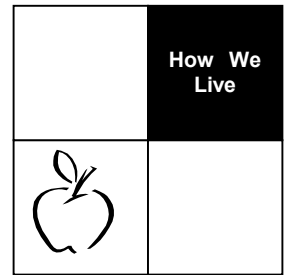


# San Francisco



**How We  
Live**

# Introduction



“How We Live” includes conditions of our social and physical environments, and actions we take that increase or decrease our risk of injury or illness. These conditions and actions are important in determining how long we will live and how healthy we will be throughout our lives. The environments that surround us at home, on the streets, in our neighborhoods, in school, and at work, all influence our health. The air we breathe, the conditions that favor tobacco use or exposure to gun violence, how long and hard we work, and our access to housing all have an impact on our health and well-being. Our activities and habits, and our access to financial, social, health care, and other essential resources all contribute to our health status. Much of the disease and injury experienced by San Franciscans could be prevented or postponed by changes in how we live.

# Economic Conditions

How We  
Live



## Income in the past 12 months below poverty level by age and household type, San Francisco 1999

San Francisco County, CA	Poverty Estimate	Non-poverty Estimate	% of pov. Status
<b>Individuals</b>	84,981	651,036	11.5%
0 to 18 years	19,347	102,797	15.8%
18 to 24 years	13,249	52,731	20.1%
25 to 44 years	24,491	243,933	9.1%
45 to 64 years	16,018	153,398	9.5%
65 years and over	11,876	98,177	10.8%
<b>Households</b>	34,655	281,391	11.0%
Married couple	4,923	101,602	4.6%
w. children <18	3,105	43,006	6.7%
Other family	7,541	41,130	15.5%
Non-family	22,191	138,659	13.8%

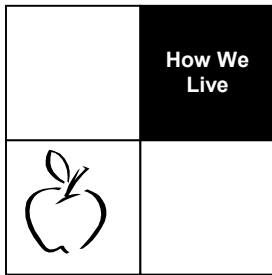
## POVERTY

Poverty continued to be highest among youth, with the highest levels among young adults 18-24 (20%) followed by children under 18 (16%). Among households, single-parent households had much higher poverty rates than married-couple families. Non-families, which in SF constitute more households than families, have poverty rates almost as high as those of non-married couple families.

The disparities in poverty rates for families by ethnicity differ by family composition, as shown in the table. Within each ethnicity, poverty rates are higher among non-couple families than among married-couple families, and among non-couple families, higher among female-headed households than among male-headed households.

## Poverty Status of Families in Past Year by Family Type and Presence of Children, San Francisco, 1999

Type of Family	% in Poverty				% of All Families in Poverty
	White, NH	Asian, NH	Latino	Black, NH	
<b>Married-couple family:</b>	2.1%	6.5%	5.8%	3.5%	39.5%
With related children under 18 years:	2.0%	7.7%	10.3%	5.8%	24.9%
No related children under 18 years	2.1%	5.1%	1.0%	1.6%	14.6%
<b>Other family:</b>	8.0%	12.0%	14.0%	26.4%	60.5%
<b>Male householder, no wife present:</b>	6.7%	8.0%	9.5%	7.2%	8.9%
With related children under 18 years:	19.2%	10.7%	13.9%	16.0%	5.9%
No related children under 18 years	0.0%	6.5%	5.4%	5.0%	3.0%
<b>Female householder, no husband present:</b>	8.6%	13.8%	15.9%	31.0%	51.6%
With related children under 18 years:	16.4%	25.1%	19.0%	37.7%	40.8%
No related children under 18 years	2.7%	7.2%	9.8%	16.9%	10.7%



# Economic Conditions

## Household Income by Family Status, San Francisco 1999

Household Income	All Households			Families			Non-Family		
	No.	%	cum %	No.	%	cum %	No.	%	cum %
Total:	316,046	100.0%		155,196	100.0%		160,850	100.0%	
<\$15,000	52,126	16.5%	16.5%	17,148	11.0%	11.0%	36,644	22.8%	22.8%
\$15,000 to \$29,999	48,337	15.3%	31.8%	22,377	14.4%	25.5%	27,280	17.0%	39.7%
\$25,000 to \$49,999	62,591	19.8%	51.6%	31,006	20.0%	45.4%	32,447	20.2%	59.9%
\$50,000 to \$74,999	57,452	18.2%	69.8%	29,350	18.9%	64.4%	27,349	17.0%	76.9%
\$75,000 to \$99,999	34,748	11.0%	80.8%	19,600	12.6%	77.0%	13,764	8.6%	85.5%
\$100,000+	60,792	19.2%	100.0%	35,715	23.0%	100.0%	23,366	14.5%	100.0%

cum. % = cumulative percent

### Poverty—continued

More than half of SF's households made less than \$50,000 a year, and almost a third made less than \$30,000. A higher proportion of family households made higher incomes than non-family households.

Many households derive income from sources other than wages, including 40% who get interest, dividends, or rent and 25% who get Social Security benefits. While only 3% get cash benefits from public assistance programs, 20% get cash or non-cash benefits (such as childcare or housing subsidies).

San Francisco families send a lot of members to work. Among married couple families, more than two-thirds have at least two workers.

## Household Income Sources and Number of Workers in Families, San Francisco 1999

	Number	Percent
<b>Households' Income sources:</b>		
Households	316,046	100%
interest, dividends, rent	125,024	40%
Social Security	77,995	25%
Supplemental Security Income (SSI)	24,157	8%
Public Assistance income	10,913	3%
Public Assistance income or noncash benefits	62,885	20%
<b>Families by number of workers:</b>		
Families	155,196	100%
Married couple families	106,525	69%
0 workers*	14,531	14%
1 worker*	20,494	19%
2 workers*	52,885	50%
3 workers*	18,615	17%

\* Percent of married couple families

# Economic Conditions

How We  
Live



## COST OF LIVING

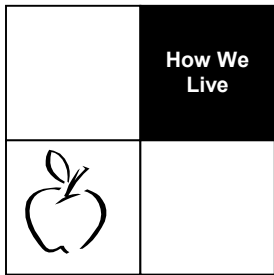
San Francisco's high cost of living is summarized in the costs, calculated by the California Budget Project, for various types of families to subsist at a modestly comfortable level in the Bay Area\*. This level, which we call the "modest standard of living" (MSOL), is probably underestimated for San Francisco itself, because the Fair Market Rent for apartments is higher in the City than the figures reflected here for the Bay Area. The hourly basic family wages needed to achieve these income levels are shown.

The Bay Area figures are around one-fifth higher than the statewide MSOL levels. The bottom of the table shows that certain low-income standards, including the statewide minimum wage (which was just raised to this level this year) and the federal poverty level (FPL), provide only a fraction of what families need to live minimally comfortably here.

\* "Bay Area" refers to Alameda, Contra Costa, Marin, San Mateo, Santa Clara, and San Francisco counties).

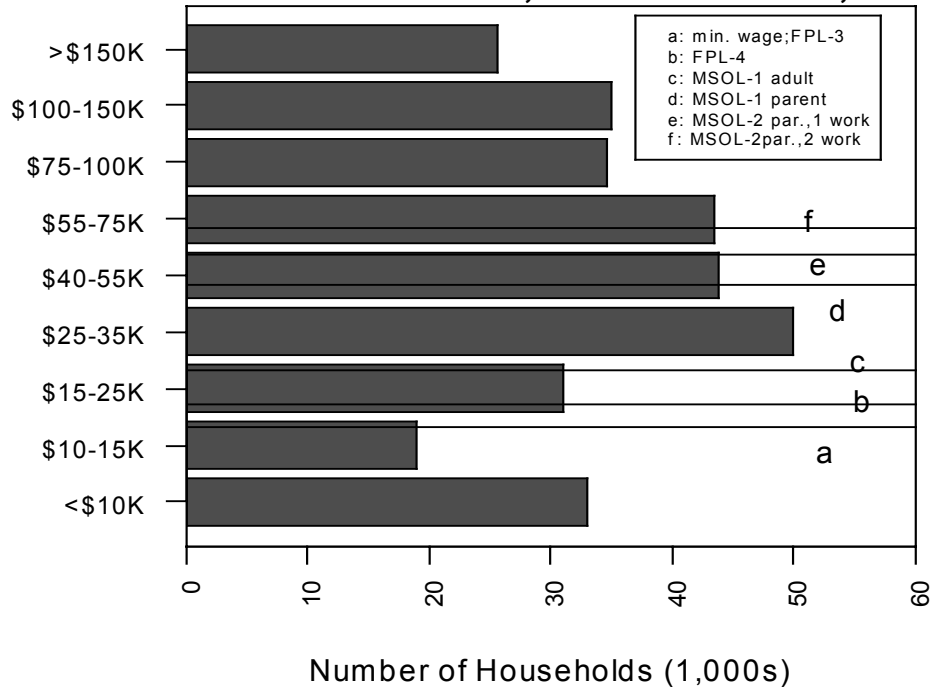
### Modest Standard of Living (MSOL): Expenses Per Month and as a Percent of Income San Francisco Bay Area, 2001

	Single Adult	Single Parent	Two Parents (One Working)	Two Parents (Two Working)
<b>Housing &amp; utilities</b>	\$ 842	\$ 1,270	\$ 1,270	\$ 1,270
	% 41%	% 28%	% 36%	% 25%
<b>Child care</b>	\$ 0	\$ 1,032	\$ 0	\$ 1,032
	% 0%	% 23%	% 0%	% 20%
<b>Transportation</b>	\$ 274	\$ 274	\$ 274	\$ 494
	% 14%	% 6%	% 8%	% 10%
<b>Food</b>	\$ 182	\$ 445	\$ 638	\$ 638
	% 9%	% 10%	% 18%	% 12%
<b>Health care</b>	\$ 134	\$ 329	\$ 391	\$ 391
	% 7%	% 7%	% 11%	% 8%
<b>Miscellaneous</b>	\$ 179	\$ 341	\$ 429	\$ 429
	% 9%	% 8%	% 12%	% 8%
<b>Taxes</b>	\$ 426	\$ 815	\$ 523	\$ 879
	% 21%	% 18%	% 15%	% 17%
<b>MONTHLY TOTAL</b>	\$ 2,037	\$ 4,506	\$ 3,525	\$ 5,133
<b>ANNUAL TOTAL</b>	\$ 24,442	\$ 54,069	\$ 42,304	\$ 61,593
<b>CALIFORNIA STATEWIDE</b>	\$ 20,503	\$ 43,443	\$ 36,245	\$ 52,034
<b>HOURLY BASIC FAMILY WAGE</b>	\$ 11.75	\$ 25.99	\$ 20.34	\$ 14.81
<b>Income standard levels...</b>				
<b>...As % of MSOL basic family wage income</b>				
<b>Ca. Minimum Wage (\$6.75/hr.)</b>	\$ 14,040	\$ 14,040	\$ 14,040	\$ 28,080
<b>Min. wage as % of MSOL</b>	57%	26%	33%	46%
<b>Federal Poverty Level (FPL)</b>	\$ 14,630	\$ 14,630	\$ 17,650	\$ 17,650
<b>FPL as % of MSOL</b>	60%	27%	42%	29%
<b>SF living wage (\$10/hr.)</b>	\$ 20,800	\$ 20,800	\$ 20,800	\$ 41,600
<b>Living wage as % of MSOL</b>	85%	38%	49%	68%



