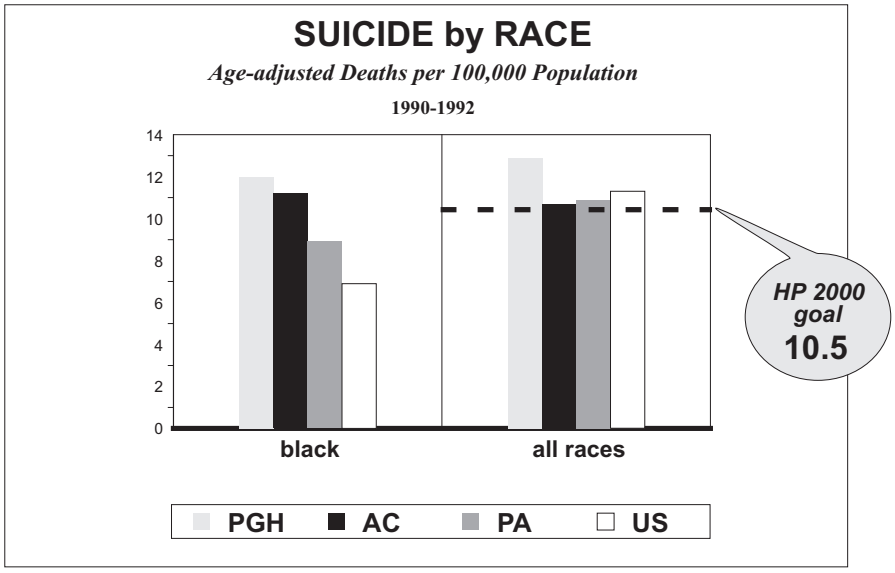
Rates are higher for black populations, reflecting the impact of homicide on young black males. The year 2000 race-specific target is 72.4 homicides per 100,000 black males aged 15–34.

How does local data compare with state and national data?

Homicides occur less often in Allegheny County than they do in the state and nation, both overall and racially. As with infant mortality, the overall homicide rate in Pittsburgh is influenced by the city's racial composition. On a race-specific basis there is essentially no difference between the city and county.

Our newest local data paint a different picture. Homicides have increased dramatically for 1993 and 1994. Both Allegheny County and Pittsburgh now exceed the targets. In 1994 the overall rates were 9.0 in the county and 19.8 in the city (target = 7.2). The rates among 15- to 34-year-old black men were 174.9 in the county and 196.8 in the city (target=72.4).





SUICIDE

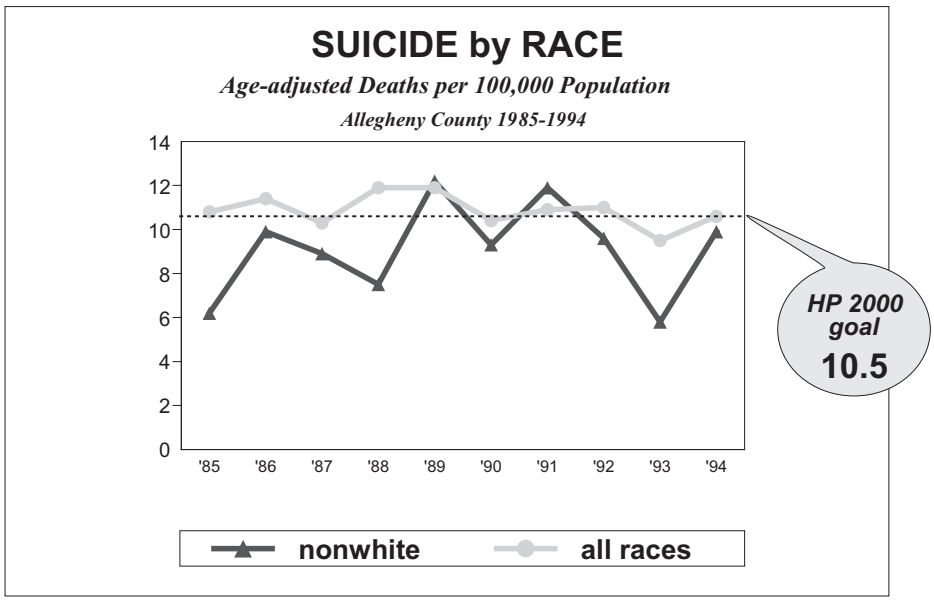
Locally, suicide is the third leading cause of death among 15- to 34-year-olds. Men commit suicide 4 times as often as women. White men commit suicide more often than any other group.

