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

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

OREGON’S DEMOGRAPHICS

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

Because it is important to monitor the health of populations, the State of Oregon collects data on health disparities by race and ethnicity. However, reporting by race and ethnicity is a tricky business and requires that some assumptions be made. Racial and ethnic categories reflect social constructs that are not necessarily based on biology, anthropology, or genetics. Broad categories used for data collection may obscure, rather than illuminate, important health disparities. For example, the racial category of “Black or African American” does not distinguish between an African American with roots in the U.S. dating back hundreds of years and a recent refugee from Africa. Similarly, the racial category of “White” includes individuals from culturally diverse ethnic communities, such as Eastern European and Middle Eastern. Data on racial and ethnic health disparities, or lack thereof, should be interpreted thoughtfully due to these inherent limitations.

DISPARITIES IN MORTALITY

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

DISPARITIES IN HEALTH BEHAVIORS

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

Obesity rates also vary across communities. The prevalence of adult obesity is very high among Latinos, African Americans, and American Indians/Alaska Natives, while the prevalence of obesity among Asian/Pacific Islander-
Table. Prevalence of select chronic conditions among adult Oregonians by race and ethnicity

<table>
<thead>
<tr>
<th>Condition</th>
<th>Non-Latino</th>
<th>American Indian/Alaska Native</th>
<th>Asian/Pacific-Islanders</th>
<th>White</th>
<th>Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td></td>
<td>30%</td>
<td>38%</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>Obesity</td>
<td></td>
<td>29%</td>
<td>30%</td>
<td>15%</td>
<td>24%</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>13.4%</td>
<td>12.2%</td>
<td>7.2%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td>41.4%</td>
<td>29.5%</td>
<td>18.9%</td>
<td>25.3%</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td>16.5%</td>
<td>15.3%</td>
<td>6.4%</td>
<td>10.1%</td>
</tr>
</tbody>
</table>

All estimates have been age adjusted to the U.S. standard population, 2000

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

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

Racial and ethnic disparities also exist in rates of teen pregnancy. In Oregon, Latinos, African Americans, and American Indians/Alaska Natives have teen pregnancy rates that are 2–3 times higher than non-Latino whites (Figure 2).

RECOMMENDATIONS

Health disparities must be addressed at a population level, but it is helpful for clinicians to be aware of the impact that social and economic conditions have on the health of individual patients. The Oregon Public Health Division is joining the U.S. Department of Health & Human Services and the World Health Organization in addressing the social determinants of health by working to achieve the Healthy People 2020 goal of “Creating social and physical environments that promote good health for all.” Tools being used include health-impact assessments to review needed, proposed, and existing social policies for their likely effects on health, and application of a “health-in-all-policies” strategy, which introduces improved health for all and the closing of health gaps as goals to be shared across all areas of government.

REFERENCES