# Economic Conditions

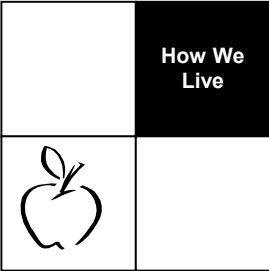
**Household Income and Selected Income Standards, San Francisco, 1999**



**INCOME**

This figure shows San Francisco’s estimated household income distribution, with various income standards shown for reference. It shows that, while a substantial number and proportion of households have higher incomes, there are also very many who make less than the basic family wage needed for families to live modestly. The households include a large number of non-families, most of them single-person households, but even so, more than 50,000 such households have incomes below the level of the California minimum wage.

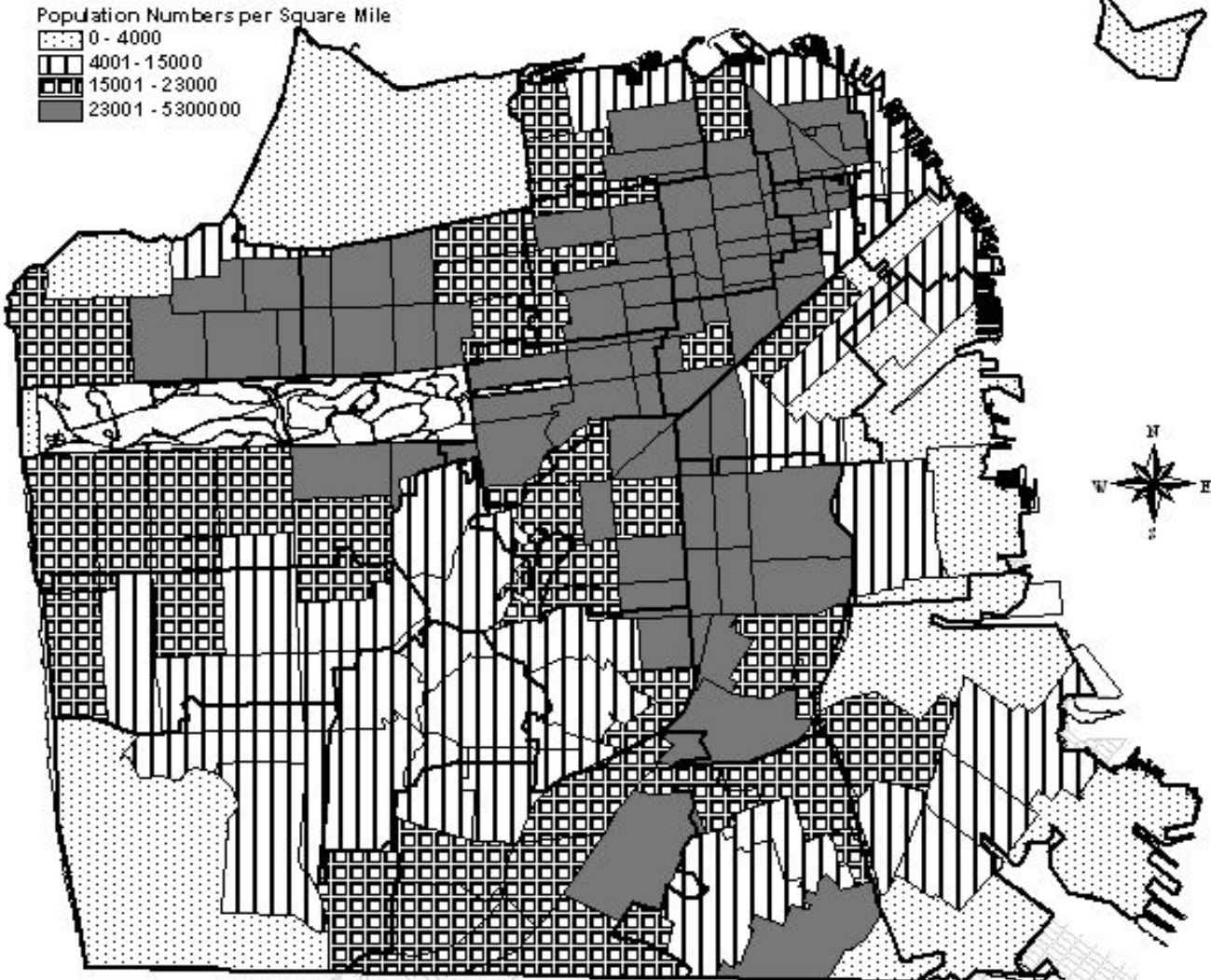
# Economic Conditions



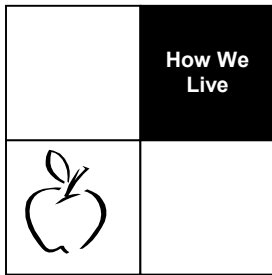
### Income—continued

This map shows the areas of highest and lowest population density in the City. It complements the next map, showing income levels. Many of the most densely populated areas correspond with low income areas, including Chinatown, North Beach, the Tenderloin, Western Addition, and the Mission.

Population Density by Census Tract with Zip Code Boundaries  
San Francisco, 1999



Data Source : San Francisco Planning Department  
San Francisco Department of Public Health - Population Health and Prevention Management Information Systems

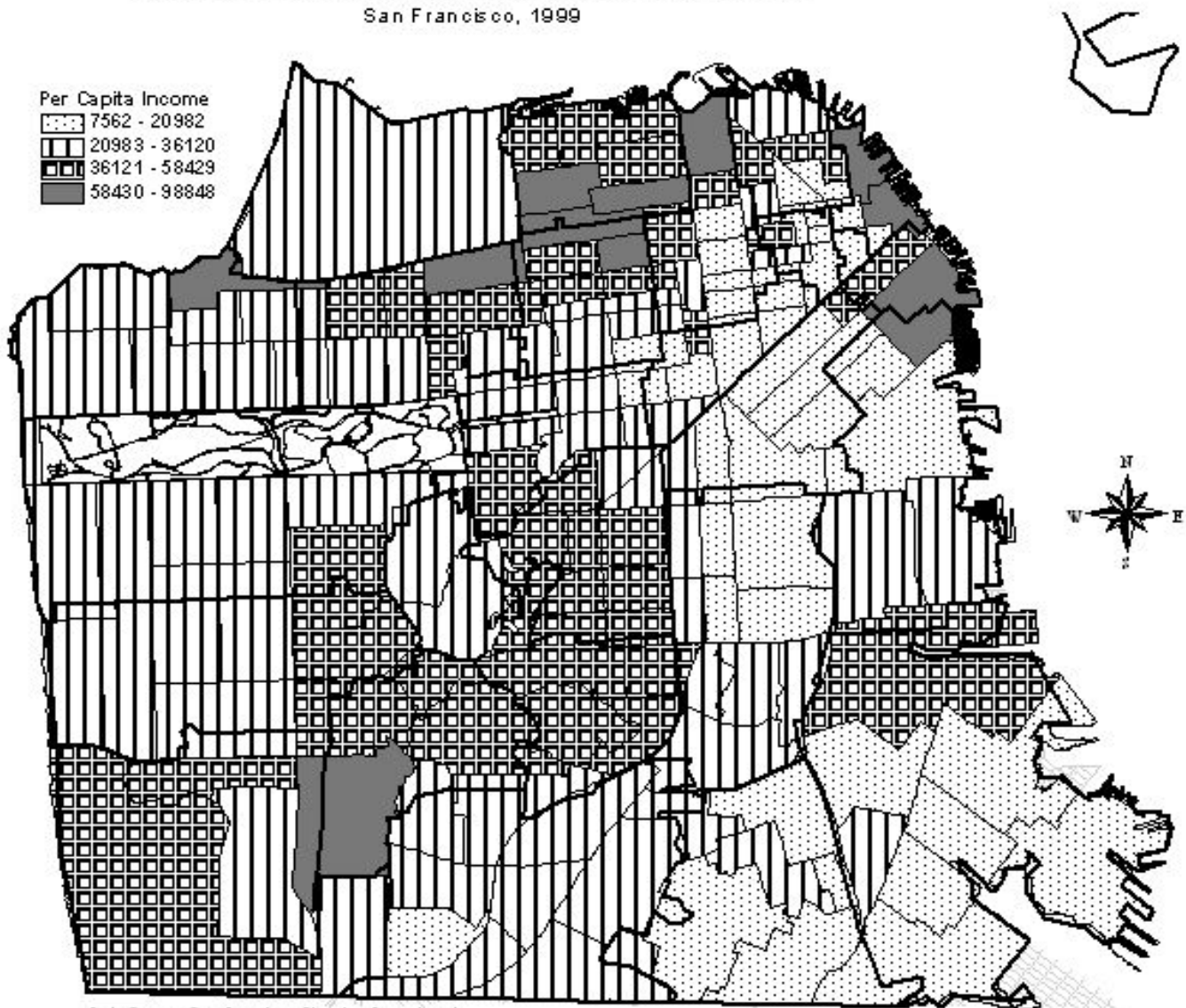


# Economic Conditions

## Income—continued

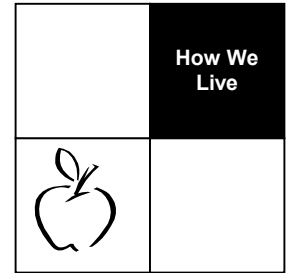
Income, at every level, is a powerful determinant of health (wealthier people tend to be healthier than middle-income people; the poorest tend to suffer from the worst health). This map shows the geographic distribution of per capita income in San Francisco. The poorest segments of the population (dotted on the map) are located in the eastern portions of the City.