Do any of us meet the target?

The year 2000 target is 10.5 suicides per 100,000 population. Allegheny County and Pennsylvania are close to the target (10.7 and 10.9, respectively). The United States and Pittsburgh have further to go (11.3 and 12.9, respectively).

How does local data compare with state and national data?

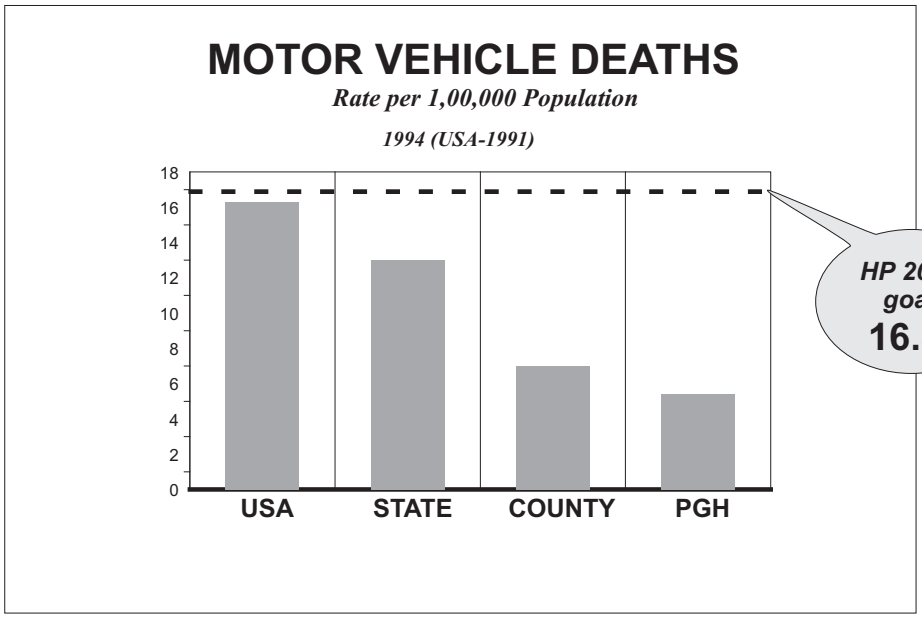
Suicide rates in Pittsburgh compare poorly to the other three areas—both the white and black rates are conspicuously higher. Also, because most of the county's black population lives in Pittsburgh (63%), any countywide black rate is heavily influenced by the city's situation. For suicides, the high rate for blacks in Allegheny County is largely a reflection of the high city rate. The countywide rate for whites is more similar to the state and nation. The rate is much less influenced by the city because the city comprises only 22% of the total white population.



Our newest local data are encouraging. In both the city and county, the rates have decreased since the 1990–92 period. Allegheny County dipped below the target in 1993 (9.5) but returned above it the next year (10.6 in 1994). In Pittsburgh the rates fell to 11.7 in 1993 and 11.6 in 1994.

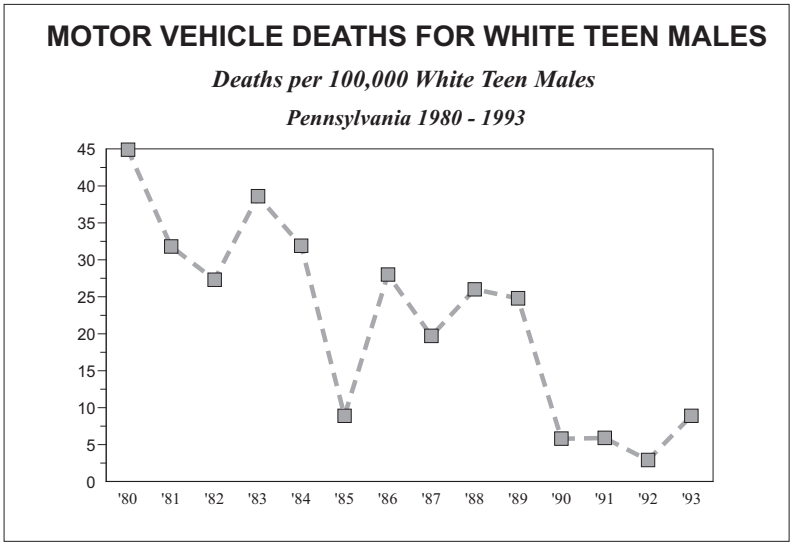
MOTOR VEHICLE DEATHS

Motor vehicle deaths tend to cluster in younger populations. During the past 5 years, 35 county teenagers died in motor vehicle accidents. Among males, black teens currently have a higher rate than white teens. A decade ago, white teen males had the highest automobile death rates. Since then there has been a dramatic decrease in traffic deaths among white teen males.



