

**2000**  
**STATE OF THE CITY**  
**PUBLIC HEALTH ADDRESS**

Mitchell H. Katz, M.D.  
Director of Health  
San Francisco  
Department of Public Health  
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***The mission of the  
San Francisco  
Department of Public Health  
is to promote and protect  
the health of all San Franciscans.***

## **2000 STATE OF THE CITY PUBLIC HEALTH ADDRESS**

President Ammiano and members of the San Francisco Board of Supervisors thank you for the opportunity to speak to you today on the state of public health in our City.

When I meet with health officials from other localities, I realize how lucky I am to be the Health Director in San Francisco, a city where the Board of Supervisors and the Mayor truly understand the needs of public health.

If money speaks louder than words, than the support of Mayor Brown and this Board of Supervisors has been thunderous. While other county health departments have had to cut back their services to cope with decreased Federal and State reimbursements, Mayor Brown and this Board have increased the City's general support of the Health Department by one hundred million dollars over the last three years. This infusion of funds has protected the City's delicately woven safety net.

Unfortunately, the Health Department faces unrelenting decreases in Federal and State revenues. The reason that the Federal and State governments have posted huge budget surpluses, is that they have pushed the cost of health care for poor people to counties. Sadly, in other counties people go without the health care that they need. Your financial support has made it possible for this care to be provided by our Health Department.

Compounding the problem of decreased revenue has been an increased demand for services. Throughout the State of California the number of uninsured persons has increased. This has occurred because the growth in the California economy has resulted in more people working, but working for employers who are not providing health insurance. They earn too much to qualify for Medicaid, but not enough to afford private health insurance. These people, the working poor, are our responsibility. In addition, the epidemics of HIV/AIDS, substance abuse, mental health and homelessness result in an increasing number of complex patients who, when they become ill due to medical illness, require prolonged hospital stays. A study of homeless persons in New York City published in the New England Journal showed that homeless persons had hospitalizations twice as long as housed persons for the very same illnesses. You do not need to be a health economist to know that decreased revenue and increased need spells financial ruin for a department such as ours.

Although the illness infecting safety net health providers like ourselves is very severe, I believe the prognosis is good. On the revenue side there is a growing recognition on Federal and State levels that some of the surpluses must go to resuscitating county safety net providers. My staff and I are working hard advocating for these changes on a State and Federal level. The growing dissatisfaction with managed health care, I hope, will fuel a national movement to a single payer health insurance program.

In the area of caring for patients with complex needs, I believe San Francisco can be a leader. We were, after all, the city that developed extensive community-based services to prevent the need for costly hospitalization for people with HIV/AIDS. We are the city that has driven down the rates of tuberculosis among homeless individuals and the city that never experienced the epidemic of

multidrug resistant tuberculosis, because we went out to peoples' homes and SRO hotels and soup kitchens and made sure they took their tuberculosis medications. Our affiliation with the University of California San Francisco puts San Francisco General Hospital at the forefront of efforts to provide the best possible care for medically and socially complex individuals.

By necessity the care for socially and medically complex individuals will be different than for those with isolated medical needs: let me illustrate. A typical San Francisco General Hospital patient is a middle-aged male with a history of substance abuse and mental illness who has lived on and off the streets of San Francisco for years. I have taken care of this man, over and over again, since I started working at San Francisco General Hospital in 1986. Sometimes he is African-American, sometimes he is Asian, sometimes he is Latino, sometimes he is White. Occasionally (although less often) he is female. But he is always poor. He requires frequent emergency department visits and prolonged hospitalizations. He is a heavy smoker and has chronic obstructive pulmonary disease. As you or I might, he sometimes develops pneumonia. Many people with pneumonia can be treated in their homes with strong oral antibiotics. He has no home. He will always need to be admitted to the hospital. Even people with homes sometime need hospitalization when they have serious symptoms. However, after four or five days of intravenous antibiotics they can generally be discharged. Because of his heavy smoking, his pneumonia is always slow to resolve. Even after several days of intravenous antibiotics he is not strong enough to go back out on his own. During one of his typical hospital stays, we spend about \$15,000 on him, yet we do not materially change this man's life.

My goal is to do better for this man and for the others like him. To do so, we must move our system, which is heavily oriented towards acute hospitalization, toward a broader continuum of

community-based services. In this time of decreased Federal and State revenues, I cannot allow the hospital services to soak up all of the money. I must put more money into community-based alternatives and prevention.

That is the reason that our health department has become the only health department in the country to master lease rooms in single occupancy hotels and provide supportive services in those settings for our patients. This past year we have opened the Pacific Bay Inn and the Windsor Hotel. With your help we will open the LeNain Hotel for homeless seniors. Although some believe that the job of housing individuals should not be that of a public health department, our department is the one with the most direct financial interest in providing housing. If my patient were housed, he would need fewer emergency department and hospital admissions.

My patient needs substance abuse treatment services. I am proud that since its inception in 1996-97, our Treatment On Demand Initiative has increased treatment slots by 1,974. Despite this increase in treatment slots my patient has been on the waiting list for methadone maintenance for months. With your help, we will increase methadone maintenance slots in the next year.

Sometimes my patient is hospitalized due to a soft tissue infection common among injection drug users. In 1998-99, San Francisco General Hospital saw an average of 12 patients a day for soft tissue injury and spent over \$18 million to provide care to these patients. An outpatient program will be developed that will improve their access to care and reduce the cost of it.

My patient needs mental health treatment. I'm pleased that over the last five years, our Community Mental Health Services Section has successfully reshaped the delivery of community

mental health services, emphasizing case management and outreach services. This has enabled us to reduce the number of hospital days. There is more that we can do. My patient should never be kept in an acute care psychiatric ward longer than he needs to be. When he is no longer acutely psychotic, he should be moved to a more appropriate setting.

Sometimes, even after an extended hospital stay, my patient is not well enough to be released. At such times I am thankful that Laguna Honda Hospital exists to provide rehabilitation for him. I am grateful to the members of the Board and the San Francisco voters who strongly supported rebuilding Laguna Honda Hospital. However, as with inpatient psychiatric services, my patient should never be cared for at Laguna Honda Hospital if he can thrive in a less restrictive community-based setting. That's why we are working closely with the Department's Long Term Care Planning Task Force and with advocates for the elderly and disabled, to insure a variety of community-based alternatives.

Although for my patient, it is too late for primary prevention and early intervention, his children and their children should not endure the same pain as he has. We must work to prevent disease. For that reason, despite the decreased revenue my department is receiving, we are increasing our financial support for prevention. We have partnered with the community to open the Bayview Hunter's Point Health and Environmental Resource Center. The Center will address breast cancer, asthma, prostate cancer and the environment. We are augmenting community-based and individual-based prevention services, such as the African-American Health Initiative, children's mental health and tobacco control. We are also expanding our adult immunization clinic. Because several diseases are preventable through immunizations. While our school system

insures that children are vaccinated by the time they are of school age, there is no system to insure that adults avoid diseases like hepatitis A and B. That is why we created the clinic.

Despite our fiscal challenges, we will never abandon our goal of improving health by expanding services, planning new initiatives, and focusing on health promotion and prevention. I would like to recognize my staff and their commitment to providing services in a professional, respectful and culturally competent manner. With our job freeze, many of my staff perform two and three jobs, and I am proud of them and grateful to them. I would also like to acknowledge the San Francisco Health Commission for their vision and leadership on health issues.

Thank you for the opportunity to speak to you today regarding the public health of our city. The attached written report provides additional information. I look forward to working with you over the next year to fulfill the Department's mission of protecting and promoting the health of all San Franciscans.



**Department of Public Health**  
**Efforts to Address**  
**Selected Public Health Issues**

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# Public Health Issues

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- ❑ San Francisco's major public health challenges:
  - homelessness and lack of affordable housing
  - aging population with increasing long-term care needs
  - high substance abuse/addiction
  - high prevalence of mental health problems
  - high number of uninsured
  - high prevalence of HIV/AIDS
  - a high proportion of injuries and deaths that could be reduced by prevention
  - disparities in the health status and access to health insurance of different racial and ethnic communities
  - high incidence of some communicable diseases (e.g., tuberculosis, gonorrhea)
  - environmental health concerns

# Leading Causes of Premature Mortality by Sex, San Francisco 1998

1998 Rank	Cause of Death	Expected Years of Life Lost	Deaths	Average Expected Years of Life Lost	1997 Rank
<b>MALE</b>					
1	Ischemic heart disease	12,340	839	14.7	1
2	HIV infection/AIDS	6,625	163	40.6	2
3	Drug poisoning, UI	5,207	119	43.8	4
4	Lung cancer	3,525	200	17.6	3
5	Lower resp. (Pneumonia)	2,965	232	12.8	7
6	Cerebrovascular (Stroke)	2,926	203	14.4	5
7	Suicide	2,890	73	39.6	6
8	Homicide	1,986	37	53.7	9
9	Chronic obstr. pulm. diseas	1,880	136	13.8	*
10	Inflam/infect/cardiomyop	1,820	74	24.6	*
<b>FEMALE</b>					
1	Ischemic heart disease	8,165	852	9.6	1
2	Cerebrovascular (Stroke)	3,052	297	10.3	2
3	Breast cancer	2,499	115	21.7	3
4	Lung cancer	2,239	138	16.2	4
5	Lower resp. (Pneumonia)	2,192	275	8.0	5
6	Drug poisoning, UI	1,153	24	48.0	7
7	Chronic obstr. pulm. diseas	1,074	87	12.3	9
8	Colorectal cancer	997	80	12.5	6
9	Diabetes mellitus	765	58	13.2	8
10	Genito-urinary diseases	764	72	10.6	*

\* Not in 1997 top 10 causes of premature mortality

# Homelessness and Housing

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- ❑ Lack of affordable housing poses a significant barrier to improving the health status for indigent residents.
- ❑ Homeless patients made up 31% of patient days at San Francisco General Hospital.
- ❑ The City's low vacancy rate and high cost housing market result in extreme competition for purchase of available properties creating a significant barrier to providers interested in developing supportive housing programs.
- ❑ The Mayor's Office on Homelessness is undertaking an updated count of the City's homeless population.

# Homelessness and Housing Response

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## **INCREASED RELIANCE ON HOUSING ALTERNATIVES**

- ❑ As the Department strives to rely less on institutional care, Housing Services is increasingly acting as a link between our hospital-based delivery system and the development of community-based alternatives.
- ❑ The Department provides approximately \$11.5 million in funding to assist over 2,500 people through emergency housing, rent subsidies and services linked to transitional and permanent housing.

## **DIRECT ACCESS TO HOUSING**

- ❑ This project provides supportive housing for chronically homeless people who have been revolving through the streets and emergency care settings such as shelters, emergency rooms, jails and other institutions.
- ❑ The Department leases the Pacific Bay Inn and the Windsor Hotel which combined provide 170 units. Currently, all units in both hotels are full.
- ❑ In the new fiscal year the Department anticipates starting its third Direct Access to Housing Program project, the Le Nain Hotel. The hotel has 92 units and will target homeless seniors.

## **SHORT-TERM STABILIZATION PROGRAM**

- ❑ Housing Services has teamed up with the Department of Psychiatry to establish 30 additional beds to provide stabilization services following a discharge from SFGH. Projected start-up for this project is January 2001.

## **REDESIGN OF AIDS EMERGENCY HOUSING PROGRAM**

- ❑ Housing Services has convened a working group to improve longer-term stability of emergency housing for people with AIDS.

# Long-Term Care

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- ❑ Elderly and disabled need access to a wider range of social and medical support services.
- ❑ In San Francisco County, licensed community care residential facilities provide 1,071 beds in Adult Residential Facilities, and 2,530 beds in Residential Care Facilities for the Elderly.<sup>1</sup>
- ❑ Two years ago there were 3,625 nursing facility beds in San Francisco.<sup>2</sup> Today there are 3,445 beds or a reduction of 180 beds.

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<sup>1</sup> California Department of Social Services, Community Licensing Division, Licensing Information System, Directory Report, March 2000.

<sup>2</sup> San Francisco Nursing Facility Bed Study.

# Long-Term Care Response

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## **NON-INSTITUTIONAL LONG-TERM CARE SERVICES NEEDS**

- ❑ To prepare for the needs of an aging population the Department continues to expand its home care program. Department transitional housing units are also being expanded so that people in hospitals and skilled nursing facilities can be discharged back into the community.

## **ASSISTED LIVING NEEDS**

- ❑ The Department is expanding assisted living options and other alternative methods of care. The Laguna Honda Replacement Project under Proposition A will include 140 assisted living units.
- ❑ In addition, the Department supports and will expand its Adult Day Health Care Programs and Senior Nutrition Programs in the new skilled nursing facility.

## **SKILLED NURSING SERVICES NEEDS**

- ❑ During the past year the need for long-term care services has been advocated by disabled and independent living representatives, community groups, consumers, and providers. Long-term care needs have also been documented in reports by the Long-Term Care Task Force and the Laguna Honda Hospital Replacement Project.
- ❑ The Department with the support of the entire San Francisco community, completed a significant accomplishment with the successful passage of Proposition A in November of 1999. The passage of Proposition A guarantees the replacement of Laguna Honda Hospital and Rehabilitation Center and the development of assisted living units on the campus.

# Substance Abuse

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- ❑ San Francisco's three-year average age adjusted death rate for drug-related deaths from 1996 to 1998 is 18.1 per 100,000 population. This rate is the highest in the state and well above the California state average rate of 7.5.<sup>1</sup>
- ❑ During FY 1998-1999, 4,700 injection drug users (IDUs) with soft tissue infections were seen at San Francisco General Hospital Emergency Department. Of those 4,700, 40% were admitted with an average charge per admission of \$12,000.
- ❑ However, San Francisco's heroin-related hospital admission rate and heroin-related death rate are still three times higher than the California state average.<sup>2</sup>
- ❑ While in past years San Francisco ranked the highest nationally in heroin-related ED admissions, last year San Francisco dropped to number four in the country due to Treatment on Demand.
- ❑ Injection drug use, the dominant method of heroin use in San Francisco, is associated with significant health risks. It is estimated that over 90% of San Francisco's IDUs are infected with Hepatitis C virus (HCV).<sup>3</sup>
- ❑ Approximately 19.6% of San Francisco's estimated 17,100 IDUs are infected with HIV.<sup>4</sup>

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<sup>1</sup> California Department of Health Services, County Health Status Profiles, April 2000.

<sup>2</sup> Cunningham J.K., Thielemier M.A., et al., "Heroin/Opioid-Related Hospital Admissions: Trends and Regional Variations in California (1986-1995)," Public Statistics Institute, Irvine, California, (1997).

<sup>3</sup> Dr. Brian Edlin, Urban Health Study. Presentation to Patient Population Subcommittee, 12/16/98.

<sup>4</sup> Community Substance Abuse Services (CSAS), Epidemiology, San Francisco Department of Public Health.



# Substance Abuse Response

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## **SERVICE EXPANSIONS**

- ❑ Community Substance Abuse Services (CSAS) enhanced services in existing programs for people with multi-disorders including substance abuse problems, HIV and mental illness.
- ❑ Substance abuse treatment in the County Jails has been expanded.
- ❑ Three federal grants have been received for expansion of medically supported detoxification, outcome research, and expansion of methadone treatment for a total of \$2.5 million.

## **GROWTH IN YOUTH SERVICES**

- ❑ Two community based organizations have been selected to open youth service centers in the Spring of 2000. Programs will provide substance abuse treatment and outreach services to at-risk for, or engaged in, substance abuse activities.

## **IMPROVED ACCESS FOR LATINO POPULATION**

- ❑ The first residential substance abuse treatment program for mono-lingual Spanish speaking clients has opened.

## **STREAMLINED CARE FOR INJECTION DRUG USERS WITH SOFT TISSUE INFECTIONS**

- ❑ The Department is developing a program to streamline care for Injection Drug Users (IDUs) with soft tissue infections through an outpatient Wound Center located at San Francisco General Hospital.
- ❑ Services will include surgical incision and drainage, pain management, substance abuse counseling, and wound care follow-up.

# Substance Abuse Response

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## **EFFORTS TO ADDRESS SAN FRANCISCO'S HEROIN EPIDEMIC**

- ❑ Goal: To expand methadone maintenance treatment access for heroin addicted clients in order to reduce the morbidity and mortality of the users and to help prevent the potential spread of communicable diseases.
- ❑ In mid-April 2000, the Department will begin a 12 month feasibility study on office-based opiate addiction treatment. The study will develop recommendations on assessment and enrollment of patients, fiscal analysis and options for third-party reimbursements for specific services.

# Tobacco

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- ❑ In San Francisco smokers include:
  - 12% of middle school students,
  - 19% of high school students and
  - 17.7% of adults.
  
- ❑ A random survey of San Francisco stores in 1999 found that 15.7% sold tobacco to minors.
  
- ❑ Twenty percent (20%) of San Francisco's children and adolescents are exposed to environmental tobacco smoke in the home.
  
- ❑ A random survey in 1999 found 91.4% of restaurant bars in compliance with the smokefree bar law while only 39.7% of stand-alone bars were in compliance. In 1998, 96.5% of restaurant bars and 50.6% of stand-alone bars were in compliance.
  
- ❑ The Department received 487 complaints of violations of the "no smoking in bars" law in 1999.

# Tobacco

## Response

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### YOUTH AND TOBACCO

- ❑ The Department provided funding, training, and technical assistance to nine youth community capacity building projects. Youth conducted action research and based on their findings, successfully advocated for:
  - Enforcement of law requiring warning labels on bidis (Indian cigarettes) popular among San Francisco youth.
  - Enforcement of ban on importation of bidis produced with indentured child labor in India.
  - Passage of school board policy banning purchase of tobacco subsidiary products.
- ❑ Active enforcement of illegal tobacco sales to minors by the Police Department and the local ordinance banning outdoor tobacco ads by the Department of Consumer Protection.

### TOBACCO EDUCATION

- ❑ Using messages developed through focus groups, the Department developed Cable TV ads encouraging smoking parents to smoke outdoors to protect their children from environmental tobacco smoke.
- ❑ During 1999, 155 smokers enrolled in the Department's Stop Smoking classes. Among participants who completed both pre-tests and post-tests, 55% quit.

### SMOKE FREE BAR LAW

- ❑ In response to complaints, 13 bar owners and 71 patrons were cited for illegal smoking in bars.
- ❑ Educational letters were sent to bar owners following complaints informing them of their duties and legal liabilities.

# Mental Health

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- ❑ Between FY 1992-1993 and FY 1998-1999, the number of clients served in Community Mental Health Services increased from 16,255 to 21,212.
- ❑ Approximately 8,000 (40%) of CMHS clients are uninsured.<sup>1</sup>
- ❑ People with psychiatric disabilities make up more than half of the City's unsheltered homeless population, but only 5% to 15% of the shelter population.<sup>2</sup>
- ❑ Involuntary hospitalization rates have been higher in San Francisco than in all other counties by a substantial margin.<sup>2</sup>

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<sup>1</sup> San Francisco, Mental Health Board Annual Report, April 1999.

<sup>2</sup> San Francisco Department of Public Health, Division of Mental Health Supported Housing Plan, 1995-2000.