Per Capita Income by Census Tract with Zip Code Boundaries  
San Francisco, 1999



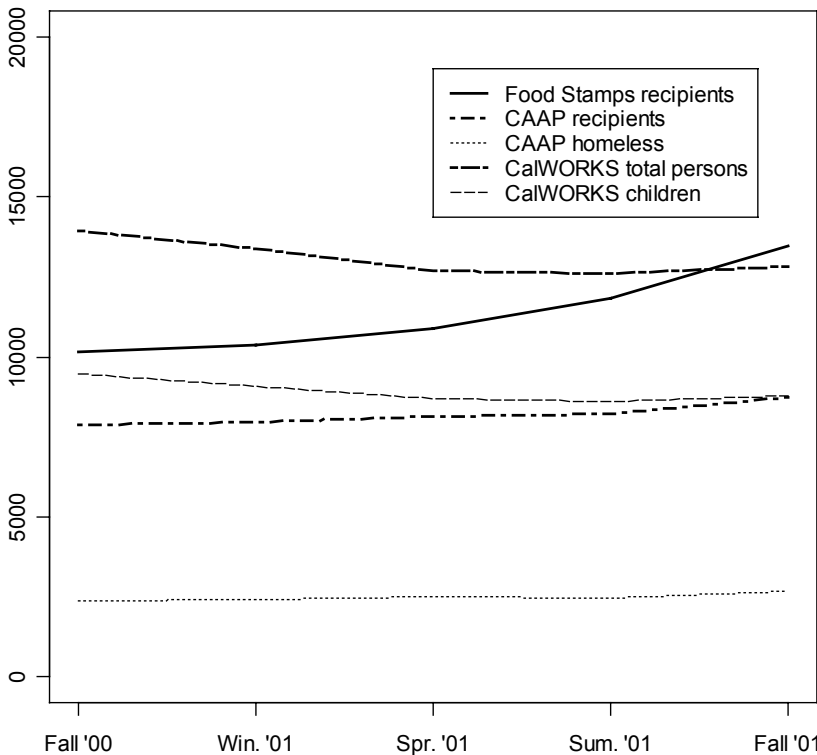
Data Source: San Francisco Planning Department  
San Francisco Department of Public Health - Population Health and Prevention - Management Information Systems





# Economic Conditions

**San Franciscans Receiving Public Assistance, Fall 2000-Fall 2001**

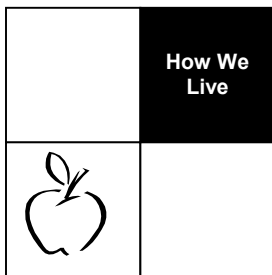


**PUBLIC ASSISTANCE**

The three main benefit programs are:

- CalWorks, serving families with children (the descendent of AFDC, since changed by the 1996 welfare reform to the Federal Temporary Assistance to Needy Families (TANF) program);
- County Adult Assistance Program (CAAP) for needy adults, generally single, not supporting children; and
- Non-Assistance Food Stamps (NAFS) part of the Federal food stamp program not covering TANF recipients.

Over the past year, as the economy declined, the number of non-assistance food stamps recipient went up by 33%; CAAP recipients increased by 11%, including a 14% rise in the number of homeless clients in the program. However, the number of CalWorks recipients, including children, declined by 8%.



# Economic Conditions

## AFFORDABLE HOUSING AND HOMELESSNESS

While homelessness continues to be an important and visible problem in San Francisco, it represents the extreme end of a spectrum of problems reflecting the intersection of lack of affordable housing, incomes below minimal subsistence needs, and in some cases behavioral, mental and physical problems.

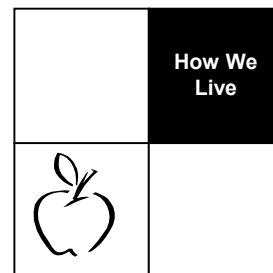
For many low income people, the next step above homelessness is the bare living conditions of SROs, single room occupancy hotels. While these often house single individuals, families also live there. This table summarizes the results of a recent survey of families living in SROs in San Francisco. It shows that more than half of the families in SROs live in Chinatown, followed by the Mission and Tenderloin. For most, English is not the preferred language. Half have full-time workers and a quarter have part-time workers. 91% cite insufficient income and 63% cite lack of affordable housing as barriers to better housing. They pay an average of 40% of their income for rent, and their average stay in this SRO is over 4 years (longer in Chinatown). A quarter are on waiting lists for low income housing. The most common health problems cited as worsened due to their housing situation are breathing/respiratory problems (68% of those responding), followed by lack of light (31%) and then sleep deprivation and children's space constraints. (the latter 3 all in Chinatown).

### Characteristics of Families with Children Living in San Francisco SRO Hotels\*

	SF Total		Chinatown		Mission		Tenderloin		SoMa		Other	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Families residing in SROs	453	100%	279	62%	52	11%	58	13%	16	4%	48	11%
SRO hotels with families residing	158	100%	85	54%	15	9%	36	23%	**	6%	13	8%
Average rooms per family	1.1		1.1		1.2		1.0		1.1		1.1	
Average years living in this SRO	4.3		5.8		3		2		1.3		3.3	
Lived in < 1 year		32%		21%		55%		75%		89%		68%
Average members per family	3.4		3.7		3.3		3.2		2.5		3.1	
Adult caregivers	776		523		81		83		21		68	
Families w. 2+ adult caregivers	323	66%	244	87%	29	56%	25	43%	5	30%	20	42%
Children < 18	760	100%	490	64%	84	11%	91	12%	19	3%	76	10%
<b>Ethnicity</b>												
African American	44	10%	**	**	**	**	13	22%	12	73%	14	28%
Asian	291	64%	272	97%	**	**	**	9%	**	**	**	18%
Latino	73	18%	**	**	40	78%	18	31%	**	**	12	26%
White	20	4%	**	**	**	**	13	22%	**	**	**	10%
<b>Caregivers' preferred language</b>												
Cantonese	457	59%	443	85%								15%
English	117	15%	**	1%	19	23%	55	66%	18	85%	20	30%
Spanish	116	15%	**	**	62	77%	18	22%	**	**	**	52%
Toison	75	10%	70	13%	**	**	**	6%	**	**	**	**
Other	**	**	**	**	**	**	**	**	**	15%	**	**
<b>Revenue sources &amp; costs</b>												
	776		523		81		83		21		68	
Full-time job	378	49%	273	52%	41	51%	30	36%	**	**	30	43%
Part-time job	195	25%	137	26%	22	27%	18	21%	**	**	**	26%
No income	92	12%	65	13%	**	7%	11	13%	**	**	**	13%
SSI	33	4%	12	2%	**	**	11	11%	**	33%	**	**
TANF, CalWORKS, GA, PAES, SSIP	45		**		10		24		**		**	
Average monthly income	\$ 1,316		\$ 1,524		\$ 935		\$ 1,067		\$ 858		\$ 1,488	
Average monthly rent	\$ 523	40%	\$ 392	26%	\$ 515	55%	\$ 724	68%	\$ 1,062	124%	\$ 710	48%
Average monthly food spending	\$ 503	38%	\$ 624	41%	\$ 357	38%	\$ 307	29%	\$ 423	49%	\$ 462	31%
Families w. relatives in other SROs	53	12%	32	12%	**	**	**	**	**	**	**	26%
On low-income housing wait list	116	26%	47	17%	13	25%	22	37%	10	60%	25	53%
Ave. years since lived in safe & stable hou:	5.2		7		6.1		3.1		3.4		2.8	
<b>Barriers to better housing</b>												
Insufficient income	412	91%	270	97%	42	80%	53	91%	14	90%	33	68%
Lack of affordable housing	283	63%	182	65%	20	38%	48	83%	11	71%	22	46%
<b>SROs worsened health? (no. answering)</b>												
Breathing/respiratory problems	161	68%	147	79%	**	36%	**	30%	**	**	**	**
Lack of light	73	31%	73	40%	**	**	**	**	**	**	**	**
Sleep deprived	35	15%	35	19%	**	**	**	**	**	**	**	**
Children's space constraints	35	15%	35	19%	**	**	**	**	**	**	**	**

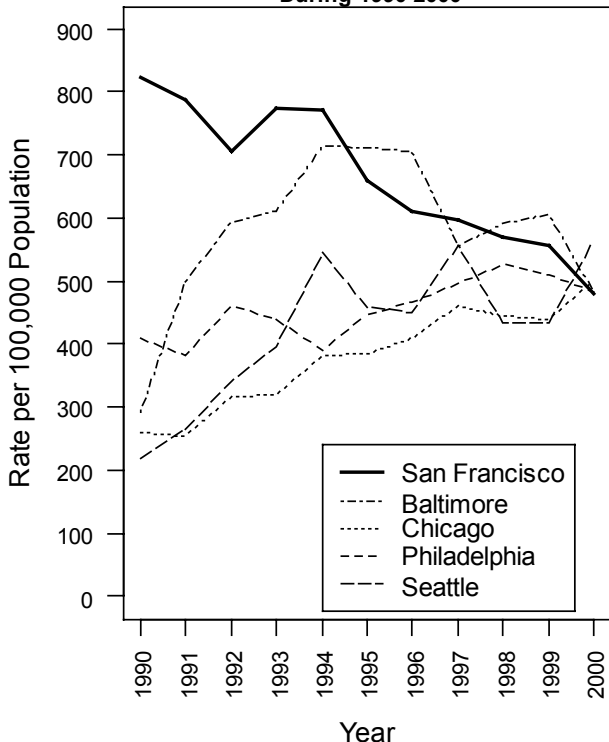
\* SRO: Single Room Occupancy

\*\* Numbers not shown for < 10 cases; %s not shown < 5 cases.



