NATIONAL CENTER FOR HEALTH STATISTICS DATA LINE

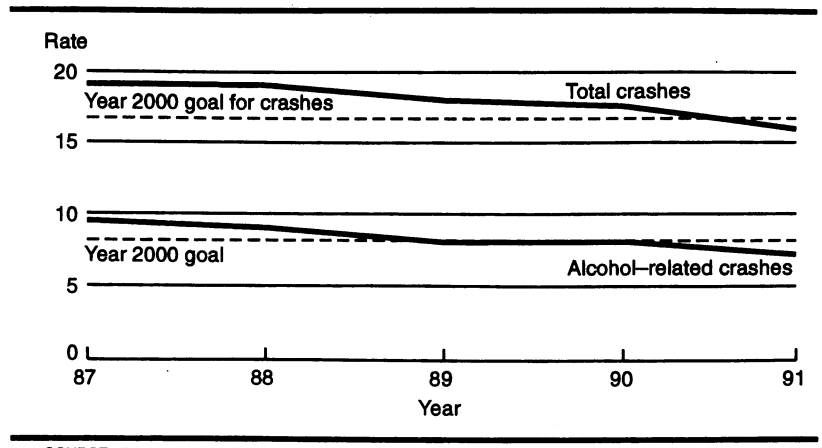
The most recent report card on the state of the nation's health shows continued progress against chronic disease and premature death, but serious shortcomings in progress toward many national health goals, including those to reduce disparities in the health of members of racial and ethnic minority groups.

"Health, United States, 1992," (*1*) the latest in a series of annual reports issued by the National Center for Health Statistics (NCHS), was published this year combined with "Healthy People 2000 Review," the first progress assessment of the Healthy People 2000 Program, a national effort to meet more than 300 national health objectives by the year 2000.

The assessment of the Healthy People 2000 Program shows progress in lowering the overall infant mortality rate and in reducing risk factors like smoking and high levels of blood cholesterol. However, it also shows either no progress or regressions in rates of homicide, receipt of early prenatal care, and low birth weight (less than 2,500 grams [g]), especially among black infants. The Public Health Service (PHS) coordinates the Year 2000 Program, which seeks to increase the span of healthy life, reduce disparities in health, and achieve equality in access to preventive health services.

NCHS is the Federal Government's principal vital and health statistics agency. NCHS data systems cover the health field from birth to death, including overall health status, lifestyle and exposure to unhealthy influences, the onset and diagnosis of illness and disability, and the use of health care. NCHS is part of PHS's Centers for Disease Control and Prevention.

Motor vehicle crash death rates per 100,000 population, United States, 1987–91



SOURCE: "Health, United States, 1992," Centers for Disease Control and Prevention, National Center for Health Statistics. Data from Department of Transportation, National Highway Traffic Safety Administration.

Health Status

The Health, U.S., series uses trend data to track health status during past decades and the latest statistics to examine current patterns. The new report shows the most notable progress in chronic disease and chronic disease risk factors. Among those findings are the following:

• Average life expectancy at birth increased by almost 2 years during the past decade and now stands at 75.7 years of age.

• During 1980–90, the age-adjusted death rate for heart disease, the leading cause of death for men and women, declined 25 percent, continuing the downward trend of the 1970s.

• Stroke, the third leading cause of death, dropped 32 percent during the 1980s.

• Key risk factors, such as rates of smoking and high levels of blood cholesterol, also improved. In 1991, as in 1990, about a quarter of adults were smokers, down from 37 percent in the mid-1970s. Policies that prohibit or severely restrict smoking in the workplace have more than doubled the proportion of smoke-free worksites with 50 employees or more, from 27 percent in 1985 to 59 percent in 1992.

• The population's blood cholesterol levels have declined during the past decade. Data for 1991 show that only 20 percent had high levels, compared with 26 percent a decade earlier, essentially reaching the Healthy People 2000 goal.