# Mental Health

## Response

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### **INCREASE IN CASE MANAGEMENT AND OUTPATIENT SERVICES**

- ❑ In FY 1998-1999:
  - Community Mental Health Services (CMHS) case management services increased by 7%.
  - Outpatient and case management programs were able to reduce their client's hospital days by 26%.
- ❑ In CMHS Children's Services, eight new programs were developed with Medi-Cal funding to serve approximately 300 new under-served clients in FY 1999-2000.
- ❑ In FY 1998-1999, CMHS increased homeless outreach by redirecting two positions to the Mobile Support and Treatment Team to add capacity and provide services in the Bayview District.
- ❑ In FY 1999-2000, CMHS increased funding to providers for outreach services targeted at homeless individuals, and limited and non-English speaking populations in non-traditional settings.

### **SAN FRANCISCO MENTAL HEALTH PLAN**

#### *Development*

- ❑ Over the past five years, CMHS has developed the San Francisco Mental Health Plan (SFMHP). SFMHP provides specialized mental health services and is regulated by the State of California.
- ❑ SFMHP is the safety net foundation for San Franciscans who are at risk for mental illness and who are without adequate insurance or financial support.

#### *Administrative Changes*

- ❑ Formation of the SFMHP involved reshaping the delivery of community mental health services by:

# Mental Health

## Response

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### **SAN FRANCISCO MENTAL HEALTH PLAN**

#### *Administrative Changes (Continued)*

- Integrating private providers (clinicians, psychiatrists and group practices) with the public clinic based system to form the System of Care,
- Creating a centralized toll-free line for making treatment referrals,
- Reshaping priorities to focus more broadly on the mental health needs of all San Franciscans rather than just the seriously mentally ill.

#### *SFMHP Goals*

- Increase access to outpatient mental health services for San Francisco Medi-Cal beneficiaries and uninsured residents.
- Reduce unnecessary institutionalization and costs by assuring availability of adequate community alternatives.

### **SUPPORT OF COMMUNITY SYSTEM OF CARE**

- In FY 1999-2000, CMHS is adding 23 residential care beds and an acute diversion residential treatment program.
- In FY 1999-2000, CMHS increased its intensive in-home “wrap-around” services to foster care children over 3 years of age.

### **IMPROVED ACCESS TO MEDICATIONS**

- In April of 2000, CMHS will introduce a new pharmacy benefits program, to improve its ability to manage pharmaceutical benefits and assure that uninsured consumers have access to the medications they need.

# San Francisco's Uninsured

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- ❑ California's uninsured population increased by 276,000 in 1998 to 7.3 million.<sup>1</sup>
- ❑ Of those 7.3 million uninsured, 6 million are in working families.<sup>1</sup>
- ❑ As of November 1999, 1.48 million uninsured children in California were eligible for Medi-Cal or the Healthy Families Program, but were not enrolled.<sup>1</sup>
  - Based on March 1998 and 1999 Current Population Surveys it is estimated that 10% of uninsured children eligible for Medi-Cal or the Healthy Families Program live in the Greater Bay Area Region encompassing San Francisco County. <sup>1</sup>
- ❑ An estimated 130,000 San Franciscans are uninsured.<sup>2</sup>

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<sup>1</sup> HH Schauffler and ER Brown. The State of Health Insurance in California, 1999. Berkeley, CA: Regents of the University of California, January 2000.

<sup>2</sup> Mayor's Blue Ribbon Committee on Universal Health Care, Achieving Health Insurance for San Francisco's Uninsured, May 1998.



# San Francisco's Uninsured

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## **SAN FRANCISCO'S EFFORTS TO EXPAND HEALTH COVERAGE**

San Francisco remains committed to expanding health care coverage to uninsured and has taken the following incremental steps:

### **❑ MAYOR'S BLUE RIBBON COMMITTEE ON UNIVERSAL HEALTH CARE**

- As a part of the Mayor's proposal to expand coverage the Department administered a survey among San Francisco small businesses.
- The objectives of the survey were to: 1) characterize the current rates at which small San Francisco firms offer, and employees of small firms accept, employer-sponsored health insurance coverage, and 2) estimate the rates of employer and employee participation in a proposed San Francisco purchasing alliance program.

### **❑ HEALTHY WORKERS**

- The Department, in conjunction with, the Department of Human Services, the In-Home Supportive Services Authority and Local 250 implemented a program to provide health care coverage for approximately 4,500 in-home support services workers.

### **❑ SAN FRANCISCO CHILD CARE PROVIDERS HEALTH CARE BENEFITS PILOT**

- In FY 1999-2000 the Mayor committed \$250,000 to launch a pilot program to increase access to health insurance for child care providers.
- The pilot program provides a subsidy for eligible family child care providers in the first phase of the program and expands subsidies to eligible child care centers in the second phase. The program will create a child care provider purchasing pool for health care.
- The Mayor's Department of Children, Youth and Their Families is implementing this pilot program through a contract with the San Francisco Health Plan.

# San Francisco's Uninsured

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## ❑ **MEDI-CAL COVERAGE**

- In collaboration with the Department of Human Services and the Bringing Up Healthy Kids Coalition, the Department is supporting efforts to broaden outreach and enrollment in the Medi-Cal program. Medi-Cal provides no or low-cost health care coverage to certain low-income families.

## ❑ **HEALTHY FAMILIES EXPANSION**

- The Department and other community advocates continue to work on expanding enrollment in California's Healthy Families Program (HFP) which provides health, dental and vision care coverage to uninsured children.
- San Francisco's current enrollment in HFP is 7,313.
- Currently, there are over 38 entities certified to enroll children into the Healthy Families Program. The Department's Community Health Network is certified to train its eligibility workers about the program.

## ❑ **SAN FRANCISCO BRINGING UP HEALTHY KIDS COALITION (BUHK)**

- The Department is a participant in this Coalition which advocates and promotes health care coverage to uninsured children and families.
- Currently, the Coalition is working with San Francisco Unified School District on a strategy to determine if participating children in free or reduced-price school meal programs are eligible for Medi-Cal, Healthy Families, Kaiser Cares for Kids or other no or low cost health insurance.

# HIV/AIDS

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- ❑ San Francisco's rate of reported AIDS cases of 103.51 cases per 100,000 population (for the time period of 1996-1998) is well above the Year 2000 Objective case rate of 43.00.<sup>1</sup>
- ❑ In San Francisco the majority of reported AIDS cases continues to be among men who sex with men and injection drug users.
- ❑ Between 1990 and 1999,\* AIDS cases declined 80.1% in all transmission categories. However, in some ethnic groups the decline in AIDS cases was less (see page 29 of Appendix A):
- ❑ 6% or 506 of living AIDS cases are women.<sup>2</sup>
- ❑ Of the 8,598 living AIDS cases in San Francisco:
  - 68% or 5,889 cases are among Whites,
  - 15% or 1259 cases are among African Americans,
  - 13% or 1097 cases are among Latinos,
  - 4% or 305 cases are among Asian/Pacific Islanders and
  - <1% or 48 cases are among Native Americans.<sup>2</sup>

\*Cases reported may not be complete in later years. Cases reported by year of diagnosis.

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<sup>1</sup> California Department of Health Services, County Health Status Profiles, April 2000.

<sup>2</sup> Quarterly AIDS Surveillance Report, San Francisco Department of Public Health, AIDS Cases Reported through March 2000, (April, 2000).

# HIV/AIDS

## Response

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### **COMMUNITY BASED PROVIDER NETWORK**

- ❑ The goal of the community based provider network is to reduce the number of new HIV infections by targeting populations who may not have access to stand-alone HIV services, but who may have access to other public health services.

### **TARGETING HIV PREVENTION SERVICES**

- ❑ Continue to target communities with the largest number of AIDS cases:
  - Men who have sex with Men (MSM)
  - MSM Injection Drug Users (IDUs)

But also increase services to emerging populations such as women.

### **PREVENTION FOR POSITIVES PROGRAM**

- ❑ A new prevention project was developed to improve HIV positive individuals ability to access a system of health care and social support services.

### **SUPPORTING OUTREACH THROUGH COMMUNITY PLANNING**

- ❑ HIV Prevention Section will be evaluating community planning efforts to ensure outreach to and input from at-risk and impacted communities.
- ❑ The community planning process is facilitating community members input into design, evaluation and accountability of programs and services.

# Health Promotion and Prevention

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- ❑ Improved health outcomes are possible when prevention strategies take into account social and cultural and contexts.
- ❑ Injury epidemiology is leading to a growing awareness that specific types of injuries in specific populations are predictable and preventable.
- ❑ San Francisco's crude death rate from unintentional injuries was 38.0 per 100,000 population, above both the California crude death rate and the Year 2000 National Objective for the time period 1996-1998.<sup>1</sup>
- ❑ Tobacco is the leading preventable cause of death in the United States. Environmental interventions to reduce tobacco use including regulatory changes, media campaigns, and community capacity building have been successful.

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<sup>1</sup> California Department of Health Services, County Health Status Profiles, April 2000.

# Health Promotion and Prevention

## Response

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### **NUTRITION PROMOTION**

- ❑ Women, Infants and Children (WIC) has a special project to encourage good nutrition through reading to children. KQED TV supports this project by providing children's books with nutritional messages in English, Spanish, and Chinese.
- ❑ The Nutrition Network Project, administered by the Children, Youth and Families Section, targets San Francisco's under-served populations to promote healthy eating and physically active lifestyles. The project uses social marketing techniques to reach a large number of people.

### **INJURY PREVENTION**

- ❑ A public education campaign, *Stop Red Light Running*, was sponsored to decrease San Francisco's high rate of motor vehicle collisions caused by drivers running redlights and injuring 1,400 persons each year.
- ❑ The CHDP Health Education KIDS Plate Helmet Project provided 620 helmets to low income children ages 5-12. The project encouraged proper helmet use and instructions about safe bicycling, skate boarding and roller blading. The project is a collaborative effort between Blue Cross, The San Francisco Health Plan, and the Department.

### **TOBACCO POLICY ADVOCACY**

- ❑ The Department supported Booker T. Washington Community Service Center's investigation of the use of bidis (Indian cigarettes) among youth as well as their availability in stores and illegal sales rate. This community capacity building process consisted of filing a complaint with the Federal Trade Commission which resulted in mandated warning labels on bidis packages.

# Communicable Diseases

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- ❑ San Francisco's tuberculosis case rate of 26.61 per 100,000 population is well above the Year 2000 National Objective of 3.50 for the time period 1996-1998.<sup>1</sup>
- ❑ Tuberculosis disproportionately affects immigrants, the homeless and persons with AIDS.
- ❑ San Francisco's crude case rate of reported primary and secondary syphilis cases at 4.93 per 100,000 population is above the Year 2000 National Objective crude case rate of 4.00 for the time period of 1996-1998.<sup>1</sup>
- ❑ Rates for gonorrhea, chlamydia, and syphilis within the adolescent population increased 15% between 1998-1999 (see page 30 of Appendix A).

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<sup>1</sup> California Department of Health Services, County Health Status Profiles, 2000.

# Communicable Diseases

## Response

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### **TUBERCULOSIS CONTROL GUIDELINES**

- ❑ The Tuberculosis Control Section in conjunction with the American Lung Association and the San Francisco TB Task Force developed TB control guidelines which were adopted by San Francisco homeless shelters as community standards.
- ❑ The Department is developing TB control guidelines for single-room-occupancy (SRO) hotels in high incidence TB areas.

### **SYPHILIS OUTBREAK MANAGEMENT**

- ❑ The Department identified a cluster of early syphilis among gay men who met the majority of their sexual partners in a chat room on the Internet.
- ❑ The Department worked closely with Planet Out, the largest gay Internet community in the world, to educate and inform users of the syphilis outbreak and to urge them to get tested. The Department's approach to this incidence is being used nationally as a model for other STD programs.

### **EXPANDING STD SCREENING**

- ❑ STD Services worked with the San Francisco Unified School District to make STD screening and free condoms available to students in the public high schools.
- ❑ During this fiscal year 664 youth were screened for STDs and 16 new infections were identified and treated.
- ❑ The STD Program operates the largest jail STD screening project in the United States. This fiscal year the jail STD screening project provided treatment for nearly 90% of persons identified in the jails with an STD.

### **EXPANDED STD TREATMENT**

- ❑ In collaboration with COYOTE and the Exotic Dancers Alliance, the STD Program has established the St. James Infirmary, which provides free, confidential non-judgmental medical and social services to sex workers.



# Communicable Diseases

## Response

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### **EXPANDED STD TREATMENT (CONTINUED)**

- ❑ STD Services implemented single dose therapy for gonorrhea and chlamydia to make treatment for these infections as simple as possible.
  
- ❑ STD Services program implemented a program whereby patients are given preventive therapy for their sexual partners who are unlikely to come in for clinic based evaluation and treatment.
  
- ❑ The STD Program is one of two sites in San Francisco which offers HIV post-exposure prevention services to individuals who have been exposed to HIV.

# Environmental Health

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- ❑ Analysis of zip code level hospitalization data indicates asthma is not uniformly distributed geographically among San Francisco residents.
- ❑ New environmental health issues include indoor air quality and its relationship to asthma and emerging pathogens and chemical contaminants in municipal water.
- ❑ The amount of solid waste produced in San Francisco continues to increase. The City's recycling efforts are effective and improving, but still fall short of the state-mandated goal of 50% of total solid wastes.
- ❑ The public health definition of key environmental determinants has broadened to recognize community and social contexts. Public health goals now include preventing deterioration of neighborhood infrastructure, countering targeted media promotion of behaviors (e.g., cigarette smoking), restricting residential alcohol outlet density, expanding access to good nutrition, increasing access to open space and encouraging social cohesion.

# Environmental Health

## Response

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### **ASSESSING HOME LIVING CONDITIONS**

- ❑ The Department initiated collaboration with adult asthma care physicians at San Francisco General Hospital to provide environmental assessments of the homes of patients with asthma to identify and eliminate suspected environmental triggers.

### **SOLID WASTE CLEANUP**

- ❑ The Department monitored and oversaw, the cleanup and removal of over 3,000 cubic yards of solid waste illegally disposed on a vacant lot in the Bayview-Hunters Point District. The Department and the City Attorney's Office pursued legal action against the illegal solid waste operator resulting in the closure of the illegal business.

### **ADDRESSING ENVIRONMENTAL ISSUES WITH THE COMMUNITY**

- ❑ The Environmental Health Section is working to collaborate with communities and other City agencies to improve health outcomes associated with environmental risk factors:
  - Staff have attended neighborhood meetings in the Richmond, the Mission, Chinatown, Fisherman's Wharf, the Tenderloin and Bayview Hunters Point (BVHP) to better understand community environmental concerns.
  - A quality of life team consisting of personnel from the Department, the Port, San Francisco Police Department and Department of Public Works randomly conduct visits at Fisherman's Wharf for educational and inspection purposes.
  - Environmental Health continues to participate and support the Bayview Hunters Point Health and Environmental Resource Center in its effort to decrease alcohol sales in this neighborhood.

# Children, Youth, and Families

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- ❑ San Francisco's adolescent birth rate to (mothers aged 15 to 19) of 33.3 per 1,000 females is low compared to the State average of 57.2 for the time period 1996-1998. However, African-American and Hispanic adolescents account for a disproportionate share of births to adolescent mothers compared to the distribution of all births in San Francisco by race and ethnicity (see page 40 of Appendix A).<sup>1</sup>
- ❑ From January 1998 through September 1999, 1,768 child care slots were created in family day care homes and child care centers.<sup>2</sup>
  - There is an increased need for access to health services in child care centers.

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<sup>1</sup> California Department of Health Services, County Health Status Profiles, April 2000.

<sup>2</sup> San Francisco Child Care Planning and Advisory Council: Needs Assessment and Data Analysis, January 2000.

# Children, Youth, and Families

## Response

---

### TEEN PREGNANCY

- ❑ In conjunction with Children, Youth and Family Services, Maxine Hall Health Center launched the Teen Smart Program to tackle the high teen pregnancy rate among African American teens in the City's Western Addition
  - Provides comprehensive primary care and sexual health-related services through a team approach involving community outreach.

### HEALTH AND SAFETY FOR CHILDREN IN CHILDCARE

- ❑ To improve health and safety outcomes for children in childcare, the Childcare Health Project has hired public health nurses to provide health and safety consultation at four designated childcare centers in targeted San Francisco neighborhoods.

### ENHANCED HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

- ❑ California has approved a new program, *Health Care for Children in Foster Care*. New funding will allow more public health nursing services to meet the health care needs of children in foster care.
- ❑ The CHDP Foster Care Unit has been expanded to include services that are designed to improve the health status of high-risk children.
- ❑ Currently, there are 14 public health nurses who provide crucial services to approximately 3,000 kids in the Child Welfare Foster Care system.

### CHILD ABUSE PREVENTION

- ❑ The *Sistah Sistah* home visiting program was expanded to target more women. This child abuse prevention program now serves Hispanic women in their last trimester residing in Visitacion Valley (zip code 94134), in addition to, African American women residing in this zip code.

# **Overview of Department of Public Health Strategic Planning Initiative**

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# Overview of Strategic Planning

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## **DEFINITION**

- ❑ A formal ongoing process of developing, evaluating, and implementing goals to guide actions and decision making by organizations.

## **OVERARCHING GOAL**

- ❑ Better match an organization's resources and capabilities to the external environment faced by the organization.

## **PURPOSES OF STRATEGIC PLANNING**

- ❑ Re-evaluate how the Department meets its two fundamental public health roles:
  - (1) as the government entity responsible for carrying out population-based health activities and
  - (2) as a provider of health care services.
- ❑ Improve the Department's ability to develop a clear strategy for fulfilling its mission and vision statements.
- ❑ Help the Department prioritize health concerns in collaboration with the community.

# What are the Strategic Planning Goals?

- ❑ respond to San Francisco's changing demographics and health needs,
- ❑ plan with the community for health improvement,
- ❑ strengthen prevention efforts,
- ❑ identify populations the Department should serve,
- ❑ develop program priorities to maximize the effectiveness of limited resources and
- ❑ respond to funding trends.



# Guiding Principles

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- ❑ Ensure that the Department develops a clear strategy for fulfilling its mission and vision statements and clearly articulates its role in the delivery of services to San Franciscans.
- ❑ Take a broad view of health given that there are many social determinants that impact the community's health-e.g., income, education, housing.
- ❑ Continue to support the Department's roles in overseeing public's health and delivering health care services.
- ❑ Use health data (quantitative and qualitative), community needs, health mandates and program evaluation to guide the development of the Department's services.
- ❑ Ensure that health services are comprehensive (including a continuum of care) and integrated to effectively address the health problems of communities and individuals.
- ❑ Emphasize the expansion of primary prevention activities to reduce preventable illness and injury.
- ❑ Emphasize improving service integration at the following levels:
  1. integration of Population Health and Prevention and Community Health Network services within the Department,
  2. integration of Department services with community resources and providers,
  3. integration of Department services with the services of other City departments for the same populations and
  4. integration of program contracting functions to improve contracting efficiency for the contractor and Department.
- ❑ Emphasize blending revenues where possible to support service integration.
- ❑ Recommend strategies for the Department's legislative advocacy to improve San Francisco's health status and the Department's ability to address health issues.