# Substance Abuse

**Estimated Rate of Emergency Dept. Drug Episodes for Metropolitan Areas Ranked in the Top 5 During 1990-2000**

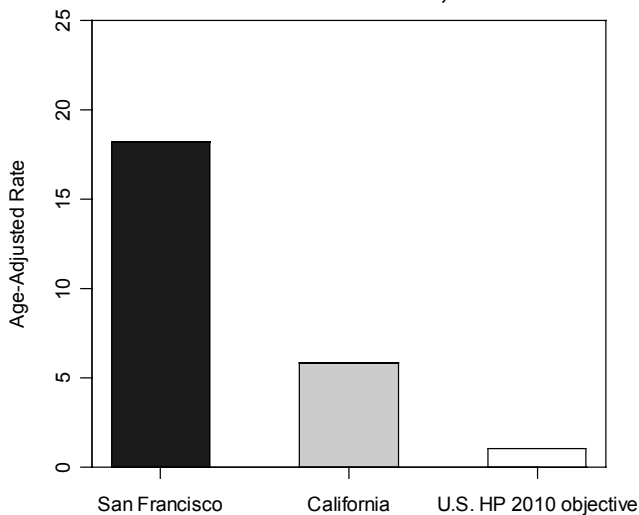


## ALCOHOL AND OTHER DRUGS

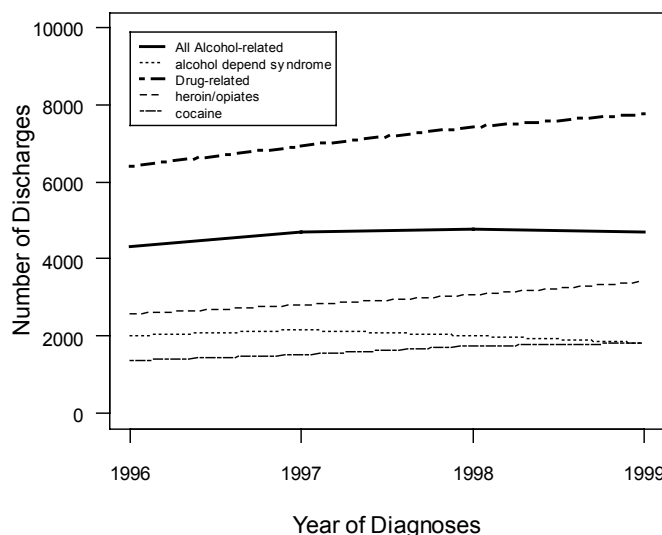
Among the cities ranking in the top 5 in the United States in emergency department drug episodes in the last decade, San Francisco has dropped from the highest rank, and has been the only one to have consistently declining rates. It is believed that the most recent decline is due in part to the advent of treatment on demand and the opening of the Wound Center unit at SFGH.

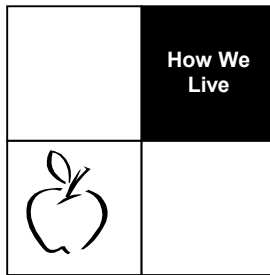
Although death rates due to drug overdose have recently declined, they continue to pose a significant public health crisis for San Francisco.

**Drug-Related Deaths, San Francisco & California, 1999-2000**



**Alcohol and Drug-Related Hospitalizations, (Any Diagnosis) San Francisco, 1996-1999**





# Substance Abuse

## Alcohol and Other Drugs—continued

The National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAA) studied the economic costs associated with alcohol and drug abuse. The study estimated that costs were \$246 billion in 1992 (the most recent year for which data were available). A large part of treatment costs were for drug and alcohol related hospitalizations

As the table below documents, the use of drugs and alcohol are associated with over 12,000 hospital admissions in 1999. These include cases where the drugs or alcohol-related problem is the main cause of hospitalization (primary diagnosis of alcohol and/or drugs), and also, to many more cases where drugs and alcohol are a contributing factor in a much larger number of hospitalizations (any alcohol or drug diagnosis).

### Alcohol & Drug Indicators: A. Hospitalizations

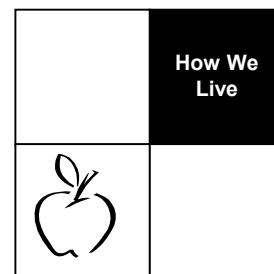
Indicator	1996	1997	1998	1999	1998-99 Change
<b>CADDS</b>					
<b>Primary drug admissions</b>					
Total admissions	13559	13452	14820	17035	15%
Number injecting	8048	7812	9060	10169	12%
<b>Primary alcohol admissions</b>					
	3464	3728	3622	4807	33%
<b>Hospital discharges</b>					
<b>Alcohol related</b>					
<b>Total, primary diagnosis</b>	708	893	828	1048	27%
<b>Alcohol related, any diagnosis*</b>	4306	4700	4757	4693	-1%
Alcohol depend syndrome	2008	2156	2009	1820	-9%
Non-depend use	637	771	910	923	1%
Alcohol liver damage	857	857	890	873	-2%
Alcohol psychoses	628	709	808	926	15%
<b>Drug related</b>					
<b>Total, primary diagnosis</b>	476	388	409	394	-4%
<b>Drug related, any diagnosis*</b>	6413	6941	7432	7776	5%
Heroin/opiates	2579	2820	3074	3421	11%
Cocaine	1375	1512	1727	1820	5%
Amphetamine	549	667	594	520	-12%
Cannabis	194	285	315	259	-18%
Barbiturates	70	60	93	106	14%
<b>Total primary diagnosis alcohol &amp; drug discharges</b>	1184	1281	1237	1442	17%
<b>Total discharges, any alcohol or drug diagnosis*</b>	10719	11641	12189	12469	2%

-- % change not calculated for less than 20 events

source: Ca. Dept. of Alcohol & Drug Programs (CDADP), *Indicators of Alcohol and Drug Abuse Annual Update 2001*

website: <http://www.adp.cahwnet.gov/pdf/coverpage.pdf>

# Substance Abuse



## Alcohol and Other Drugs—continued

The NIDA /NIAAA study estimated that half of the \$246 billion spent in 1992 on drug and alcohol abuse related expenses were for drug-related crime. In addition to costs, drug and alcohol abuse are responsible for a great loss of life among young people.

The table below shows drug and alcohol indicators that relate to law enforcement such as alcohol-involved accidents, license suspensions, and arrests. The table does not include non-alcohol and drug crimes such as robberies that are often influenced by the use and/or need for drugs and alcohol.

Alcohol was involved in 27.1% of all fatal accidents in 1999, down 11% from the previous year. The total number of license suspensions/revocations declined 13% between 1998 and 1999. Alcohol and drug related arrests also declined in 1999. Adult alcohol felony arrests were down 20%, juvenile alcohol-related arrests were down 17% and juvenile drug-related arrests were down 19% from the previous year.

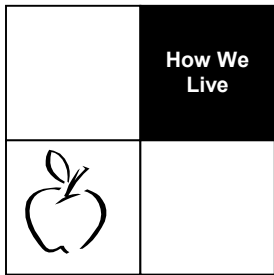
### Alcohol & Drug Indicators: B. Law Enforcement

Indicator	Year 1996	1997	1998	1999	1998-99 Change
<b>CHP MV traffic indicators</b>					
<b>Alcohol-involved accidents--Total</b>	460	385	430	417	-3%
Fatal accidents	13	10	18	13	--
% of all fatal accidents	27.7	18.5	30.5	27.1	-11%
Injury accidents	447	375	412	404	-2%
% of all injury accidents	8.5	8.0	8.1	8.4	4%
<b>Persons in alcohol-involved accidents--Total</b>	704	599	651	640	-2%
Fatal	14	10	18	13	--
% of persons killed in all fatal accidents	27.5	18.2	30	27.1	-10%
Injuries	690	589	633	627	-1%
% of persons injured in all injury accidents	8.8	8.4	8.4	8.8	5%
<b>DUI/Primary collision factor</b>	236	221	216	222	3%
Fatal accidents	8	10	7	8	--
% of all fatal accidents	17.0	18.5	11.9	16.7	40%
Injury accidents	228	211	209	214	2%
% of all injury accidents	4.3	4.5	4.1	4.4	--
<b>DMV</b>					
<b>Driver lic. suspensions/revocations--Total</b>	588	423	712	620	-13%
1st or 2d felony	17	9	24	17	-29%
1st or 2d misdemeanor	300	206	388	284	-27%
3d or 4th offense	271	208	300	319	6%
	588	423	712	620	-13%
<b>Criminal justice</b>					
<b>Adult drug-related arrests</b>	8443	9280	10941	10682	-2%
Felony	8206	8192	8920	8628	-3%
Misdemeanor	237	1088	2021	2054	2%
<b>Adult alcohol-related arrests</b>	3624	3794	4969	4919	-1%
Felony	125	124	134	107	-20%
Misdemeanor	3499	3670	4835	4812	0%
<b>Juvenile drug-related arrests</b>	688	653	627	506	-19%
<b>Juvenile alcohol-related arrests</b>	39	45	54	45	-17%
<b>Drug commitments</b>					
Ca. Rehab. Ctr.	8	4	5	2	--
Dept. of Corrections	304	178	180	159	-12%
CYA	10	2	3	6	--

-- % change not calculated for less than 20 events

source: Ca. Dept. of Alcohol & Drug Programs (CDADP), *Indicators of Alcohol and Drug Abuse Annual Update 2001*

