Data Science for Health United States 2013

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http://semanticommunity.info/Data_Science/Data_Science_for_Health_United_States_2013
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Does this persuade me that the claims and evidence are true?

- The Cover Page conveys the report is about Health Trends for the United States from the title and graphic.
- The Copyright Information says "All material, except certain quoted material, contained in this report is in the public domain and may be used and reprinted without special permission."
- This report does not have a Data Citation like the Force11 Data Citation, but could have.
- This report is produced by three government organizations: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, and National Center for Health Statistics.
- This is the 37th report on the health status of the nation and is submitted by the Secretary of the Department of Health and Human Services to the President and the Congress of the United States in compliance with Section 308 of the Public Health Service Act.
- The National Committee on Vital and Health Statistics served in a review capacity.
- The Preface clearly states the principal contents:
  - National trends in health statistics: See At a Glance Table,
  - Chartbook: See Chartbook With Special Feature on Prescription Drugs,
  - Special Feature on Prescription Drugs: See Special Feature on Prescription Drugs,
  - 135 Trend Tables: See Trend Tables, List of Trend Tables, and Trend Tables to choose from, and
  - A companion product—Health, United States: In Brief, and related data products.

I was able to add links to each of these above, except for Health, United States: In Brief because it is a 44 page PDF subset of the full report (which it links to and I find awkward) and the "related data products" which I am not sure of because there are multiple possibilities.

I had to explore the report PDF and web pages before I could make these statements with confidence.

In the broader context, this is the third of a three part activity as follows:

- A Hack-a-Thon, but with a Scraper Wiki (MindTouch) to produce a detailed Wiki Table of Contents and multiple Spreadsheet Tables for Spotfire analytics (Data Science for the HHS IDEALAB);
- A Code-a-Palooza, but without Code using Spotfire so a very large relational database (Health Datapalooza V Medicare Claims) can be used all in memory for Spotfire analytics; and
- A Meetup to mentor and train data scientists and others in creating a series of Data Publications in Data Browsers starting with Health United States 2013 (this Story)

Now I assume the PDF version of Health United States 2013 is the most authoritative version because the end product is the print and PDF versions, not a "data publication in a data browser". So the challenge is put the PDF online in such a way that serves both functions.

There is some help from the online content with Web pages that link to the figures and tables in PDF, PowerPoint, and Excel that I used below in place of the PDF contents for those for the List of Chartbook Figures and List of Trend Tables in the Table of Contents.

My inclination is to start with the PDF Table of Contents to create the initial structured content and then start populating the structure from the front and the back to the middle. I find that the back (usually Appendices) contain some of the most valuable information for data publications because they are all about the data, in this case: Appendix I. Data Sources and Appendix II. Definitions and Methods. Working with the Appendices, I can see that Appendix I. Data Sources

http://semanticommunity.info/Data_Science/Data_Science_for_Health_United_States_2013
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Sources is the metadata for the "data ecosystem" and Appendix II. Definitions and Methods is the data dictionary at the meta-level and the individual columns in the spreadsheets are the data dictionary at the element-level.

Next, I want to build the "data ecosystem", which in this case will be "a spreadsheet of the spreadsheets" for the 135 spreadsheets, of which 29 have figures, from the List of Trend Tables and List of Chartbook Figures, respectively.

Finally, I want to create a "data publication in a data browser" example for each unique feature of the Health United States 2013 like the At-a-Glance "big table" and Chart Book "data stories".

I noticed that the PDF Navigation Side-bar is confusing to use because of the overall hierarchy is not a simple Table of Contents and not every item in the hierarchy you click on goes to a separate page. PDF is definitely not a "data publication in a data browser". In addition, the page numbers in the PDF Table of Contents are not the Page Numbers of the PDF Pages. For example: The Appendix Contents says Appendix I. Data Sources is on Page 385 but it actually is Page 399 in the PDF file. How is one to properly cite the metadata and the data? There must be a better solution and there is.

There are also many details involved in copying the PDF content to MindTouch that are both art and content science like: assigning levels, chunking into paragraphs, spell checking for run-together words, etc. Sometimes on needs to edit at the markup level which MindTouch easily supports by switching from Normal-View to Source-View mode.

I want to look at every PDF page, but only reproduce one example of each section for brevity at the stage of the process of making a "data publication in a data browser".

I should also mention the importance of introducing <br> markup into the editing and using Google Chrome Find to locate and eliminate them with few exceptions. I want to pick on of the most difficult tables to show that MindTouch (and I) can deal with them. Their was only one Figure in the Appendix which I did a Snapshot of, copied to PowerPoint (or Microsoft Draw works as well), and saved it with a file name that identifies it. One I attached PDF, PNG, etc. files to the MindTouch wiki, I can move them to another page like I did with the main PDF and Cover Page Graphic in this case. Well you cannot see me move them, but trust me I did and it worked!

I have been at this for a couple of hours now and need to break for lunch. Actually, I have not been doing this full time for a couple of hours because I have had email and phone calls that interrupted me, but I was able to come right back and pick up where I left off because I am an organized person! Next I need to deal with the "data stories" and "data ecosystem". That should take me a while longer. I wonder how long it took all the authors and contributors to produce that PDF file that I am having so much fun dissecting and perfecting.

After lunch, I reviewed my work and found considerable room for improvement in organization and purpose from actually re-reading the report and paying more attention to the content than I did when first organizing and copying it to MindTouch. I think I see how to make the flow of the report more logical and integrated into a data publication. The key is the integration of the data stories and the data tables that is made possible by the on-line technologies being used than with the PDF file format and its essentially non-web browser. It is hard for me to see at this stage how a PDF file can be a data publication in a data browser on the web.

As I was working to populate the At A Glance Table and Highlights section I found Highlights for Health Insurance Coverage was omitted from the Contents. Certainly this does not mean that the "claims and evidence are not true",
just that human error is found in PDF reports that need to be corrected and can be more easily corrected in on-line versions as the authoritative source. MindTouch captures the versioning that occurs in the authoring and revision process.

MORE TO FOLLOW

Slides

Slide 1 CDC HUS 2013 Web Site

http://www.cdc.gov/nchs/hus.htm

Slide 2 MindTouch Knowledge Base

http://semanticommunity.info/Data_Science/Data_Science_for_Health_United_States_2013
Slide 3 Excel Spreadsheet

http://semanticommunity.info/api/deki/files/29426/HHSIDEALAB.xlsx?origin=mt-web

Slide 4 Cover Page

Web Player
Slide 6 Table 18

Slide 7 Table 100
Slide 8 Data Ecosystem

Spotfire Dashboard

For Internet Explorer Users and Those Wanting Full Screen Display Use: Web Player Get Spotfire for iPad App

Media, iframe, embed and object tags are not supported inside of a PDF.

Research Notes

Health United States 2013
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Suggested citation
National Center for Health Statistics.

Library of Congress Catalog Number 76–641496
For sale by Superintendent of Documents
U.S. Government Printing Office Washington, DC 20402

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Preface

*Health, United States, 2013* is the 37th report on the health status of the nation and is submitted by the Secretary of the Department of Health and Human Services to the President and the Congress of the United States in compliance with Section 308 of the Public Health Service Act. This report was compiled by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS). The National Committee on Vital and Health Statistics served in a review capacity.

The *Health, United States* series presents an annual overview of national trends in health statistics. The report contains a Chartbook that assesses the nation's health by presenting trends and current information on selected measures of morbidity, mortality, health care utilization and access, health risk factors, prevention, health insurance, and personal health care expenditures. This year's Chartbook includes a Special Feature on Prescription Drugs. The report also contains 135 Trend Tables organized around four major subject areas: health status and determinants, health care utilization, health care resources, and health care expenditures. A companion product—*Health, United States: In Brief*—features information extracted from the full report. The complete report, In Brief, and related data products are available on the *Health, United States* website at: [http://www.cdc.gov/nchs/hus.htm](http://www.cdc.gov/nchs/hus.htm).

The 2013 Edition

*Health, United States, 2013* contains a summary At a Glance table that displays selected indicators of health and their determinants, cross-referenced to charts and tables in the report. This is followed by a Highlights section, a Chartbook, detailed Trend Tables, two detailed Appendixes, and an Index. The major sections of the 2013 report are described below.

**Chartbook**

The 2013 Chartbook contains 29 charts, including 10 charts on this year's Special Feature on Prescription Drugs (Figures 20–29). This Special Feature provides an overview of prescription drug use in the United States. Data are presented on the number and classes of drugs used by Americans. Access problems—those who did not receive needed prescription drugs in the past 12 months due to cost—are presented by insurance and poverty status. The impact of specific groups of drugs used to control chronic disease (i.e., antiretrovirals to treat HIV disease and antidepressant drugs) is presented. Quality issues are examined by looking at the misuse of antibiotics to treat cold symptoms, deaths from misuse of opioid analgesic drugs, and the adoption by providers of electronic health record systems, which are designed to improve safety. And finally, the growth in national spending on prescription drugs is shown.

**Trend Tables**

The Chartbook is followed by 135 detailed Trend Tables that highlight major trends in health statistics. Comparability across editions of Health, United States is fostered by including similar Trend Tables in each volume, and timeliness is maintained by improving the content of tables to reflect key topics in public health. An important criterion used in selecting these tables is the availability of comparable national data over a period of several years.
Appendixes

Appendix I. Data Sources describes each data source used in *Health, United States* and provides references for further information about the sources. Data sources are listed alphabetically within two broad categories: Government Sources, and Private and Global Sources.

Appendix II. Definitions and Methods is an alphabetical listing of selected terms used in *Health, United States*. It also contains information on the statistical methodologies used in the report.

Index

The Index to the Trend Tables and figures is a useful tool for locating data by topic. Tables and figures are cross-referenced by such topics as child and adolescent health; older population aged 65 and over; women's health; men's health; state data; American Indian and Alaska Native, Asian, black or African American, and Hispanic-origin populations; education; injury; disability; and metropolitan and nonmetropolitan data. Many of the Index topics are also available as conveniently grouped data packages on the *Health, United States* website.

Data Considerations

Racial and Ethnic Data

Many tables in *Health, United States* present data according to race and Hispanic origin, consistent with a department-wide emphasis on expanding racial and ethnic detail when presenting health data. Trend data on race and ethnicity are presented in the greatest detail possible after taking into account the quality of the data, the amount of missing data, and the number of observations. These issues significantly affect the availability of reportable data for certain populations, such as the Native Hawaiian and Other Pacific Islander population and the American Indian and Alaska Native population. Standards for the classification of federal data on race and ethnicity are described in an appendix (See Appendix II, Race).