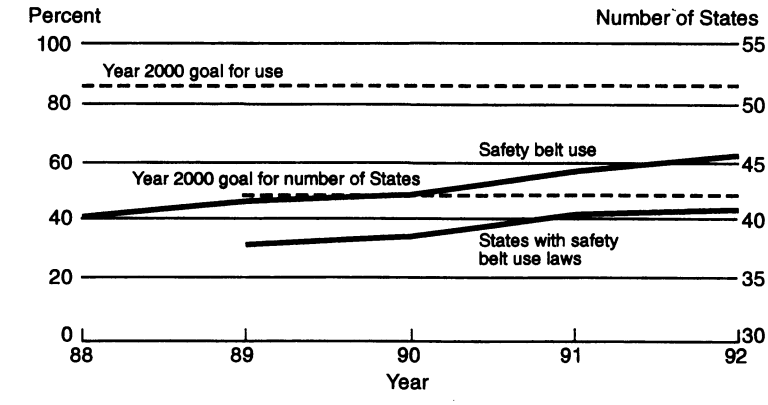
• The latest national data on health habits and risk factors show that about a quarter of adults exercise moderately five or more times a week, but only about 14 percent undertake vigorous physical activity. Worksite fitness programs may help, however, and in 1991, 83 percent of large companies had fitness programs for their employees.

• Deaths from motor vehicle crashes have declined, in part owing to an almost 20 percent drop in death rates for alcohol-related motor vehicle crashes in the period 1987–91 (figure 1). Increased use of seatbelts, which was up from 42 percent in 1988 to 62 percent in 1992, is an important factor in the decline in fatalities (figure 2). In 1992, 44 States had seatbelt use laws, compared with 33 States in 1989. Provisional data show that deaths from motor vehicle crashes continued to decline in 1992.

The report finds, however, that some serious health problems have not improved or have worsened. Homicide rates have increased since the mid-1980s, reflecting the rise in firearm-related deaths. The firearm death rate in 1990 was highest for those 15–24 years of age. The rate increased more for that age group than any other, up 50 percent during 1985–90. According to provisional data for 1991, the homicide rate has continued to rise. Homicide was the 10th leading cause of death in 1991.

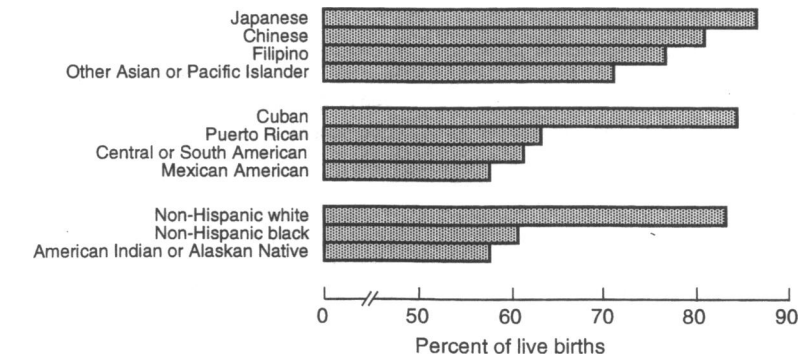
Several important indicators of maternal and child health showed setbacks or no improvement during the 1980s. Low birth weight, a significant

Use of safety belts by occupants of motor vehicles and number of States with laws on safety belt use, United States, 1988–91



SOURCE: "Health, United States, 1992," Centers for Disease Control and Prevention, National Center for Health Statistics. Data from National Health Interview Survey and the U.S. Department of Transportation, National Highway Traffic Safety Administration.

Rates of early prenatal care for pregnancies resulting in live births, by racial or ethnic group, United States, 1990



SOURCE: "Health, United States, 1992," Centers for Disease Control and Prevention, National Center for Health Statistics.

factor in infant mortality, generally was stable at about 7 percent of all births, but very low birth weight (less than 1,500 g) increased. For black infants, there was an 18 percent increase in very low birth weight, compared with a 6 percent increase for white infants during 1980–90. The rise in very low birth weight births paralleled the increase in preterm births (less than 37 weeks gestational age) during the past decade, as well as the continued rise in births to unmarried mothers and the recent jump in births to teenagers.