website: <http://www.adp.cahwnet.gov/pdf/coverage.pdf>



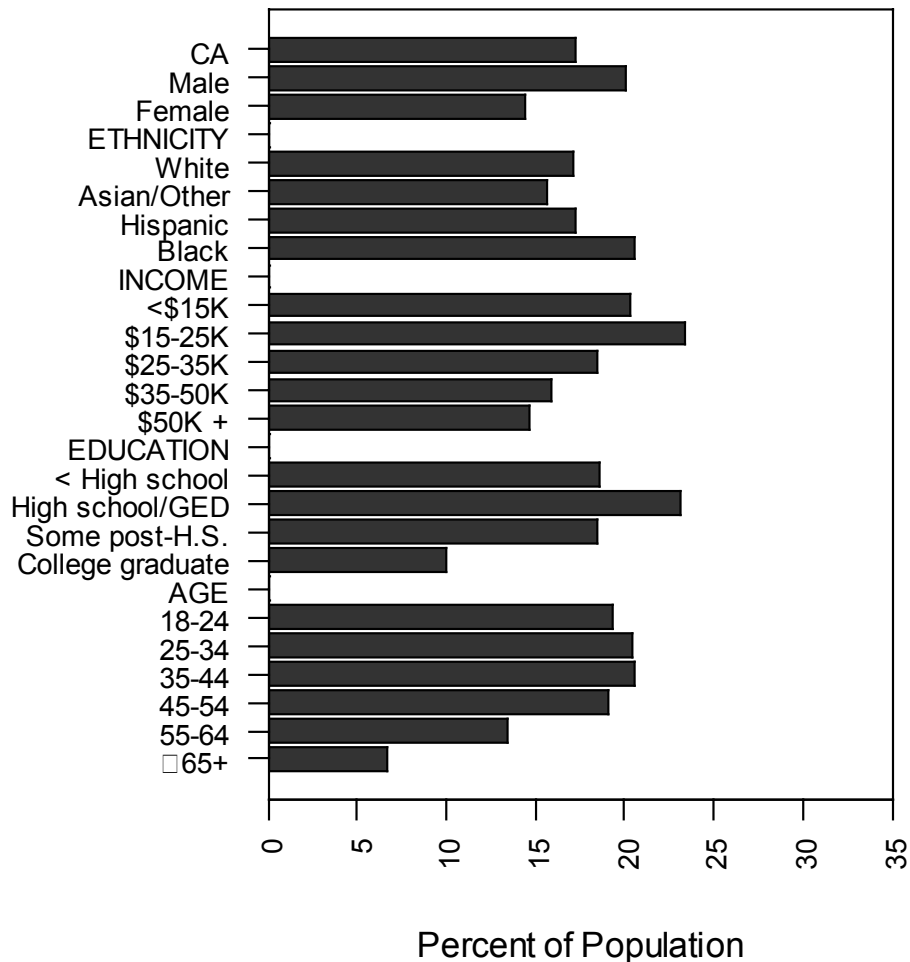
# Smoking

## SMOKING

According to the Surgeon General “Cigarette smoking is the leading preventable cause of disease and death in the United States.” Although the rates of smoking in California are lower than the national average, smoking is still one of the major contributing factor in California’s disease and death rates.

Tobacco use varies among ethnic groups, age groups, between the sexes, and among income and educational levels. In California, men smoke about a quarter as much as women. African Americans have the highest rates of smoking followed by Whites. Individuals with less income (under \$26K) are more likely to smoke than those with incomes over \$50K. Education and age seem to have the greatest impact on smoking behavior with college graduates smoking less than half as much as those without an advanced degree. Individuals over the age of 65 are the least likely to be smokers, partly because many smokers will have died before reaching oldest age groups.

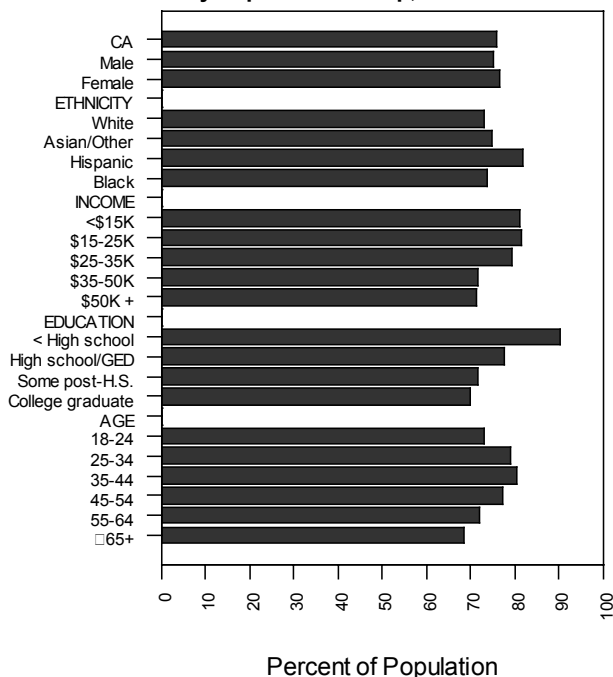
**Current Smoking by Population Group, California 2000**





# Physical Inactivity

**At Health Risk Due to Physical Inactivity by Population Group, California 2000**

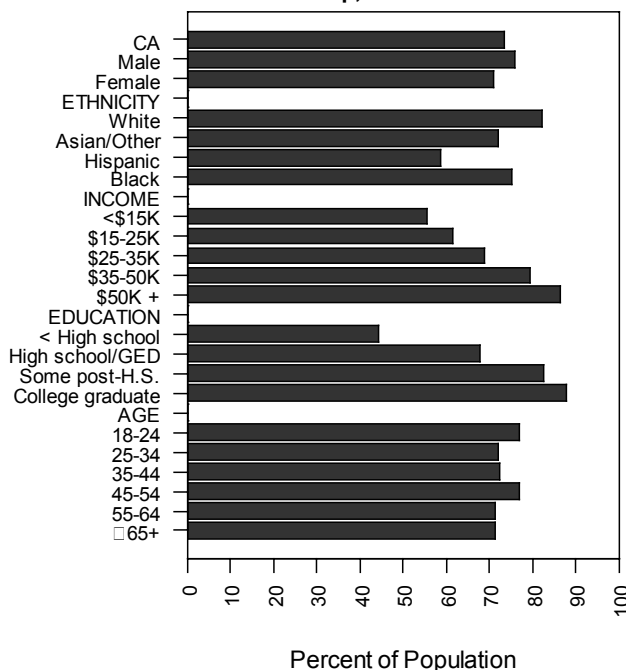


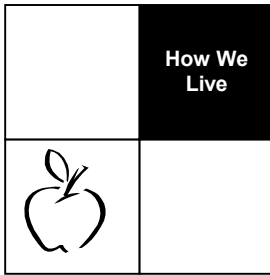
## PHYSICAL INACTIVITY

After tobacco exposure, physical inactivity is now considered the second leading determinant of death in the U.S. A recent Surgeon General's report on physical inactivity states that people who are inactive can improve their health and reduce their risk of developing or dying from heart disease, diabetes, high blood pressure, and colon cancer by becoming even moderately active on a regular basis.

In California, there are substantial differences between ethnic groups in degree of physical activity. Whites have the highest level of physical activity among ethnic groups and Hispanics the lowest. Income level correlates positively with activity level, as income increases, so do physical activity levels. Individuals making the most money (\$50K+) have the highest levels of activity. Education has a similar impact on activity levels. College graduates have the highest level of activity and those with no high school the least.

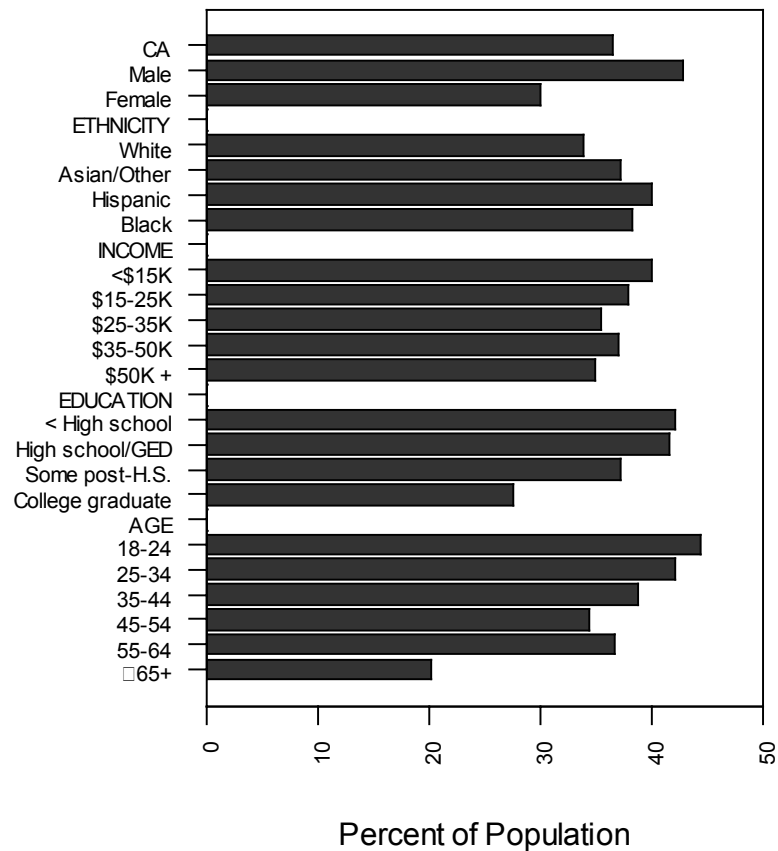
**Physical Activity by Population Group, California 2000**





# Nutrition

**Eat Fruits or Vegetables Less than 3 Times a Day  
by Population Group, California 2000**

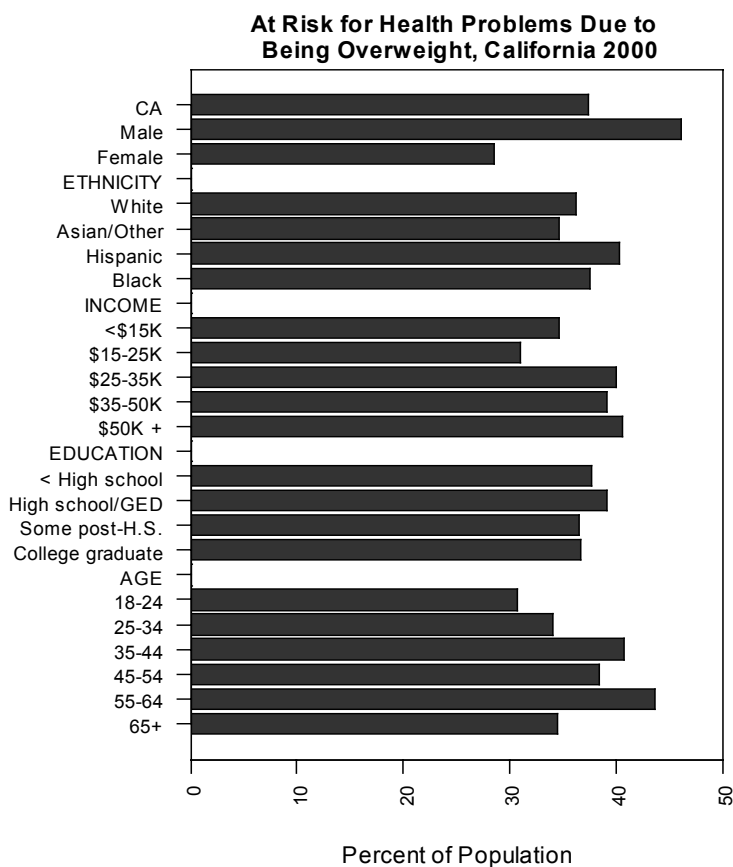
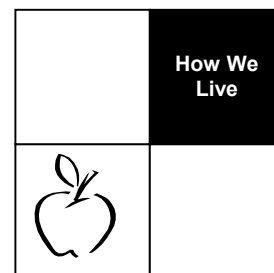


## NUTRITION

*Healthy People 2010* provides specific objectives for the consumption of fruits (75% of the population should consume fruit at least twice a day) and vegetables (50% of the population should consume at least three daily servings of vegetables, with at least one-third being dark green or orange vegetables). This graph for California shows the need for improvement across different demographic groups, especially for males, younger people, and those with less education.