Education and Income Data

Many Trend Tables in *Health, United States* present data according to socioeconomic status, using education and family income as proxy measures. Education and income data are generally obtained directly from survey respondents and are not usually available from records-based data collection systems. (See Appendix II, Education; Family income; Poverty.)

Disability Data

Disability can include the presence of physical or mental impairments that limit a person's ability to perform an important activity and affect the use of or need for support, accommodation, or intervention to improve functioning. Information on disability in the U.S. population is critical to health planning and policy. Several initiatives are currently under way to coordinate and standardize the measurement of disability across federal data systems. *Health, United States, 2009* introduced the first detailed Trend Table using data from the National Health Interview Survey to create disability measures consistent with two of the conceptual components that have been identified in disability models and legislation: basic actions difficulty and complex activity limitation. Basic actions difficulty captures limitations or difficulties in movement and sensory, emotional, or mental functioning that are associated with a health problem. Complex activity...
limitation describes limitations or restrictions in a person’s ability to participate fully in social role activities such as working or maintaining a household. Health, United States, 2010 expanded the use of these measures to many of the tables from the National Health Interview Survey. Health, United States, 2013 includes the following disability-related information for the civilian noninstitutionalized population: basic actions difficulty and complex activity limitation (Tables 49, 53, and 54), vision and hearing limitations for adults (Tables 50 and 51), and disability-related information for Medicare enrollees (Table 129), Medicaid recipients (Table 130), and veterans with service-connected disabilities (Table 132). For more information on disability statistics, see Altman and Bernstein (1).

**Statistical Significance**

All statements in the text describing differences, or lack thereof, in estimates indicate that statistical testing was performed. Differences between two point estimates were determined to be statistically significant at the 0.05 level using two-sided significance tests (z tests). In the text, the standard terminology used when a difference between two point estimates was tested is, “Between (estimate 1) and (estimate 2).” For example, the statement ‘Between 2011 and 2012’ indicates that the difference between the point estimate for 2011 and that for 2012 was tested for statistical significance.

The statistical significance of a time trend was assessed using weighted least squares regression applied to data for all years in the time period. (For a description of the trend testing technique, see the Technical Notes that follow the Chartbook.) The terminology used in the text to indicate testing of a trend is “During (time period 1) through (time period 2).” For example, the statement “During 2002 through 2012” indicates that a statistical test of trend was conducted that included estimates for all 11 years in the time period. Because statistically significant differences or trends are partly a function of sample size (i.e., the larger the sample, the smaller the change that can be detected), statistically significant differences or trends do not necessarily have public health significance (2).

Terms such as “similar,” “stable,” and “no difference” indicate that the statistics being compared were not significantly different. Lack of comment regarding the difference between statistics does not necessarily suggest that the difference was tested and found to not be significant.

Overall estimates generally have relatively small standard errors, but estimates for certain population subgroups may be based on small numbers and have relatively large standard errors. Although numbers of births and deaths from the Vital Statistics System represent complete counts (except for births in those states where data are based on a 50% sample for selected years) and are not subject to sampling error, the counts are subject to random variation, which means that the number of events that actually occur in a given year may be considered as one of a large series of possible results that could have arisen under the same circumstances. When the number of events is small and the probability of such an event is small, considerable caution must be observed in interpreting the conditions described by the estimates. Estimates that are unreliable because of large standard errors or small numbers of events are noted with an asterisk. The criteria used to designate or suppress unreliable estimates are indicated in the table footnotes.

For NCHS surveys, point estimates and their corresponding variances were calculated using the SUDAAN software package (3), which takes into consideration the complex survey design. Standard errors for other surveys or data sets were computed using the methodology recommended by the programs providing the data or were provided directly by those programs. Standard errors are available for selected tables in the spreadsheet version on the Health, United States website at: [http://www.cdc.gov/nchs/hus.htm](http://www.cdc.gov/nchs/hus.htm).
**Accessing Health, United States**

*Health, United States* can be accessed in its entirety at: [http://www.cdc.gov/nchs/hus.htm](http://www.cdc.gov/nchs/hus.htm). The website is a user-friendly resource for *Health, United States* and related products. In addition to the full report, the website contains the In Brief companion report in PDF format. Also found on the website are data conveniently organized and grouped by topic. The Chartbook figures are provided as PowerPoint slides, and the Trend Tables and Chartbook data tables are provided as spreadsheet files and individual PDFs. Many spreadsheet files include additional years of data not shown in the printed report, along with standard errors where available. Spreadsheet files for selected tables will be updated on the website when new data are available. Visitors to the website can join the Health, United States e-mail list ([http://www.cdc.gov/nchs/hus/hus_elec...ic_mailing.htm](http://www.cdc.gov/nchs/hus/hus_elec...ic_mailing.htm)) to receive announcements about release dates and notices of table updates. Previous editions of *Health, United States*, and their Chartbooks, can also be accessed from the website.


**Questions?**

If you have questions about *Health, United States* or related data products, please contact:

Office of Information Services  
Information Dissemination Staff  
National Center for Health Statistics  
Centers for Disease Control and Prevention  
3311 Toledo Road, Room 5419  
Hyattsville, MD 20782  
Phone: 1–800-CDC-INFO (1–800–232–4636)  
TTY: 1–888–232–6348  
Internet: [http://www.cdc.gov/nchs](http://www.cdc.gov/nchs)  
Online request form: [http://www.cdc.gov/cdc-info/requestform.html](http://www.cdc.gov/cdc-info/requestform.html)  
For e-mail updates on NCHS publication releases, subscribe online at: [http://www.cdc.gov/nchs/govdelivery.htm](http://www.cdc.gov/nchs/govdelivery.htm).

**References**

1


2

Acknowledgments

Overall responsibility for planning and coordinating the content of this volume rested with the National Center for Health Statistics’ (NCHS) Office of Analysis and Epidemiology, under the direction of Julia S. Holmes and Irma E. Arispe.

Production of *Health, United States, 2013*, including highlights, trend tables, and appendixes, was managed by Sheila J. Franco, Virginia M. Freid, and Julia S. Holmes. Trend tables were prepared by Mary Ann Bush, La-Tonya D. Curl, Anne K. Driscoll, Catherine R. Duran, Sheila J. Franco, Virginia M. Freid, Nancy Han, Hashini S. Khajuria, Ji-Eun Kim, Xianfen Li, Naga Shanmugam, and Rashmi Tandon, with assistance from Anita L. Powell and Ilene B. Rosen. The index was assembled by Anita L. Powell. Review and clearance books were assembled by Ilene B. Rosen. Administrative and word processing assistance was provided by Lillie C. Featherstone.

Production of the *Chartbook* was managed by Sheila J. Franco and Virginia M. Freid. The Special Feature on Prescription Drugs was prepared and written by Sheila J. Franco. Data and analysis for specific charts were provided by Sheila J. Franco, Virginia M. Freid, Hashini S. Khajuria, and Ji-Eun Kim. Charts were drafted by La-Tonya D. Curl. Technical assistance and programming were provided by Mary Ann Bush, La-Tonya D. Curl, Catherine R. Duran, Xianfen Li, Nancy Han, and Rashmi Tandon.

Publication production was performed by CDC/OSELS/ NCHS/OD/Office of Information Services, Information Design and Publishing Staff (IDPS). Project management and editorial review were provided by Barbara J.Wassell. Graphic design was provided by Dorothy M. Day, Odell D. Eldridge (contractor), and Kyung M. Park. Layout and production were done by Jacqueline M. Davis and Zung T. Le. Overview for IDPS publications and electronic products was provided by Christine J. Brown, Kimberly N. Ross, and Tommy C. Seibert, Jr. Printing was managed by Nathanael Brown, CDC/OD/ OADC.

Electronic access through the NCHS website was provided by Christine J. Brown, La-Tonya D. Curl, Jacqueline M. Davis, Virginia M. Freid, Elom L. Lawson, Zung T. Le, Anthony Liphardt, Kyung M. Park, Anita L. Powell, Anthony R. Quintana, Sharon L. Ramirez, Ilene B. Rosen, Naga Shanmugam, and Barbara J.Wassell.

Data and technical assistance were provided by staff of the following NCHS organizations: Division of Health Care Statistics: Michael Albert, Carol J. DeFrances, Chun-Ju Hsiao, Eric Jamoom, Linda F.McCaig, SusanM. Schappert, and Sayeedha Uddin; Division of Health and Nutrition Examination Surveys: Namanjeet Ahluwalia, Margaret D. Carroll, Mark S. Eberhardt, Qiuping Gu, Brian K. Kit, Cynthia L.Ogden, Ryne Paulose-Ram, and Sung Sug (Sarah)Yoon; Division of Health Interview Statistics: Patricia F. Adams, Veronica E. Benson, Debra Blackwell, Barbara Bloom, Tainya Clarke, Robin A. Cohen, Gulnur Freeman, Lindsey Jones, Whitney Kirzinger, Jacqueline Lucas, Michael Martinez, Jeannine Schiller, Charlotte A. Schoenborn, and Brian W.Ward; Division of Vital Statistics: Robert N. Anderson, Elizabeth Arias, Sally C. Curtin, Brady Hamilton, Sharon E. Kirmeyer, Kenneth D. Kochanek, Marian MacDorman, Joyce A.Martin, T.J. Mathews, Sherry L. Murphy, Michelle Osterman, Marie Thoma, Stephanie J. Ventura, Margaret Warner, and Elizabeth Wilson; Office of Analysis and Epidemiology: Lara Akinbami, Li-Hui Chen, Catherine R. Duran, Holly Hedegaard, Deborah D. Ingram, Laura A. Pratt, Cheryl V. Rose, Alan Simon, Ritu Tuteja, and Sirin Yaemsiri; Office of
Policy, Budget, and Legislation: Andrea MacKay; Office of the Center Director: Juan Albertorio and Francis C. Notzon; and Office of Research and Methodology: Meena Khare.