As in 1980, about a quarter of the women who gave birth in 1990 failed to receive prenatal care in the first 3 months of pregnancy. Differences existed by race and Hispanic origin in the percentages of mothers who receive prenatal care early. In 1990, only about 60 percent of Hispanic (except Cuban), American Indian, and non-Hispanic black mothers received care in the first trimester (figure 3). Early prenatal care reached about 80 percent among white mothers of Chinese, Japanese, Filipino, Cuban, and non-Hispanic descent. Unmarried or teenage mothers were the least likely to receive timely prenatal care. Teenage mothers, in addition, were more likely to gain too little weight during their pregnancies than were older mothers, another cause of very low birth weight.

In response to the growing interest in comparisons between health status in urban and in rural settings, the report shows age-adjusted death rates by urbanization (figure 4). Suburbs had the lowest death rates, rural counties were 12 percent higher, and large core metropolitan counties were 19 percent higher. Moreover, during 1980–90, death rates declined by 10 percent in the suburbs but only by half as much in the inner cities.

In a first-time analysis for the annual report, death rates were examined by education (figure 5). A strong relationship was shown between the level of education and death rates. Death rates during 1989–90 for men and women ages 25–44 years without a high-school education were about three times the rates for college graduates. Among middle-aged men and women there was about a two-fold difference. Education level may reflect increased awareness of, and ability to follow, health and medical advice, more favorable living circumstances, and better access to health care.

Regarding differences in risk of disease and death by race or ethnicity, Asian Americans were found to have the lowest death rates for many major causes of death, while blacks had higher death rates for many of those causes. For example, during 1988–90, Asians 45 years and older had the lowest age-adjusted death rate for heart disease, 290.1 per 100,000 population, about 25 percent lower than the rate for Hispanics and American Indians, close to half the rate for white persons, and 63 percent lower than that for blacks.

Age-adjusted death rates for cancer for American Indians, Asians, and Hispanics, ages 45 years and older, were similar, 265–278 per 100,000, and were considerably lower than the rates for whites (456.4) and for blacks (621.1).

The highest suicide rates within the 15–24-year age group were for American Indian youths, who also had the highest rates for motor vehicle crash-related deaths. During 1988–90, the motor vehicle crash-related death rate for American Indian youths ages 15–24 years (56.4 per 100,000) was 1.5 to 2.4 times the rate for white, Hispanic, or black youths, and more than 3 times the rate for Asian youth.

The highest homicide rates were reported for black teenagers and young adults. During 1988–90, the homicide rate for young black persons 15–24 years of age (67.6) was 2.5 to 3.6 times the rates for Hispanic or American Indian youths and 8 to 9 times the rates for white or Asian youths.

Health Care Utilization

The report shows strong national patterns in health care utilization,

health resources, and expenditures for health care. In 1991, slightly more than half of all surgery performed in short-stay hospitals was on an outpatient basis, three times the level in 1980. Since the mid-1980s, admissions to hospitals decreased by 8 percent, while outpatient visits grew by 38 percent. While the hospital discharge rate from non-Federal, short-stay hospitals declined by 4 percent during 1988–91, the discharge rate for persons with human immunodeficiency virus infection increased by 69 percent.

During 1980–91, the total number of short-stay hospital beds declined by 7 percent, with beds in State and local government hospitals experiencing the largest decline (20 percent). During 1980–86, beds in proprietary hospitals grew by 23 percent, followed by a 7 percent decline in the period 1986–91.

Community hospital resources and utilization vary substantially among the States. In 1990, the number of community hospital beds per 1,000 population ranged from 2.3 in Alaska to 7.0 in North Dakota. Community hospital occupancy rates ranged from 50 percent in Alaska to 86 percent in New York.