Do any of us meet the target?

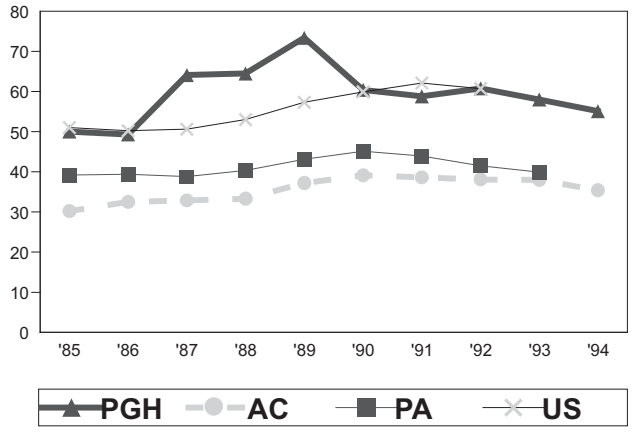
Allegheny County (7.0) and the City of Pittsburgh (5.4) have both met the national target as has Pennsylvania (13.0). Until this year Pennsylvania retained the 55 miles-per-hour speed limit on all its highways. This may have assisted in keeping our motor vehicle related deaths low. Pennsylvania's motor vehicle death rate has declined with the increasing use of seat belts and child passenger safety seats in cars.



MATERNAL AND CHILD HEALTH ISSUES

BIRTHS PER 1,000 FEMALES AGES 15-19

All Races



HP2000 goal for all race females age **15-17** is 50 ***PREGNANCIES*** per 1000

TEEN PREGNANCY AND PARENTHOOD

Many teen births are unintended. In addition to cultural and social reasons, lack of access to family planning services plays a role in these pregnancies. Many teen mothers do not receive timely prenatal care. Barriers to early prenatal care may be internal (fear, denial), economic (poverty, lack of insurance) and educational (unaware of value of prenatal care). Teen mothers also face developmental burdens when rearing a child. Childbirth frequently disrupts the mother's education, making it difficult to move into the workforce or obtain higher education. Forming a cycle, children of mothers who did not complete basic education are themselves at greater risk of dropping out of school. Increasing feminization of poverty can be linked in part to young women who are not able to complete their education and obtain employment.

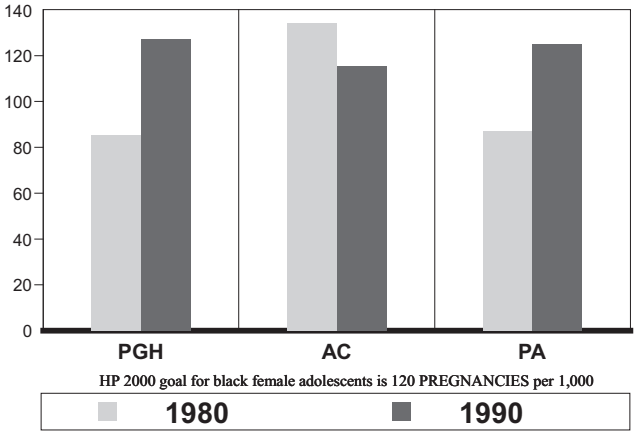
How does local data compare with state and national data?

The teenage fertility rate in Allegheny County is consistently lower than the state and national rates. The Pittsburgh rate is similar to the national rates.

BIRTH RATES FOR WOMEN, 15-19

BLACK

1980 - 1990



HP2000 goal for all race females age **15-17** is 50 ***PREGNANCIES*** per 1000

In all four areas, teen fertility rates declined between 1970 and 1980, remained stable until the mid-1980's and then increased until about 1990. Since then, the rates appear to have begun another downward trend. The current county rate (35.4 in 1994) is the lowest observed in 7 years.

In the African–American community, birth rates for teenage women are substantially higher than for all races. The rate has increased for both the state and Pittsburgh but has decreased slightly for Allegheny County.

