DISCUSSION

Health insurance coverage was made HP2010 objective 1-1 for a reason: access to health and medical services – including clinical preventive care, primary care, and tertiary care – largely depends on whether a person has health insurance. As demonstrated in many recent research studies, California has had lower health insurance coverage rates than most all other states.[1-3] Add to this news from the U.S. Census Bureau that the number of people living in "extreme poverty" (i.e., subsisting on less than half the income defined by the Federal government as the poverty line) is higher than at any time since they began collecting data, along with recent data from the U.S. Department of Labor's Consumer Expenditures Survey that show that health care costs continue to rise, and information from a recent Kaiser Foundation survey showing that about five million fewer jobs now provide health insurance than just three years ago, and you have the ingredients for disaster in the future of California's health care safety net and for the health status of its most vulnerable and at-risk populations.[4-7]

Access to quality health care across the continuum of care is a key factor for mitigating the devastating effects diseases and injuries have on our population. Take heart disease for example, the leading cause of death among Californians. Success in reducing the burden of heart diseases is important for eliminating health disparities and for increasing the years of healthy life, and involves factors including blood pressure and cholesterol screenings, managing hypertension, health education on modifiable risks such as smoking and nutrition, and access to advanced medical technology used to treat cardiac events. The declines in the coronary heart disease death rates (Objective 12-1) and in hospitalization rates for congestive heart failure (Objective 12-6) in California continue, yet health insurance status constitutes a barrier to access for as many as six million Californians under the age of 65 who are uninsured. Over the years, funding for the California Healthcare for Indigents Program in 26 large California counties declined 85 percent from $163 million in FY 1997-98 to $24 million in FY 2006-07.[8] Much more needs to be done, and having the capability to examine heart disease data and other mortality and morbidity data by insurance status and/or socioeconomic status would do much toward increasing the power of these data to inform and direct public health policy and program practices.

Viewing California's progress in achieving HP2010 objectives in the context of poverty and health insurance coverage is only one way to examine these data. Another way to look at it is in the broader context of the sheer volume and demographic diversity of California's population. As the most populous and ethnically diverse state in the nation, California has a major influence on national health status statistics. In 2000 there were an estimated 34 million Californians, or about 12 percent of the total U.S. population - by the year 2050, there are projected to be 55 million Californians. We have roughly the same proportion of males and females, and California is home to one-third of the U.S. Hispanic or

Latino population and one-third of the U.S. Asian population. Nearly one-quarter of those in the U.S. who identify themselves as "multiracial" (i.e., choosing two or more races on the Census questionnaire) reside in California.[9] Currently we have a relatively young population, with a median age of 33.3 years and an average life expectancy of 79 years.[10] In 2000, 11 percent of all Californians were age 65 and older – by the year 2050, however, it is projected that 18 percent of all Californians will be age 65 and older.

Embedded in these demographic changes is a dramatic increase in the prevalence of chronic health conditions (e.g., heart disease, cancer, diabetes, asthma, obesity, arthritis, hypertension, depression). With the projected growth in California's population, the need for care for chronic diseases and conditions will undoubtedly continue to increase. For the current health care system to adequately meet the challenge of providing clinically appropriate and cost-effective care for the chronically ill, its resources must be balanced well enough to address the complex health care demands of an aging and ethnically diverse population.[11-12]

Evidence shows that gender and racial and ethnic disparities in health status exist across a wide range of diseases and conditions, and that these remain even after adjustments are made for socioeconomic differences and other factors related to health care.[13] Health care quality is an important independent variable contributing to health status for many at-risk populations. For example, racial and ethnic disparities in malignant neoplasm (cancer) death rates correspond with evidence that use of potentially life-saving cancer screening procedures varies dramatically depending on race and ethnicity.[14-16] How the interplay between health care system utilization factors and membership in a racial or ethnic group will impact California's capabilities for achieving HP2010 goals and objectives are unknown, but potentially knowable. Continued analyses of mortality, morbidity, and utilization data by race-ethnicity and by gender will contribute much to our knowledge and understanding of the strengths and weaknesses of California's health care delivery system.

Finally, if one takes the view that the past is prologue, then another perspective on the HP2010 data for California would take its form and substance from the *Healthy California 2000 Final Review* and its predecessor reports, as well as other reports showing how California ranked nationally and regionally in the achievement of the HP2000 objectives.[17-24] The California final review for 2000, which tracked the state's progress in achieving 149 of the national health objectives, showed that we were successful in meeting 25 (54%) of the 46 general objectives targeting the entire population and 57 (55%) of the 103 objectives targeting selected age, gender, and race/ethnic populations. Overall, California achieved objectives targeting reductions in deaths attributed to coronary heart disease, cancer, alcohol-related motor vehicle accidents, suicide, unintentional injuries, work-related injuries, and infant deaths. Objectives not achieved included reductions in deaths attributed to stroke, diabetes-related

conditions, and homicide, as well objectives targeting persons living in counties not meeting EPA Air Quality Standards (California ranked 51st nationally), measles cases (ranked 50th), health insurance (ranked 45th), Pap tests (ranked 42nd), early childhood vaccinations (ranked 38th), teen births (ranked 36th), and early prenatal care (ranked 31st). Regional variations within California are striking, with many counties experiencing mortality and morbidity rates that significantly exceed both the statewide average and those targeted by the national HP2010 objectives. For example, data for 2000-2002 showed that none of California's 58 counties were meeting the HP2010 objective for reductions in deaths caused by suicide – among counties with reliable rates, suicide death rates ranged from a low of 6.3 per 100,000 population (San Mateo County) to a high of 19.9 (Humboldt County).[25] As the third leading cause of death among males aged 10-14, 15-19, 20-24, and 25-34 years, and the fourth leading cause among females aged 15-19, 20-24, 25-34, and 35-44 years, research-based interventions afford an opportunity to achieve major reductions in the burdens associated with suicides.[26]

While objective statistical interpretations can provide a wealth of information about how California is doing relative to a national objective and about how one demographic group is doing compared with another, subjective evaluations of these data can add a valuable qualitative dimension to this analysis. Thoughtfully used, statistics are powerful tools for abstracting information from complex situations. Yet we recognize that statistics can and do have limitations. As abstractions, they can take us away from the realities of individual circumstances and particular cases. As explanatory devices, they do often confuse more than clarify.

The collection of documents presented in the *Healthy California 2010* reporting provides a useful framework for discussing critical issues and priorities for the future of public health in California. Balancing the quantitative and qualitative aspects of the data used for monitoring and tracking the HP2010 objectives is a challenge we all must face in making reasonable inferences from these data. To the extent possible, resources and references for obtaining additional information specific to California and specific to a Focus Area and to HP2010 objectives are provided throughout this report. Readers and users of the *Healthy California 2010* data are encouraged to explore these, as well as other sources of data and information, in their attempts to draw conclusions from them.[27]

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