Health Professions

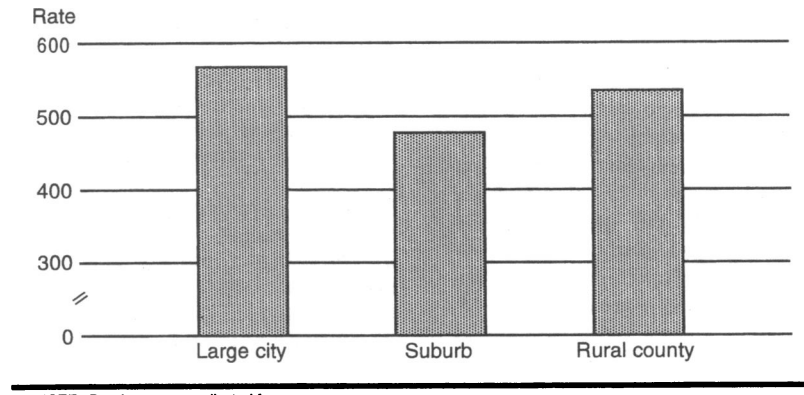
In 1990, primary care physicians (general and family practice, internal medicine, and pediatrics) accounted for 39 percent of all active non-Federal, office-based physicians. In the period 1985–90, the numbers of practicing general and family physicians, obstetricians and gynecologists, and internists each increased by 7–10 percent, while pediatricians increased by 18 percent, and general surgeons decreased by 1 percent.

After a 25 percent decline during 1985–89, the number of graduates with registered nurse (RN) degrees increased by 17 percent during 1989–91. In 1991, 27 percent of RN graduates received baccalaureate degrees, 65 percent received associate degrees, and 9 percent were graduates of diploma programs.

From 1980–81 to 1990–91, dental school enrollment declined by almost one-third to 16,000 students. During that period, enrollment by members of minority groups increased from 12 to 29 percent of dental students, primarily because of a 2.4-fold increase in the number of dental students of Asian descent. In 1990–91, 16 percent of dental students were Asian, 7 percent were Hispanic, and 6 percent were black.

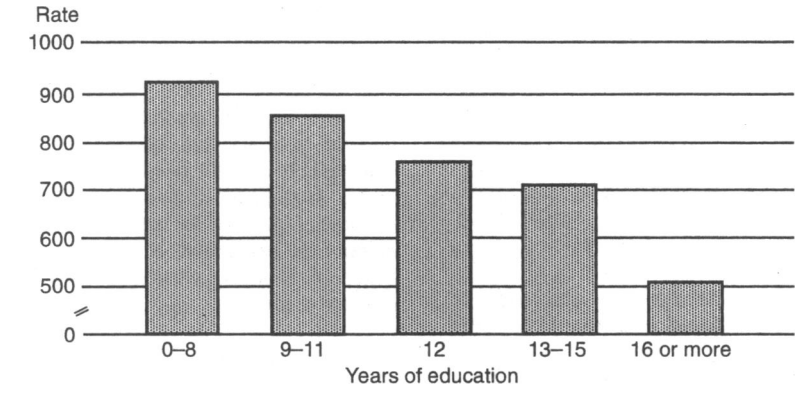
From 1980–81 to 1990–91, the proportion of female medical students increased from 27 to 37 percent. For the 1990–91 school year, about 56 percent of black medical students were female. The proportion of women students ranged from 35 to 39 percent for white, Asian, and Hispanic medical students.

Death rates per 100,000 population, by urbanization of residential setting, United States, 1989–90



NOTE: Death rates are adjusted for age.
SOURCE: "Health, United States, 1992," Centers for Disease Control and Prevention, National Center for Health Statistics.

Death rates per 100,000 population, persons 45–64 years old, by education, United States, 1989–90



SOURCE: "Health, United States, 1992," Centers for Disease Control and Prevention, National Center for Health Statistics.