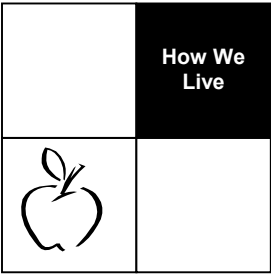


# Overweight



## OVERWEIGHT

Being overweight increases the risk of hypertension, diabetes, high cholesterol, heart disease, arthritis, breast cancer, and other health problems. *Healthy People 2010* considers overweight to be a leading health indicator. Nationally, overweight is increasing rather than decreasing. If this major health problem is to be addressed in San Francisco, we will need to find ways to increase the opportunities for physical activity in the population, in addition to assuring easy access to healthy food in all areas of the City. People at any weight level can reduce their health risks by regular physical activity.



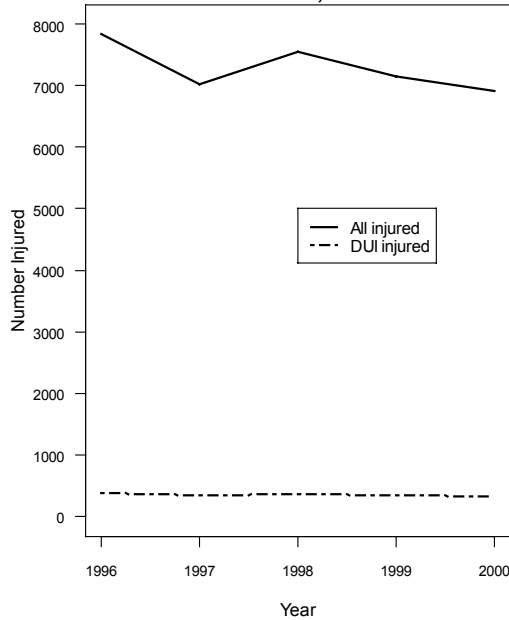
# Injuries

## UNINTENTIONAL INJURIES

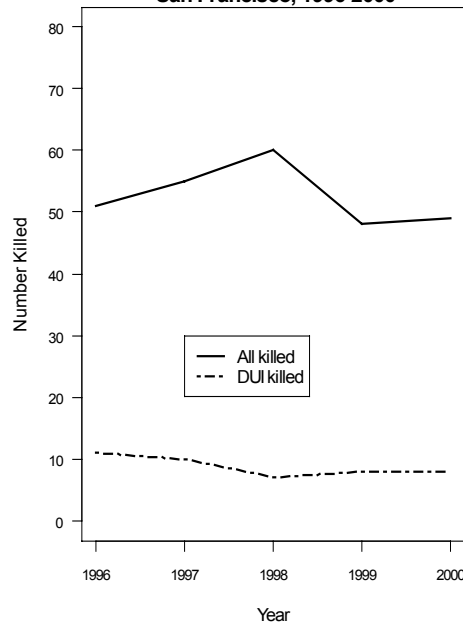
The number of people killed and injured in motor vehicle accidents has remained fairly level over the five years through 2000, as has the contribution of driving under the influence (DUI) to these injuries. DUI continues to be a much larger contributor to more severe accidents, involving fatalities, than to non-fatal injury accidents.

These figures cover all injuries involving motor vehicles. In 2000, 33 of the 49 people killed in San Francisco in motor vehicle accidents were pedestrians.

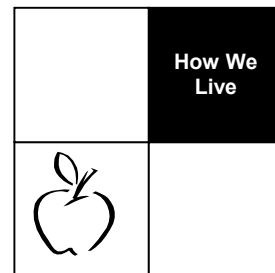
**Persons Injured in Motor Vehicle Accidents, San Francisco, 1996-2000**



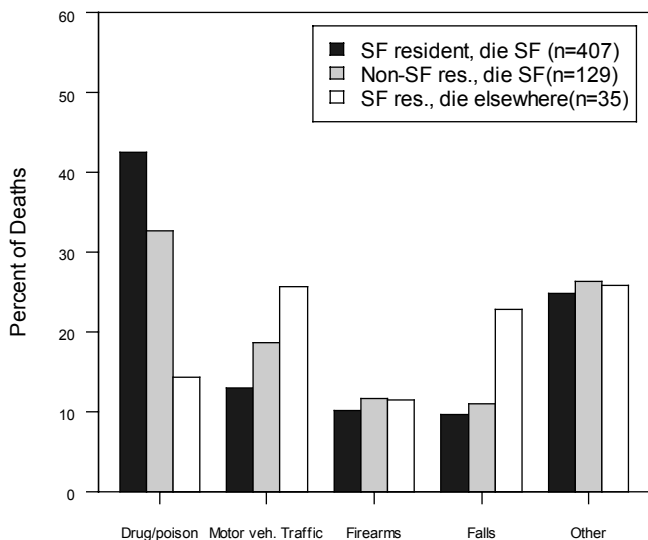
**Persons Killed in Motor Vehicle Accidents, San Francisco, 1996-2000**



# Injuries



**Mechanism of Injury Death for San Francisco Residents and Deaths in SF, 1998**



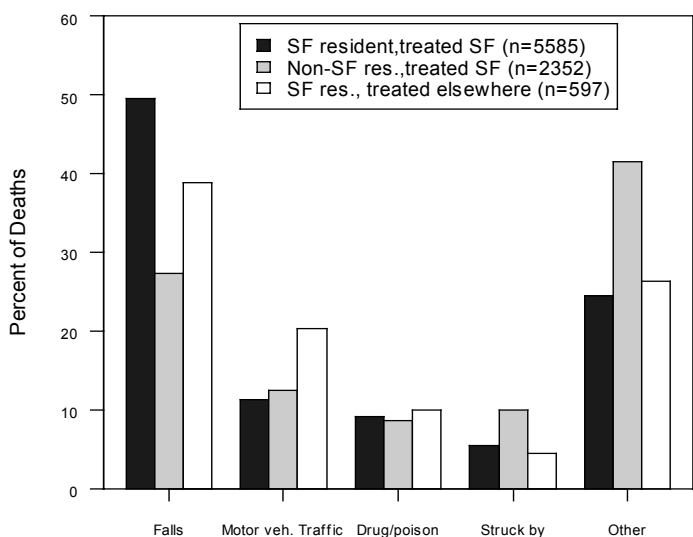
**Unintentional Injuries—  
continued**

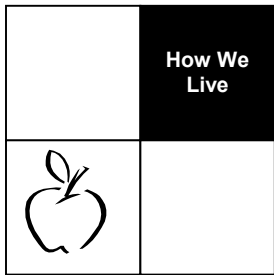
Hundreds of thousands of non-San Francisco residents spend time in the City each day, as workers or visitors to its stores, services, and tourist attractions.

These people are subject to being injured or killed here, as San Francisco residents are when they travel elsewhere.

These figures show the proportional distribution of mechanisms of injuries causing death or hospitalization for San Francisco residents here or elsewhere and for non-residents occurring here. Drug poisoning is the leading mechanism of injury death for SF residents and non-residents dying here, while falls is the leading mechanism for both residents and non-residents hospitalized here.

**Mechanism of Injury Hospitalization for San Francisco Residents and Treatment in SF, 1998**





# Injuries

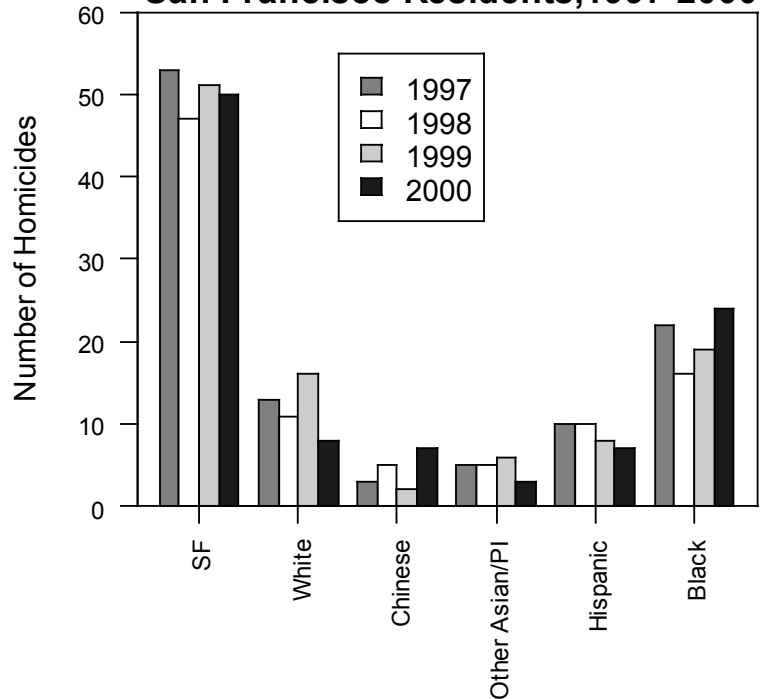
## VIOLENCE AND INTENTIONAL INJURIES

These data show the geographic distribution of 1998 assaults and the numbers of San Francisco residents, by ethnicity, who were homicide victims from 1997 through 2000.

The total number of homicides has hovered around 50 over this period. The numbers are too small to calculate reliable rates, but African Americans represent the smallest population of any of the ethnicities shown, yet have the largest number of homicide victims for each year. The number of Hispanic homicide victims is less striking but also disproportionately great compared to their share of San Francisco's population.