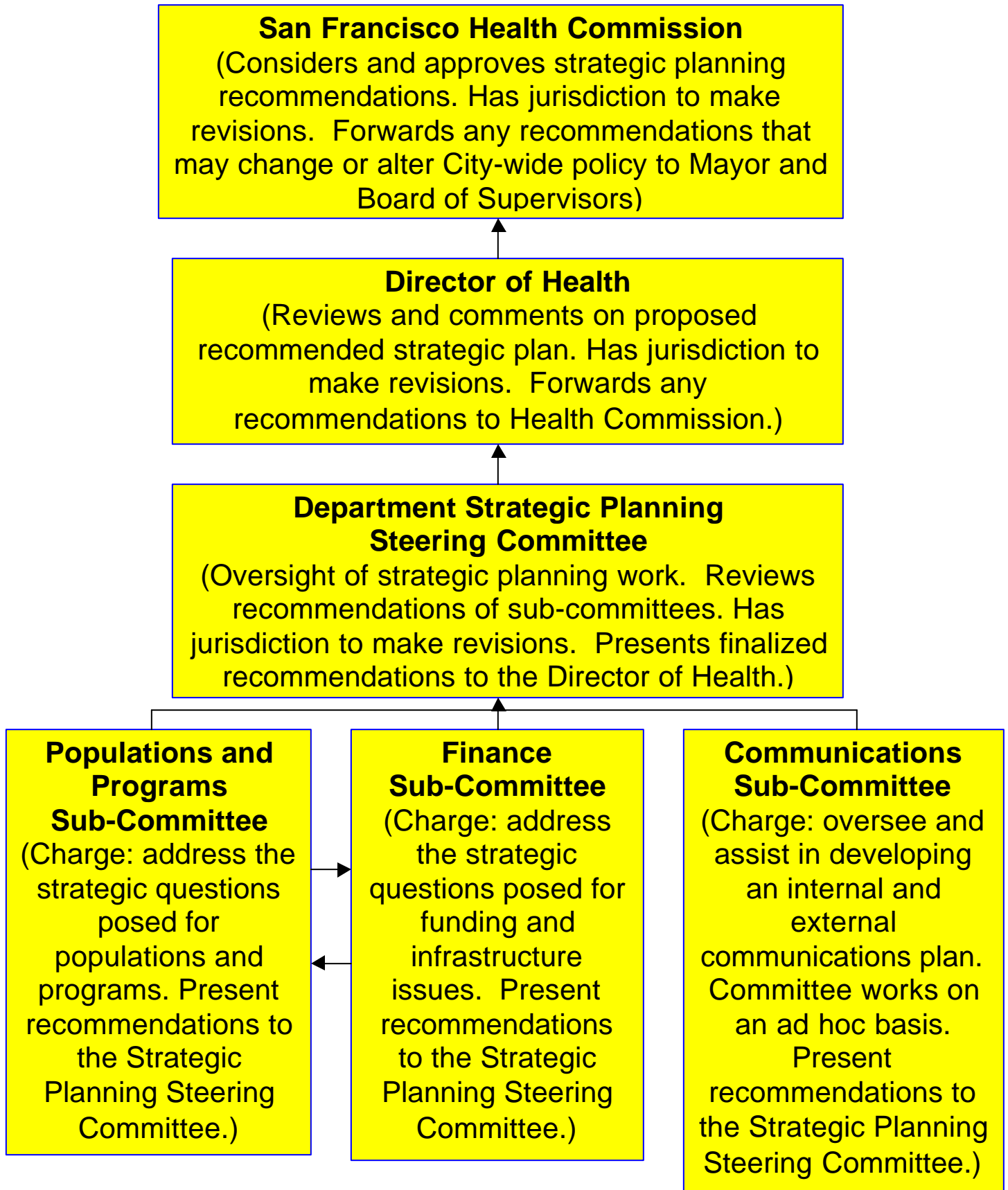
# Guiding Principles

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- ❑ Develop a strategic vision for the Department that recognizes current fiscal realities but is not driven by them.
- ❑ The overall health of San Francisco is a community-wide responsibility requiring combined and integrated resources- including public health, other providers, health advocates and community agencies.

# Committee Structure and Process

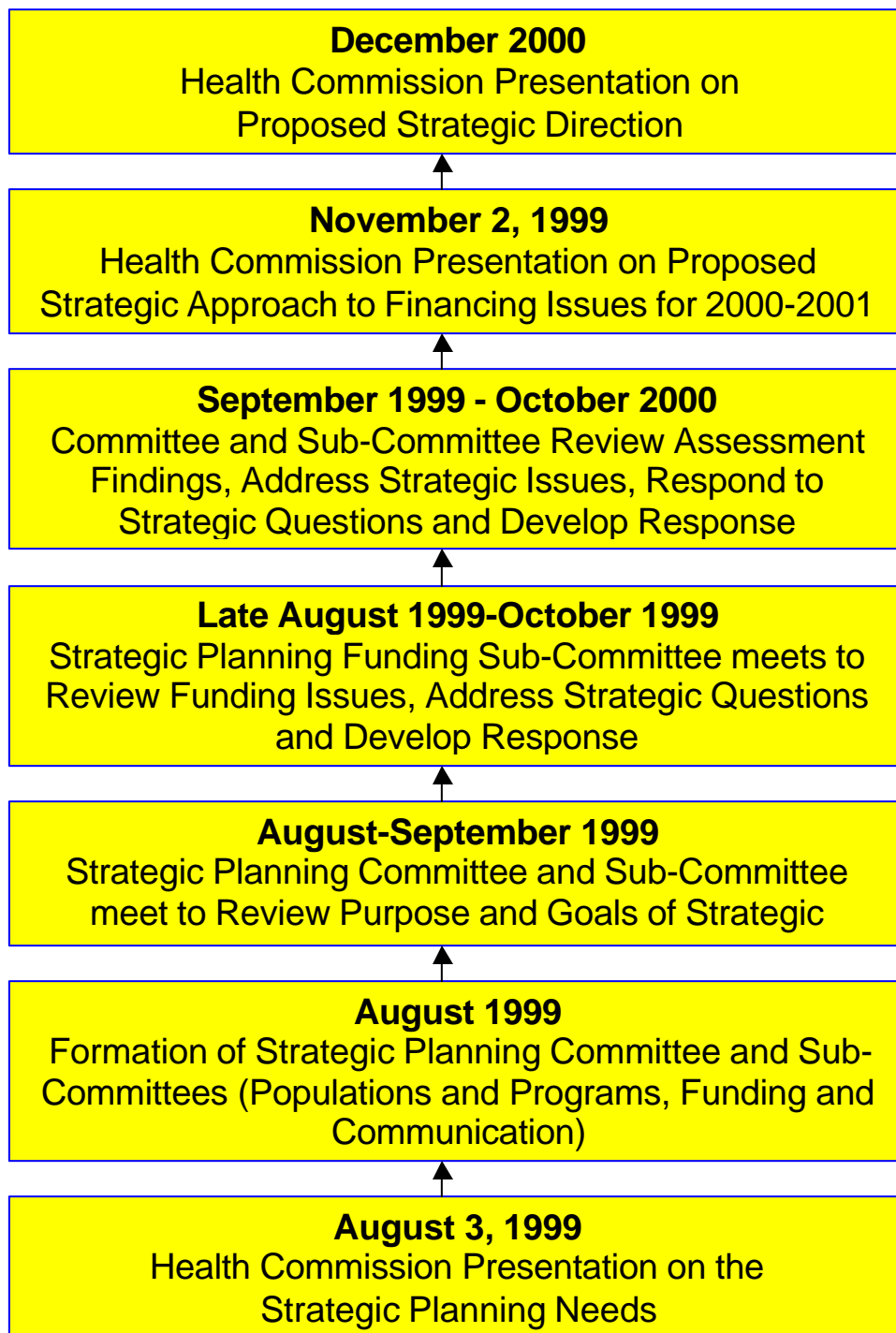
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# Proposed Strategic Planning Timeline

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## August 1999 - December 2000



# Stakeholder Involvement in Strategic Planning

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## **STAKEHOLDER REPRESENTATION**

- ❑ Members of the strategic planning committees represent a diversity of stakeholders including:
  - community providers
  - health advocates
  - businesses
  - consumers
  - staff
  - community based organizations

## **COMMUNITY MEETINGS**

- ❑ The Department will hold town hall meetings for both the public and staff at three critical junctures of the process:
  - before recommendations are developed,
  - while recommendations are being drafted and considered and
  - after the draft strategic plan has been completed.
- ❑ Over the course of the strategic planning initiative culturally competent town hall meetings will be held in all supervisorial districts to gather input into the strategic plan.
- ❑ The Department is gathering further input into the strategic plan by attending existing community advisory board and neighborhood meetings.

## **EASY ACCESS TO INFORMATION**

- ❑ Community can obtain information through a direct line to designated Department staff.
- ❑ Web Site dedicated to the Department's strategic planning initiative.



# Appendix A

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# *Introduction*

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**Who we are  
How we live  
Our health**

For Public Health Week, April 3 – 9, 2000, the Department of Public Health presents this annual overview of the health of San Franciscans. Each year we work to improve this report by adding data and information to enhance our understanding of the health of our community. Because social conditions and personal health behaviors have a significant effect on health, this year's report has been expanded to include additional statistics on social issues such as poverty and unemployment, behaviors such as exercise (physical inactivity and overweight), and health risks such as high blood pressure.

Assessment is a core function of the San Francisco Department of Public Health. It is an ongoing activity that provides us with useful information. The data used to develop this report comes from our best available sources including surveillance data, census/demographic data, program utilization or diagnosis data, vital records and surveys. In some cases, our data are limited. We are working to expand our information base as we strive to create a more complete picture of the health of San Franciscans.

We are pleased to present you with this report and hope that it will contribute to a better understanding of **who we are, how we live, and our health.**

The report was produced by the Planning and Community Health Epidemiology and Disease Control sections of the Population Health and Prevention Division of DPH

Additional copies of this report can be downloaded from our web page at [www.dph.sf.ca.us](http://www.dph.sf.ca.us) or by calling:

(415) 255-3470  
Planning Office  
Population Health and Prevention  
San Francisco Department of Public Health



# *Who We Are*

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**Who we are**  
How we live  
Our health

Who we are refers to the characteristics of the population of San Francisco. These characteristics play an important role in determining our health status. San Francisco's cultural diversity results in a wide array of health beliefs and practices. It is important that our health and social service systems provide culturally and linguistically appropriate services to this diverse population. The age of our population is also an important factor in our health status because health problems and needs generally increase as we age.

# Demographics

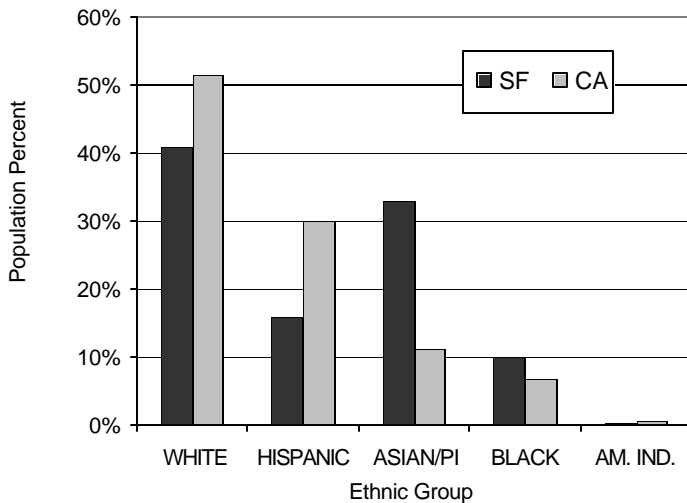
Who we are  
How we live  
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## POPULATION

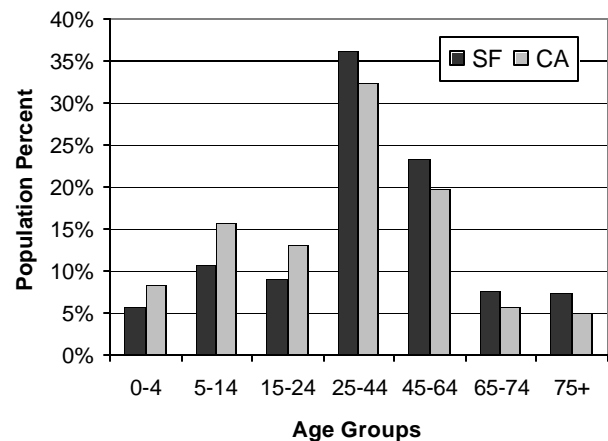
Over the last eight years, San Francisco's total population grew from 723,900 in 1990 to 784,600 in 1998, an 8.4% increase. When compared to the rest of California, San Francisco's population has a smaller proportion of children and youth under age twenty-five and a greater number of adult and senior citizens. San Francisco's unique demographic profile includes a substantially larger proportion of Asian and Pacific

Islanders, and smaller proportions of Hispanics than California as a whole. Among ethnic groups within San Francisco, whites demonstrate the lowest proportion of very young children ages 0-4 as well as the greatest proportion of middle-aged adults between the ages of 45 – 65 years old. The Hispanic population has the largest proportion of young children and the smallest number of seniors over 75 years old.

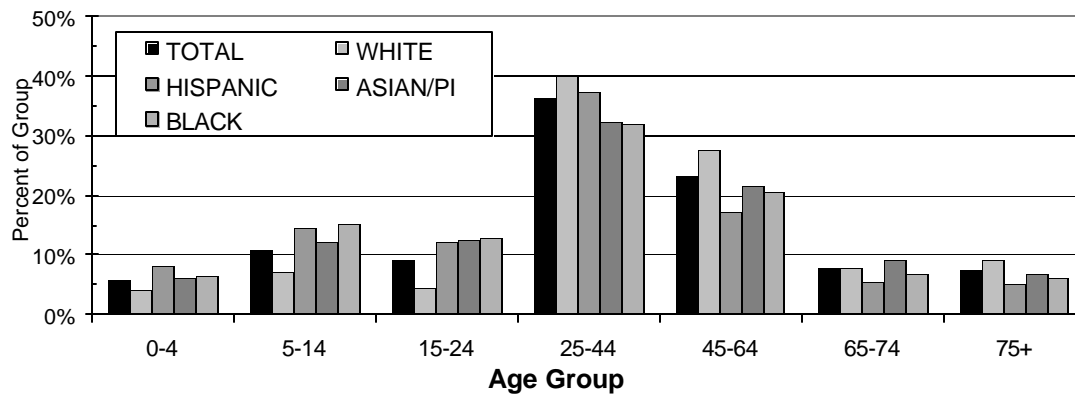
**Population by Major Ethnic Group**



**Population by Age Group**



**Age Distribution by Ethnicity**



**Source:** Ca. Dept. of Finance, *Race/Ethnic Population Estimates with Age and Sex Detail, 1970 – 2040*. Sacramento, CA, December 1998.

# Demographics

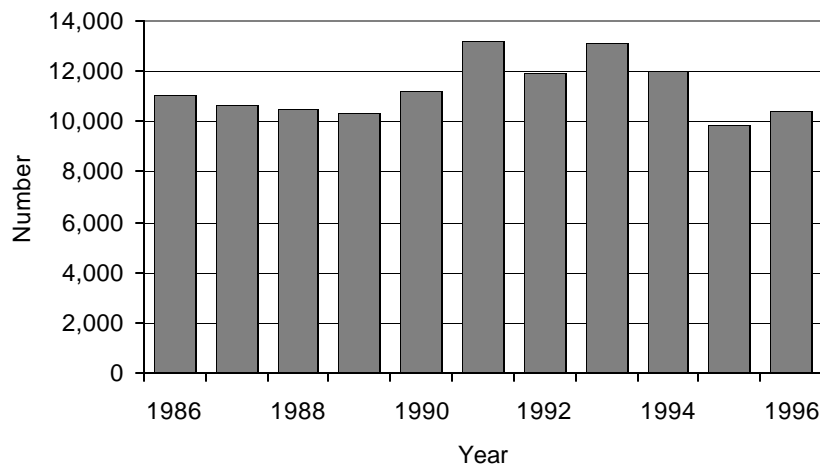
Who we are  
How we live  
Our health

## IMMIGRATION

San Francisco continues to attract many immigrants from other countries. The immigration data below reflect those people admitted for permanent residence in the U.S. via San Francisco. An unknown

number of these people actually settle elsewhere, while others admitted elsewhere settle here. It has recently been estimated that for California as a whole, 18.8% of its 1996 population were non-citizens of the U.S.

**Documented Immigrants Admitted to San Francisco, 1986 - 1996**



**Sources:** Urban Institute, Assessing the New Federalism, State Reports and Highlights, Table 1, errata (website) and United States Immigration and Naturalization Service, FedStats, <http://www.fedstats.gov/cgi-bin/mapstats/INSLookup?06075>

# Social Security

Who we are  
How we live  
Our health

Social Security, the Federal retirement insurance program, provided income support to almost one in seven San Franciscans in December 1998, 105,000 people in all. The data in the table below show how many people received benefits in

the main eligibility categories of retirement, survivorship, or disability. The average monthly benefit, shown in the last line for December 1997, falls far below the amount needed to support even a modest level of independent living in San Francisco.