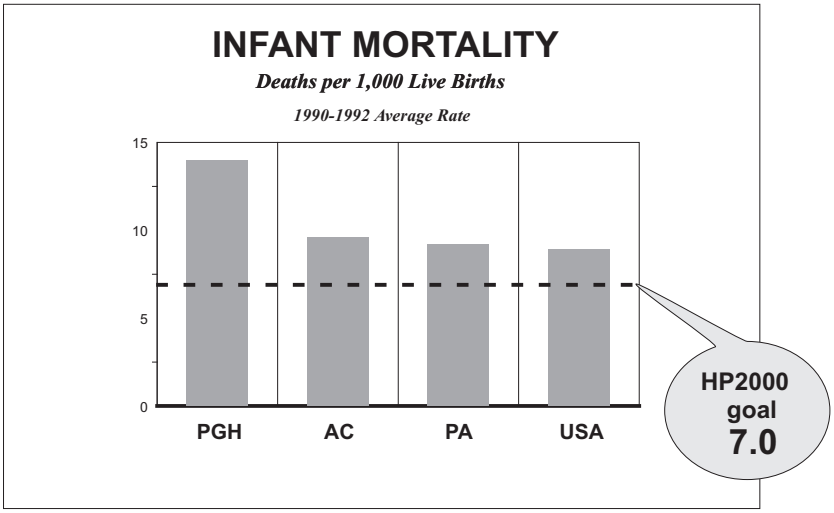
INFANT MORTALITY

Infant mortality is defined as the death of a child during the first year of life. Infant deaths are often linked with poverty, access to care issues and unintended pregnancies. Leading direct causes of infant mortality are low birth weight and premature birth.

Do any of us meet the target?

The year 2000 target is 7 deaths per 1,000 live births. None of us have achieved that level—our rates (for years 1990–92) range between 14.0 for Pittsburgh and 8.9 for the United States.

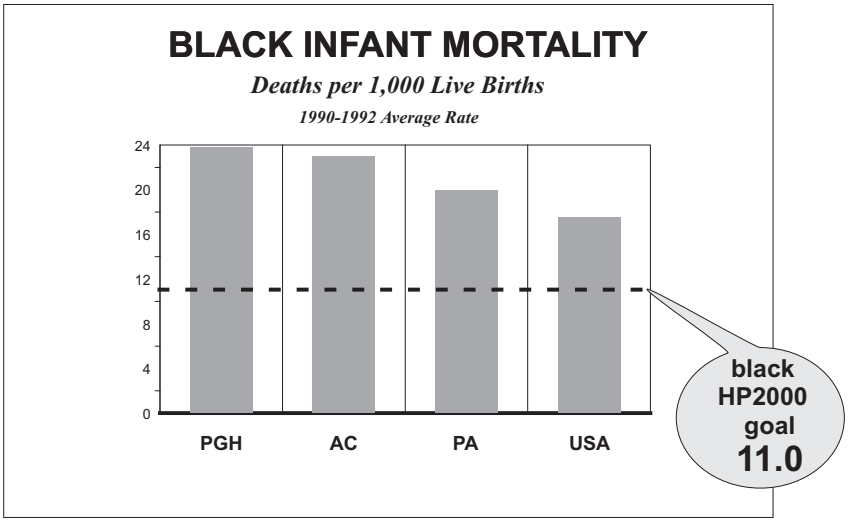
The year 2000 race-specific target for black infant mortality is 11 deaths per 1,000 births. No area has achieved that goal either, although progress continues to be made.



How does local data compare with state and national data?

