

Kansas Health Statistics Report

Kansas Department of Health and Environment – Center for Health and Environmental Statistics – No 17 – May 2003

Hospital Discharges Among Older Kansas Residents, 1995 – 2001

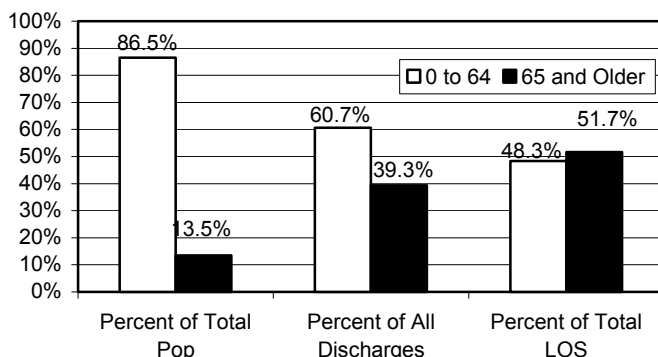
The KDHE Center for Health and Environmental Statistics (CHES), in partnership with the Kansas Hospital Association, has reviewed hospital discharge data for 1995 – 2001 and offers the following highlights.

General Highlights

Elderly Kansans are over represented in hospital discharge data (Figure 1).

- The elderly made up 13.5% of the Kansas population.
- Discharges involving older Kansans accounted for 39% of all discharges.
- The elderly used over half (51.7%) of the total number of days hospitalized length of stay (LOS).

Figure 1. Population and Hospital Discharges by Age Group, 1995 - 2001



Diagnoses

Diagnoses for the elderly were categorized according to the Clinical Classification Software (CCS) system. Diagnosis rates for the elderly by gender are shown in Table 1.

The table shows diagnostic categories and discharge rates (number of discharges per 1,000 population) for males and females; also shown is a column displaying the results of subtracting female rates from male rates. The rows are arranged in order of ascending difference.

- Elderly men are hospitalized much more frequently than women for Diseases of the Circulatory System
- Men are also hospitalized more often for Diseases of the Respiratory System and Neoplasms.
- Women have higher discharge rates for eleven of the sixteen categories;

For women, the greatest divergence from men occurs with problems associated with Injury and Poisoning and with Diseases of Musculoskeletal System and Connective Tissue.

Table 1. Leading Diagnoses for Hospital Discharges to Kansans 65 Years and Over by Gender, 1995 – 2001

Level 1 CCS Category	Males *	Females*	Difference
Injury And Poisoning	25.7	34.9	-9.2
Diseases Of Musculoskeletal System & Connective Tissue	17.2	22.5	-5.3
Diseases Of The Digestive System	33.0	37.4	-4.4
Endocrine, Nutritional, Metabolic, & Immunity Disorders	11.1	14.9	-3.8
Symptoms, Signs & Ill-Defined Cond/Factors Infl Health	12.3	14.7	-2.4
Mental Disorders	7.2	8.7	-1.4
Diseases Of The Skin And Subcutaneous Tissue	3.8	4.6	-0.8
Diseases Of Nervous System And Sense Organs	5.3	5.8	-0.5
Diseases Of Blood And Blood-Forming Organs	2.8	2.9	-0.1
Other, Unclassified	0.5	0.6	-0.1
Congenital Anomalies	0.1	0.2	-0.1
Infectious And Parasitic Diseases	6.3	6.0	0.2
Diseases Of The Genitourinary System	19.1	15.4	3.7
Neoplasms	23.8	18.1	5.7
Diseases Of The Respiratory System	51.5	42.7	8.8
Diseases Of The Circulatory System	112.5	93.9	18.6

Residence Data

* Discharges per 1,000 Population

Procedures

Procedures requiring hospitalization were also classified using CCS (Table 2). Table 2 lists the top five procedures for men and for women, along with the discharge rates (number of discharges per 1,000 population) and the mean length of stay (LOS).

- For men, three of the top five procedures were related to heart problems.
- Procedures were also frequently performed to deal with prostate problems.
- For women, the single most frequently performed procedure was due to gastrointestinal problems.
- Three of the top five procedures for women involved bone and joint problems.