Additional data and technical assistance were provided by the following organizations of the Centers for Disease Control and Prevention (CDC): National Center for Chronic Disease Prevention and Health Promotion: Karen Pazol; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: Anna Satcher Johnson and Rachel SternWynn; Office of Public Health Scientific Services, Center for Surveillance, Epidemiology, and Laboratory Services: Ruth Ann Jajosky; National Institute for Occupational Safety and Health: Roger Rosa; by the following organizations within the Department of Health and Human Services: Agency for Healthcare Research and Quality: Roxanne Andrews, Kellyn Carper, David Kashihara, and Steven R. Machlin; Centers for Medicare & Medicaid Services: Mary Carol Barron, Joseph Benson, Aaron Catlin, Cathy Cowan, Maria Diacogiannis, Bridget Dickensheets, Nathan Espinosa, Micah Hartman, Deborah W. Kidd, Barbara S. Klees, David Lassman, Anne Martin, Maggie S. Murgolo, Arun Natarajan, Jason G. Petroski, Joseph F. Regan, Benjamin E. Washington and Lekha Whittle; National Institutes of Health: Brenda Edwards, Missy Jamison, and Marsha Lopez; Substance Abuse and Mental Health Services Administration: Joe Gfroerer and Beth Han; and by the following governmental and nongovernmental organizations: U.S. Census Bureau: Bernadette D. Proctor; Bureau of Labor Statistics: Christen Byler and Audrey Watson; Department of Veterans Affairs: Tom Garin, Pheakdey Lim, and Dat Tran; American Association of Colleges of Pharmacy: Jennifer M. Patton; American Association of Colleges of Osteopathic Medicine: Lindsey Jurd; American Association of Colleges of Podiatric Medicine: Kelly Foster and Moraiith G. North; American Dental Education Association: Sylvia M. Zeno; Association of American Medical Colleges: Geoffrey Redden; Association of Schools and Colleges of Optometry: Joanne Zuckerman; Association of Schools of Public Health: Kristin C. Dolinski; Cowles Research Group: C. McKee Cowles; and NOVA Research Company: Shilpa Bengeri.

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Source: [http://www.cdc.gov/nchs/hus/contents...artbookfigures](http://www.cdc.gov/nchs/hus/contents...artbookfigures)

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- [PPT - 279 KB]
- [PDF - 299 KB]
- [XLS - 310 KB]

Figure 2. Infant, neonatal, and postneonatal mortality rates: United States, 2000-2010


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**Figure 3.** Age-adjusted death rates for selected causes of death for all ages, by sex: United States, 2000-2010

**Figure 4.** Motor vehicle-related death rates among persons aged 15-24, by sex and age: United States, 2000-2010

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[PDF - 299 KB] [XLS - 310 KB]

Table 73. No usual source of health care among adults aged 18-64, by selected characteristics: United States, average annual, selected years 1993-1994 through 2011-2012

[PDF - 299 KB] [XLS - 310 KB]

Table 74. Delay or nonreceipt of needed medical care, nonreceipt of needed prescription drugs, or nonreceipt of needed dental care during the past 12 months due to cost, by selected characteristics: United States, selected years 1997-2012

[PDF - 299 KB] [XLS - 310 KB]

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[PDF - 299 KB]  [XLS - 310 KB]

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[PDF - 299 KB]  [XLS - 310 KB]

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- [PDF - 299 KB]
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Table 100. Hospital admissions, average length of stay, outpatient visits, and outpatient surgery, by type of ownership and size of hospital: United States, selected years 1975-2011

- [PDF - 299 KB]

Table 100. Hospital admissions average length of stay, outpatient visits, and outpatient surgery, by type of ownership and size of hospital: United States, selected years 1975–2011

[Data are based on reporting by a census of hospitals]

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---Data not available.
1 The category of nonfederal hospitals comprises psychiatric, tuberculosis and other respiratory diseases hospitals, and long-term and short-term general and other special hospitals. See Appendix II, Hospital.
2 Community hospitals are nonfederal short-term general and special hospitals whose facilities and services are available to the public. See Appendix II, Hospital.
3 Average length of stay is calculated as the number of inpatient days divided by the number of admissions. See Appendix II, Average length of stay.
4 Outpatient visits include visits to the emergency department, outpatient department, referred visits (pharmacy, EKG, radiology), and outpatient surgery. See Appendix II, Outpatient visit.
5 Total surgeries is a measure of patients with at least one surgical procedure. Persons with multiple surgical procedures during the same outpatient visit or inpatient stay are counted only once. See Appendix II, Outpatient surgery.

Personnel

Table 101. Active physicians and physicians in patient care, by state: United States, selected years 1975-2011

[PDF - 299 KB]

Table 102. Doctors of medicine, by place of medical education and activity: United States and outlying U.S. areas, selected years 1975-2011

[PDF - 299 KB]

Table 103. Doctors of medicine in primary care, by specialty: United States and outlying U.S. areas, selected years 1949-2011

[PDF - 299 KB]

Table 104. Active dentists, by state: United States, selected years 1993-2011

[PDF - 299 KB]

Table 105. Healthcare employment and wages, by selected occupations: United States, selected years 2001-2012

[PDF - 299 KB]
[XLS - 310 KB]

Table 106. First-year enrollment and graduates of health professions schools, and number of schools, by selected profession: United States, selected academic years 1980-1981 through 2010-2011

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Facilities

Table 107. Hospitals, beds, and occupancy rates, by type of ownership and size of hospital: United States, selected years 1975-2011

Table 108. Community hospital beds and average annual percent change, by state: United States, selected years 1970-2011

Table 109. Occupancy rates in community hospitals and average annual percent change, by state: United States, selected years 1970-2011

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Table 111. Medicare-certified providers and suppliers: United States, selected years 1975-2011
Health Care Expenditures and Payors

National Health Expenditures

Table 112. Gross domestic product, national health expenditures, per capita amounts, percent distribution, and average annual percent change: United States, selected years 1960-2011

[PDF - 299 KB] [XLS - 310 KB]

Table 113. Consumer Price Index and average annual percent change for all items, selected items, and medical care components: United States, selected years 1960-2012

[PDF - 299 KB] [XLS - 310 KB]

Table 114. National health expenditures, average annual percent change, and percent distribution, by type of expenditure: United States, selected years 1960-2011

[PDF - 299 KB] [XLS - 310 KB]

Table 115. Personal health care expenditures, by source of funds and type of expenditure: United States, selected years 1960-2011

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Table 116. Cost of hospital discharges with common hospital operating room procedures in nonfederal community hospitals, by age and selected principal procedure: United States, selected years 2000-2011

[PDF - 299 KB]

[XLS - 310 KB]

Table 117. Expenses for health care and prescribed medicine, by selected population characteristics: United States, selected years 1987-2010

[PDF - 299 KB]

[XLS - 310 KB]

Table 118. Sources of payment for health care, by selected population characteristics: United States, selected years 1987-2010

[PDF - 299 KB]

[XLS - 310 KB]

Table 119. Out-of-pocket health care expenses among persons with medical expenses, by age: United States, selected years 1987-2010

[PDF - 299 KB]

[XLS - 310 KB]

Table 120. Expenditures for health services and supplies and percent distribution, by sponsor: United States, selected years 1987-2011

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Table 121. Employers’ costs per employee-hour worked for total compensation, wages and salaries, and health insurance, by selected characteristics: United States, selected years 1991-2013

Health Care Coverage and Major Federal Programs

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Table 123. Private health insurance coverage obtained through the workplace among persons under age 65, by selected characteristics: United States, selected years 1984-2012

Table 124. Medicaid coverage among persons under age 65, by selected characteristics: United States, selected years 1984-2012
Table 125. No health insurance coverage among persons under age 65, by selected characteristics: United States, selected years 1984-2012

[PDF - 299 KB] [XLS - 310 KB]

Table 126. Health insurance coverage of noninstitutionalized Medicare beneficiaries aged 65 and over, by type of coverage and selected characteristics: United States, selected years 1992-2011

[PDF - 299 KB] [XLS - 310 KB]

Table 127. Medicare enrollees and expenditures and percent distribution, by Medicare program and type of service: United States and other areas, selected years 1970-2012

[PDF - 299 KB] [XLS - 310 KB]

Table 128. Medicare enrollees and program payments among fee-for-service Medicare beneficiaries, by sex and age: United States and other areas, selected years 1994-2012

[PDF - 299 KB] [XLS - 310 KB]

Table 129. Medicare beneficiaries, by race, Hispanic origin, and selected characteristics: United States, selected years 1992-2010

[PDF - 299 KB]
Table 130. Medicaid beneficiaries and payments, by basis of eligibility, and race and Hispanic origin: United States, selected fiscal years 1999-2010

Table 131. Medicaid beneficiaries and payments, by type of service: United States, selected fiscal years 1999-2010

Table 132. Department of Veterans Affairs health care expenditures and use, and persons treated, by selected characteristics: United States, selected fiscal years 1970-2012

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- [PDF - 299 KB]
- [XLS - 310 KB]

Table 135. Persons without health insurance coverage, by state: United States, average annual, 2003-2005 through 2010-2012

- [PDF - 299 KB]
- [XLS - 310 KB]

At a Glance Table and Highlights

At a Glance Table

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<th>Value (year)</th>
<th>Value (year)</th>
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<td>Life Expectancy, in years</td>
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<td>At birth</td>
<td>At birth 76.8 (2000)</td>
<td>78.5 (2009)</td>
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<td>Infant deaths per 1,000 live births</td>
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<td>All infants</td>
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<td>Deaths per 100,000 population, age-adjusted</td>
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Updated: Sat, 19 Sep 2015 01:46:15 GMT
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<td>Cancer</td>
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<td>Chronic lower respiratory diseases</td>
<td>44.2</td>
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<td>Stroke</td>
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<td>Influenza and pneumonia</td>
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<td>Suicide</td>
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<td>Morbidity and Risk Factors</td>
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<td>Fair or poor health, percent</td>
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<td>All ages</td>
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<td>Heart disease (ever told), percent</td>
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<td>11.3</td>
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<td>Cancer (ever told), percent</td>
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<td>Hypertension, 1 percent</td>
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Table 52

Table 44

Table 64
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<td><strong>High serum total cholesterol, 2 percent</strong></td>
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Table 64

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Figure 10/Table 64

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<td>12.1</td>
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<td>6–11 years</td>
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<td>12–19 years</td>
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<td><strong>Cigarette smoking, percent</strong></td>
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Table 56

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<td>14.9</td>
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<td>15.1</td>
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<td>65 years and over</td>
<td>7.4</td>
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Tables 86 and 87
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<th>Year 3</th>
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<td>17.6</td>
<td>18.2</td>
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Dental visit in past year, percent

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<td>65 years and over</td>
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Prescription drug in past 30 days, percent

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<th>Year 3</th>
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<td>24.0</td>
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<td>18–44 years</td>
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<td>45–64 years</td>
<td>54.8</td>
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<td>66.2</td>
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<tr>
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Hospitalization in past year, percent