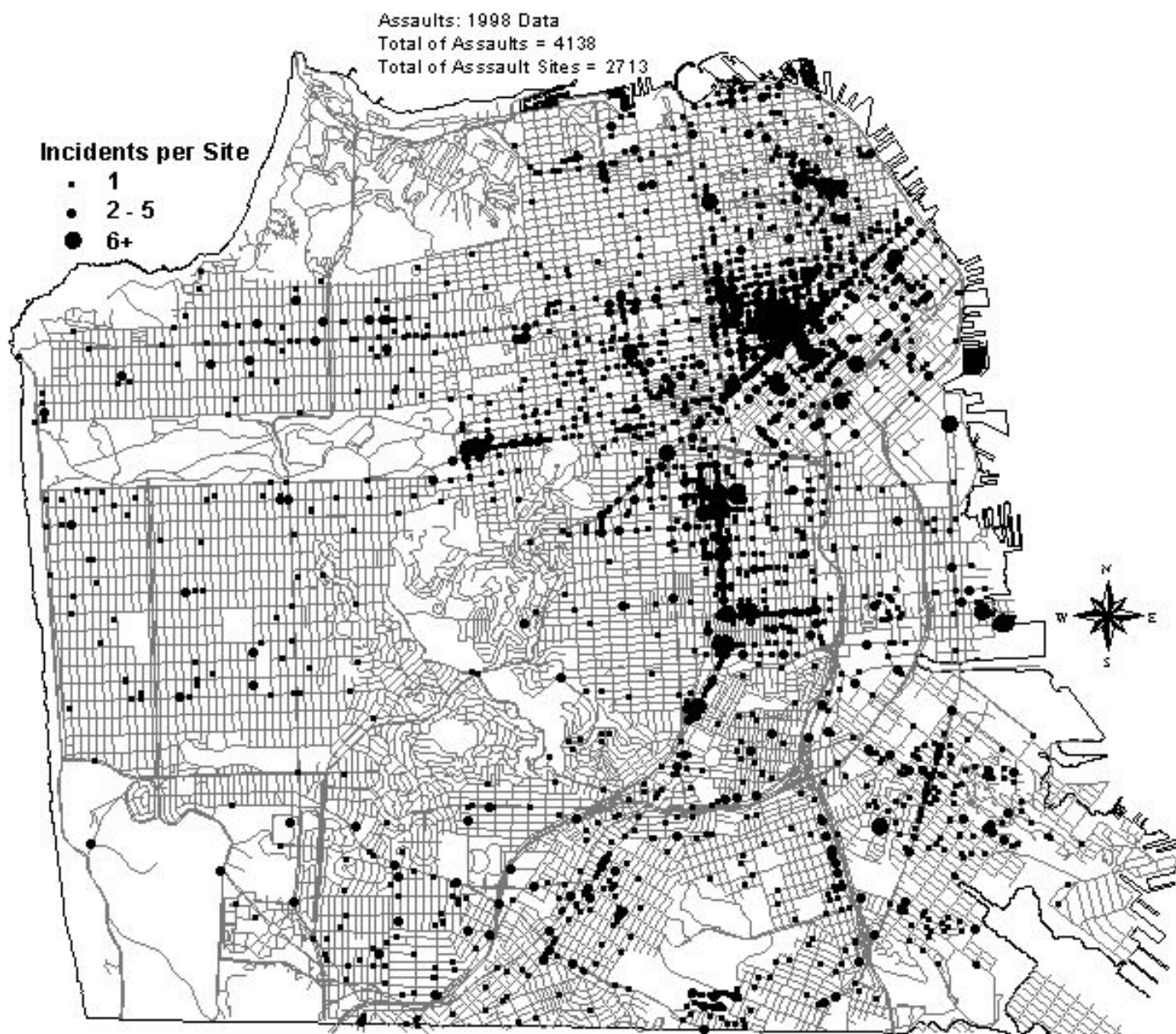
The assault map shows the heaviest concentration along the Market and Mission St. corridors and in the Tenderloin, with other concentrations including Haight near Golden Gate Park, North Beach, and along and around 3d in Bayview Hunters Point. The areas of densest concentration on this map are within areas of highest residential density and lower income shown in earlier maps.

**Homicides by Ethnicity, San Francisco Residents, 1997-2000**

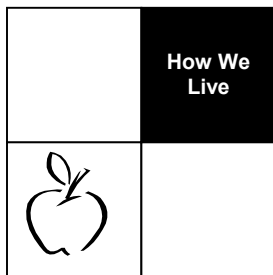


# Injuries

How We  
Live



Data Source: San Francisco Fire Department EMS Division, 1998 Paramedic Data  
 San Francisco Department of Public Health Population Health and Prevention Management Information Systems



# Environmental Health

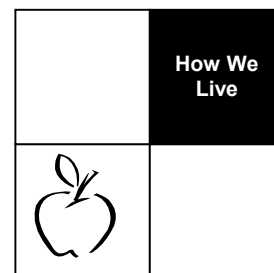
## San Francisco Air Quality Monitoring Data, 1999-2001

### AIR QUALITY

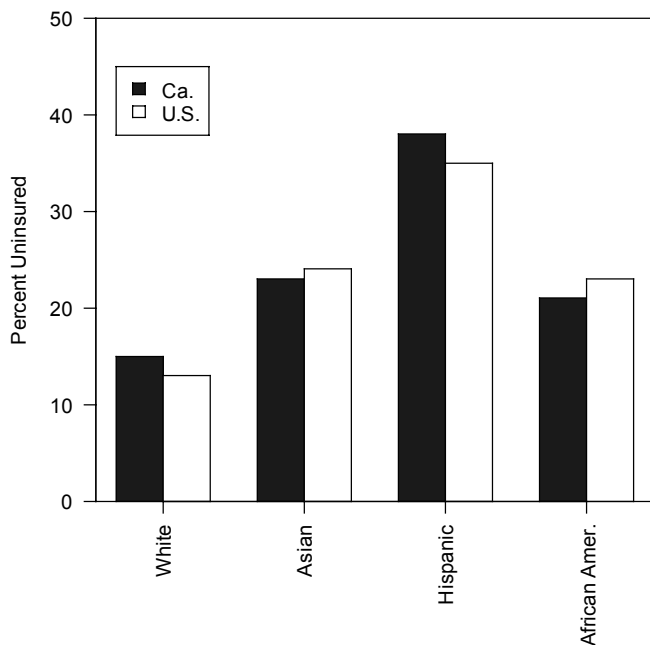
There are many aspects of the physical and social environment that impact people's health and well-being. An aspect of the physical environment for which we have monitoring data is air quality. The federal Clean Air Act directs the Environmental Protection Agency (EPA) to implement health based standards for certain air pollutants, including ozone, nitrogen oxide, and particulate matter (PM10). The ozone and nitrogen oxide standards were not exceeded over the last 3 years, but particulates exceeded the state standard (which is stricter than the federal standard) on 17 days over the 3 years (compared to 6 days exceeded in the previous 4 years). Particulate matter can make asthma and other respiratory problems worse. Major sources of particulates in the Bay Area include industrial emissions, motor vehicles, road dust, construction, demolition, and residential wood smoke.

Measure	Standard	1999		2000		2001	
		Date	No.	Date	No.	Date	No.
<b>OZONE</b>							
Maximum Hourly							
Days > state standard	.09 ppm*		0		0		0
Days > national standard	.12 ppm*		0		0		0
Highest 4 days measured	High	30-Sep	0.079	14-Jun	0.058	7-May	0.061
	2d high	10-Oct	0.070	17-Sep	0.055	30-May	0.061
	3d high	23-Oct	0.063	2-Apr	0.051	31-May	0.059
	4th high	26-Sep	0.061	1-Apr	0.049	11-Apr	0.051
Year's coverage			97		99		75
*(Days with 1 measurement greater than the state (0.09 parts per million) or national (0.12 ppm) standard)							
Daily 8-Hour Averages							
Days > national standard	.08 ppm		0		0		0
Highest 4 days measured	High	22-Oct	0.057	22-Apr	0.043	1-Apr	0.047
	2d high	30-Sep	0.056	2-Apr	0.042	10-Apr	0.047
	3d high	23-Oct	0.056	2-May	0.042	30-May	0.047
	4th high	5-Nov	0.050	27-Feb	0.041	15-Apr	0.046
Year's coverage			97		99		75
*(Days w. 1 8-hour period greater than the national 8-hour standard of 0.08 parts per million)							
<b>NITROGEN OXIDE</b>							
Days > state standard	.25 ppm*		0		0		0
Annual average			0.021		0.020		
Highest 4 days measured	High	30-Sep	0.103	19-Sep	0.074	20-Jun	0.073
	2d high	28-Sep	0.082	7-Dec	0.069	7-May	0.061
	3d high	20-Oct	0.082	12-Sep	0.069	5-Jan	0.059
	4th high	28-Dec	0.077	14-Jun	0.069	8-May	0.059
Year's coverage			97		99		32
*(Days w. 1 measurement greater than the state hourly standard of 0.25 parts per million)							
<b>PARTICULATES (PM10)</b>							
State standard	50 mcm*						
Days > standard (measured)**			6		2		5
Days > standard (calculated)**			36		12		24
Annual average			22.6		21.6		25.8
National standard	150 mcm*						
Days > standard (measured)			0		0		0
Days > standard (calculated)			0		0		0
Annual average			26.4		24		28.9
Highest 4 days measured	High	21-Oct	77.9	20-Dec	63.2	7-Jan	64.6
	2d high	26-Dec	69.4	7-Jan	53	18-Jun	56.4
	3d high	29-Jun	67.6	16-Aug	46.3	7-May	55.4
	4th high	15-Oct	59.8	8-Dec	43.9	1-Jan	54.8
Year's coverage			100		99		39
*(Days with a measurement greater than the standard, in micrograms per cubic centimeter (mcm). State and national averages differ because state calculates a geometric mean, and national uses arithmetic mean							
** (Measured days are those with actual measurements exceeding standards. Measurements typically collected every 6 days. Calculated days are expected number had measurements been taken daily.)							
Year's coverage shows percent of days with expected high pollutants that were actually monitored.							