Inside This Issue

Hospital Discharges in Elderly	1
US Hospital Stays Shorter	2
Preliminary Abortion Report.....	2
HIPAA Privacy Rules	3
TBI in Children	4
Contraceptive Health	
Insurance Costs	4
Bremby Chairs HCDGB	4
Syphilis Investigation Results	4
News Notes	5

Table 2. Leading Procedures for Hospital Discharges to Kansans 65 Years and Over by Gender, 1995 - 2001

	Count	Rates	Mean LOS
Percutaneous Transluminal Coronary Angioplasty (PTCA)	11,575	11.4	3.6
Diagnostic Cardiac Catheterization, Coronary Arteriography	9,696	9.5	4.1
Transurethral Resection Of Prostate (TURP)	9,257	9.1	3.3
Upper Gastrointestinal Endoscopy, Biopsy	8,357	8.2	5.7
Coronary Artery Bypass Graft (CABG)	7,587	7.5	9.4
Females			
	Count	Rates	Mean LOS
Upper Gastrointestinal Endoscopy, Biopsy	13,182	9.0	5.8
Hip Replacement, Total And Partial	11,842	8.0	6.0
Arthroplasty Knee	11,144	7.6	4.8
Treatment, Fracture Or Dislocation Of Hip And Femur	10,474	7.1	6.7
Diagnostic Cardiac Catheterization, Coronary Arteriography	9,788	6.6	4.2

Conclusion

CHES expects to publish a more detailed examination of hospital discharge data in the future. The previously released study of hospital discharges for elderly Kansans for the years 1995 to 1999 can be viewed at the following URL <http://www.accesskansas.org/hcdgb/khcdpubs.html>.

*Rachel Lindbloom, MA LSCSW & Donald Owen
Health Care Data*

Hospital Stays Continue To Get Shorter

The Centers for Disease Control and Prevention reports hospital stays for U.S. patients continue to get shorter, and heart disease remains the main reason for hospitalization.

CDC's most recent data shows the country's 32.7 million hospital patients had average stays of 4.9 days in 2001. The study is conducted each year, using data from hospital discharges.

Most patients were in the hospital for three days or less; 27 percent stayed for 4 to 7 days, and 16 percent stayed longer than a week.

Patients stayed in hospitals for about 8 days in 1970.

Drug treatment, surgical advances, better outpatient care, and more efficient in-house analysis of which patients should stay and which patients should be sent to outpatient centers have contributed to the decline.

Changes in the Medicare system in the 1980s and 1990s also contributed to shorter hospital stays by allowing many patients to leave hospitals for post-acute care facilities.

About 4.3 million people were hospitalized for heart disease in 2001. Hospitalization for elderly congestive heart failure patients increased by 62 percent from 1980 to 2001.

The study did not break out the findings by state.

Associated Press

2002 Preliminary Abortion Report Issued

Total reported Kansas abortions were 11,844 in 2002. The figure represents an almost five-percent decrease (4.7%) from the 2001 total of 12,422 (Table 3). Kansas residents obtained 6,298 abortions, 121 (1.9%) fewer than the prior year. Out-of-state residents obtained 5,546 abortions, 457 (7.6%) less than the year before. The number of Missouri residents obtaining abortions in Kansas decreased from 5,136 in 2001 to 4,784 (6.9%).

Table 3. Abortions in Kansas by Selected Characteristics, 2002

	N	Percent
<i>Residence</i>		
Total Reported	11,844	100.0
In-state residents	6,298	53.2
Out-of-state residents	5,546	46.8
<i>Age-group</i>		
Under 15 years	88	0.8
15-19 years	2,243	18.9
20-24 years	4,110	34.7
25-29 years	2,541	21.5
30-34 years	1,637	13.8
35-39 years	893	7.5
40-44 years	308	2.6
45 years and over	24	0.2
Hispanic	821	6.9
Non-Hispanic	11,023	93.1
<i>Marital Status</i>		
Married	2,162	18.3
Unmarried	9,650	81.7
Not Stated	32	0.0
<i>Weeks Gestation</i>		
Less than 9 weeks	7,027	59.4
9-12 weeks	2,927	24.7
13-16 weeks	863	7.3
17-21 weeks	447	3.8
22 weeks & over	564	4.8
Not Stated	16	0.0

Declines were reported in all age-groups except for 45 years and over (up 60.0%) and under 15 years of age (up 6.0%). Declines in the 15-24 years of age category accounted for over half (58.8%) of the overall decrease in reported abortions.