## San Francisco Social Security Recipients, 1998

Social Security State or County	Retirement Benefits				Survivor Benefits		Disability Benefits			Aged 65 or older	
	Total	Retired workers	Wives & husbands	Children	Widows & widowers	Children	Disabled workers	Wives & husbands	Children	Men	Women
CA	4,050,885	2,592,286	290,078	46,380	431,486	171,921	404,574	14,230	109,950	1,282,189	1,741,974
SF	105,155	70,850	5,760	1,250	9,990	2,765	12,900	175	1,465	32,975	47,335
SF % of CA	2.6%	2.7%	2.0%	2.7%	2.3%	1.6%	3.2%	1.2%	1.3%	2.6%	2.7%
Benefits/beneficiary (Dec. '97)											
SF	\$ 716.94	\$ 765.91	\$ 881.18	\$ 334.41	\$ 735.01	\$ 511.47	\$ 734.30	\$ 177.78	\$ 221.09	\$ 828.22	\$ 693.09

**Source:** Social Security Administration, SSI Recipients by State and County, December 1998, Table 3  
[http://www.ssa.gov/policy/pubs/pubs\\_pages/pubs\\_programDataByGeographic.htm](http://www.ssa.gov/policy/pubs/pubs_pages/pubs_programDataByGeographic.htm)

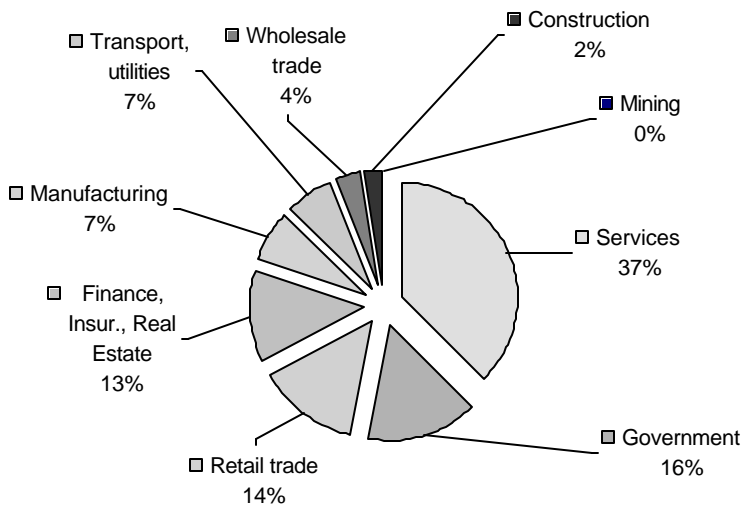
# Jobs

**Who we are**  
 How we live  
 Our health

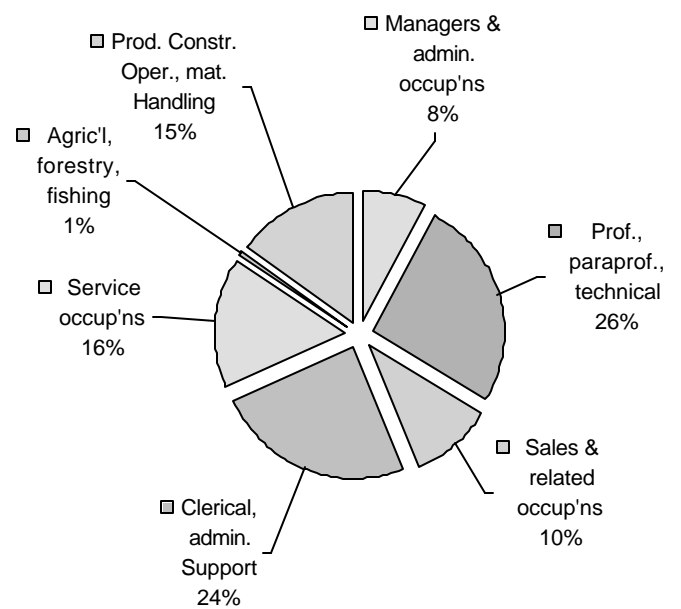
San Francisco provided an estimated 539,600 jobs in 1999. As the figures below show, a high proportion of these jobs are concentrated in the service industry and government, with a high proportion of professional, technical and support

occupations. The number of jobs far exceeds the size of San Francisco's resident labor force of an estimated 422,000, reflecting the fact that many people who do not live in San Francisco commute here to work.

**Employment by Industry, San Francisco, 1999**



**San Francisco Employment by Major Occupational Group, 1999**

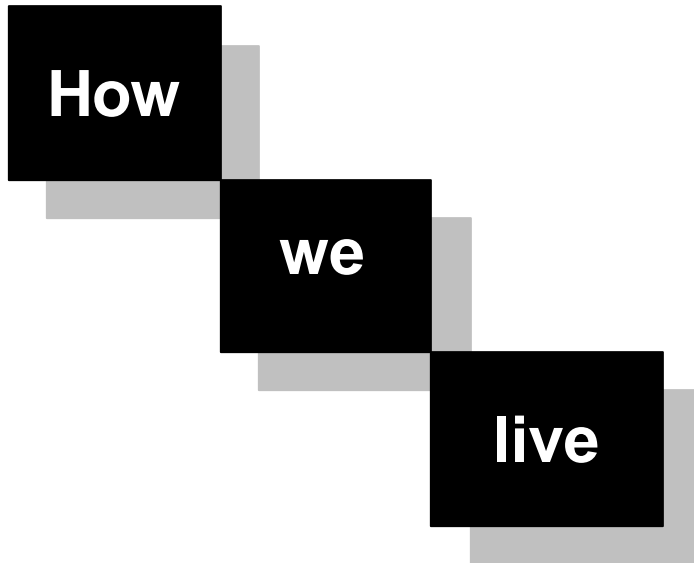


Source: California Employment Development Department, Labor Market Information Division



# San Francisco

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Who we are  
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Our health

# *How We Live*

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Who we are  
**How we live**  
Our health

How we live determines much about how long we live and how healthy we are – what health-influencing conditions we are exposed to, and what personal and community resources are available to us. The environments that surround us at home, on the streets, in our neighborhoods, in school, and at work, all can influence our health. So do our activities and habits, and our access to financial, social, health care, and other essential resources. Most disease and injury experienced by San Franciscans could be prevented or postponed by changes in how we live.

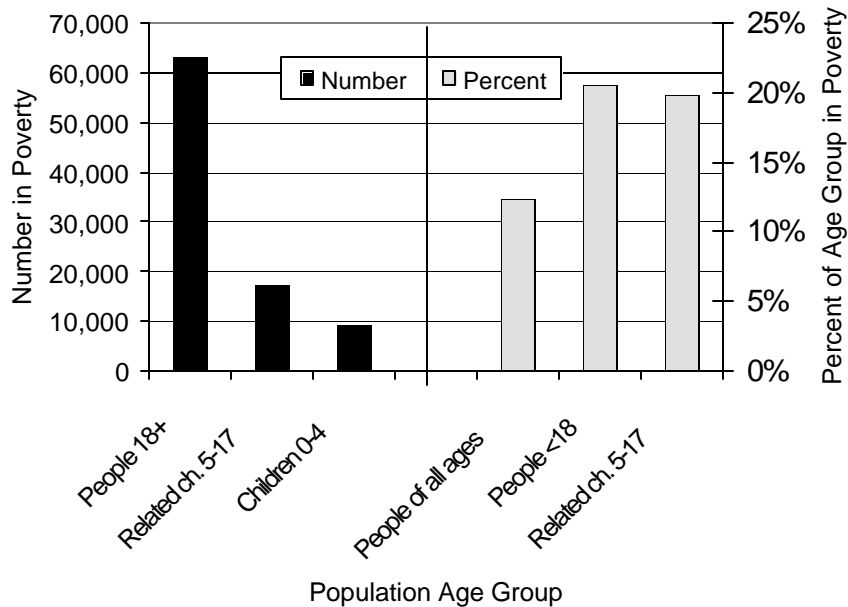
# Poverty

Who we are  
**How we live**  
 Our health

Compared to higher-income populations, groups living in poverty have higher mortality from many causes, report themselves to be less healthy, are less likely to have regular sources of health care, and seek health attention less often. Since Federal poverty levels are set for the nation by a formula which greatly underestimates the real costs needed for subsistence-level

living in San Francisco, the Federal poverty estimates for 1995 shown in the figure below, likely underestimate the size of the population living in poverty here.

**San Francisco Poverty  
 Population by Age, 1995**



**Source:** United States Bureau of the Census, Small Area Income and Poverty Estimates Program, released February, 1999.

# Poverty

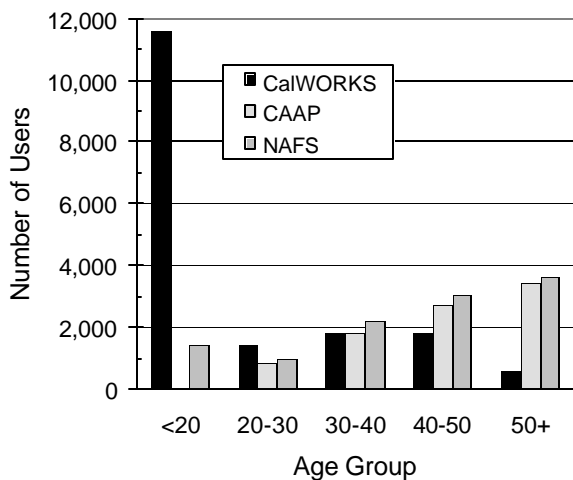
Who we are  
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## PUBLIC ASSISTANCE

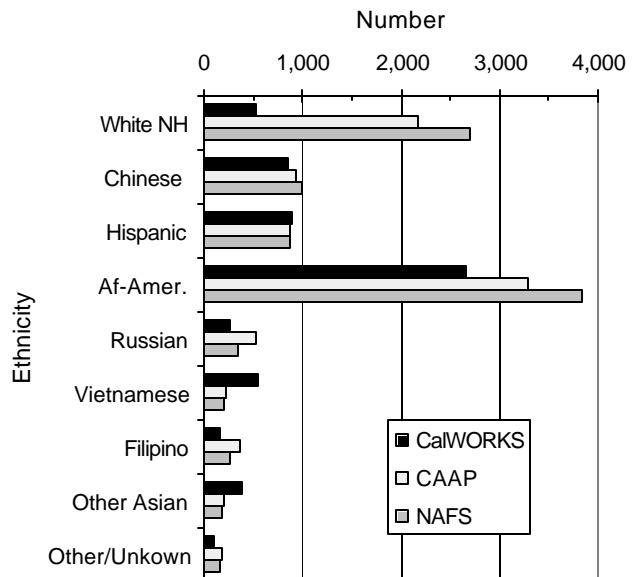
Demographics of public assistance users provides a reflection of the distribution of San Francisco's low income population, although program eligibility restrictions, time limits, and differential use by population

groups influences the picture of participants shown by the data below.

**Public Assistance Users by Age**



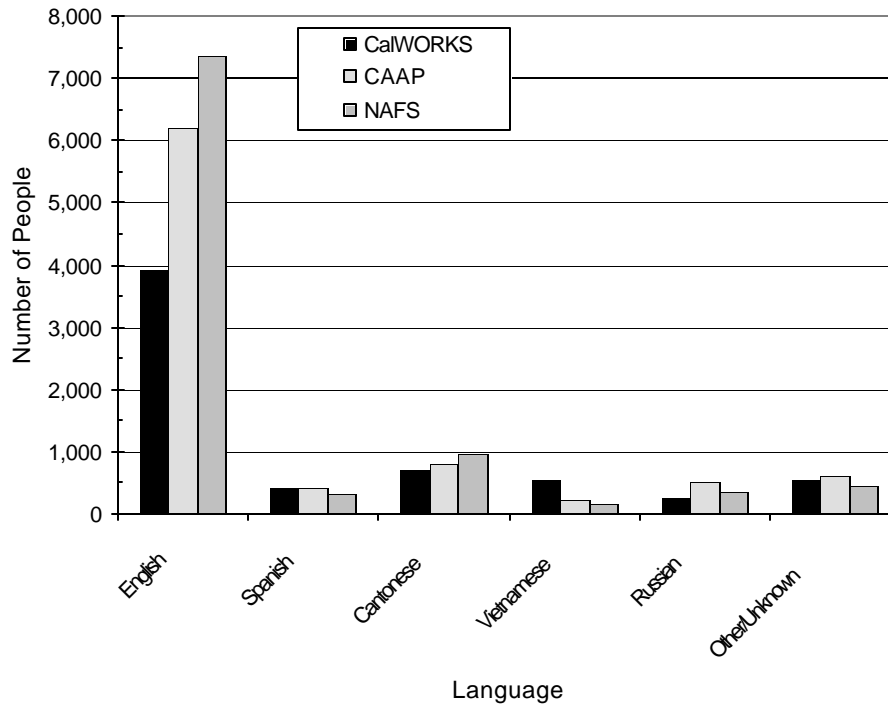
**Public Assistance Users by Ethnicity**



**Sources:** SF Department of Human Services, January 2000, CalWORKS SnapShot Quarterly Report  
 SF Department of Human Services, December 1999, CAAP SnapShot Quarterly Report  
 SF Department of Human Services, December 1999, NAFS SnapShot Quarterly Report

## PUBLIC ASSISTANCE—CONT.

*Public Assistance Users by Language*



The three main benefit programs shown are:

- CalWORKs, serving families with children (the descendent of AFDC, since changed by the 1996 welfare reform to the federal TANF program, Temporary Assistance to Needy Families);
- CAAP (formerly GA, General Assistance, for needy adults not supporting children); and
- Food Stamps, the Federal program most widely available to low-income persons. NAFS refers to Non-Assistance Food Stamps, the part of the

program for people not automatically eligible through enrollment in other programs.

These are “snapshot” data, showing enrollment at a point in time. They are from the SF Dept. of Human Services’ most recent quarterly reports for each program, December 1999 for NAFS and CAAP, and January 2000 for CalWORKS. For CalWORKS recipients under age 20, 145 were caregivers rather than dependent children.

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**Sources:** SF Department of Human Services, January 2000, CalWorks SnapShot Quarterly Report  
 SF Department of Human Services, December 1999, CAAP SnapShot Quarterly Report  
 SF Department of Human Services, December 1999, NAFS SnapShot Quarterly Report

# Cost of Living

Who we are  
**How we live**  
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San Francisco is an expensive place to live, especially for housing. A recent study estimated the minimum cost needed for families with two children to be able to live comfortably in each region and for California overall. San Francisco is part of Region IV, which includes Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara counties. The results for this region are shown below, along with

comparisons of the minimum comfortable cost of living (COL) to San Francisco's median household income and to income levels provided by several standards used for low-income families. The income needed in the Bay Area is about 20% greater than that needed for the whole State, and all the low income standards fall well below the minimum income level needed to live comfortably in the Bay Area.

## Bay Area Minimum Comfortable Cost -of- Living (COL) Comparisons

<b>BAY AREA (REGION IV)</b> (San Francisco, Alameda, Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara)			
Expenses (1st row = monthly expenses; 2d row = expense as % of Minimum COL)			
Expense	Family		
	Single parent	Two Parents (One Working)	Two Working Parents
<b>Housing/Utilities</b>	\$ 827	\$ 1,035	\$ 1,035
	22.5%	34.0%	23.1%
<b>Child Care</b>	\$ 1,106	\$ -	\$ 1,106
	30.0%	0.0%	24.7%
<b>Transportation</b>	\$ 244	\$ 244	\$ 244
	6.6%	8.0%	5.4%
<b>Food</b>	\$ 382	\$ 583	\$ 583
	10.4%	19.2%	13.0%
<b>Health Care</b>	\$ 255	\$ 390	\$ 390
	6.9%	12.8%	8.7%
<b>Miscellaneous</b>	\$ 311	\$ 379	\$ 379
	8.4%	12.5%	8.5%
<b>Taxes</b>	\$ 556	\$ 412	\$ 741
	15.1%	13.5%	16.5%
<b>Monthly Total</b>	\$ 3,681	\$ 3,043	\$ 4,478
	100.0%	100.0%	100.0%
<b>Annual Total</b>	\$ 44,172	\$ 36,516	\$ 53,736
<b>Basic family wage (Hourly)</b>	\$ 21.24	\$ 17.56	\$ 12.92

**Source:** California Budget Project, Making Ends Meet: How Much does It Cost to Raise a Family in California? Sacramento, October 1999

# Cost of Living

Who we are  
**How we live**  
 Our health

## COST OF LIVING—CONT.

### California Minimum comfortable Cost-of-Living (COL) Comparisons

CALIFORNIA				
Expenses (1st row = monthly expenses; 2Nd row = expense as % of Minimum COL)				Region IV as % of California Statewide Costs
Expense	Family			
	Single parent	Two Parents (One Working)	Two Working Parents	
<b>Housing/Utilities</b>	\$ 608	\$ 762	\$ 762	136%
	19.8%	29.2%	20.4%	
<b>Child Care</b>	\$ 926	\$ -	\$ 926	119%
	30.2%	0.0%	24.8%	
<b>Transportation</b>	\$ 244	\$ 244	\$ 244	100%
	8.0%	9.3%	6.5%	
<b>Food</b>	\$ 382	\$ 583	\$ 583	100%
	12.4%	22.3%	15.6%	
<b>Health Care</b>	\$ 216	\$ 330	\$ 330	118%
	7.0%	12.6%	8.8%	
<b>Miscellaneous</b>	\$ 311	\$ 379	\$ 379	100%
	10.1%	14.5%	10.1%	
<b>Taxes</b>	\$ 382	\$ 315	\$ 516	146%
	12.4%	12.1%	13.8%	
<b>Monthly Total</b>	\$ 3,069	\$ 2,613	\$ 3,740	120%
	100.0%	100.0%	100.0%	
<b>Annual Total</b>	\$ 36,828	\$ 31,356	\$ 44,880	120%
<b>Basic family wage (Hourly)</b>	\$ 17.71	\$ 15.08	\$ 10.79	

**Source:** California Budget Project, Making Ends Meet: How Much does It Cost to Raise a Family in California? Sacramento, October 1999

# Cost of Living

Who we are  
**How we live**  
 Our health

## COST OF LIVING—CONT.

### Earning Level Comparisons

#### Earnings Level Comparisons:

How do various income standards compare to the minimum comfortable cost-of-living level?

Income Standard	Bay Area Annual Income			California Annual Income			Hourly Wage
	Single Parent	Two Parents (one working)	Two Working Parents	Single Parent	Two Parents (one working)	Two Working Parents	
Federal Poverty Level (FPL)	\$ 13,880	\$ 16,700	\$ 16,700	\$ 13,880	\$ 16,700	\$ 16,700	Fam 1: \$6.67
Min. COL as % of FPL	318%	219%	322%	265%	188%	269%	Fam 2: \$8.03
FPL as % of COL	31%	46%	31%	38%	53%	37%	Fam. 3: \$4.01
CA Minimum Wage	\$ 11,960	\$ 11,960	\$ 23,920	\$ 11,960	\$ 11,960	\$ 23,920	\$5.75
Min. Wage as % of COL	27%	33%	45%	32%	38%	53%	
Living wage	\$ 22,880	\$ 22,880	\$ 45,760	\$ 22,880	\$ 22,880	\$ 45,760	\$11.00
Living wage as % of COL	52%	63%	85%	62%	73%	102%	
Low Income	\$ 30,000	\$ 30,000	\$ 30,000	\$ 30,000	\$ 30,000	\$ 30,000	Fam. 1,2: \$14.42
Low income as % of COL	68%	82%	56%	81%	96%	67%	Fam. 3: \$7.21
SF median household income	\$ 40,131	\$ 40,131	\$ 40,131	\$ 40,131	\$ 40,131	\$ 40,131	Fam. 1,2: \$19.29
Median income % of COL	91%	110%	75%	109%	128%	89%	Fam. 3: \$9.65

Notes: Basic family wage = hourly wage necessary per full-time worker to supply household income = basic area COL  
 Full time work calculated as 52 wk/yr. x 40 hr/wk = 2,080 hr/yr.

Source: California Budget Project, Making Ends Meet: How Much does It Cost to Raise a Family in California? Sacramento, October 1999



# Child Care

Who we are  
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Child care is an important issue for families with young children and working parents. It has important influences on children's development, parents' travel and work schedules, quality of life, and family finances. San Francisco has licensed child care slots for 32% of its 58,900 children who have working parents (three-fifths of the children under age 14). This proportion is

better than California's statewide figure of 21%, but still far below the need here. The cost of licensed child care also represents a large share of household income for low and many middle income families. While there are numerous state and Federal programs to subsidize these costs for low-income families, they only partially meet of the need for quality child care slots.

## San Francisco Child Care Supply/Demand, 1999

Children Living with Working Parents	Children		Children in care outside family	
	Number	Percent	Number	Percent
Children 0-5	25,899	57%	13,209	51%
Children 6-13	33,062	61%	6,612	20%
Total Children 0-13	58,961	59%		
Licensed Child Care Supply	18,994			
Licensed Child Care Supply as % of Need		32%		

## Child Care Costs, San Francisco, 1999

	Average Annual Cost for 1 Child
Full-time care (in a center, infant <2 yrs.)	\$6,407
As % of full-time minimum wage earnings	54%
As % of full-time living wage earnings*	28%
As % of San Francisco median household income	16%

\*Living wage earnings calculated for \$11.00/hr.