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<th>Year 3</th>
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<td>6.1</td>
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<tr>
<td>45–64 years</td>
<td>8.4</td>
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<td>8.0</td>
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<tr>
<td>65 years and over</td>
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Health Insurance and Access to Care

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<td>7.0</td>
<td>6.6</td>
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<td>Under 18 years</td>
<td>22.4</td>
<td>25.4</td>
<td>24.8</td>
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<td>19–25 years</td>
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<tr>
<td>Age Group</td>
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<td>2011</td>
<td>2012</td>
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<td>---------------------</td>
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<tr>
<td>45–64 years</td>
<td>12.6</td>
<td>15.4</td>
<td>15.6</td>
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<td>Delayed or did not</td>
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<td>receive needed</td>
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<td>medical care in</td>
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<tr>
<td>past 12 months due</td>
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<tr>
<td>to cost percent</td>
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<td>Under 18 years</td>
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**Health Care Resources**

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<td>population 4</td>
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<td>41.1 (MA)</td>
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<thead>
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<th>Resource</th>
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<th>Lowest State</th>
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<td>6.0 (ND)</td>
<td>1.9 (NM, NV, OR, UT, WA)</td>
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<td>population 5</td>
<td>2.6 (2010)</td>
<td>5.1 (ND)</td>
<td>1.7 (OR, WA)</td>
</tr>
<tr>
<td></td>
<td>2.6 (2011)</td>
<td>5.0 (SD)</td>
<td>1.7 (WA)</td>
</tr>
</tbody>
</table>

**Expenditures**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Total, in trillions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditures</td>
<td>$1.2 (2000)</td>
</tr>
<tr>
<td>Personal healthcare expenditures,</td>
<td>$2.2 (2010)</td>
</tr>
<tr>
<td>in dollars</td>
<td>$2.3 (2011)</td>
</tr>
</tbody>
</table>

Table 74

Table 101

Table 108

Table 115

1 Having measured high blood pressure (systolic pressure of at least 140 mm Hg or diastolic pressure of at least 90 mm Hg) and/or respondent report of taking antihypertensive medication.

2 Having high serum total cholesterol of 240 mg/dL or greater.

3 Obesity is a body mass index (BMI) greater than or equal to 30. Height and weight are measured rather than self-reported.

4 Copyright 2013. Used with permission of the American Medical Association.

5 Copyright 2013. Used with permission of Health Forum LLC, an affiliate of the American Hospital Association.

NOTES: Some estimates shown in this table are not shown in the PDF or printed versions but can be found in the spreadsheet version of the cited tables. For more information and the spreadsheet version of the tables, see the complete report, Health, United States, 2013, available from: http://www.cdc.gov/nchs/hus.htm.

Highlights

Life Expectancy and Mortality

In 2010, life expectancy at birth in the United States for the total population was 78.7 years—76.2 years for males and 81.0 years for females (Table 18).

Between 2000 and 2010, life expectancy at birth increased 2.1 years for males and 1.7 years for females. The gap in life expectancy between males and females narrowed from 5.2 years in 2000 to 4.8 years in 2010 (Table 18).

Between 2000 and 2010, life expectancy at birth increased more for the black than for the white population, thereby narrowing the gap in life expectancy between these two racial groups. In 2000, life expectancy at birth for the white population was 5.5 years longer than for the black population; by 2010, the difference had narrowed to 3.8 years (Table 18).

Between 2000 and 2010, the infant mortality rate decreased 11%, from 6.91 to 6.15 deaths per 1,000 live births. In 2000, the infant mortality rate for white mothers was 5.68, compared with 14.09 for black mothers; by 2010 the infant mortality rate declined to 5.20 among white mothers and 11.63 among black mothers (Table 13).

Between 2000 and 2010, the age-adjusted heart disease death rate decreased 30%, from 257.6 to 179.1 deaths per 100,000 population. In 2010, 24% of all deaths in the United States were from heart disease (Tables 22 and 26).

Between 2000 and 2010, the age-adjusted cancer death rate decreased 13%, from 199.6 to 172.8 deaths per 100,000 population. In 2010, 23% of all deaths in the United States were from cancer (Tables 22 and 28).
Fertility and Natality

Between 2002 and 2012, the birth rate among teenagers aged 15–19 fell 31%, from 42.6 to 29.4 live births per 1,000 females—a record low for the United States (Table 3).

The percentage of low-birthweight births [infants weighing less than 2,500 grams (5.5 pounds) at birth] was 7.99% in 2012, down 3% since 2006 when it was 8.26% (Table 6).

Health Risk Factors

Children

Between 2003–2004 and 2011–2012, the prevalence of obesity among children aged 2–5 years decreased from 14.0% to 8.4% (Table 64 and Figure 10).

The prevalence of obesity among children aged 6–11 was stable between 2003–2004 and 2011–2012. In 2011–2012, 17.7% of children aged 6–11 were obese (Table 64 and Figure 10).

In 2011–2012, 20.5% of adolescents aged 12–19 were obese, which was not significantly different from the prevalence in 2003–2004 (Table 64 and Figure 10).

In 2011, 15.8% of students in grades 9–12 seriously considered suicide, and the percentage was higher among female students (19.3%) than among male students (12.5%) (Table 62).

Adults

In 2012, 20.3% of adults aged 18 and over met the 2008 federal physical activity guidelines for both aerobic activity and muscle strengthening (Table 68).

Between 1988–1994 and 2009–2012, the percentage of adults aged 20 and over with grade 1 obesity [a body mass index (BMI) of 30.0–34.9] increased from 14.8% to 20.4%. Those with grade 2 obesity (BMI of 35.0–39.9) rose from 5.2% to 8.6%, and those with grade 3 or higher obesity (BMI of 40 or higher) doubled, from 3.0% to 6.3% (percentages are age-adjusted) (Table 69).

In 2012, 18.1% of adults aged 18 and over were current cigarette smokers, a decline from 2000 (23.2%). Men were more likely than women to be current cigarette smokers (20.5% compared with 15.8%) in 2012 (Table 56).

Measures of Health and Disease Prevalence

In 2010–2012, 5.5% of children under age 18 had an asthma attack in the past year, and 5.2% had a food allergy (Table 41).

Among children aged 5–17, 9.9% had attention deficit hyperactivity disorder and 5.8% had serious emotional or behavioral difficulties in 2010–2012 (Table 41).
In 2012, the percentage of noninstitutionalized adults who reported their health as fair or poor ranged from 6.4% of those aged 18–44 to 26.6% of those aged 75 and over (Table 52).

In 2012, 26.2% of noninstitutionalized adults aged 18–64 reported a disability (defined as any basic actions difficulty or complex activity limitation), compared with 58.7% of those aged 65 and over (Table 49).

In 2011–2012, among noninstitutionalized adults aged 75 and over, 43.5% of men and 31.5% of women had ever been told by a physician or other health professional that they had heart disease (Table 44 and Figure 6).

In 2011–2012, among noninstitutionalized adults aged 75 and over, 24.7% of men and 19.3% of women had ever been told by a physician or other health professional that they had cancer (excluding squamous and basal cell skin cancers) (Table 44).

In 2009–2012, nearly one-half (47%) of adults aged 20 and over with hypertension continued to have uncontrolled high blood pressure (Table 65 and Figure 9).

Health Care Utilization

Use of Health Care Services

In 2012, 15.7% of persons had no health care visits in the past year, 47.3% had 1–3 health care visits, 24.0% had 4–9 visits, and 13.1% had 10 or more visits. Health care visits for illness, preventive care, or an injury include visits to see a health care provider at physician offices, emergency departments, clinics or some other place, and home visits by health care professionals (Table 78).

In 2011, there were 126 million visits to hospital outpatient departments and 136 million visits to hospital emergency departments (Table 89).

In 2012, 82.3% of children aged 2–17 years, 61.6% of adults aged 18–64, and 61.8% of adults aged 65 and over had visited a dentist in the past year (Table 91).

The percentage of the population taking at least one prescription drug during the past 30 days increased from 39.1% in 1988–1994 to 47.5% in 2007–2010. During the same period, the percentage taking three or more prescription drugs rose from 11.8% to 20.8%, and the percentage taking five or more drugs more than doubled, from 4.0% to 10.1% (percentages are age-adjusted) (Table 92 and Figure 20).

Use of Preventive Medical Care Services

In 2012, 68% of children aged 19–35 months had completed a combined series of childhood vaccinations (at least 4 doses of diphtheria/tetanus/pertussis vaccine, 3 doses of polio vaccine, 1 dose of measles-containing vaccine, 3 or 4 doses of Haemophilus influenzae type b vaccine depending on product type, 3 doses of hepatitis B vaccine, 1 dose of varicella vaccine, and 4 doses of pneumococcal conjugate vaccine) (Table 79).
In 2012, 37.7% of noninstitutionalized adults aged 18 and over had received an influenza vaccination in the past year. Influenza vaccination increased with age, with 26.3% of those aged 18–49, 42.8% of those aged 50–64, and 66.5% of those aged 65 and over reporting an influenza vaccination in the past year (Table 81 and Figure 12).

In 2012, 59.9% of noninstitutionalized adults aged 65 and over ever had a pneumococcal vaccination (Table 82 and Figure 12).

**Nonreceipt of Needed Medical Care, Prescription Drugs, and Dental Care Due to Cost**

Between 2002 and 2012, among adults aged 18–64, the percentage who reported not receiving or delaying seeking needed medical care due to cost in the past 12 months increased from 9.7% to 13.3%. The percentage not receiving needed prescription drugs due to cost increased from 7.6% to 9.4%, and the percentage not receiving needed dental care due to cost grew from 10.4% to 14.8% (Table 74).

In 2012, 33.0% of adults aged 18–64 who were uninsured during the past 12 months did not get or delayed seeking needed medical care due to cost in the past 12 months, compared with 6.6% of adults aged 18–64 who were insured continuously during the past 12 months (Table 74).

**Health Care Resources**

In 2011, there were 26.1 physicians in patient care per 10,000 population in the United States. The number of patient care physicians per 10,000 population ranged from 17.7 in Idaho to 41.1 in Massachusetts and 68.3 in the District of Columbia (Table 101).

In 2011, the United States had 4,973 community hospitals and 797,403 community hospital beds. Community hospital occupancy averaged 64.3% in 2011, similar to the level in 2010 (Table 107).

In 2012, there were 15,673 certified nursing homes with 1,703,213 nursing home beds. Nursing home occupancy averaged 81.2% in 2012. Nursing home occupancy ranged from 60.0% in Oregon to 91.9% in Rhode Island and 94.1% in the District of Columbia (Table 110).