The number of black women obtaining abortions increased by 68 (2.51%) to 2,774 in 2002. Black women obtained 23.5% of the abortions reported in 2002. The number of Hispanic women obtaining abortions decreased by 51 (5.8%) to 821 in 2002. Hispanic women accounted for 6.9% of abortions reported.

Declines were noted in all gestation age categories except for 13-16 weeks. The number of procedures performed to women at 22 weeks gestation or greater, decreased by 71 (11.2%) to 564.

Procedures performed at 22 weeks or greater accounted for less than five percent (4.8%) of all reported abortions.

No partial birth procedures were performed in 2002. Procedures involving Digoxin/Induction decreased by 75 (12.4%) to 528 in 2002. The use of methotrexate decreased by 4 (1.27%) to 310. The number of procedures using mifepristone (RU486) increased by 480 (256.7%) to 667.

The number of physician certifications reported in 2002 was 12,219.

*Greg Crawford & Karen Sommer, MA
Vital Statistics Data Analysis*

HIPAA Privacy Rules Go Into Effect

Millions of health plans, hospitals, doctors and other health care providers around the country began complying with new federal privacy regulations on April 14. The regulations, promulgated under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, set a national floor of privacy protections to reassure patients their medical records are kept confidential.

The rules ensure appropriate privacy safeguards are in place as information technologies are used to improve patient quality of care. Consumers will benefit from these new limits on the way their personal medical records may be used or disclosed by those entrusted with this sensitive information.

The new protections give patients greater access to their medical records and more control over how their health plans and health care providers use personal information. Consumers will get a notice explaining how their health plans, doctors, pharmacies and other health care providers use, disclose, and protect their personal information. In addition, consumers will have the ability to see and copy their health records and to request corrections of any errors included in their records. Consumers may file complaints about privacy issues with their health plans or providers or with the Office for Civil Rights.

The new rules also reflect a common-sense balance between protecting patients' privacy and ensuring the best quality care for patients. They do not interfere with the ability of doctors to treat their patients, and they allow important public health activities, such as tracking infectious disease outbreaks and reporting adverse drug events, to continue. For more information about HIPAA, go to <http://www.hhs.gov/ocr/hipaa/>.

*Elizabeth W. Saadi, PhD
Office of Health Care Information*

Traumatic Brain Injuries (TBI) in Children ages 0-14

TBI are an important public health issue because "...brain injuries are among the most likely types of injury to cause death or permanent disability..."(1) even though the literature shows a decreasing trend in TBI mortality (2). In the general population nationally, TBI-related deaths declined 11% between 1989 and 1999, from 21.9 to 19.4/ 100,000 population, respectively. Nationally, the major causes of TBI-related deaths were firearms (40%), motor vehicle related (34%), and fall related (10%). Among youths aged 0-19 years motor vehicle TBI's were the leading cause of death (2).

The Healthy People 2010 objective 15-1: "Reduce hospitalization for nonfatal head injuries." addresses this important concern. The objective target is 45 hospitalizations per 100,000 population. The 1998 national baseline rate is 60.6 hospitalizations for nonfatal head injuries per 100,000 population (3) (age adjusted to the year 2000 standard population), which compares to 65.6/100,000 (4) (age adjusted to the year 2000 standard population) in Kansas in 1998.

Nationally, each year among children ages 0-14 years, it is estimated that 3,000 deaths, 29,000 hospitalizations and 400,000 emergency visits are related to traumatic brain injury (5).

In Kansas, from 1999 through 2001, there was an average of 31 deaths due to TBI each year in children ages 0-14, corresponding to a rate of 5.3/100,000 population. Unintentional injuries accounted for 81% of fatal TBI injuries.