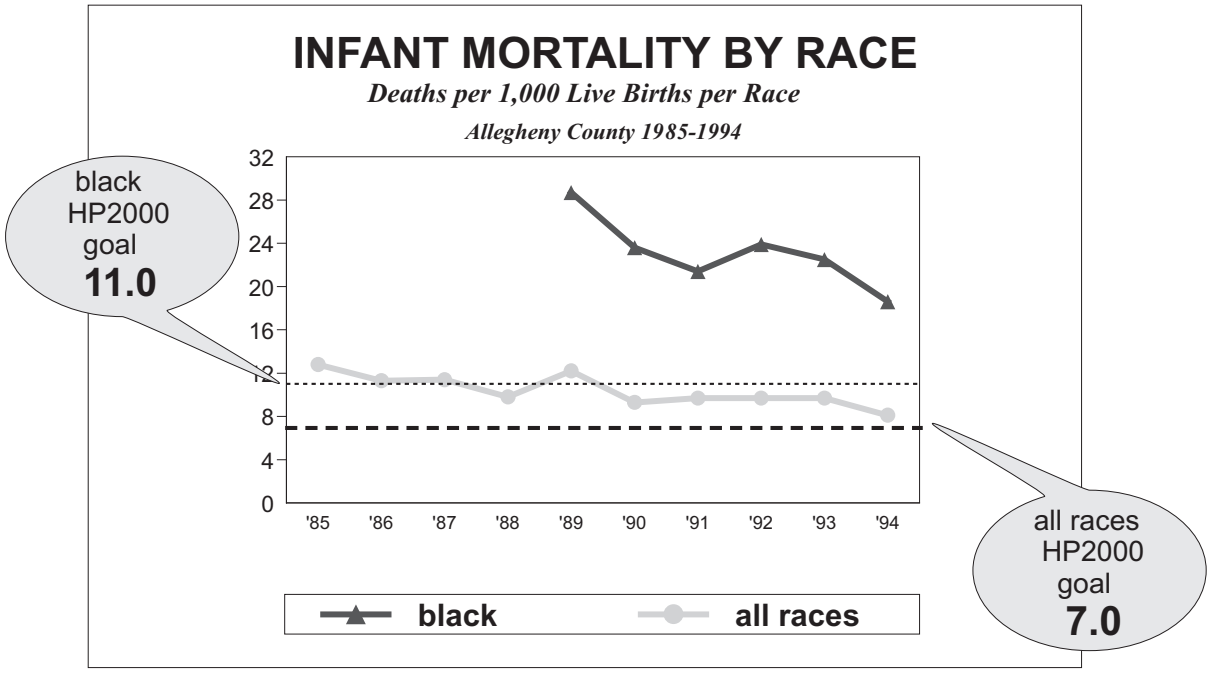
Compared with the state and nation, infant mortality is slightly higher in Allegheny County and substantially higher in Pittsburgh. However, looking at only the overall infant mortality rate can be misleading. Infant death rates are known to be disproportionately high among African–Americans. Pittsburgh has a substantial African–American population (about 27% of the city) compared with the county (only 12%). The seemingly large difference between the city and county infant mortality rates is only a reflection of their different racial compositions. On a race-specific basis there is essentially no difference between them.

Locally, infant mortality is clearly on a steady but slow decline, both overall and racially. Our most recent Allegheny County data are very encouraging—the 1994 overall rate of 8.1 is the lowest rate ever recorded here. For black infant mortality the current rate is 18.6, and is also a record low.



Healthy Start approaches the reduction of infant mortality holistically.

Healthy Start, the federally funded initiative to reduce infant mortality by 50% in five years, is entering its fourth program year October 1995. Healthy Start approaches the reduction of infant mortality holistically by forming partnerships to look at the total environment—health care for pregnant women and infants, removal of locally identified barriers such as child care and transportation, increased awareness of the value of prenatal care, postponement of pregnancy until the completion of a young woman's education and reduction of behavioral risks. Healthy Start, with an active community advisor system, has caused institutional changes such as moving WIC sites into hospitals with large prenatal clinics.



IMPORTANCE OF POVERTY

Poverty adversely affects health status in a number of ways: Inadequate housing, poor nutrition, crime, stress, poor educational attainment and lack of access to primary health care are among the by-products of poverty that increase the risk of poor health for poor communities. People in lower socioeconomic classes tend to die earlier from chronic diseases, from intentional injuries and in some cases from infectious diseases than do people from higher socioeconomic levels.

According to the 1990 census, 36 of Allegheny County's neighborhoods, clustered mainly in Pittsburgh's Central City, Northside, East End and Mon Valley, have poverty levels of 25% or more. The impact of poverty is particularly severe for African–Americans. Research conducted by the Center for Social and Urban Research at the University of Pittsburgh indicates that the economic conditions of African–Americans are worse in Pittsburgh and Allegheny County than in almost any of the other 50 largest cities and counties in the United States. Our African–American poverty rates rank fourth; our African–American unemployment rates rank fifth nationally. Pittsburgh has the eighth lowest standard of living for African–Americans among all large United States cities. The city and county have the fourth greatest difference between black and white poverty rates (*Health Environmental Scan*, Jewish Health Foundation, 1995).