**Health Care Expenditures and Payers**

**Health Care Expenditures**

In 2011, personal health care expenditures in the United States totaled $2.3 trillion, a 4.1% increase from 2010. The average per capita personal health care expenditure for the total U.S. population was $7,326 in 2011 (Table 112).

Expenditures for hospital care accounted for 31.5% of all national health care expenditures in 2011. Physician and clinical services accounted for 20.0% of the total, prescription drugs for 9.7%, and nursing care facilities and continuing care retirement communities for 5.5% (Table 114).

In 2011, prescription drug expenditures totaled $263 billion, a 2.9% increase from 2010 (Table 114).

In 2011, the average cost for the entire hospitalization involving a heart valve procedure was $53,282, a coronary artery
bypass graft procedure was $38,707, cardiac pacemaker insertion or replacement was $33,194, and spinal fusion was $27,570 (Table 116).

**Health Care Payers**

In 2011, 34.5% of all personal health care expenditures were paid by private health insurance, 22.9% were paid by Medicare and 16.4% by Medicaid; consumers paid 13.5% out of pocket; and the remainder was paid by other types of insurance, payers, and programs (Table 115).

In 2010, children under age 21 accounted for 48.3% of Medicaid recipients but only 19.8% of Medicaid expenditures. Aged, blind, and persons with disabilities accounted for 20.8% of Medicaid recipients and 62.8% of Medicaid expenditures (Table 130).

In 2012, the Medicare program had 50.7 million enrollees and expenditures of $574.2 billion, up from $549.1 billion the previous year. Expenditures for the Medicare drug program (Part D) were $66.9 billion in 2012 (Table 127).

**Health Insurance Coverage**

*My Note: This section was omitted in the Contents (page IX in he PDF)*

Between 2002 and 2012, the percentage of the population under age 65 with private health insurance obtained through the workplace declined from 65.3% to 56.9% (Table 123).

In 2012, 6.6% of children under age 18 and 20.9% of adults aged 18–64 had no health insurance coverage (public or private) at the time of interview (Table 125).

Between 2002 and 2012, among children in families with income just above the poverty level (100%–199% of poverty), the percentage of uninsured children under age 18 dropped from 17.0% to 10.4%, while the percentage with coverage through Medicaid or the Children’s Health Insurance Program (CHIP) increased from 38.6% to 57.3% (Tables 124 and 125).

Between 2010 and 2012, the percentage of adults aged 19–25 who were uninsured decreased from 33.8% to 26.3% (Table 125 and Figure 15).

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**Chartbook With Special Feature on Prescription Drugs**

**Mortality**

**Life Expectancy at Birth**

*My Note: Link goes to Web Page: [http://www.cdc.gov/nchs/hus/contents2013.htm#fig01](http://www.cdc.gov/nchs/hus/contents2013.htm#fig01) It could be internal to this page and be faster! I could reproduce the left-most and right-most grapha from Table 18 reformatted for Spotfire.*
The gap in life expectancy at birth between white persons and black persons persists but has narrowed since 1990.

Life expectancy is a measure often used to gauge the overall health of a population. Between 1980 and 2010, life expectancy at birth in the United States increased from 70.0 years to 76.2 years for males and from 77.4 years to 81.0 years for females. Racial disparities in life expectancy at birth persisted for both males and females in 2010 but have narrowed since 1990 (1). Life expectancy at birth was 8.2 years longer for white males than for black males in 1990, and 4.7 years longer for white males than for black males in 2010. In 1990, life expectancy at birth was 5.8 years longer for white females than for black females; by 2010, life expectancy at birth was 3.3 years longer for white females than for black females. In 2010, Hispanic males and females had longer life expectancy at birth than non-Hispanic white or non-Hispanic black males and females.

NOTE: Life expectancy by Hispanic origin was available starting in 2006.

SOURCE: CDC/NCHS, Health, United States, 2013, Table 18. Data from the National Vital Statistics System (NVSS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2013.htm#fig01

Infant Mortality

Selected Causes of Death

Motor Vehicle-related Death Rates

Natality
Teenage Childbearing

Morbidity

Heart Disease Prevalence

Disability Measures

Basic Actions Difficulty and Complex Activity Limitation

Health Risk Factors

Current Cigarette Smoking

Uncontrolled High Blood Pressure

Obesity Among Children

Overweight and Obesity Among Adults

Prevention

Influenza and Pneumococcal Vaccination

Vaccination Coverage Among Adolescents Aged 13–17

Health Insurance

Coverage Among Adults Aged 18–64

Coverage Among Adults Aged 19–25

Utilization and Access

Emergency Department Use
Usual Source of Care Among Children

Delay or Nonreceipt of Medical Care or Nonreceipt of Dental Care Due to Cost

Personal Health Care Expenditures

Major Source of Funds

Special Feature on Prescription Drugs

Introduction

Prescription Drug Use

Prescription Drug Use by Drug Class

Polypharmacy

Nonreceipt of Needed Prescription Drugs

Due to Cost

Deaths from HIV Disease

Use of Antidepressants

Antibiotics Prescribed for Colds

Computerized Systems for Prescription Drugs

Deaths Involving Opioid Analgesics

Spending on Prescription Drugs

Data Tables for Special Feature
Technical Notes

My Note: Need to add links?

Data Sources and Comparability

Data for the Health, United States, 2013 Chartbook come from many surveys and data systems and cover a broad range of years. Detailed descriptions of the data sources included in the Chartbook are provided in Appendix I. Additional information clarifying and qualifying the data are included in the table notes and in Appendix II. Definitions and Methods.

Data Presentation

Many measures in the Chartbook are shown for people in specific age groups because of the strong effect of age on most health outcomes. Some estimates are age-adjusted using the age distribution of the 2000 standard population; where this has been done, it is noted in the data tables that accompany the charts. Age-adjusted rates are computed to eliminate differences in observed rates that result from age differences in population composition (see Appendix II, Age adjustment). For some charts, data years are combined to increase sample size and the reliability of the estimates. Some charts present time trends, and others focus on differences in estimates among population subgroups for the most recent time point available. Trends are generally shown on a linear scale to emphasize absolute differences over time. The time trends for the overall mortality measures are shown on a logarithmic (log) scale to emphasize the rate of change and to enable measures with large differences in magnitude to be shown on the same chart. Point estimates and standard errors for Figures 1–19 are available in the Trend Table and Excel spreadsheet specified in the Note below the chart. Data tables with point estimates and standard errors (when appropriate) accompany Figures 20–29. Some data tables contain additional data that were not graphed because of space considerations.

Statistical Testing

Data trends can be described in many ways. For trend analyses presented in the Chartbook, increases or decreases in the estimates over time are measured by the annual percent change using the weighted least squares regression method. Statistically significant changes in the trend are assessed at the 0.05 level using the National Cancer Institute’s Joinpoint software. For more information on Joinpoint, see: http://surveillance.cancer.gov/joinpoint/. For analyses that compare two time periods, differences between the two periods were assessed for statistical significance at the 0.05 level using two-sided significance tests (z-tests).

Terms such as “similar,” “stable,” and “no difference” used in the text indicate that the statistics being compared were not significantly different. Lack of comment regarding the difference between statistics does not necessarily suggest that the difference was tested and found to be not significant. Because statistically significant differences or trends are partly a function of sample size (the larger the sample, the smaller the change that can be detected), they do not necessarily have public health significance (81)). Testing and comparisons use the estimates and standard errors in the trend and data tables, not the rounded estimates shown in the charts.
Overall estimates generally have relatively small sampling errors, but estimates for certain population subgroups may be based on small numbers and have relatively large sampling errors. Numbers of deaths obtained from the National Vital Statistics System represent complete counts and therefore are not subject to sampling error. They are, however, subject to random variation, which means that the number of events that actually occur in a given year may be considered as one of a large series of possible results that could have arisen under the same circumstances. When the number of events is small and the probability of such an event is small, considerable caution must be observed in interpreting the conditions described by the charts. Estimates that are unreliable because of large sampling errors or small numbers of events have been noted with an asterisk. The criteria used to designate or suppress unreliable estimates are indicated in the notes to the applicable tables or charts.

For NCHS surveys, point estimates and their corresponding variances were calculated using the SUDAAN software package, which takes into consideration the complex survey design (82). Standard errors for other surveys or data sets were computed using the methodology recommended by the programs providing the data, or were provided directly by those programs.

### Survey Questions and Coding

Additional information on data used in the Special Feature, including exact wording of questions and coding schemes, is detailed below.

Figures 20–22 and 25. The National Health and Nutrition Examination Survey (NHANES) questionnaire administered to all participants included a question on whether they had taken a prescription drug in the past 30 days [RXDUSE]. Those who answered “yes” were asked to show the interviewer the medication containers for all the prescriptions. For each drug reported, the interviewer entered the product's complete name from the container. If no container was available, the interviewer asked the participant to verbally report the name of the drug. Only prescriptions the respondent themselves took are included. Prescriptions administered in other health care settings, such as physician offices and hospital outpatient departments, are not collected. Over-the-counter drugs play an important role in health care, but most of the analysis in this feature focuses only on prescription drugs.

More information on prescription drug data collection and coding in NHANES is available from: [http://www.cdc.gov/nchs/nhanes/nhanes1999-2000/RXQ_DRUG.htm](http://www.cdc.gov/nchs/nhanes/nhanes1999-2000/RXQ_DRUG.htm). Also see Appendix I, National Health and Nutrition Examination Survey; Appendix II, Drug. Figure 21. Data are from NHANES and are based on prescription drugs the respondent reported taking in the past 30 days. For each drug reported, the interviewer entered the product's complete name from the container and the drug was categorized into therapeutic classes. Drug classes cited are from Lexicon Plus (Cerner Multum, Denver, CO), a proprietary comprehensive database of all prescription and some nonprescription drug products available in the U.S. drug market.