Source: California Child Care Resource & Referral network, 1999 *California Child Care Portfolio*.

# Risk Factors

Who we are  
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Many of the deaths in San Francisco can be attributed to seven well-known risk factors: tobacco use, poor diet and not enough exercise, excessive or ill-timed alcohol consumption, environmental toxins, guns, unsafe sex, and illegal drugs (primarily heroin). These risks, or determinants,

contribute to the leading causes of death in San Francisco in complex ways. The symbols in the table below indicate the approximate share of these causes of death that may be attributable to these determinants.

**San Francisco Prevention Attribution Matrix for Leading Causes of Premature Mortality, 1998**

Rank	Specific Cause of Death	Tobacco	Diet, lack of Exercise	Alcohol	Environ. Toxins	Guns	Sexual Behavior	Illegal Drugs
1	Ischemic heart disease (IHD)	●	●	+				
2	HIV Infection/AIDS			?			▲	●
3	Drug poisoning (mostly heroin overdose)			●				▲
4	Cerebrovascular (Stroke)	●	●	■+				■
5	Lung cancer	▲	?		■			
6	Lower resp. infection (Pneumonia)	●		■	■			
7	Suicide			●		●		■
8	Chronic obstr. Pulm. Disease (COPD)	▲			■			
9	Colorectal cancer	■	●	■				
10	Breast cancer	?	■	■				
11	Homicide			●		▲		●
12	Inflam/infect/cardiomyopathy		■	■				■
13	Chronic liver disease & cirrhosis			▲				■
14	Motor vehicle-traffic			●				■
15	Alcohol use (psych dx)			▲				

Specific cause of death ranking is by years of lost life (using a life expectancy table that begins with 82.5 years at birth). Ranking is based on 1998 mortality data. For methods see Aragon et al, *San Francisco burden of Disease and Injury: Mortality Analysis, 1990-1995*, San Francisco Department of Public Health, December 1998.

- ▲ Attributable fraction estimated to be greater than 40%
- Attributable fraction estimated to be between 10% and 40%
- Attributable fraction estimated to be between 2% and 10%
- + Protective effect of moderate alcohol consumption
- ? More than two studies but no consensus

Source: San Francisco Department of Public Health, Population Health and Prevention

# Alcohol, Tobacco, & Other Drugs

Who we are  
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## SUBSTANCE ABUSE

The use of alcohol, tobacco and other drugs adversely affects the lives of all San Franciscans. Statistics for 1994 – 1996 indicate that San Francisco had the highest annual rate of drug related deaths among California counties (20.5 per 100,000). Related deaths due to heroin, cocaine, and speed increased slightly between 1996 and 1999.

## Substance Abuse Facts and Figures

### Impact of Substance Abuse

San Francisco has the highest rate of speed-related emergency room visits among U.S. cities, 65 per 100,000 (1996–97)

San Francisco has the highest concentration of retail liquor licenses among California counties (1997)

### Substance Abuse and the Homeless

More than half (56%) of the deaths among the homeless were directly caused by drugs or alcohol (1997)

Eighty-nine percent of the deaths caused by drugs among the homeless were related to heroin (1997)

Seventy-five percent of homeless youth reported ever using heroin, speed, or cocaine (1993-95)

### Injection Drug Use

There were an estimated 17,100 injection drug users (IDUs) living in San Francisco (1997)

6,017 IDUs were admitted to San Francisco drug treatment programs (FY 98-99)

3,332 injection drug users were HIV positive (1997)

Alcohol, tobacco and other drugs also play a key role in the amount and severity of disease and injury in San Francisco. Drug poisoning, primarily overdoses of heroin and cocaine, remains the third leading cause of premature death in San Francisco.

## Summary of Substance Abuse Indicators by Drug, San Francisco, 1996-1999

Indicator	Drug				
	Heroin	Cocaine	Speed	Marijuana	Alcohol
CSAS clients* in treatment 1998-1999	5,447	2,710	1,002	738	3,731
Drug-caused deaths, 1997-98	130	101	27	--	--
Emergency-room drug mentions, 1998	2,386	1,843	616	394	--
Alcohol and drug arrests	7,214	2,098		2,370	7,160
Students using monthly, 1997	--	575	--	3,450	8,339

\*Total number of unduplicated clients in treatment: 14,282

For the latest year statistics were available (1998), the use of drugs and/or alcohol directly caused or contributed to the death of 540 San Franciscans<sup>1</sup> with 117 of those deaths one hundred per cent attributable to alcohol. For these purposes, alcohol and drug-related deaths are those deaths that are directly attributable to alcohol or drug diagnoses and include both illicit drugs and legal drugs such as prescription and over the counter medications. These statistics do not include deaths by causes that are often closely associated with alcohol and drug abuse such as homicides, suicides, motor vehicle accidents, or other unintentional accidents.

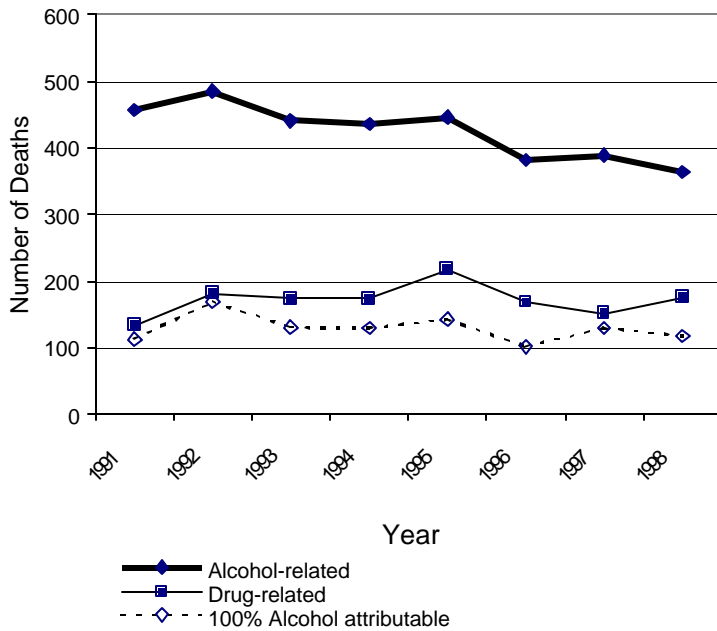
**Source:** Community Substance Abuse Services (CSAS), Epidemiology, San Francisco Department of Public Health

# Alcohol, Tobacco, & Other Drugs

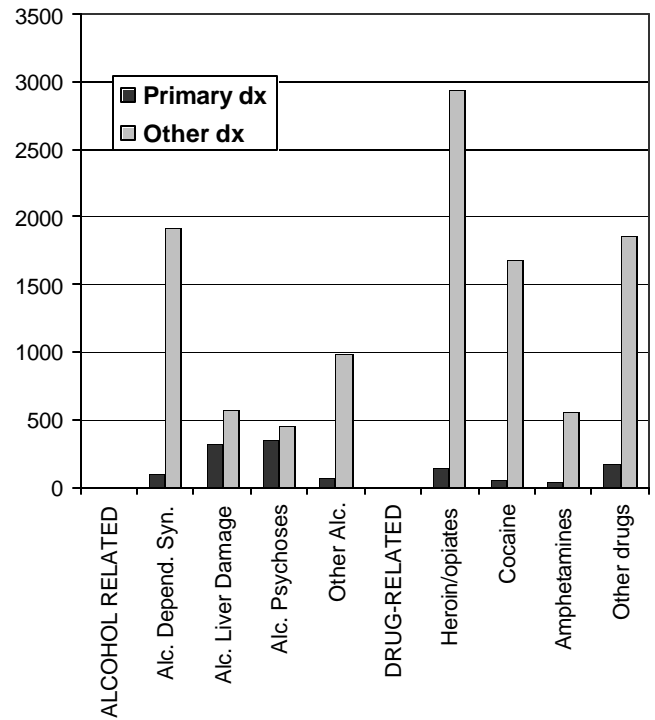
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## SUBSTANCE ABUSE—CONT.

**Alcohol and Drug Related Deaths, San Francisco, 1991 - 1998**



**Alcohol and Drug Related Hospitalizations, San Francisco, 1997 - 1998**



Drug and alcohol use and abuse also account for a significant number of hospitalizations in San Francisco. While the number of hospitalizations attributable solely to drugs and/or alcohol are limited, the number in which drugs and/or alcohol are identified as a contributing factor is considerable. In 1998, there were a total of 3,074 hospitalizations resulting from the use of heroin and other opiates alone.

**Source:** California Department of Alcohol and Drug Programs (California Department of Health Services Data)

# Alcohol, Tobacco, & Other Drugs

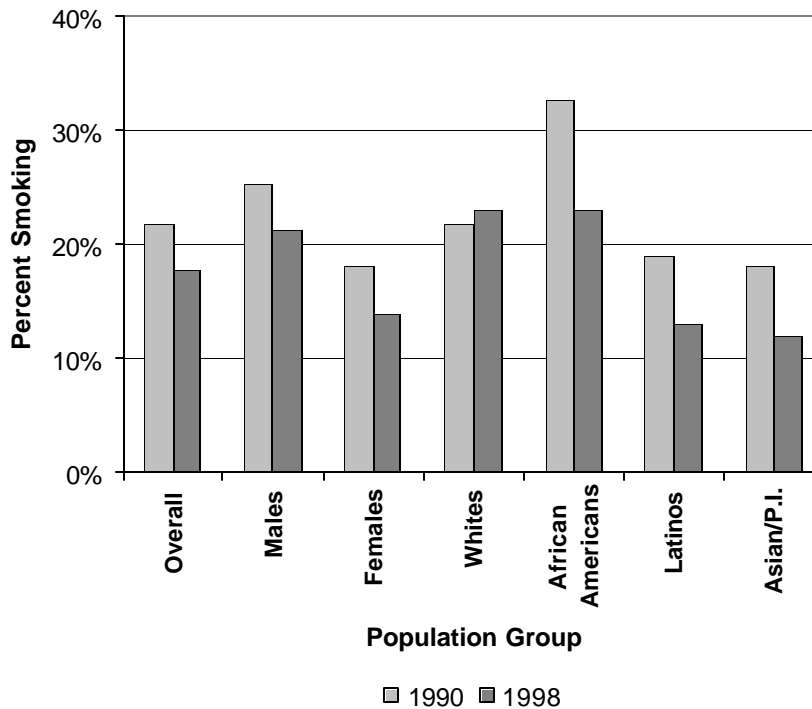
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## TOBACCO

From 1990 to 1995, about 10% of deaths in San Francisco were attributable to tobacco. Since 1990, smoking rates in San Francisco have decreased in the overall population

and in all ethnic groups except whites. In 1998, one-sixth of randomly surveyed San Francisco tobacco vendors illegally sold tobacco to people under age 18, indicating that tobacco is too readily available to underage youth.

*Percent of Smokers by Population Group.  
San Francisco, 1990 and 1998*



Source: Tobacco Control Program, San Francisco Department of Public Health

# Physical Inactivity

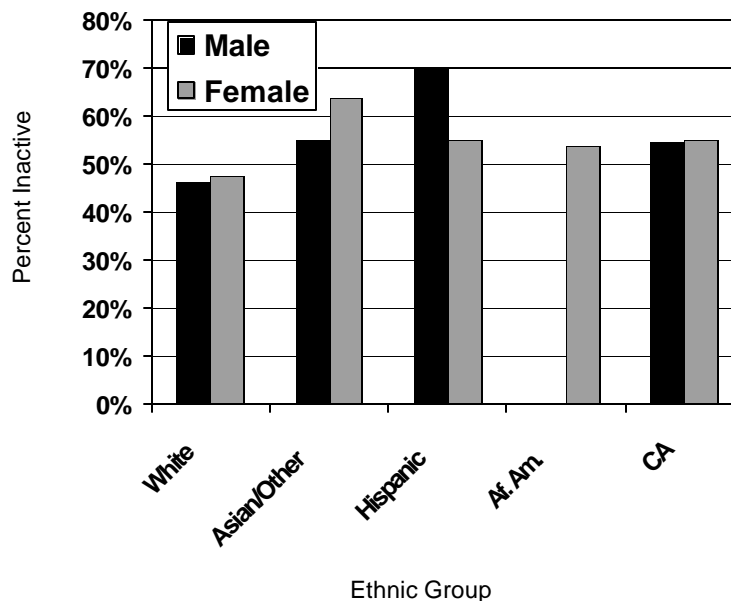
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It has been estimated that physical inactivity in the U.S. has been implicated in perhaps a quarter of a million deaths a year, including about 25% of all chronic disease deaths. It affects cardiovascular risk through its influence on blood pressure, cholesterol, weight, and other mechanisms. In California, the prevalence in adults has remained fairly steady at just over half since 1984. There are big ethnic differences, with Hispanic men (70.4%) and women (66.2%) most likely to be inactive. Between 50% and 54% of African-American men and women are also likely to be sedentary. Asian/other women (63%) are more likely than men (44%) to be inactive. There are no age

differences, but there are differences by education. College graduates have significantly lower inactivity prevalence (44%) than those with no more than a high school education (63%).

In the Bay Area, white women have lower percents inactive than Hispanic (64%) or Asian/other women, but not different than African-American women, who are much less inactive than their statewide counterparts. White men are also significantly less inactive than Hispanic men. There were insufficient data to estimate the prevalence for Bay Area African-American men.

**Percent Physical Inactivity by Ethnicity and Sex, San Francisco Bay Area, 1994 - 1996**



**Sources:** Gazzinga JM, Kao C, et. al. *Cardiovascular Disease Risk Factors Among California Adults, 1984-1996*. Sacramento: California Department of Health Services and UCSF, Institute for Health and Aging, 1998. pp. 22,26. Missing/insufficient data due to small subgroup sample size (<50). Data from Ca. BRFSS. Bay Area counties are SF, Alameda, San Mateo, and Santa Clara.

# Overweight

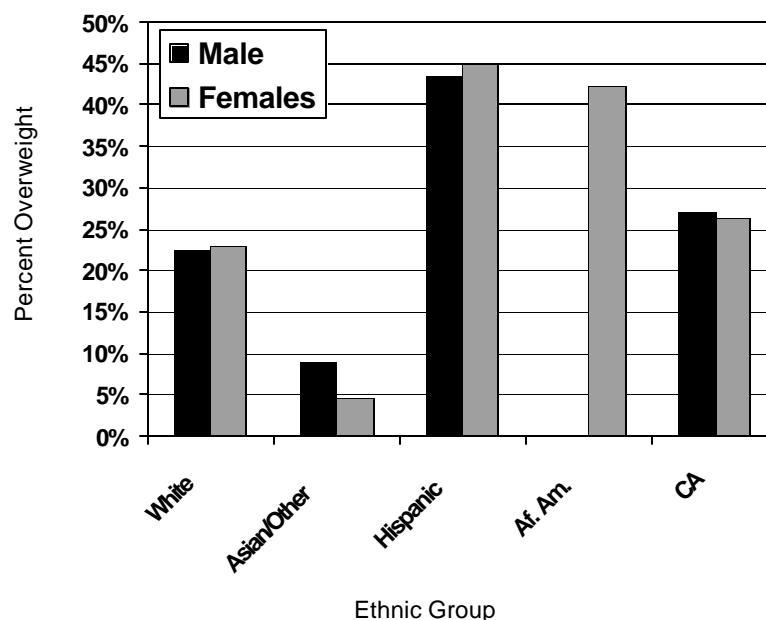
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Overweight, measured by body mass index (a ratio between height and weight), is an important risk factor for heart disease, both in itself and also through its contribution to high cholesterol, high blood pressure and diabetes. Frequency of being overweight has been increasing among Californians, rising by over 50% from 1984 to 1996 -- by 41% for women and 60% for men. By 1996, 27% of adults were estimated to be overweight. Statewide, there were no differences by sex within any ethnicity, but Hispanic women (42.7%) and men (34.6%) and African-American women (40.2%) and men (37.0%) had significantly higher overweight prevalences than white women (24.2%) or men (25.1%). Proportion overweight rises across age groups through

ages 45-54, and then declines somewhat among older ages. The proportion overweight among college graduates (20.4%) is more than a third less than among those with no education beyond high school (31.4%).

In the Bay Area, percentages of those overweight did not differ by sex within ethnic groups. Hispanic men had significantly higher prevalence than white men, who were themselves much higher than Asian/other men. There were insufficient data for a reliable estimate for African-American men. Among women, African-Americans and Hispanics were higher than whites, who were higher than Asian/other women.

**Percent Overweight by Ethnicity and Sex,  
San Francisco Bay Area,  
1994 - 1996**



A convenient chart for determining body mass index and overweight is available at [www.shapeup.org/bmi/chart.htm](http://www.shapeup.org/bmi/chart.htm).

**Sources:** Gazzinga JM, Kao C, et. al. *Cardiovascular Disease Risk Factors Among California Adults, 1984-1996*. Sacramento: California Department of Health Services and UCSF, Institute for Health and Aging, 1998. pp. 22,26. Missing/insufficient data due to small subgroup sample size (<50). Data from Ca. BRFS. Bay Area counties are SF, Alameda, San Mateo, and Santa Clara.

# Injuries

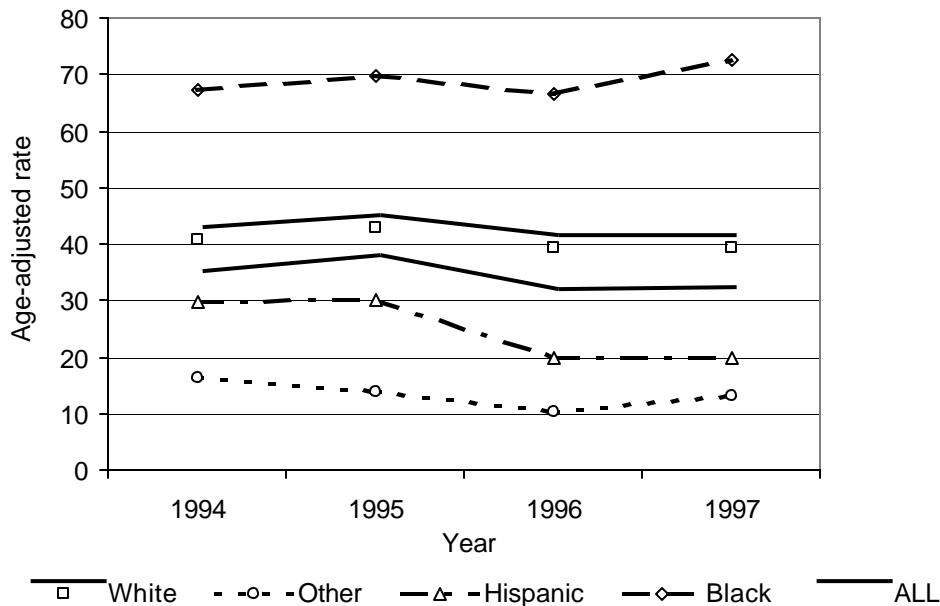
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## UNINTENTIONAL INJURY, SUICIDE, AND HOMICIDE

Injuries account for a significant proportion of deaths, hospitalizations, and emergency responses in San Francisco. Injury death rates include both intentional (homicide and suicide), and unintentional injuries. Of the 293 unintentional injury deaths of San Francisco residents in 1997, 117 (42%)

were due to drug poisoning and 56 (19%) to motor vehicle traffic. Unintentional death rates are disproportionately higher in the African American population accounting for 20.8% of all unintentional deaths in 1997. African Americans also have higher death rates from homicides compared to other ethnic groups, while whites experience the highest suicide rates of all ethnic groups.