Youth adds another dimension to the high risk status of poor families in our county. Children who grow up in poverty are more likely to be physically and mentally ill; to have poor school outcomes; to become sexually active at an early age; to become pregnant as a teenager; to be involved in the criminal justice system; and to be victims of violence (*A Handbook for Action*, PA Partnerships for Children, 1994). The public health problems of violence, teen pregnancy and infant mortality are the devastating results of poor minority youth who see no future for themselves and are ill-prepared for a productive adult life.

The impact of poverty is particularly severe for African Americans.

Many low-income and minority families also do not have timely access to the kind of care that can effectively reduce the health risks described in this report. There are several reasons for this. The most serious health risks, chronic and infectious diseases, can be averted through early and regular checkups. Unfortunately, many poor families do not have permanent medical homes, and given the many stresses and problems of poverty, preventive health care is not a priority concern. Transportation is also a barrier to access. Many of Pittsburgh's and Allegheny County's public housing communities are concentrated tracts of subsidized housing in isolated areas. Public transportation is inadequate, and taxis often refuse fares to these communities because of crime. Lack of health insurance is another barrier. In 1993, 7.6% of the adult population aged 18–64 in the Blue Cross Western PA region were transitionally uninsured and 10.7% were chronically uninsured (*Health Environmental Scan*). Without adequate health insurance, many poor people delay treatment until illnesses become severe.

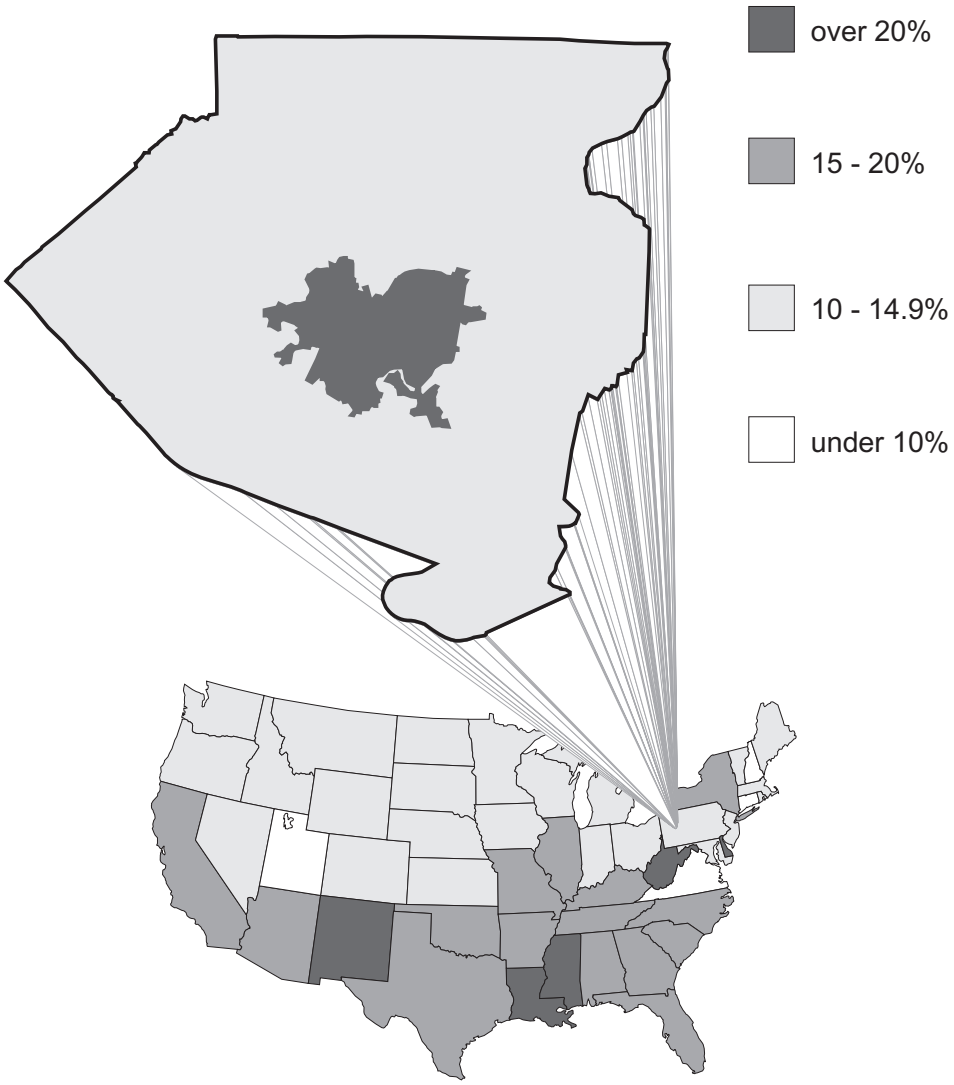
Given the importance of behavior and lifestyle to preventive health care, traditional medical facilities are not always the appropriate agency for improving community health. Social agencies, many of which are in poor neighborhoods and culturally sensitive to the African–American community, are well positioned to reinforce prevention messages and address the social conditions that contribute to poor health outcomes. These organizations are natural partners for the