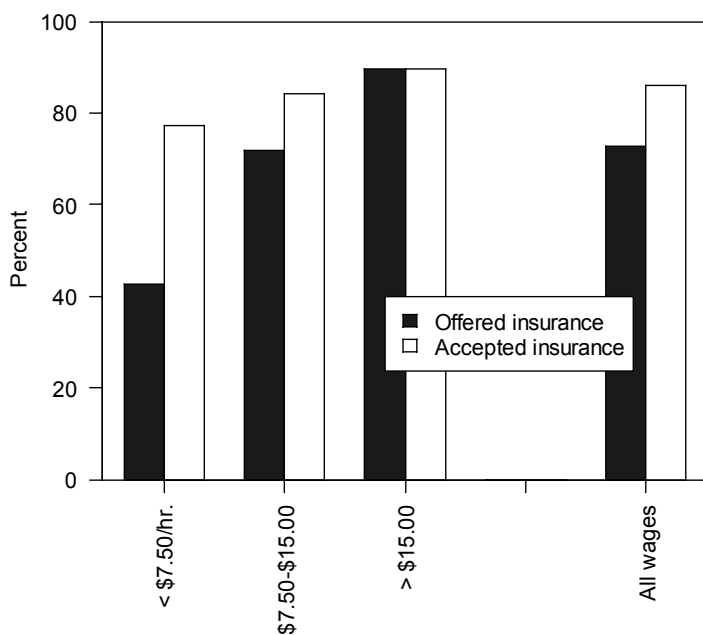
# Access to Health Care



**Percent Uninsured by Ethnicity,  
California and US, 1997-1999**



**Percent of Workers Offered and Accepting,  
Health Insurance by Wage Level, California, 1999**



## UNINSURED

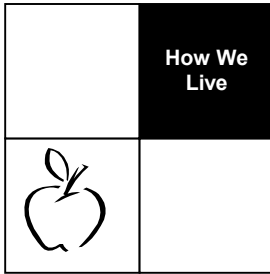
Access to health care services is a significant issue in San Francisco, as it is throughout California and the rest of the United States. Lack of access to preventive and ongoing health care services leads to higher rates of preventable disease and injuries and poorer health outcomes from illness and injury. A common indicator of access to health care services is the availability of health insurance.

It is estimated that about a quarter of our population is uninsured. Compared to other large metropolitan areas, ours has a higher proportion of uninsured, and a higher proportion of low-income people who are uninsured. The majority of residents without health insurance are employed (full or part-time) or are members of families with working adults.

Among low-income people, the uninsured were less likely to have a usual source of health care or to have seen a doctor in the past year. They were also more likely to have delayed or not gotten health care they thought they needed. The San Francisco metropolitan area was worse in each of these categories than the average for other metropolitan areas.

Generally in California, as in the rest of the US, whites have the lowest percent uninsured, African Americans and Asians have higher percents, and Hispanics have the highest percentage uninsured.

As the lower figure shows, lower income workers in California are much less likely to have insurance offered as a benefit through their employer. When it is offered, lower wage workers are also slightly less likely to accept it, probably due to the difficulty of affording co-payments. In San Francisco, those who are uninsured are likely to use the public health system which is available to them.

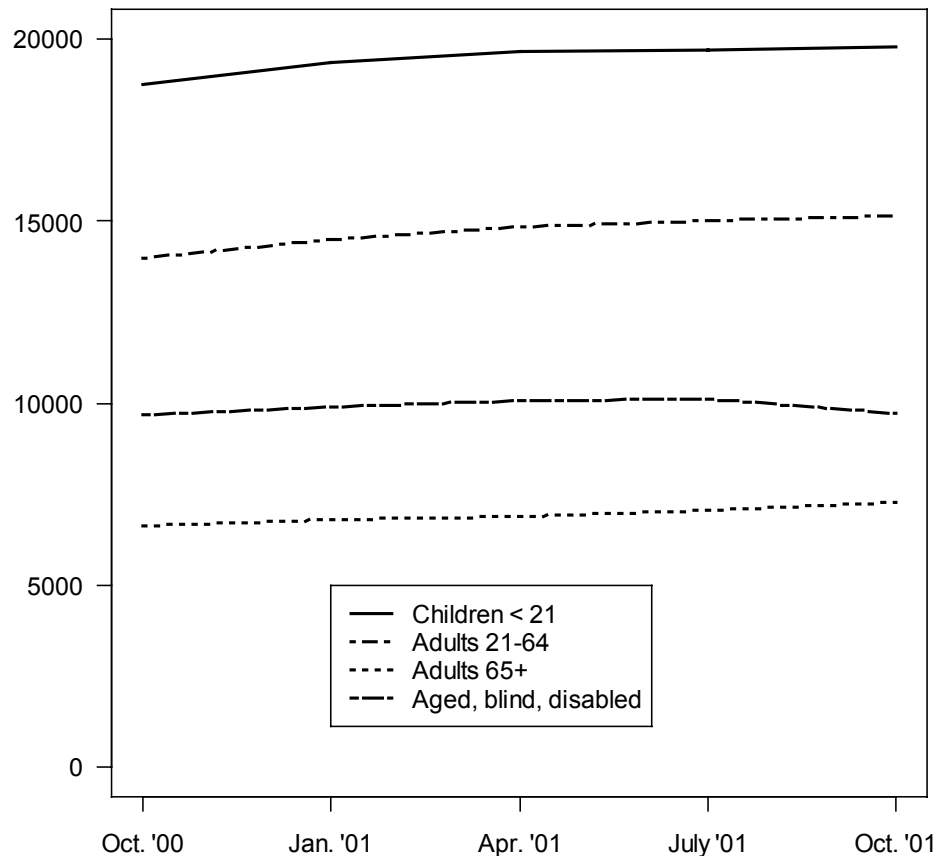


# Access to Health Care

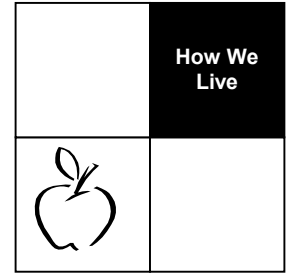
## MEDI-CAL

Although they are the smallest part of San Francisco's population (see "Who We Are"), children make up the largest proportion (by age) of the Medi-Cal population, here and throughout California. The program's eligibility rules have been developed over time to include a larger share of low-income children, but not adults. Because of Medi-Cal for children and Medicare for those over 65, non-elderly adults – a larger share of San Francisco's population than that of the rest of the state – generally have the highest uninsured rates. Over the year from October 2000 to October 2001, San Francisco enrollees of all ages increased: children under age 21 by 5.5%, adults 21-64 by 8%, and adults over 65 by 10%.

**San Franciscans Enrolled in Medi-Cal by Age and Condition, Oct. 2000-2001**

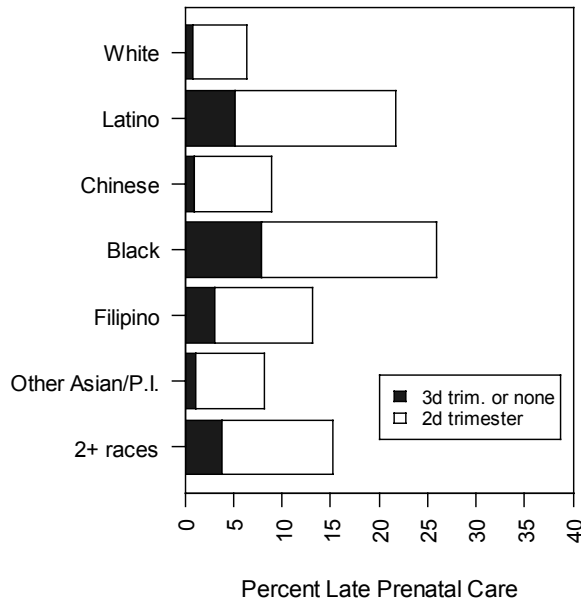






# Access to Health Care

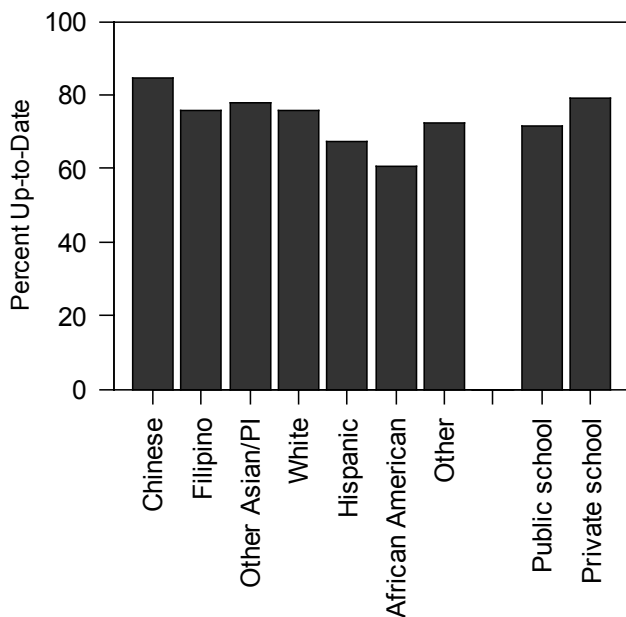
**Late Prenatal Care by Mother's Ethnicity, San Francisco, 2000**



### PRENATAL CARE

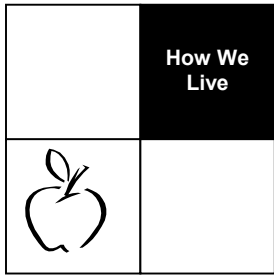
Pregnant women should begin prenatal care in the first trimester; later entry into care is generally associated with worse perinatal and infant health outcomes. African American women continue to have the lowest percentages of early prenatal care, although the 2000 percentages of late care are somewhat lower than those for 1999 for African American, Hispanic, and Filipino women—the three ethnicities with the highest 1999 late prenatal care percentages.

**Percent Up-to-Date on Immunizations at Age 2 by Ethnicity and School Type, San Francisco, 1999**



### IMMUNIZATIONS

The last expanded Kindergarten retrospective study of up-to-date immunizations for which data are now available, done in 1999, provide the results shown here. Data are only shown for groups with more than 100 children's records reviewed. Chinese children did slightly better and African American children slightly worse in terms of percents immunized. Percentages with up-to-date immunizations in 1999 in San Francisco were better than California levels, and also had improved over the 1996 survey, Citywide and for Hispanic and African American children.



# Access to Health Care

## DENTAL CARE

Access to dental care is important for good oral health, including screening for mouth and tongue cancer, and is also considered an indicator of general access to health care. In the absence of local data, these California data indicate an across the board need for increased access to and/or use of preventive dental services. There are disparities in such use, with the need greater the lower the income, education and age category, and among African Americans and Hispanics.

**Had Teeth Cleaned by Dentist or Hygienist Within Past Year, California 1999**