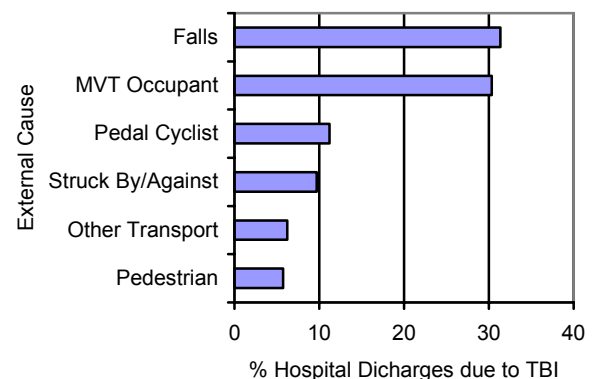
Death data in children ages 0-14 years with a TBI related to unintentional injury show:

- 61% of deaths were male which corresponds to a rate of 5.1/100,000 population, which compares to 3.4/100,000 in the female population.

- 49% of deaths were youth ages 10-14 (5.4/100,000 population), 35 % were children 0-4 (2.9/100,000), and 16% were children ages 5-9 years (4.5/100,000).
- 61% of deaths due to TBI were among occupants in motor vehicle crashes.
- 12% of deaths due to TBI were pedestrian (both in traffic and non-traffic).

Hospital discharge data, 1999 and 2000, showed an average of 296 injury related TBI hospital discharges each year (51.1 hospital discharges/100,000 population). In children ages 0-14, the specific ages with the highest hospital discharge rates were infants under 1 year (74.4/100,000) and youth 14 years old (54.4/100,000). Approximately 71% (1999-2000) of injury related hospital discharges in children 0-14 with a TBI included an external cause of injury code (e-code). Therefore, the findings in this report likely underestimate the overall burden of injury in the state of Kansas.

Figure 2. Common Causes of Unintentional Injury TBI Hospitalizations, Ages 0-14, Kansas, 1999-2000



Kansas Hospital Association

Hospital discharge data, children ages 0-14 with a TBI caused by an unintentional injury show:

- 63% of hospitalizations were male for a rate of 45.6/100,000, which compares to 26.1/100,000 in the female population.
- 10% of hospitalizations were infants under 1 year (37.2/100,000), 25% were children 1-4 (23.2/100,000), 30% were children 5-9 (21.3/100,000), and 35% were youths aged 10-14 (23.5/100,000).
- Falls accounted for the highest percentage of hospitalizations (31%) followed closely by motor vehicle occupant in a crash (30%) (Figure 2).

For a better understanding of the incidence and causes of traumatic brain injury in children aged 0-14, a statewide emergency room surveillance system would be invaluable; however, at the present, this is not available in Kansas.

Caution should be taken when comparing mortality and morbidity data. Hospital discharge data uses ICD-9-CM coding, and mortality data, starting with 1999, uses ICD-10 coding. ICD-9 classification includes an external cause code (e-code) to identify the cause and intent of the injury or poisoning (n-code). The ICD-10 classification system uses an alphanumeric coding system denoting both the nature of injury and external causes.

*Carol Moyer, MPH
Bureau of Health Promotion*

References

- 1 CDC. Traumatic brain injury. Available at <http://www.cdc.gov/ncipc/factsheets/tbi.htm>. Accessed March 20, 2003.
- 2 Adekoya, N., Thurman, D. J., White, D. D., Webb, K. W. Surveillance for traumatic brain injury deaths — United States, 1989–1998. *MMWR*, vol. 51, No. SS-10. Dec 6, 2002
- 3 National Hospital Discharge Survey (NHDS), CDC, NCHS
- 4 Kansas Hospital Association. Kansas Hospital Discharge Data System.
- 5 Langlois, J, Gotsch K. Traumatic brain injury in the United States: assessing outcomes in children. Atlanta (GA): National Center for Injury Prevention and Control, CDC; 2001.

Costs of Health Insurance Coverage of Contraceptives

The KDHE Center for Health and Environmental Statistics researched a question before the 2003 Kansas Legislature whether insurance companies should be required to cover contraceptive drug costs. Such a requirement is part of House Bill 2185. The Kansas Insurance Department authorized KDHE to use the Kansas Health Insurance Information System (KHIS) database to review the data, and summarize findings.

The Center reviewed year 2001 KHIS claims data submitted by insurance plans providing contraceptive coverage. These plans are primarily for groups where such coverage is market-driven by employers. Total claim amounts paid by these plans were almost \$700 million. The costs covered non-permanent contraceptive procedures, drugs, implants, devices, supplies, and counseling.