- The category antiasthmatics includes one or more asthma drugs, including bronchodilators, mast cell stabilizers, inhaled corticosteroids, mucolytics, inhaled antiinfectives, leukotriene modifiers, and antiasthmatic combinations (level 2, class 125, 130, 131, or 243).
- The category antibiotics includes one or more antibiotic drugs, including antituberculosis agents, cephalosporins, leprostatics, macrolide derivatives, miscellaneous antibiotics, penicillins, quinolones, sulfonamides, tetracyclines, urinary anti-infectives, aminoglycosides, lincomycin derivatives, and glycopeptide antibiotics (level 2, class 6, 8–18, 240, 315, or 406).
• The category central nervous system stimulants includes one or more central nervous system stimulants (level 2, class 71).
• The category analgesics includes one or more analgesic drugs (level 2, class 58).
• The category antidepressants includes one or more antidepressant drugs (level 2, class 249).
• The category cardiovascular agents includes one or more cardiovascular agents, agents for hypertensive emergencies, ACE inhibitors, peripherally acting antiadrenergic agents, centrally acting antiadrenergic agents, antianginal agents, antiarrhythmic agents, calcium channel blocking agents, diuretics, inotropic agents, miscellaneous cardiovascular agents, peripheral vasodilators, vasodilators, vasopressors, angiotensin II inhibitors, agents for pulmonary hypertension, aldosterone receptor antagonists, renin inhibitors, anticholinergic agents, and catecholamines (level 1, class 40).
• The category cholesterol-lowering drugs includes one or more antihyperlipidemic drugs (level 2, class 19).
• The category anti-acid reflux drugs includes one or more proton pump inhibitors or H2 antagonists (level 2, class 94 or 272).
• The category antidiabetic agents includes one or more antidiabetic drugs (level 2, class 99).
• The category anticoagulants includes one or more anticoagulants or antiplatelet agents (level 2, class 82 or 83).

Figure 23. Data are from National Health Interview Survey and are based on adults responding to the question, “During the past 12 months was there any time when you needed prescription medicine but didn't get it because [person] couldn't afford it?” [AHCAFYR1]. Survey respondents may be covered by health insurance at the time of interview but may have experienced one or more lapses in coverage during the 12 months prior to interview. To be consistent with the 12-month period used to determine prescription drug access issues, insurance status during the prior 12 months was used. Insurance status during the prior 12 months was determined using two questions: (a) all persons without a known comprehensive health insurance plan were asked, “About how long has it been since [person] last had health care coverage?” [HILAST]; and (b) all persons with known health insurance coverage were asked, “In the past 12 months, was there any time when [person] did NOT have ANY health insurance coverage?” [HINOTYR]. Also see Appendix II, Health insurance coverage.

Figure 26. Data are from the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey: Emergency Department and Outpatient Components. The following drugs codes were used to identify antibiotics: 00007, 00009, 00028, 00062, 00103, 00125, 00194, 00340, 00345, 00349, 00391, 01017, 01044, 01046, 01053, 01054, 01189, 01196, 01242, 01315, 01630, 01635, 01640, 01865, 01865, 02047, 02070, 02102, 02116, 02146, 02161, 02987, 03059, 03081, 03109, 03138, 03220, 03283, 03331, 03425, 03430, 03430, 03441, 04156, 04157, 04180, 04235, 04240, 04264, 04528, 04531, 04586, 05117, 05156, 05190, 05207, 05232, 05233, 05245, 05690, 05955, 05983, 05985, 05987, 05993, 05995, 06097, 06215, 06217, 06128, 06130, 06131, 06133, 06162, 06196, 06204, 06224, 06238, 06839, 06883, 07015, 07067, 07561, 0758, 08030, 08081, 08113, 08130, 08132, 08150, 08252, 08268, 08373, 08468, 08496, 08557, 08574, 08640, 09182, 09379, 09433, 09569, 09611, 09752, 09846, 09878, 09892, 10340, 10350, 10355, 10363, 10364, 10705, 10820, 10845, 10875, 10905, 11553, 11555, 11561, 11565, 11558, 11660, 11665, 11667, 11669, 11905, 12967, 13350, 13355, 15490, 15495, 16472, 16475, 16480, 16482, 16685, 17150, 17270, 18325, 18645, 19050, 19263, 19460, 19465, 19698, 20140, 20175, 20215, 20218, 20490, 21250, 21385, 22233, 22238, 22340, 22670, 22935, 23047, 23125, 23150, 23185, 23195, 23215, 23220, 23221, 23222, 23223, 23225, 23228, 23230, 23305, 23500, 23603, 23605, 24228, 24435, 24440, 24465, 24848, 25070, 25075, 25130, 25575, 25860, 26795, 26800, 26825, 26940, 26960, 27835, 27840, 28205, 28258, 28260, 28280, 28285, 28320, 29078, 29315, 29838, 29843, 29888, 29897, 30025, 30035, 30575, 30725, 30850, 31020, 31045, 31050, 31055, 31060, 31075, 31645, 31650, 31870, 32020.
32423, 32430, 33068, 33092, 33155, 33355, 33400, 33410, 33425, 33430, 33780, 33805, 34085, 34090, 34950, 34970, 34975, 34990, 40310, 41785, 50036, 60115, 60120, 60125, 60295, 60335, 60485, 60500, 60505, 60780, 61085, 61185, 61295, 61410, 61415, 61470, 89015, 89027, 89028, 89029, 89059, 89075, 89076, 90105, 91015, 91017, 91059, 91067, 91068, 91069, 91070, 91075, 91094, 92004, 92006, 92013, 92029, 92031, 92109, 92110, 92111, 92112, 92140, 93038, 93088, 93093, 93098, 93166, 93179, 93214, 93230, 93301, 93303, 93338, 93360, 93377, 93414, 93417, 94037, 94129, 94139, 94146, 94169, 95028, 95037, 95149, 95167, 95187, 96070, 96087, 97001, 97004, 97045, 97132, 97163, 98029, 98040, 98061, 98066, 98082, 99001, 99014, 99022, 99073, 99135.

Figure 27. Data are from the National Ambulatory Medical Care Survey (NAMCS), the National Hospital Ambulatory Medical Care Survey: Outpatient (NHAMCS–OPD) and Emergency Department (NHAMCS–ED) Components, and the National Survey of Residential Care Facilities (NSRCF).

Data from NAMCS, NHAMCS–OPD, and NHAMCS–ED were based on the following questions about the four types of computerized systems. The variable names are in this order: NAMCS, NHAMCS–OPD, NHAMCS–ED. If the provider reported that they had the system but it was turned off, they were classified as not having that computer system type. If the response was unknown, blank, or otherwise missing, the record was excluded from the analysis. Missing values can be handled in a variety of ways. Estimates in Health, United States may differ from other estimates based on the same data presented elsewhere if missing values were handled differently.

- **Ordering prescriptions**: “Does your practice have a computerized system for orders for prescriptions?” [ECPOE, ECPOEO, ECPOEE]. Six percent of physician offices, 6% of hospital OPDs, and 5% of hospital EDs had their ordering prescriptions systems turned off and were counted as not having an ordering prescriptions system.

- **Warning of drug interactions and contraindications**: “If practice has a computerized system for orders for prescriptions, are there warnings of drug interactions or contraindications provided?” Providers who did not have a system for ordering prescriptions or had it turned off (prior question) were not asked this question and were classified as not having a warning system [EWARN, EWARN0, EWARNE].

- ** Submitting prescriptions electronically to pharmacy**: “If practice has a computerized system for orders for prescriptions, are prescriptions sent electronically to pharmacy?” Providers who did not have a system for ordering prescriptions or had it turned off (prior question) were not asked this question and were classified as not having a system to submit prescriptions electronically [ESCRIP, EESCRIP0, EESCRIP].

- **Including patient's allergies and current medications (in clinical notes system)**: Based on two questions, “If practice has a computerized system for clinical notes, do they include a comprehensive list of the patient's allergies (including allergies to medication)?” and “If practice has a computerized system for clinical notes, do they include a list of medications that the patient is taking?” Only providers with “Yes” to both questions were counted as having a system recording patient's allergies and medications. Providers who did not have a system for clinical notes or had it turned off (prior question) were not asked these questions and were classified as not having a system to record allergies and medications electronically [EMEDS, EMEDSO, EMEDSE, and EALLERG, EALLERGO, EALLERGE]. Five percent of physician offices, 4% of hospital OPDs, and less than 1% of hospital EDs had their clinical notes systems turned off and were counted as not having a patient's allergies or medications system.

Data from NSRCF were based on the following questions about the four types of computerized systems. Providers were shown a card with a list of computer systems and asked which types their facility had. If the response was unknown, blank, or otherwise missing, the record was excluded from the analysis.

- **Ordering prescriptions**: “Does this facility have the following computerized capabilities? ORDERS FOR PRESCRIPTIONS?” [ITPRESC].

- **Warning of drug interactions and contraindications**: “Does this facility have the following computerized capabilities? WARNING OF DRUG INTERACTIONS OR CONTRAINDICATIONS?” [ITCONTRA].
• **Submitting prescriptions electronically to pharmacy**: “Does this facility's computerized system support electronic health information exchange with PHARMACY?” [ITPHARM].

• **Including patient's allergies and current medications (in clinical notes system)**: Based on two questions: “Does this facility have the following computerized capabilities? MAINTAINING ACTIVE MEDICATION ALLERGY LIST?” and “Does this facility have the following computerized capabilities? MAINTAINING LIST OF RESIDENT'S MEDICATIONS?” [TRXLIST and ITALLERG].

Figure 28. Propoxyphene was withdrawn from the market in 2010. However, because the chart includes data back to 2000, propoxyphene is included in the list of synthetic drugs.

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**References**


3. NCHS. 2010 mortality file [unpublished analysis].


16. CDC. Advisory Committee on Immunization Practices (ACIP) recommended immunization schedules for persons aged 0 through 18 years and adults aged 19 years and older—United States, 2013. MMWR 2013;62(01):1–1. Available from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6201a1_w.


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38.


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66. Venkatesh KK, Mayer KH, Carpenter CC. Low-cost generic drugs under the President's Emergency Plan for AIDS Relief drove down treatment cost; more are needed. Health Aff (Millwood) 2012;31(7):1429–38.


Trend Tables

Health Status and Determinants

Population

Fertility and Natality

Mortality

Determinants and Measures of Health
Introduction

Health, United States consolidates the most current data on the health of the population of the United States, the availability and use of health resources, and health care expenditures. Information was obtained from the data files and published reports of many federal government, private, and global agencies and organizations. In each case, the sponsoring agency or organization collected data using its own methods and procedures. Therefore, data in this report may vary considerably with respect to source, method of collection, definitions, and reference period.

Although a detailed description and comprehensive evaluation of each data source are beyond the scope of this appendix, readers should be aware of the general strengths and weaknesses of the different data collection systems shown in Health, United States. For example, population-based surveys obtain socioeconomic data, data on family
characteristics, and information on the impact of an illness, such as days lost from work or limitation of activity. These data are limited by the amount of information a respondent remembers or is willing to report. For example, a respondent may not know detailed medical information, such as a precise diagnosis or the type of procedure performed, and therefore cannot report that information. In contrast, records-based surveys, which collect data from physician and hospital records, usually contain good diagnostic information but little or no information about the socioeconomic characteristics of individuals or the impact of illnesses on individuals.