medical community in the development of a comprehensive and integrated public health system for Allegheny County.

The third essential partner in efforts to improve the health of poor communities is government. Public policy is key to ensuring that poor communities have the right kinds of supports to alleviate the conditions of poverty. The current debate on welfare reform must be closely analyzed for changes that would impede or improve the economic status of Allegheny County's poor. Helping our legislators understand the connections between poverty and health is incumbent upon the Health Department and its partners in public health.

PERSONS BELOW POVERTY LEVEL

City & County data from 1989
State data from 1992



THE IMPORTANCE OF BEHAVIOR IN IMPROVING HEALTH

Healthy lifestyles empower individuals to change their health status for the better, to reduce excess risks and to increase the odds that their golden years will be good years. A mounting body of research confirms that a prudent lifestyle—not smoking, maintaining weight within recommended limits, exercising regularly, eating a low fat/high fiber balanced diet, drinking moderately or not at all, practicing safe sex, always using seat belts, keeping immunizations and health screenings up to date and managing stress—can postpone or prevent many major chronic diseases and some infectious diseases.

This choice cannot be dictated but rather must be integrated into each individual's pattern of daily living. Making changes in life behavior is not easy. Our tendency to look for a "vaccine" that is fast, cheap and works for everyone can lead us to support approaches that have little value. Local heart disease and cancer mortality rates clearly indicate that we need to invest health behavior with the thoughtful scrutiny and multifaceted efforts that have been successful in other related areas. The payback for behavioral change often does not appear immediately and diseases prevented or postponed are difficult to quantify.

We do not have strong statistical sources for the prevalence of local health risk behaviors. We draw inferences from death rates and disease incidence and couple that information with state and national health risk data. Until the Health Department can collect statistically valid information about the prevalence of smoking, obesity, alcohol use, seat belt use, exercise and food choices, we must rely on estimates based upon other studies and observations. This makes it difficult to evaluate the success of any interventions.

A prudent lifestyle can postpone or prevent many major chronic diseases.

RECOMMENDATIONS

Based upon the health statistics and upon our assessment of the health systems in this county we have developed five recommendations to sustain positive areas and improve areas which are lagging.

SUPPORT AND EXPAND EFFECTIVE PROGRAMS

Liz Schorr, in her book *Within Our Reach*, concluded that we know what works and need to sustain these efforts. Our progress in reducing infant mortality, gonorrhea (STD), unintentional injuries and immunization preventable diseases is encouraging. We must now resist the temptation to dilute successful programs, pulling away staff, resources and funding because the problem has decreased. Society often forgets that underlying social conditions and risk factors that contributed to the conditions may not have fundamentally changed. If we withdraw resources without fundamental changes in underlying risk factors and social conditions, the problem will return and gains made will be lost.

This does not mean that the program delivery system is untouchable. Creative strategies to sustain successful programs need to explore institutional change as an effective as well as cost efficient alternative. Changes in our systems will require that we develop innovative ways to address problems and maximize existing resources. Public/private partnerships should continue to be the heart of efforts to sustain gains in health status and to move to the next level.

ENCOURAGE COLLABORATION AMONG HEALTH, SOCIAL SERVICE AND COMMUNITY ORGANIZATIONS TO CHANGE SOCIAL CONDITIONS AND BEHAVIORS THAT LEAD TO POOR HEALTH OUTCOMES

Today more than ever, no one organization can “do it all.” Collaboration and cooperation make sense not only in terms of maximizing existing resources but also in terms of planning and implementing programs that meet emerging needs.