Health Care Expenditures

In 1991, national expenditures for health care totaled $752 billion, equivalent to an average of $2,868 per person. Health expenditures comprised 13.2 percent of the gross domestic product (GDP) in 1991, up from 12.2 percent in 1990. GDP increased by 2.8 percent, but national expenditures for health care rose by 11.4 percent in 1990–91. Health spending in 1991 accounted for a larger share of GDP than in any other industrialized country, and the gap has been widening. Canada, the country with the second highest health share of GDP in 1991, devoted 10 percent of GDP to health.

In 1991, rising prices explained the largest portion (54 percent) of growth in personal health care expenditures. Nine percent of the growth was attributed to population increase and 37 percent to changes in the use or kinds of services and supplies.

Publication Notes

"Health, United States, 1992," 17th in the series submitted by the Secretary of Health and Human Services to the President and Congress, in compliance with Section 308 of the Public

Health Service Act, presents national trends in public health statistics. The new report contains 145 detailed tables organized around 4 major subject areas: health status and determinants, utilization of health resources, health care resources, and health care expenditures. Appendices describe each data source, provide references for further information, list alphabetically terms used in the report, describe population bases used for age adjustment, and provide information on diagnostic coding and procedures.

"Healthy People 2000 Review" is the first in a series of annual reports intended to profile the nation's health as an integral part of the Healthy People 2000 program. Future editions will be published separately from the Health, U.S. series and are to focus on specific topics, such as injury prevention, or on specific populations groups, such as racial or ethnic minority groups. The first report provides tracking data for many objectives and subobjectives in the 22 priority areas.

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NCHS publications and assistance in obtaining printed and electronic data products are available from the NCHS Scientific and Technical Information Branch, Room 1064, Hyattsville, MD 20782; tel. (301) 436–8500.

Copies of the 392-page combined report are offered for sale to the public by the Superintendent of Documents, U.S. Government Printing Office (GPO), Washington, DC 20402; stock no. 017–022–01218–9, price $29. A pocket version with highlights of the full report is available without charge from NCHS.

The combined report is available on diskette in two electronic formats. Ordering information is available from the Superintendent of Documents, (202) 783–3238, and the National Technical Information Service (NTIS), (703) 487–4650. The 145 detailed tables and index from "Health, United States, 1992," and tabular data for the 26 graphs from "Healthy People 2000 Review" are available for IBM-compatible personal computers. The tables are in Lotus 1–2–3 worksheet files. Lotus 1–2–3, version 2 or higher, or a program than can read Lotus spreadsheet (.WK1) files, such as Lotus Symphony, or Microsoft Excel, is required to use the files. The files are compressed. Installation of the tables requires 70 kilobytes of free memory, DOS 2.0 or higher, and 2 megabytes of hard disk space. Directions for decompression and copying are provided.

Ordering information for diskettes: 3.5-in. diskette, GPO stock no. 017–022–012148, price $15, NTIS order no. PB93–505410, price $45; 5.25-in. diskette, GPO stock no. 017–022–012154, price $15, NTIS order no. PB93–505428, price $45.

Text, charts, and tables of the combined report are available as a Folio Infobase from either GPO or NTIS. Keyword searches may be made using Folio Previews software, which is on the diskettes. Other functions of the software are printing, marking, and saving text as word processing files and saving tables as text files. Graphic files may be viewed in color, printed, and saved to view in graphics programs. Context help and tutorials are on the diskettes. To install those files, DOS 3.0 and 5 megabytes of free memory are required. Directions for use and a command card are provided with the diskettes. A Windows version of the folio diskette is planned.

Ordering information for the folio disk: 3.5-in. diskette, GPO stock no. 017–022–01217–1, price $14, NTIS order no. PB93–505436, price $65; 5.25-in. diskette, GPO stock no. 017–022–01216–2, price $12.50, NTIS order no. PB93–505444, price $65.

Reference

1. National Center for Health Statistics: Health, United States, 1992, and Healthy People 2000 review. DHHS Publication No. 93–1232. Centers for Disease Control and Prevention, Hyattsville, MD, 1993.