Different data collection systems may cover different populations, and understanding these differences is critical to interpreting the resulting data. Data on vital statistics and national expenditures cover the entire population. However, most data on morbidity cover only the civilian noninstitutionalized population and thus may not include data for military personnel, who are usually young; for institutionalized people, including the prison population, who may be of any age; or for nursing home residents, who are usually older.

All data collection systems are subject to error, and records may be incomplete or contain inaccurate information. Respondents may not remember essential information, a question may not mean the same thing to different respondents, and some institutions or individuals may not respond at all. It is not always possible to measure the magnitude of these errors or their effect on the data. Where possible, table notes describe the universe and method of data collection, to assist users in evaluating data quality.

Some information is collected in more than one survey, and estimates of the same statistic may vary among surveys because of different survey methodologies, sampling frames, questionnaires, definitions, and tabulation categories. For example, cigarette use is measured by the National Health Interview Survey, the National Survey on Drug Use & Health, the Monitoring the Future Study, and the Youth Risk Behavior Survey. These surveys use slightly different questions, cover persons of differing ages, and interview in diverse settings (e.g., at school compared with at home), so estimates will differ.

Overall estimates generally have relatively small sampling errors, but estimates for certain population subgroups may be based on a small sample size and have relatively large sampling errors. Numbers of births and deaths from the National Vital Statistics System represent complete counts (except for births in those states where data are based on a 50% sample for certain years). Therefore, these data are not subject to sampling error. However, when the figures are used for analytical purposes, such as the comparison of rates over a period, the number of events that actually occurred may be considered as one of a large series of possible results that could have arisen under the same circumstances. When the number of events is small and the probability of such an event is rare, estimates may be unstable, and considerable caution must be used in interpreting the statistics. Estimates that are unreliable because of large sampling errors or small numbers of events are noted with asterisks in tables, and the criteria used to determine unreliable estimates are indicated in an accompanying footnote.

In this appendix, government data sources are listed alphabetically by data set name, and private and global sources are listed separately. To the extent possible, government data systems are described using a standard format. The Overview is a brief, general statement about the purpose or objectives of the data system. The Selected Content section lists major data elements that are collected or estimated using interpolation or modeling. The Data Years section gives the years the survey or data system has existed or been fielded. The Coverage section describes the population that the data system represents: for example, residents of the United States, the noninstitutionalized population, persons in specific population groups, or other entities that make up the survey. The Methodology section presents a short
description of the methods used to collect the data. The Sample Size and Response Rate section provides these statistics for surveys. The Issues Affecting Interpretation section describes major changes in the data collection methodology or other factors that must be considered when analyzing trends: for example, a major survey redesign that may introduce a discontinuity in the trend. For additional information about the methodology, data files, and history of a data source, consult the References and For More Information sections that follow each summary.

**Government Sources**

**Abortion Surveillance System**

CDC/National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

**Overview**

The Abortion Surveillance System documents the number and characteristics of women obtaining legal induced abortions, monitors teenage and unintended pregnancy, and assists in efforts to identify and reduce preventable causes of morbidity and mortality associated with abortions.

**Selected Content**

System content includes age, race, ethnicity, marital status, previous live births, period of gestation, and previous induced abortions among women obtaining legal induced abortions.

**Data Years**

Each year, CDC requests abortion data from the central health agencies of 52 reporting areas (the 50 states, D.C., and New York City). This information is provided voluntarily to CDC and has been presented in Health, United States, 2013 from 2001 onward. Two measures are presented in this table: the total number of abortions excluding the states which did not report for that particular year; and the 46 states which reported continuously for 2001–2010 (the six states which did not report continuously for the period 2001–2010 include: Alaska, California, Louisiana, Maryland, New Hampshire, and West Virginia). The following states did not report abortion data to CDC on an annual basis: in 2001–2002, Alaska, California, and New Hampshire; in 2003 and 2004, California, New Hampshire, and West Virginia; in 2005 and 2006, California, Louisiana, and New Hampshire; in 2007 and 2008, California, Maryland, and New Hampshire; in 2009 and 2010, California, Maryland, and New Hampshire.

**Coverage**

The system includes women of all ages, including adolescents, who obtain legal induced abortions. Methodology. Each year, CDC requests tabulated data to document the number and characteristics of women obtaining abortions in the United States. For the purpose of surveillance, a legal induced abortion is defined as an intervention performed by a licensed clinician (e.g., a physician, nurse-midwife, nurse practitioner, or physician assistant) that is
intended to terminate a suspected or known ongoing intrauterine pregnancy and produce a nonviable fetus at any gestational age.

In most states, collection of abortion data is facilitated by the legal requirement for hospitals, facilities, and physicians to report abortions to a central health agency. These central health agencies voluntarily provide CDC the aggregate numbers for the abortion data they have collected. Although reporting to CDC is voluntary, most reporting areas provide aggregate abortion numbers; during 2001–2010, a total of 46 reporting areas provided CDC a continuous annual record of abortion numbers.

**Issues Affecting Interpretation**

The findings in this report are subject to several limitations. First, because reporting requirements are established by the individual reporting areas, the collection of data varies, and CDC is unable to obtain the total number of abortions performed in the United States. During the period covered by this report, the total annual number of abortions recorded by CDC was 65%–69% of the number recorded by the Guttmacher Institute, which uses numerous active follow-up techniques to increase the completeness of the data obtained through its periodic national census of abortion providers. Although most reporting areas collect and send abortion data to CDC, this information is given to CDC voluntarily. During 2001–2010, 6 of the 52 reporting areas did not provide CDC with data on a consistent annual basis. As a result, the abortion numbers these areas report to CDC are incomplete. Moreover, even in states that legally require medical providers to submit a report for all the abortions they perform, enforcement of this requirement varies.

Second, because reporting requirements are established by the individual reporting areas, many states have developed reporting forms that do not resemble the template CDC created for technical guidance. Consequently, many reporting areas do not collect all the information CDC compiles on the characteristics of women obtaining abortions (e.g., age, race, and ethnicity).

Third, abortion data are compiled and reported to CDC by the central health agency of the reporting area in which the abortion was performed rather than the reporting area in which the woman lived. This overcounts abortion statistics for reporting areas in which a high percentage of abortions are obtained by out-of-state residents and undercounts abortions for states with limited abortion services, more stringent legal requirements for obtaining an abortion, or geographic proximity to services in another state.

Finally, adjustments for socioeconomic status cannot be made because CDC does not collect abortion data by education or income, and joint analysis of many variables of interest (e.g., age, race, and ethnicity) is precluded because reporting areas provide CDC with aggregate numbers rather than individual-level records.

**Reference**

For More Information

See the NCCDPHP surveillance and research website at: http://www.cdc.gov/reproductivehealth/stats/index.htm.

Census of Fatal Occupational Injuries (CFOI)

Consumer Price Index (CPI)

Current Population Survey (CPS)

Department of Veterans Affairs National Enrollment and Patient Databases

Employee Benefits Survey—See Appendix I, National Compensation Survey (NCS).

Healthcare Cost and Utilization Project (HCUP), Nationwide Inpatient Sample

Medicaid Statistical Information System (MSIS)

Medical Expenditure Panel Survey (MEPS)

Medicare Administrative Data

Medicare Current Beneficiary Survey (MCBS)

Monitoring the Future (MTF) Study

National Ambulatory Medical Care Survey (NAMCS)

National Compensation Survey (NCS)

National Health Expenditure Accounts (NHEA)

National Health and Nutrition Examination Survey (NHANES)
National Health Interview Survey (NHIS)

National HIV Surveillance System

National Hospital Ambulatory Medical Care Survey (NHAMCS)

National Hospital Discharge Survey (NHDS)

National Immunization Survey (NIS)

National Income and Product Accounts (NIPA)

National Medical Expenditure Survey (NMES)—See Appendix I, Medical Expenditure Panel Survey (MEPS).

National Notifiable Disease Surveillance System (NNDSS)

National Survey of Family Growth (NSFG)

National Survey of Residential Care Facilities (NSRCF)

National Survey on Drug Use & Health (NSDUH)

National Vital Statistics System (NVSS)

Birth File

Fetal Death Data Set

Mortality File

Multiple Cause-of-Death File
Linked Birth/Infant Death Data Set

Compressed Mortality File (CMF)

Occupational Employment Statistics (OES)

Population Census and Population Estimates

Decennial Census

Race Data on the 1990 Census

Race Data on the 2000 Census

Race Data on the 2010 Census

Modified Decennial Census Files

Postcensal Population Estimates

Intercensal Population Estimates

Bridged-race Population Estimates

Quality Improvement Evaluation System (QIES)

Sexually Transmitted Disease (STD) Surveillance

Surveillance, Epidemiology, and End Results Program (SEER)

United States Renal Data System (USRDS)
Youth Risk Behavior Survey (YRBS)

Private and Global Sources

American Association of Colleges of Osteopathic Medicine (AACOM)

American Association of Colleges of Pharmacy (AACP)

American Association of Colleges of Podiatric Medicine (AACPM)

American Dental Association (ADA)

American Hospital Association (AHA) Annual Survey of Hospitals

American Medical Association (AMA) Physician Masterfile

American Osteopathic Association (AOA)

Association of American Medical Colleges (AAMC)

Association of Schools and Colleges of Optometry (ASCO)

Association of Schools of Public Health (ASPH)

Guttmacher Institute Abortion Provider Census

Organisation for Economic Co-operation and Development (OECD) Health Data

Appendix II. Definitions and Methods

Introduction

My Note: There are links for these Tables to the actual Tables. Why not put the Tables right below, instead of at the end?
This appendix contains an alphabetical listing of terms used in *Health, United States*, and these definitions are specific to the data presented in this report. The methods used for calculating age-adjusted rates, average annual rates of change, relative standard errors, birth rates, death rates, and years of potential life lost are described. Included are standard populations used for age adjustment (Tables I and II), the years when the revisions for *International Classification of Diseases* (ICD) codes were in effect (Table III), codes for cause of death from the 6th through 10th revisions of ICD (Table IV), and comparability ratios between the 9th and 10th revisions (ICD–9 and ICD–10) for selected causes (Table V), imputed family income percentages from the National Health Interview Survey (NHIS) (Table VI), an analysis of the effect of added probe questions for Medicare and Medicaid coverage on health insurance rates in NHIS (Table VII), industry codes from the North American Industry Classification System (NAICS) (Table VIII), and ICD–9 Clinical Modification (ICD–9–CM) codes for external causes of injury, diagnostic, and procedure categories (Tables IX–XII). Standards for presenting federal data on race and ethnicity are described, and sample tabulations of NHIS data comparing the 1977 and 1997 Office of Management and Budget standards for the classification of federal data on race and ethnicity are presented in Tables XIII and XIV.