**Unintentional Injury Death Rates by Ethnicity, San Francisco, 1994 - 1997**



Source: California Department of Health Services Website, Vital Query System



# Injuries

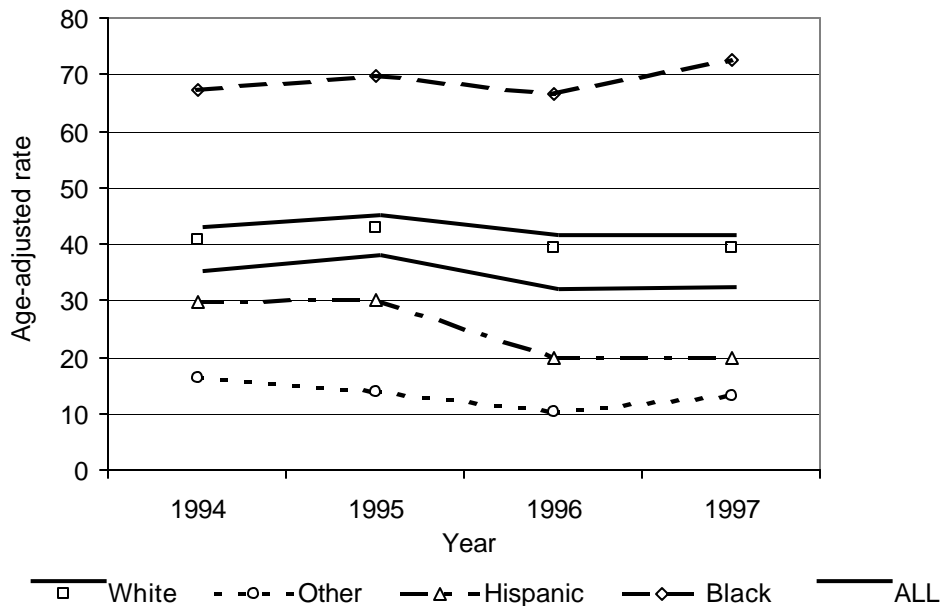
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## UNINTENTIONAL INJURY, SUICIDE, AND HOMICIDE

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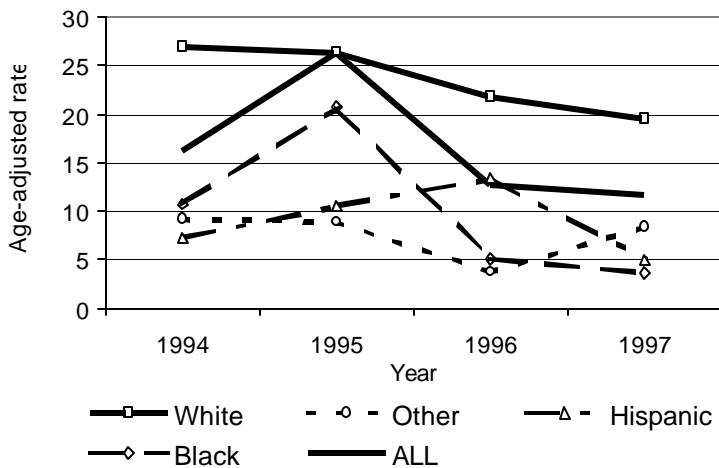
# Injuries

Who we are  
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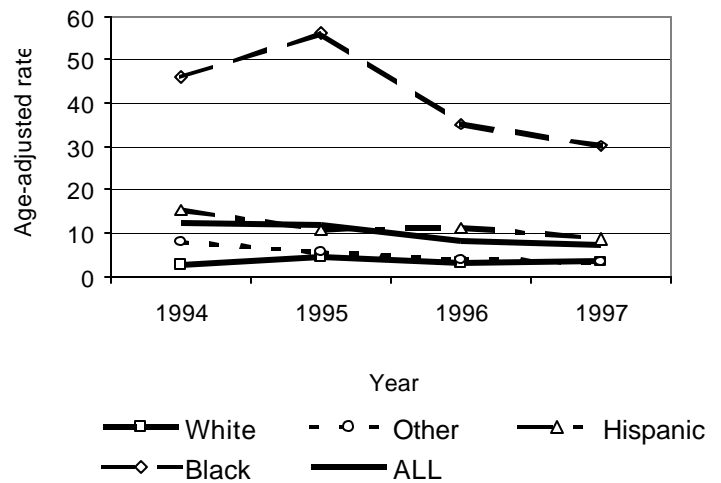
## UNINTENTIONAL INJURIES, SUICIDES, AND HOMICIDE—CONT.

In 1997, 26% of 114 suicides and 62% of 53 homicides of San Francisco residents involved firearms. The Medical Examiner found alcohol in 28% and illegal drugs in 18% of suicide victims, and alcohol in 38% and illegal drugs in 44% of homicide victims.

### Age-Adjusted Suicide Rate by Ethnicity, San Francisco, 1994 - 1997



### Age-Adjusted Homicide Rate by Ethnicity, San Francisco, 1994 - 1997



Source: California Department of Health Services, Website, Vital Query System

# Environmental Health

Who we are  
**How we live**  
Our health

Three key indicators of the quality of our physical environment are solid waste generation, elevated blood lead levels and air quality.

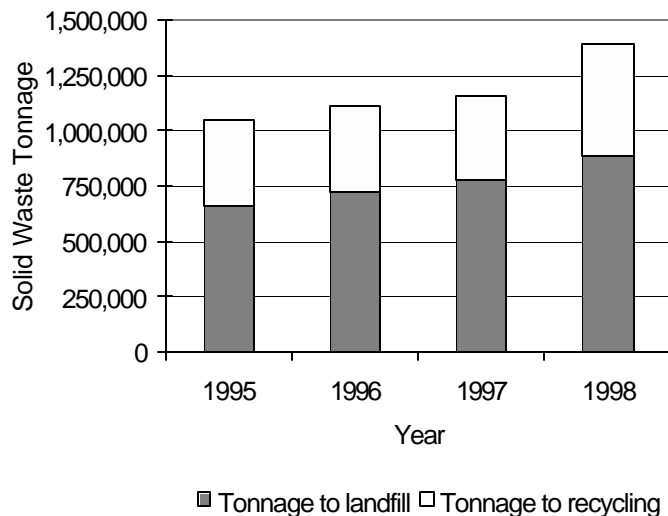
## **SOLID WASTE**

From 1995 to 1998, the amount of solid waste produced in San Francisco has increased. This increase may be related to the growing economy, including increased construction, tourism, and consumption. At the same time, the City's recycling efforts are paying off with a greater percentage of generated waste being recycled and diverted from landfills. However, San Francisco continues to send more to landfills than the Healthy People 2000 goal of 3.2 pounds per person of waste. In addition, the per capita amount, which includes waste from San Francisco's numerous non-resident workers and tourists, has also been increasing.

## **LEAD**

The most common environmental sources of lead for San Francisco children with elevated blood lead levels are lead-based paint, lead-contaminated soil, and lead dust. From 1991 to 1998, the San Francisco Department of Public Health's Child Environmental Health Promotion Program (CEHP, formerly Childhood Lead Prevention Program) identified up to 106 children annually with blood lead levels high enough to warrant case management services. The number of cases dropped to 37 in both 1997 and 1998. These numbers should not be confused with rates, since only positive screening results are reported, and we do not know how many children were tested each year.

***Solid Waste Disposal  
San Francisco, 1995-1998***



**Source:** R Bhatia, MD, "Annual Report to the Health Commission: Status of Environmental Health Programs in San Francisco," SFDPH, March, 2000

# Environmental Health

Who we are  
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## AIR QUALITY

The Federal Clean Air Act directs the EPA to develop and promulgate health based standards for certain "criteria" ambient air pollutants including ozone, respirable particulate matter (PM<sub>10</sub>), sulfur dioxide, nitrogen dioxide, carbon monoxide, and lead. Since 1993, the state air pollution standards for ozone, carbon monoxide,

nitrogen dioxide, and sulfur dioxide have not been exceeded in San Francisco. However, there have been several occasions on which daily concentrations of particles have been higher than the 24-hr PM<sub>10</sub> standard. In the Bay Area, major sources of PM<sub>10</sub> include industrial emissions, motor vehicles, road dust, construction, demolition, and residential wood smoke.

### San Francisco Air Pollution Maximum Concentrations and Exceedances based on California Standards, 1993 - 1997

Pollutant	California Standards	1995		1996		1997		1998	
		Max	X*	Max	X*	Max	X*	Max	X*
Ozone <sup>1</sup>	9 pphm (1-hr avg.)	9	0	7	0	7	0	5	0
Carbon Monoxide <sup>2</sup>	9 pphm (1-hr avg.)	4.4	0	3.7	0	4.2	0	4.0	0
Nitrogen Dioxide <sup>1</sup>	25 pphm (1-hr avg.)	9	0	8	0	7	0	8	0
Sulfur Dioxide <sup>3</sup>	50 ppb (24-hr avg.)	7	0	8	0	6	0	6	0
PM <sub>10</sub> <sup>3,4</sup> (µg/m3)**	30 µg/m3 (ann. Geo. Mean) 50 µg/m3 (24-hr avg.)	22.1	0	21.4	2	22.4	0	20.1	1

1 = Avg. 1-hour maximum; 2 = Avg. 8-hour maximum; 3 = 24-hour avg.; 4 = annual geometric mean

\*X = # exceedances based on state standards, which are stricter than national standards for Ozone, Sulfur Dioxide, and PM<sub>10</sub>

\*\* PM<sub>10</sub> is measured every 6 days, so the number of exceedances can be estimated as 6 times the number shown

**Sources:** Bay Area Air Quality Management District; data available through February, 2000; and R Bhatia, MD, "annual report to the Health commission: Status of Environmental Health Programs in San Francisco," SFDPH, March, 2000

# Access to Health Care

Who we are  
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## ACCESS TO HEALTH CARE

Access to health care services is a significant issue in San Francisco, as it is throughout California and the rest of the U.S. Lack of access to preventive and ongoing health care services leads to higher rates of preventable disease and injuries and poorer health

outcomes from illness and injury. A common indicator of access to health care services is the availability of health insurance. San Francisco is similar to the rest of California in that the majority of residents without health insurance are employed (full-time or part-time) or are members of families with working adults.

### *Health Care Coverage Status, San Francisco, 1997*

<b>Health Coverage Status</b>	<b>% of Population</b>	<b>Number of Residents</b>
Employer-based coverage	53%	407,900
Individually purchased	6%	46,400
Publicly funded		
Medi-Cal	9%	73,200
Medicare	15%	115,500
Uninsured	17%	130,000
<b>Uninsured Category</b>	<b>% of Uninsured</b>	
Working adults	68%	88,000
Indigent adults	14%	18,000
Other adults	8%	11,000
Children and youth	10%	13,000

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**Source:** Mayor's Blue Ribbon committee on Universal Health Care, *Achieving Health Insurance for San Francisco's Uninsured*, May, 1998.



# *Our Health*

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Who we are  
How we live  
**Our health**

Our health is largely a product of who we are and how we live. Our data show how many people face a variety of diseases and injuries. Our data do not show all disabling conditions, nor do they illustrate the quality of life that people experience. However, these data do provide us with a measure of many of the pressing health issues that we must tackle as individuals, as communities, and as a city.

# Major Causes of Death

Who we are  
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## AGE ADJUSTED MORTALITY RATES

Major causes of death are a standard component of health indicator data. Healthy People 2000 objectives are set for many cases of mortality, which allow for national, state, and local comparisons.

This table shows how San Francisco compares to California and the national objectives in the most recent data available. San Francisco was among the best counties in the state for lung cancer mortality, but continues as the worst for drug-related deaths.

*Age Adjusted Mortality Rates for Major Causes of Death,  
San Francisco, 1994 - 1998*

CA County Ranking	CAUSE	1996 - 98 Deaths/yr. (avg.)	Crude Death Rate	San Francisco Age-Adjusted Death Rate	95% Confidence Limits		State Age-Adjusted Death Rate	Nat'l Obj.	Obj. Met
					Lower	Upper			
27	ALL CAUSES	6,961	895.5	439.4	426.9	451.8	425.7	N/E	
31	CORONARY HEART DISEASE	1,689	217.3	83.8	78.9	88.6	93.9	100.0	YES
27	CEREBROVASCULAR DISEASE	531	68.2	24.9	22.3	27.5	25.3	20.0	NO
12	ALL CANCERS	1,503	193.3	102.9	97.0	108.8	110.3	130.0	YES
6	LUNG CANCER	363	46.7	25.1	22.2	27.9	30.0	42.0	YES
18	FEMALE BREAST CANCER	111	28.3	16.3	12.9	19.8	18.3	20.6	YES
24	UNINTENTIONAL INJURIES	295	38.0	29.9	26.1	33.7	24.2	29.3	
	MOTOR VEHICLE ACCIDENT	58	7.4	7.0	4.9	9.0	11.4	14.2	YES
38	HOMICIDE	52	6.7	7.5	5.2	9.7	9.0	7.2	NO
35	SUICIDE	110	14.2	11.3	9.0	13.6	9.4	10.5	NO
58	DRUG-RELATED DEATHS	166	21.4	18.1	15.2	21.0	7.5	3.0	NO
16	FIREARM INJURIES	63	8.1	8.3	6.0	10.6	1.6	11.6	NO

Age adjusted to standard 1940 US population.

Source: California Department of Health Services, County Health Status Profiles, April 2000



# Major Causes of Death

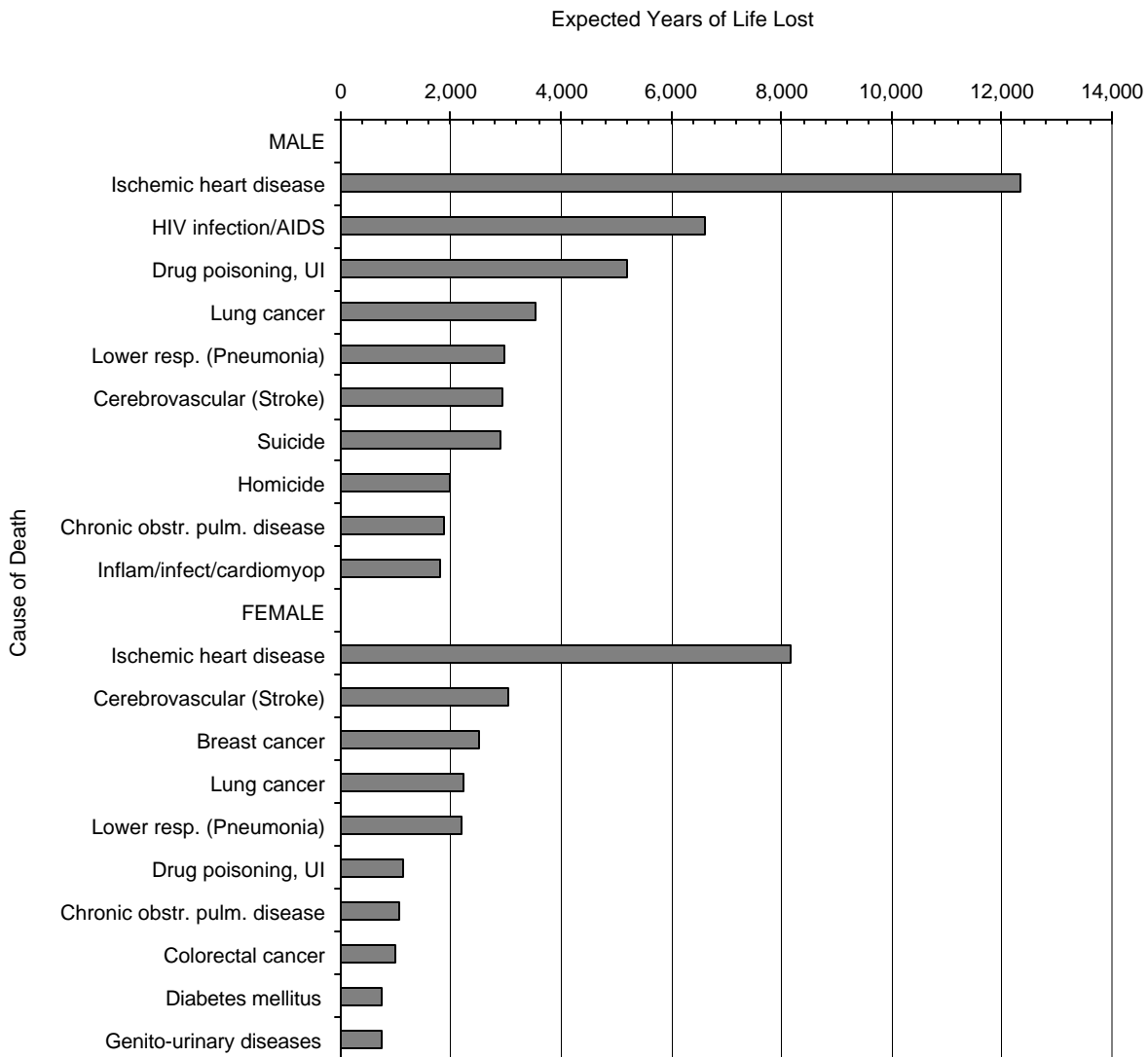
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## PREMATURE DEATH

Leading causes of death are also analyzed by measuring Standard Expected Years of Life Lost (SEYLL) for specific causes of death. By giving greater weight to deaths of younger people, this measure emphasizes premature mortality. The years of life lost for a person dying are based on life

expectancy for persons of their age at the time of death. Ischemic heart disease is the leading cause of premature death for men and women. AIDS continues as the second leading cause of death for men. However, drug poisoning, mainly heroin overdose, has replaced lung cancer as the third leading cause of premature death for men and has become the sixth leading cause for women.

**Leading Causes of Premature Death by Sex, San Francisco, 1998**



Source: State of California Vital Records, 1998

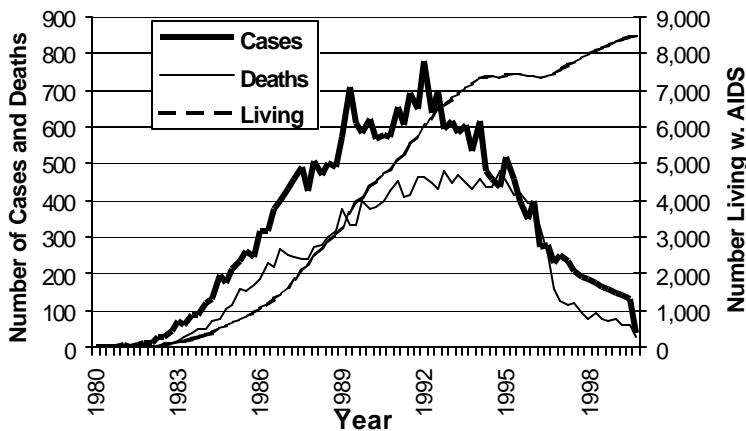
# Communicable Disease

Who we are  
How we live  
**Our health**

## HIV/AIDS

From 1990 to 1996, AIDS was the leading cause of preventable death in San Francisco as measured by expected years of life lost. However, due to prevention efforts and the increased efficacy of new drug therapies, the number of deaths attributable to AIDS has been declining since 1995 while the number of persons living with AIDS and HIV has been increasing. In addition, the number of new cases of AIDS diagnosed since 1992 has been declining, making AIDS the second leading cause of premature mortality in San Francisco in 1997 and 1998. Although AIDS affects people of all genders, ethnicity, and sexual orientation, in San Francisco, it remains predominantly a disease of men who have sex with men and intravenous drug users.

