

An understanding of the health status of a population is necessary to plan, implement, describe, and evaluate public health programs that control and prevent adverse health events. A 1988 Institute of Medicine committee,<sup>1</sup> in a report entitled, *The Future of Public Health* recommended that...

“...every public health agency regularly and systematically collect, assemble, analyze, and make available information on the health of the community, including statistics on health status, community health needs, and epidemiologic and other studies of health problems.”

Utah’s population is becoming increasingly diverse and many voices have expressed the need for health data on racial and ethnic populations in Utah. In addition, the United States has made elimination of health disparities one of its two overriding goals for the year 2010.<sup>2</sup> If we are to eliminate disparities, we must first identify and understand them. This report is an attempt to provide health status data on Utah’s racial and ethnic populations.

Health status has many dimensions and is measured in a variety of ways. This report used data from a variety of sources to provide as comprehensive a view of health status as possible. The core of the report was provided by the Healthy People 2000 health status indicators.<sup>3-7</sup> Those 18 health status indicators were developed as part of Healthy People 2000.<sup>4</sup> This report includes data on 16 of the 18 health status indicators.\* The report also examined leading causes of death by age group and sex, selected lifestyles and behaviors measured by the Behavioral Risk Factor Surveillance System, and life expectancy from birth.

The Healthy People 2000 Health Status indicators and other measures have been prepared for five racial and ethnic populations in Utah and for the overall Utah population. Recent national data by race and ethnicity are presented when available. The five population group designations examined in this report were American Indian, Asian/Pacific Islander, Black, Hispanic, and White. These were based on standard U.S. Census Bureau categories and on the ways that the data could be examined in the data sets used. In some cases, these designations group together population groups that may differ in health status as well as culturally and socioeconomically.

For a number of the indicators, it is difficult to obtain a precise measure of the indicator for individual racial and ethnic populations because their populations in Utah are small. To improve precision, data from several years have been combined. In addition, to indicate the precision of the results, we have included bars on the graphs indicating confidence intervals, which can be interpreted as the range in which we are 95 percent confident that the true rate lies. A narrow confidence interval (a small range) indicates that the result is based on a larger amount of data than one with a wide confidence interval (a large range). For example, the graph for infant mortality on page 3 shows a narrow confidence interval for Whites, which is a relatively large population in Utah, and a wide interval for Blacks, which is a much smaller population. The rate for Whites can be considered to have been more precisely measured than the rate for Blacks.

The narratives for the individual health status measures briefly describe the relationships among the rates for the racial and ethnic populations in Utah and also between Utah and national rates. The narratives were intended to identify the most important findings and not to be a comprehensive analysis of the data.

These results should be useful for all Utahns interested and involved in determining health policy for Utah. We hope they are useful and can be used by members of Utah's racial and ethnic populations. These results are only a first step, however. Improvements are needed in the data systems used for this report. In addition, special studies will be needed to fully describe the health of Utah's increasingly diverse population.

\* The indicator, proportion of persons living in counties exceeding U.S. Environmental Protection Agency standards for air quality during the previous year, uses air quality data that are collected at the county level. There was no way to analyze this indicator based on race and ethnicity; therefore, we have omitted the air quality indicator from this report. For the indicator, reported measles incidence, race/ethnicity was missing for about 40% of cases during 1993-1997 making meaningful analyses by race/ethnic population impossible.