Prevention, while not glamorous or high tech, works. Effective programs must blend health care, health education, environmental modification and public policy to create a culture supporting a prudent lifestyle. Economic development efforts that bring money into depressed communities, provide jobs with adequate salary and benefits and support community-wide efforts to revitalize areas are equally important contributors to overall health status. Collaborative efforts, with each organization identifying their strength and with citizen input into planning and implementation, bring expertise and insights to the table. All partners can contribute to an environment supporting change in social conditions.

Programs to change health risk behaviors and to foster economic development must be designed to reach very specific populations. One size does not fit all. We must borrow from the business world, studying the unique problems and strengths of specific populations in order to design programs to fit. Only by joining with many partners can we realistically achieve this.

TARGET HEALTH PROMOTION/HEALTHY LIFESTYLE PRO-GRAMMING TO THE AFRICAN-AMERICAN COMMUNITIES FOCUSING ON HIGH RISK AREAS

One of the goals of Healthy People 2000 is to reduce health disparities between total population and population groups that experience above average incidence of death, disability and disease. In Allegheny County these disparities are most visible in the African-American community, as documented by excess deaths in heart disease, cancer, injuries and stroke. Prevention efforts to close this gap must address behavioral risk factors like diet, smoking and weight, and address utilization of primary health care for early diagnosis and treatment.

David Satcher, MD, Director of the Centers for Disease Control and Prevention, recommends that "prevention efforts to reduce risk factors associated with chronic diseases should be tailored to ...racial and ethnic minorities." Targeted programming must be planned with and by members of the African-American community and should be culturally sensitive. Planning must acknowledge the barriers created by poverty, transportation, concerns about personal safety, and conflicting priorities. Partnerships and strategies to sustain programming beyond initial pilot stages are essential.

MOVE COLLABORATIVE VIOLENCE PREVENTION EFFORTS TO THE FOREFRONT

Violence has emerged during this last decade as the leading cause of death in young African-American males. Certain communities within Allegheny County have been devastated by increased violence associated with gang related activity. This is a public health problem. The public health model — data collection and analysis, community based problem solving and collaborative interventions — has a potential to come to grips with this deadly plague. This issue must be addressed by community partnerships among many types of organizations and citizens leading to focused and targeted interventions. A solution cannot be imposed by government or law enforcement acting alone. As resources and funding for human services appear to be diminishing it will be difficult to redeploy funds into efforts to reduce violence, but this public health problem must move higher on the priority list.

STUDY AND DOCUMENT THE EFFECTS OF POVERTY ON HEALTH STATUS IN THE CONTEXT OF WELFARE REFORM

This is a time of proposed change in the structure of government and in the funding of many human service programs. Managed care will have impacts upon families, individuals and health care systems as use of emergency rooms for primary care declines. We need to scrutinize indicators as changes occur in welfare, in health care, in funding patterns and in populations. Data systems must collect useful information to support timely health status monitoring. There is an on-going need to identify those communities or populations at greatest risk and work closely with the community to watch health indicators and problems. Findings should be used to influence proposed changes in welfare and health care benefits.

BIBLIOGRAPHY

Allegheny County Health Department. ***Healthy Start Comprehensive Plan***. Pittsburgh, PA. 1992.

Allegheny County Health Department. ***Mortality and Natality Reports***. Pittsubrgh, PA. 1995.

Centers for Disease Control and Prevention. ***Chronic Disease in Minority Populations***. Atlanta: Centers for Disease Control and Prevention. 1992.

The Jewish Healthcare Foundation of Pittsburgh. ***Community Health Centers: Making a Difference***. Pittsburgh, PA. 1993.

The Jewish Healthcare Foundation of Pittsburgh. ***Health Environmental Scan***. Pittsburgh, PA. 1995.

Just Harvest. ***Hometown Hunger***. Pittsburgh, PA. 1994.

PA Department of Health. ***Pennsylvania Assessment: Healthy People 2000***. Harrisburg, PA. 1994.

PA Partnerships for Children. ***A Handbook for Action***. Harrisburg, PA. 1994.

Schorr, Lisbeth A. ***Within Our Reach***. Doubleday. New York. 1988.

U.S. Public Health Service. ***Healthy People 2000 Review: 1992***. Atlanta: Centers for Disease Control and Prevention. 1993.

U.S. Public Health Service. ***Pennsylvania State Health Profile***. Atlanta: Centers for Disease Control and Prevention. 1995.