**AIDS Cases, Deaths, and Numbers of Persons Living with AIDS, San Francisco, 1990 - 1999**



**AIDS Cases by Transmission Category, Ethnicity, and Year of Diagnosis, San Francisco, 1990 - 1999**

Transmission Category	Number of Cases				Difference 1990 - 1999	
	1990	1992	1995	1999*	Cases	% Change
Gay/bi men	1857	2058	1281	300	-1557	-83.8
Injection drug users (IDU)	124	217	174	80	-44	-35.5
Gay/bi men + IDU	290	341	201	57	-233	-80.3
Lesbian/bi fem + IDU	3	8	4	1	-2	-66.7
Hemophiliac	2	7	5	1	-1	-50.0
Heterosexual	26	42	32	10	-16	-61.5
Transfusion	13	11	10	2	-11	-84.6
Other	12	19	17	11	-1	-8.3
Pediatric (0-12)	4	2	3	2	-2	-50.0
<b>SEX</b>						
Male	2266	2591	1640	424	-1842	-81.3
Female	65	114	87	40	-25	-38.5
<b>ETHNICITY</b>						
White	1772	1937	1183	277	-1495	-84.4
Af. American	258	331	259	83	-175	-67.8
Hispanic	220	342	212	79	-141	-64.1
API/Other	66	71	65	22	-44	-66.7
Native Am.	15	24	8	3	-12	-80.0
<b>TOTAL</b>	<b>2331</b>	<b>2705</b>	<b>1727</b>	<b>464</b>	<b>-1867</b>	<b>-80.1</b>

\* Cases reported may not be complete in later years. Cases reported by year of diagnosis.

**Source:** Quarterly AIDS Surveillance Report, San Francisco Department of Public Health, AIDS Cases Reported through December, 1999 (January, 2000)

# Communicable Disease

Who we are  
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## SEXUALLY TRANSMITTED DISEASES (STDs)

Rates for sexually transmitted diseases (STDs) decreased significantly in San Francisco between the late 1970s and 1998. Between 1998 and 1999, there was a slight decrease in STD rates in the general population. However, rates for gonorrhea, chlamydia, and syphilis within specific

populations, such as adolescents, actually increased. Last year, San Francisco met the Healthy People 2000 objectives for overall rates of congenital syphilis and for rates of gonorrhea in women and adolescents, and within the African American community. Healthy People 2010 sets the objective for the reduction of gonorrhea at 19 cases per 100,000 over the next ten years within all ethnic and age groups.

*Selected San Francisco STD Rates, San Francisco, 1997 - 1999*

Disease	Number of cases			San Francisco Rate	
	1997	1998	1999	1998	1999
Gonorrhea: all groups	1,497	1,852	1,593	255.8	220
➤ African American	473	604	565	791.2	740.1
➤ Asian	53	60	61	29.2	29.7
➤ Hispanic	129	179	188	177.7	186.7
➤ White	556	679	676	201.4	---
Adolescents (< 20)	181	250	205	492.7	579.7
Chlamydia	2,253	2,611	2,670	---	368.8
Early Syphilis	73	40	41	5.5	5.7
Congenital Syphilis	2	1	1	12.3	---

**Source:** San Francisco Department of Public Health, Annual STD Summary, 1998 and "San Francisco Monthly STD Report, data for December, 1999", (January, 2000)

# Communicable Disease

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## TUBERCULOSIS

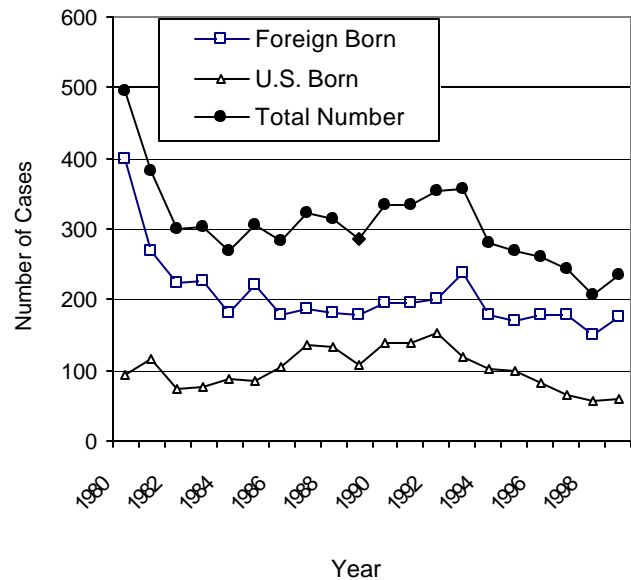
In 1999, there were 235 documented cases of Tuberculosis (TB) in San Francisco. This represents only a slight increase from last year's lowest ever recorded number of new cases (207). The increase occurred among African Americans, Southeast Asians and Filipinos while the number of cases in whites decreased last year. The rates are well above the Healthy People 2010 objective for new TB infection of 1 per 100,000 for all ethnic and age groups.

### *Tuberculosis Rates by Ethnicity Compared to California and United States Rates, 1999*

Ethnic Group	SF Rate
Asian/Pacific Island	74.4
African American	44.5
Hispanic	23.8
White	7.1

Tuberculosis continues to disproportionately affect those populations who pose the greatest challenge with regards to medication compliance and monitoring; immigrants, the homeless, and persons with AIDS. In 1999, 74.4% of new active cases of TB occurred among foreign-born residents of San Francisco. The largest majority of foreign-born cases occurred in Asian immigrants, mainly Chinese, Filipino, and Southeast Asians. Of those persons tested for AIDS (111 cases) 25.2% tested positive, and the homeless represented another 14.9% of new active TB cases in 1999.

### *Foreign-Born Tuberculosis Cases, San Francisco, 1980-1999*



Drug-resistant strains of TB peaked in 1996 at 20.4% of new cases. In 1999 15.7% of cases were documented as drug resistant.

**Source:** San Francisco Tuberculosis Control Program, 1999, 2000

# Non-Communicable Disease

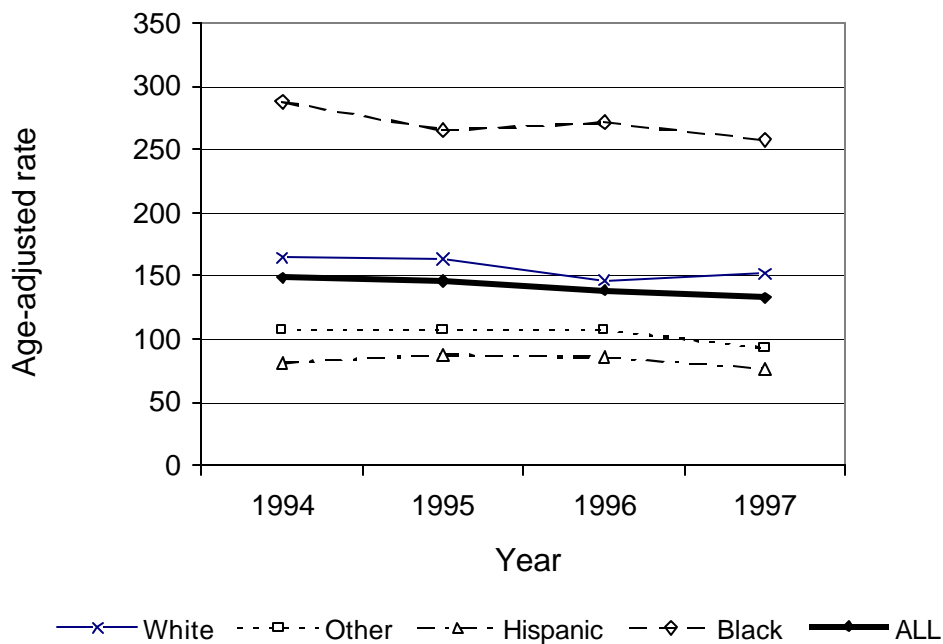
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## CARDIOVASCULAR DISEASE

Cardiovascular disease includes ischemic heart disease (IHD), stroke, and other forms of heart disease. IHD is the leading cause of death for both men and women, and stroke is among the leading causes each year. Rates have been declining somewhat among all groups, but there are still very large differences across ethnicities in San Francisco (as there are elsewhere). African Americans have by far the highest rates,

well over twice that of the groups with the lowest rates, Asian/others and Hispanics. Whites' rates are inbetween, significantly lower than African Americans but still significantly higher than the other groups. IHD and stroke mortality rates among males of each ethnicity are significantly higher than rates among females. A large part of these differences can be attributed to differing exposures to well-established risks (see pp 15).

**Age Adjusted Cardiovascular Death Rates by Ethnicity, San Francisco, 1994 - 1997**



Source: California Department of Health Services Website, Vital Query System

# Non-Communicable Disease

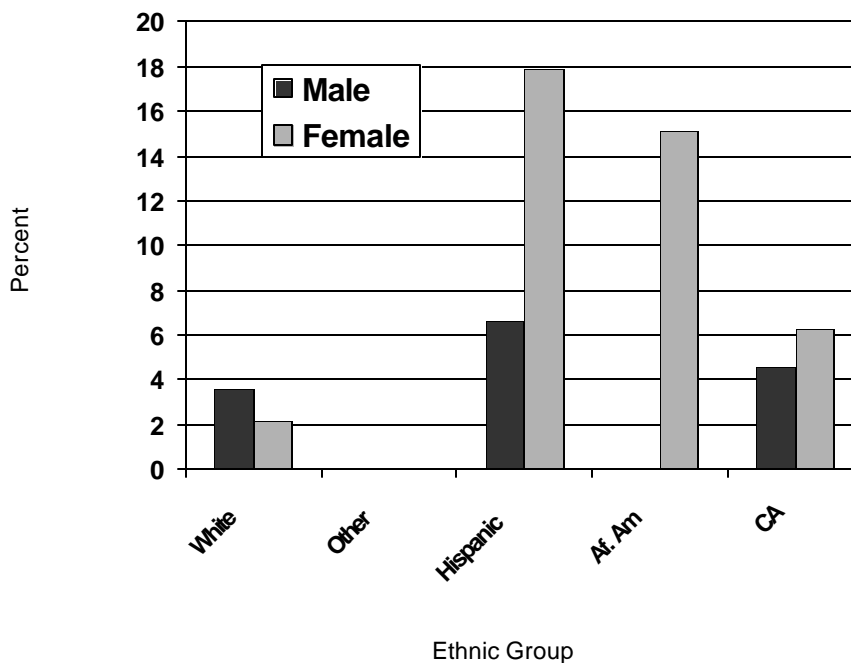
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## DIABETES

People with Diabetes are 2 to 4 times as likely to die from coronary heart disease and twice as likely to die from stroke as people without diabetes. More than 80% of people with diabetes die from some form of cardiovascular disease. Diabetes prevalence increases with age and body weight, and is lower among college graduates (4%) than among those with no more than a high school education (7.2%). Diabetes has been increasing among California adults since the mid-1980s,

especially among women. Statewide, Hispanics (12.9%) and African-Americans (14.5) have higher rates than whites (4.3%). Prevalence by ethnicity and sex for the Bay Area (San Francisco, San Mateo, Santa Clara, and Alameda counties) are shown in the graph below. For those groups with sufficient data, the prevalence among Hispanic and African-American females was significantly greater than among white females. Where bars are missing, data were insufficient to produce a reliable estimate for that group.

**Diabetes Prevalence by  
Ethnicity and Sex, San Francisco  
Bay Area, 1994 - 1996**



**Source:** Gazzinga JM, Kao C, et. al. *Cardiovascular Disease Risk Factors Among California Adults, 1984-1996*. Sacramento: California Department of Health Services and UCSF, Institute for Health and Aging, 1998. pp. 22,26. Missing/insufficient data due to small subgroup sample size (<50). Data from Ca. BRFSS. Bay Area counties are SF, Alameda, San Mateo, and Santa Clara.

# Non-Communicable Disease

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## HIGH BLOOD PRESSURE (HYPERTENSION)

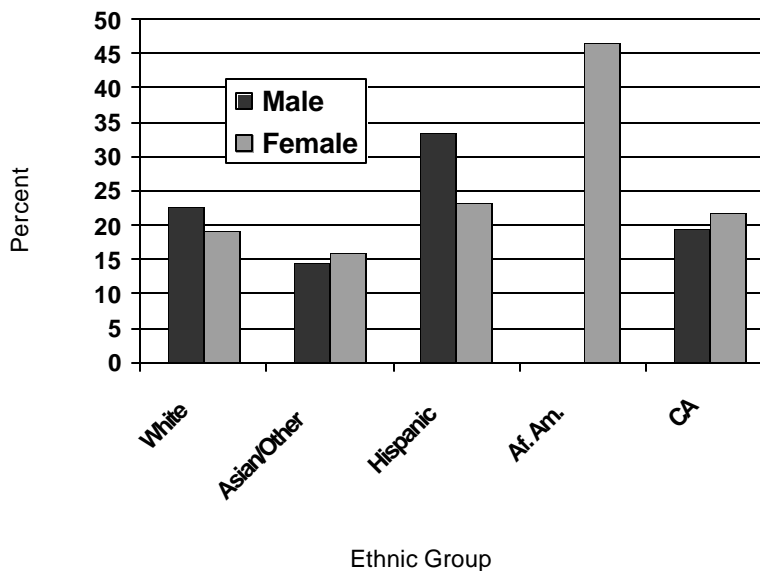
High blood pressure (HBP) is the single most important risk factor for stroke. People with uncontrolled HBP are as much as seven times more likely to develop stroke than others, and three to four times as likely to develop heart disease as well. Most high blood pressure can be prevented or controlled by a combination of regular exercise, weight control, limiting sodium and alcohol in the diet, and, if necessary, prescription medications.

HBP prevalence has stayed relatively steady since the mid-1980s. Prevalence increases greatly with age. Sex differences in prevalence are relatively small, but there

are significant ethnic differences. African-Americans have the highest prevalence; with men (41.5%) having significantly higher prevalence than Asian/other (15.6%), Hispanic (22.1%), or white (22.8%) men, and African American women (35%) being higher than white women (23.7%).

Bay Area prevalences are shown in the figure below for groups for which data were sufficient to make reliable estimates. There are no significant male-female differences within ethnic groups. Among men, Hispanics have significantly higher prevalence than Asian/other, and African-American women have significantly higher prevalence than women of any of the other ethnic group.

**High Blood Pressure Prevalence in San Francisco Bay Area, 1994 - 1996**



**Source:** Gazzinga JM, Kao C, et. al. *Cardiovascular Disease Risk Factors Among California Adults, 1984-1996*. Sacramento: California Department of Health Services and UCSF, Institute for Health and Aging, 1998. pp. 22,26. Missing/insufficient data due to small subgroup sample size (<50). Data from Ca. BRFS. Bay Area counties are SF, Alameda, San Mateo, and Santa Clara.

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## CANCER

From 1992 to 1996, the highest rate of cancer incidence (occurrence) among males was for prostate cancer, followed by lung cancer. However, lung cancer had three times the death rate of prostate cancer. Among females, breast cancer had

the highest incidence, more than double that of lung cancer, but the death rate from lung cancer was slightly higher than that of breast cancer. There are important differences by sex and ethnicity in both cancer incidence and morbidity.

**Age -Adjusted San Francisco Cancer Incidence Rates by Sex and Ethnicity, 1992 - 1996**

	ALL					Males				Females			
	ALL	M	F			White	Af. Am.	Latino	Asian/ Other	White	Af. Am.	Latino	Asian/ Other
	No.	No.	Rate	No.	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate	Rate
All cancers	21,160	12,267	*543.3	8,893	329.6	**636.7	***771.8	*387.5	332.1	*398	*380.8	233.3	245.5
Prostate cancer	2,911	2,911	135.7			**148.9	***255	*97.4	72.5				
Lung cancer	2,593	1,516	*71.3	1,077	38.1	76.2	125.6	32.6	60.7	*47.8	*58.0	21.2	25.9
Breast cancer (invasive)	2,568			2,568	101.1					*131.8	*112.5	69.0	63.2
Colorectal cancer (invasive)	2,310	1,153	*52.5	1,157	37.7	*54.7	***72.5	37.0	48.4	*39.9	37.0	26.9	*38.4
Kaposi's sarcoma	1,659	1,647	57.4	12	0.3	85.3	47.8	50.0	6.1	0.5			
Non-Hodgkin's lymphoma	1,392	1,074	*42.8	318	11.3	***57.5	*33.8	*38.0	15.4	12.4	11.2	10.0	9.0
Bladder cancer	717	511	*23.4	206	6.4	***33.1	17.9	13.3	11.2	*9.0	*7.9	3.5	3.3
Mouth/oropharynx cancers	575	396	*18.8	179	6.7	21.0	*28.1	13.0	15.1	*7.1	*7.4	1.8	*7.9
Breast cancer (in situ)	542			542	23.1					*27.9	*28.4	11.6	18.0
Corpus uteri cancer	523			523	20.5					*25.6	*20.2	9.4	15.9
Stomach cancer	488	294	*13.5	194	6.4	11.4	*24.2	10.9	15.0	5.5	5.0	5.5	8.5
Melanoma/skin cancers (invasive)	457	273	*11.7	184	7.3	21.2				*13.9		2.1	
Pancreas cancer	449	215	*9.9	234	7.1	10.6	*15.9	9.7	7.1	7.2	***15.4	5.0	4.8
Leukemia	437	237	*11.7	200	8.2	12.7	13.7	10.0	9.4	9.4	7.0	5.6	7.0
Liver cancer	391	297	*14.0	94	3.4	8.6	*18.9	10.0	*22.7	1.7	4.7	2.8	*5.9
Ovarian cancer	360			360	14.4					***20.2	9.9	12.1	9.0
Kidney	350	191	*8.9	159	6.3	*9.8	*13.0	9.6	5.4	*6.4	*13.8	7.1	3.0
Cervix uteri cancer	258			258	10.3					7.8	12.5	*15.9	9.9
Brain & N.S. cancer	250	155	*7.7	95	3.8	9.4	6.6	5.8	6.0	6.4	3.7		1.6
Mult. myeloma	190	105	4.7	85	3.1	4.8	***13.0	3.1	2.7	2.5	***12.1	2.5	1.5
Esophageal cancer	188	136	*6.4	52	2.0	*6.3	***16.6	1.9	4.9	*2.8	*4.2		0.7
Colorectal cancer (in situ)	149	89	*4.1	60	2.0								

Age adjusted to standard 1970 US population, rates per 100,000 per year

Ranked by total number of incident cancers

\* significantly higher than lowest ethnicity group

\*\* significantly higher than next lower ethnicity group

\*\*\* significantly higher than all other ethnicity groups

Source: NCCC, Cancer Incidence & Mortality in the San Francisco Bay Area, 1988-1996. March, 1999



# Non-Communicable Disease

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## Age-Adjusted Cancer Mortality Rates, San Francisco, 1992 - 1996

	ALL	Male		Female		Male Rates				Female Rates			
	No.	No.	Rate	No.	Rate	White	African-American	Latino	Asian/Other	White	African-American	Latino	Asian/Other
All cancers	7,227	4,141	*188.2	3,086	130.1	**206.3	***317.8	131.2	141.8	*141.5	***190.9	83.9	90.1
Lung cancer	1,967	1,152	*53.8	815	27.1	**57.9	***101.4	26.3	*42.6	*35.5	*45.2	10.9	16.2
Colorectal cancer	883	446	*19.6	437	13.0	*21.8	*28.8	14.0	15.0	*13.6	*18.5	7.7	13.2
Breast cancer	568			568	20.3					*23.6	***35.3	13.9	12.8
Prostate cancer	483	483	20.3			**23.2	***50.5	*17.1	8.0				
Pancreas cancer	397	177	8.1	220	6.4	*9.7	10.6	7.5	5.1	*7.4	*12.6	3.8	3.9
Non-Hodgkin's lymphoma	343	184	*8.1	159	4.8	9.4	6.0	9.2	5.5	6.1	4.6	4.0	3.0
Stomach cancer	304	184	*8.3	120	3.8	5.6	*18.4	*8.5	*9.8	2.9	3.6	4.4	5.0
Liver cancer	293	221	*10.5	72	2.4	6.4	*15.8	8.0	*16.3	0.9	3.1		4.9
Leukemia	289	150	*7.0	139	4.9	7.5	9.6	5.8	5.0	5.0	4.0	4.5	5.0
Ovarian cancer	198			198	7.2					*9.8	5.0	7.0	3.6

Age adjusted to standard 1970 US population, rates per 100,000 per year  
Ranked by total number of deaths. Rates not reported for fewer than 5 cases.