**Appendix II: Listing of Terms**

**Acquired immunodeficiency syndrome (AIDS)**

Human immunodeficiency virus (HIV) is the pathogen that causes AIDS, and HIV disease is the term that encompasses all the condition’s stages—from infection to the deterioration of the immune system and the onset of opportunistic diseases. However, AIDS is still the term most people use to refer to the immune deficiency caused by HIV. An AIDS diagnosis (indicating that the person has reached the late stages of the disease) is given to people with HIV who have CD4⁺ cell (also known as T cells or T4 cells, which are the main target of HIV) counts below 200 cells per cubic millimeter (fewer than 200 cells/μL) or less than 14% of total lymphocytes, or who have been diagnosed with at least one of a set of opportunistic diseases. All 50 states, the District of Columbia (D.C.) and six U.S. dependent areas (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, Republic of Palau, and the U.S. Virgin Islands) report AIDS cases to CDC using a uniform surveillance case definition and case report form. The case reporting definitions were expanded in 1985 (see MMWR 1985;34:373–5); 1987 [MMWR 1987;36(SS–01):1S–15S]; and 1993 for adults and adolescents [MMWR 1992; 41(RR–17):1– 19]; and in 1994 for pediatric cases [MMWR 1994;43(RR– 12):1–19]. The revisions incorporated a broader range of AIDS-indicator diseases and conditions and used HIV diagnostic tests to improve the sensitivity and specificity of the definition. The 1993 expansion of the case definition caused a temporary distortion of AIDS incidence trends.

In 2005, CDC collaborated with the Council of State and Territorial Epidemiologists (CSTE) to recommend a change in the AIDS case definition to require laboratory confirmation of HIV infection in addition to a CD4⁺ T-lymphocyte count of less than 200 cells/μL, a CD4⁺ T-lymphocyte percentage of total lymphocytes of less than 14%, or diagnosis of an AIDS-defining condition.

From 2008 to the present, a revised HIV case definition was used to classify HIV infection among adults, adolescents, and children. The revised definition incorporates the following HIV infection classification staging system:

- HIV infection, stage 1: No AIDS-defining condition and either CD4 count of 500 cells/μL or more or CD4 percentage of total lymphocytes of 29% or more.
• HIV infection, stage 2: No AIDS-defining condition and either a CD4 count of 200–499 cells/μL or a CD4 percentage of total lymphocytes of 14%–28%.

• HIV infection, stage 3 (AIDS): Documentation of an AIDS-defining condition or either a CD4 count of less than 200 cells/μL or a CD4 percentage of total lymphocytes of less than 14%. Documentation of an AIDS-defining condition supersedes a CD4 count or percentage that would not, by itself, be the basis for a stage 3 (AIDS) classification.

• HIV infection, stage unknown: No reported information on AIDS-defining conditions and no information available on CD4 count or percentage [see MMWR 2008;57(RR–10):1–8].

• In 1996, regimens of proven combinations of medications, known as highly active antiretroviral therapy (HAART), became the standard of care for HIV and AIDS. These therapies have prevented or delayed the onset of AIDS and premature death among many HIV-infected persons, and this should be considered when interpreting trend data. AIDS surveillance data are published annually by CDC in the HIV/AIDS Surveillance Report, available from: http://www.cdc.gov/hiv/topics-surveillance/resources/reports/index.htm.[Also see Appendix II, Human immunodeficiency virus (HIV) disease.]

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Active physician—See Appendix II, Physician.

Activities of daily living (ADL)

Admission

Age

Age adjustment

AIDS—See Appendix II, Acquired immunodeficiency syndrome (AIDS).

Alcohol consumption

Any-listed diagnosis—See Appendix II, Diagnosis.

Average annual rate of change (percent change)

Average length of stay

Basic actions difficulty
Bed, health facility

Binge drinking

Birth cohort

Birth rate—See Appendix II, Rate: Birth and related rates.

Birthweight

Blood pressure, high

Body mass index (BMI)

Cause of death

Cause-of-death ranking

Children's Health Insurance Program (CHIP)

Cholesterol

Cigarette smoking

Civilian noninstitutionalized population; Civilian population—See Appendix II, Population.

Colorectal tests or procedures

Community hospital—See Appendix II, Hospital.

Comparability ratio
Compensation—See Appendix II, Employer costs for employee compensation.

Complex activity limitation

Consumer Price Index (CPI)

Contraception

Cost-charge ratio

Critical access hospital—See Appendix II, Hospital.

Crude birth rate; Crude death rate—See Appendix II, Rate: Birth and related rates; Rate: Death and related rates.

Days of care

Death rate—See Appendix II, Rate: Death and related rates.

Dental caries

Dental visit

Diabetes

Diagnosis

Diagnostic and other nonsurgical procedure—See Appendix II, Procedure.

Discharge

Domiciliary care home—See Appendix II, Long-term care facility; Nursing home.
Drug

Drug abuse—See Appendix II, *Illicit drug use*.

Education

Emergency department

Emergency department or emergency room visit

Employer costs for employee compensation

End-stage renal disease (ESRD)

Ethnicity—See Appendix II, *Hispanic origin*.

Exercise—See Appendix II, *Physical activity, leisure-time*.

Expenditures—See Appendix II, *Health expenditures, national*. [Also see Appendix I, *National Health Expenditure Accounts (NHEA)*.]

External cause of injury

Family income

Federal hospital—See Appendix II, *Hospital*.

Fee-for-service health insurance

Fertility rate—See Appendix II, *Rate: Birth and related rates*.

General hospital—See Appendix II, *Hospital*.
Geographic region

Figure I. U.S. Census Bureau: Four geographic regions and nine divisions of the United States
Gestation

Gross domestic product (GDP)

Health care contact

Health expenditures, national

Health insurance coverage

Health maintenance organization (HMO)

Health services and supplies expenditures—See Appendix II, Health expenditures, national.

Health status, respondent-assessed

Hearing trouble

Hispanic origin

HIV—See Appendix II, Human immunodeficiency virus (HIV) disease.

Home visit

Hospital

Hospital-based physician—See Appendix II, Physician.

Hospital day—See Appendix II, Days of care.

Hospital utilization
Human immunodeficiency virus (HIV) disease

Hypertension—See Appendix II, Blood pressure, high.

ICD; ICD codes—See Appendix II, Cause of death; International Classification of Diseases (ICD).

Illicit drug use

Immunization—See Appendix II, Vaccination.

Incidence

Income—See Appendix II, Family income.

Individual practice association (IPA)—See Appendix II, Health maintenance organization (HMO).

Industry of employment

Infant death

Injury

Injury-related visit

Inpatient

Inpatient care—See Appendix II, Hospital utilization.

Inpatient day—See Appendix II, Days of care.

Instrumental activities of daily living (IADL)
Insurance—See Appendix II, Health insurance coverage.

Intermediate care facility—See Appendix II, Nursing home.

International Classification of Diseases (ICD)

International Classification of Diseases, 9th Revision, Clinical Modification (ICD–9–CM)

International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD–10–CM/PCS)

Late fetal death rate—See Appendix II, Rate: Death and related rates.

Leading causes of death—See Appendix II, Cause-of-death ranking.

Length of stay—See Appendix II, Average length of stay.

Life expectancy

Limitation of activity

Long-term care facility

Low birthweight—See Appendix II, Birthweight.

Mammography

Managed care

Marital status

Maternal age—See Appendix II, Age.
Maternal education—See Appendix II, Education.

Medicaid

Medicaid payments

Medical specialty—See Appendix II, Physician specialty.

Medicare

Metropolitan statistical area (MSA)

Micropolitan statistical area

Multum Lexicon Plus therapeutic class

Neonatal mortality rate—See Appendix II, Rate: Death and related rates.

Nonprofit hospital—See Appendix II, Hospital.

North American Industry Classification System (NAICS)—See Appendix II, Industry of employment.

Notifiable disease

Nursing home

Nursing home expenditures—See Appendix II, Health expenditures, national.

Obesity—See Appendix II, Body mass index (BMI).

Occupancy rate
Office-based physician—See Appendix II, Physician.

Office visit

Operation—See Appendix II, Procedure.

Outpatient department

Outpatient surgery

Outpatient visit

Overweight—See Appendix II, Body mass index (BMI).

Pap smear

Patient—See Appendix II, Inpatient; Office visit; Outpatient visit.

Percent change/percentage change—See Appendix II, Average annual rate of change (percent change).

Perinatal mortality rate; ratio—See Appendix II, Rate: Death and related rates.

Personal care home with or without nursing—See Appendix II, Nursing home.

Personal health care expenditures—See Appendix II, Health expenditures, national.

Physical activity, leisure-time

Physician

Physician specialty
Population

Postneonatal mortality rate—See Appendix II, *Rate: Death and related rates.*

Poverty

Preferred provider organization (PPO)

Prenatal care

Prevalence

Primary care specialty—See Appendix II, *Physician specialty.*

Private expenditures—See Appendix II, *Health expenditures, national.*

Procedure

Proprietary hospital—See Appendix II, *Hospital.*

Public expenditures—See Appendix II, *Health expenditures, national.*

Purchasing power parities (PPPs)

Race

Rate

Region—See Appendix II, *Geographic region.*

Registered hospital—See Appendix II, *Hospital.*
Registration area

Relative standard error (RSE)

Relative survival rate

Reporting area

Resident, health facility

Resident population—See Appendix II, Population.

Rural—See Appendix II, Urbanization.

Self-assessment of health—See Appendix II, Health status, respondent-assessed.

Serious psychological distress

Short-stay hospital—See Appendix II, Hospital.

Skilled nursing facility—See Appendix II, Nursing home.

Smoker—See Appendix II, Cigarette smoking.

Special hospital—See Appendix II, Hospital.

Substance use

Suicidal ideation

Surgery—See Appendix II, Outpatient surgery; Procedure.
Surgical specialty—See Appendix II, Physician specialty.

Tobacco use—See Appendix II, Cigarette smoking.

Uninsured

Urbanization

Usual source of care

Vaccination

Wages and salaries—See Appendix II, Employer costs for employee compensation.

Years of potential life lost (YPLL)

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Index

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