- \* rate significantly higher than lowest rate of other ethnicity groups
- \*\* rate significantly higher than next lower ethnicity group rate
- \*\*\*rate significantly higher than rates of all other ethnicity groups

# Non-Communicable Disease

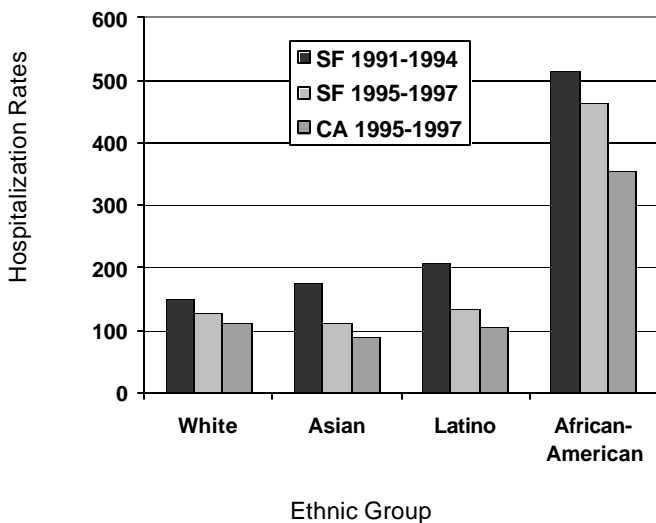
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## ASTHMA

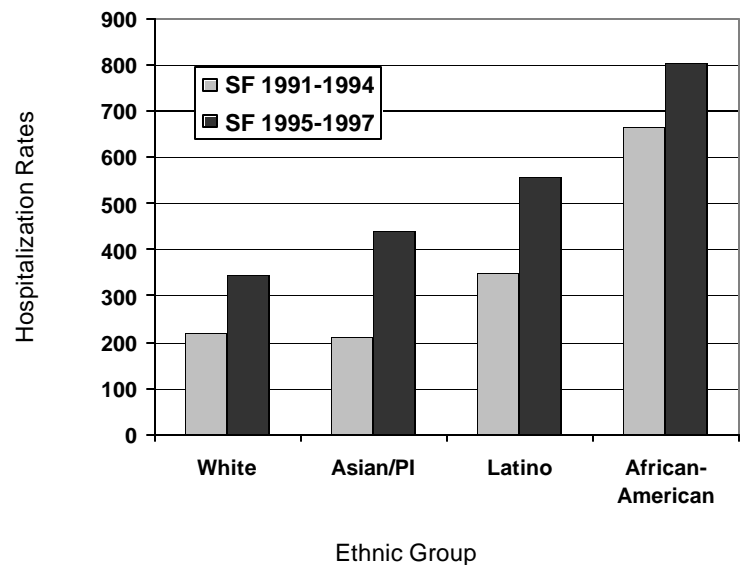
San Francisco's hospitalization rate for asthma between 1995 – 1997 was 160 per 100,000. This was slightly higher than that for the State as a whole (120 per 100,000). However, when hospitalization rates are examined by age and ethnicity, a very different picture unfolds. In San Francisco

between 1995 – 1997, children (age 0-14) experienced nearly double the hospitalization rate for asthma than did the general San Francisco population (317 per 100,000), and African Americans of all ages, experience more than three times the general hospitalization rate for asthma (463 per 100,000).

**Asthma Hospitalization Rates by Ethnicity, San Francisco 1991-1997 and California 1995-1997**



**Asthma Hospitalization Rates, Children 0-14, San Francisco, 1991-1997**



**Sources:** CDHS, Ca. County Asthma Hospitalization Chart Book, August, 1997  
CDHS, Ca. County Asthma Hospitalization Chart Book, Draft not released  
J. Mann, Asthma in San Francisco, SFDPH, 2/18/00 draft

# Disability

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We have no systematic data showing the number of San Franciscans whose ability to function in daily living are hampered to various degrees by disabilities. Among those who are more severely disabled, such that their ability to work is seriously compromised, many will receive Supplemental Security Income (SSI). This federal program is administered by the Social Security Administration; recipients' benefits are supplemented by the state SSP program.

benefits from the program. Of these, 44% were classified as aged and 54% as blind or disabled. This differs markedly from the statewide program proportions of 31% aged and 69% blind or disabled. Accordingly, a much higher proportion of SSI recipients were over 65 in San Francisco (56%) than in California (44%), and a lower proportion were under age 18 (2.1%, compared to 7.6% statewide). Almost a third of San Franciscans on SSI also received social security retirement, survivor or disability benefits.

These data, from December 1998, show that 46,000 San Franciscans received

## Supplemental Security Income Recipients San Francisco, 1998

	Total	Category		Age			SSI w. OASDI	Amount of Payments (\$1,000)
		Aged	Blind & Disabled	< 18	18-64	65+		
<b>CA</b>	1,042,002	324,774	717,228	78,861	505,786	457,355	393,012	496,115
<b>Part of Total</b>	1.000	0.312	0.688	0.076	0.485	0.439	0.377	
<b>SF</b>	46,036	20,096	25,940	975	19,112	25,949	14,727	23,452
<b>Part of Total</b>	1.000	0.437	0.563	0.021	0.415	0.564	0.320	
<b>SF as % of CA</b>	4.4%	6.2%	3.6%	1.2%	3.8%	5.7%	3.7%	4.7%

**Source:** Social Security Administration, SSI Recipients by state and County, December 1998, Table 3  
[http://www.ssa.gov/policy/pubs/pubs\\_pages/pubs\\_programDataByGeographic.htm](http://www.ssa.gov/policy/pubs/pubs_pages/pubs_programDataByGeographic.htm)

# Mental Health

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## MENTAL ILLNESS

San Francisco Department of Public Health Community Mental Health Services (CMHS) serves San Francisco residents with severe mental illness. CMHS's client profile by primary diagnoses of clients is consistent with other U.S. jurisdictions providing services to individuals with severe mental illness.

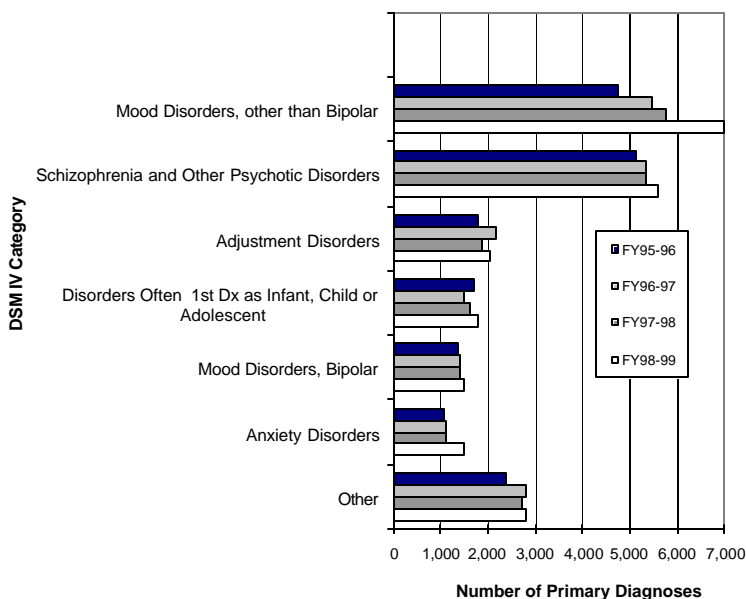
The total number of CMHS clients increased in 1998-99, reflecting the initiation of the San Francisco Mental Health Plan and the Plan's community outreach efforts to make

eligible persons aware of services.

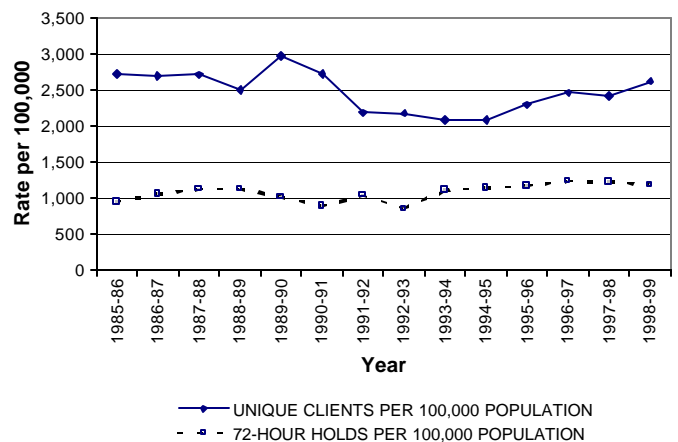
According to state law, individuals who are a danger to themselves or others or are greatly mentally disabled may be detained for up to 72 hours ("5150s") for evaluation and treatment.

Recent data on the occurrence of less severe mental health conditions and needs in the population at large in San Francisco are not available. However, according to a World Health Organization Study of years of life lost to death or disability, depression is the leading cause of years lost to disability in countries with established market economies like the United States.

### Primary diagnoses of Community Mental Health Services Clients, San Francisco, FY 1995-1996 to FY 1998-1999



### Community Mental Health Services Client and 72-Hour emergency Hold (5150s) Rates, San Francisco, FY 1985-86 to FY 1998-99



**Source:** Mental Health Section, San Francisco Department of Public Health  
CJL Murray and AD Lopez eds., *The Global Burden of Disease*, vol. 1, Harvard University Press, 1996.

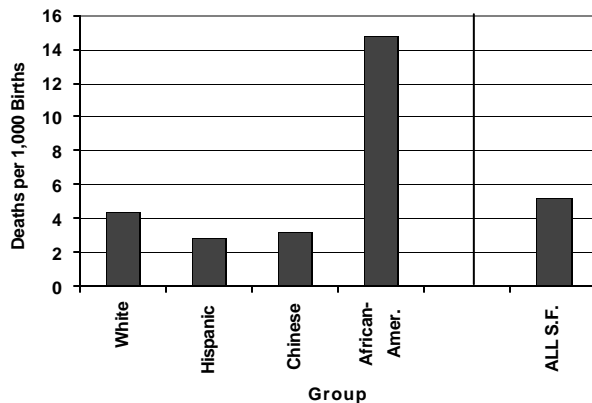
# Maternal and Child Health

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## INFANT MORTALITY

In 1998, there were 8,149 births to San Francisco residents. Infant mortality is recognized worldwide as a core indicator of a community's health status. In 1998, there were 42 deaths of infants less than 1 year old in San Francisco, resulting in an infant death rate of 5.2 per 1,000 live births. San Francisco has achieved the Healthy People 2000 goal of reducing the infant mortality rate to no more than seven per 1,000 live births, but there is a significant disparity in infant mortality between African Americans and other Ethnic groups.

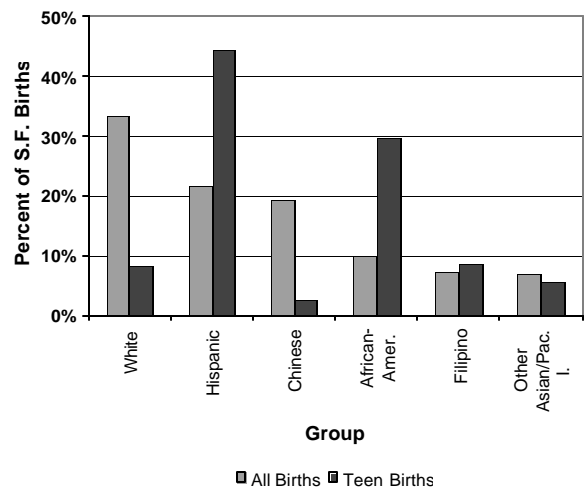
**Infant Mortality Rate, by Ethnicity, San Francisco, 1998**



## TEEN PREGNANCY

Adolescent childbearing has important health and social consequences for young women, their babies, and their families. Pregnant adolescents are more likely to have inadequate prenatal care. The younger the adolescent mother, the more likely she is to have poor pregnancy outcomes such as preterm delivery and a low birthweight infant, and to be chronically poor as an adult. In 1998, there were 499 births to San Francisco teens; 61.5% were ages 18 to 19, 32% were ages 16 to 17, and 7% were ages 13 to 15. African American and Hispanic adolescents account for a disproportionate share of births to adolescent mothers compared to the distribution of all births in San Francisco by race and ethnicity.

**Distribution of Births by Ethnicity, All Ages and Teen births, San Francisco, 1998**



**Source:** San Francisco Department of Public Health, Vital Records, San Francisco, 1998

# Maternal and Child Health

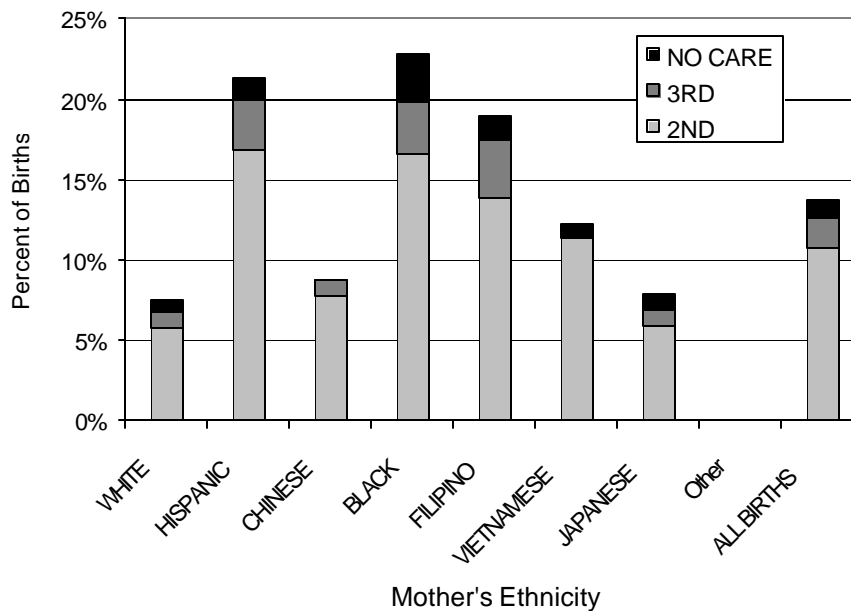
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## LATE PRENATAL CARE (PNC)

To promote the healthiest pregnancies and birth outcomes it is considered important for women to come in for a prenatal checkup during the first trimester (i.e., during first three months) of their pregnancies. Early prenatal care (PNC) is often used as an indicator of how well a population group is connected to regular sources of health care.

In San Francisco in 1998, 86% of the births were preceded by early PNC; the national Year 2000 objective is 90%. However, later care is unequally distributed by ethnicity (shown in graph) and age (not shown), with more than 20% of African-American (24%) and Hispanic (21%) births having late or no prenatal care, and Filipinos almost as much (19%).

**Trimester Prenatal Care Began by Mother's Ethnicity  
San Francisco, 1998**



**Source:** San Francisco Department of Public Health, AVSS Birth Certificates and Records  
Prepared by Population Health, Records and Statistics, September, 1999.

# Maternal and Child Health

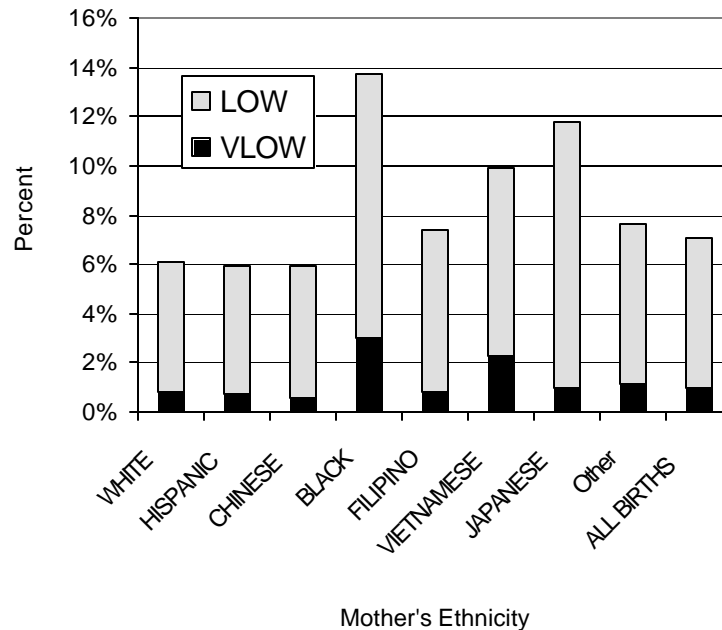
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## LOW BIRTH WEIGHT

Low birth weight (birth weight less than 2500 grams) increases infants' risk of infant mortality and other health problems, and very low birth weight (birth weight less than 1500 grams) increases these risks even

more. In San Francisco as elsewhere, increased low birth weight rates are associated with higher prevalence of late prenatal care in most populations, as seen here for African-American births. That association does not appear to hold as well among Hispanics.

**Percent Low Birth Weight by Ethnicity  
San Francisco, 1998**



Definitions: LOW = 1500 – 2499 grams, VLOW = < 1500 grams.

**Source:** San Francisco Department of Public Health, AVSS Birth Certificates and Records  
Prepared by Population Health, Records and Statistics, August, 1999, Rev September, 1999.