Data show 0.6% of aggregate claim payments were for costs that would be mandated coverage if HB 2185 passed. Accordingly, plans that do not currently cover these costs, on the average, would expect a proportionate premium increase. However, there would be variations based on the populations covered.

Groups with greater than average proportions of females under age 45 would have larger increases, and groups with lesser exposed demographics would have smaller increases. The largest increases would occur in individual plans, where age and sex rating will increase premiums up to 3% for younger females.

These results are consistent with national studies by Tillinghast in 1996 for the Health Insurance Association of America and by Buck Consultants in 1998 for The Alan Guttmacher Institute. Both studies projected aggregate increases in claim costs of less than 1%. Given that unit costs for contraceptives and associated services have not increased at a rate faster than healthcare generally, the results of those studies seem to continue to be valid.

It is difficult to estimate healthcare cost savings from this mandate. Obviously, the costs of an unwanted pregnancy are vastly greater than the cost of contraceptives. There are no means of estimating any reduction in the number of unwanted pregnancies.

*Kansas Health Insurance Information System
Health Care Data Analysis*

Certificate Revision Underway

The KDHE Center for Health and Environmental Statistics has begun the process of revising the design of Kansas birth and death certificates. The revisions follow a process involving the National Center for Health Statistics to identify a minimum dataset and prepare standard U.S. certificates.

The new standard certificates make a number of changes to the data collected (for information on the changes see KHSR # 16 <http://www.kdhe.state.ks.us/ches/khsnews/khs16.pdf>).

Samples of the current KDHE birth, death, fetal death, marriage and marriage dissolution certificates can be reviewed at: http://www.kdhe.state.ks.us/vital/ovs_certificate_comments.html. By comparing the present certificate to the U.S. Standard Certificate, one can see the additions and deletions to the data collected on the standard certificates.

Researchers, physicians, and public health agencies are encouraged to review and consider commenting on the data element changes on the standard certificates. Kansas will be able to add fields to the certificates if warranted. Public meetings where comments on the changes will be received have not yet been scheduled. Check the web site for dates.

For information on the U.S. standard certificates, visit the NCHS web site http://www.cdc.gov/nchs/vital_certs_rev.htm. Copies of the drafts may be downloaded, along with instructions on how the data will be collected and organized.

The standard certificates are the result of consultation between the National Center for Health Statistics (NCHS), state registrars from the 50 states, and representatives from public health and medical organizations. The standard certificate represents the minimum dataset the states must provide to NCHS. However, states may collect additional data if warranted.

Persons who want to be notified of the revision process may subscribe to the Kansas Health Statistics Report e-mail list by emailing Kansas.Health.Statistics@kdhe.state.ks.us. Updates will also be distributed to Kansas Rural Health Information Service subscribers.

Center for Health and Environmental Statistics

Secretary to Chair Data Governing Board

KDHE Secretary Roderick L. Bremby has agreed to serve as the chair of the Kansas Health Care Data Governing Board, succeeding State Registrar and Center for Health and Environmental Statistics Director Dr. Lorne A. Phillips. The Center's Office of Health Care Information provides staff support to the HCDGB.

Bremby, appointed Secretary by Governor Kathleen Sebelius, most recently served as a research assistant professor and associate director of the Work Group on Health Promotion and Community Development.

Reported Early Syphilis Infections in Kansas 2002

Prevention and intervention of syphilis is a major health concern in Kansas. Many areas report few or no syphilis cases but are at significant risk for syphilis because of one or more of the following characteristics:

- History of high syphilis rates in the 1990s,
- Port or border jurisdiction or are located along migration paths,
- Located along drug trafficking corridors, and
- Include groups that are disproportionately affected by syphilis such as illicit drug users and people exchanging sex for money or drugs.

Areas that include one or more of these characteristics are called, "Potential Re-emergence Areas" and the Centers for Disease Control and Prevention recommends that states focus primarily on enhanced surveillance and rapid outbreak response in these areas (1). The KDHE STD Program seeks to utilize all possible resources in delivering rapid and comprehensive prevention and intervention strategies to control early syphilis cases (infections less than 12 months duration).

From 1991 to 2000, reported cases of early syphilis declined in Kansas, but in 2001 there was a three-fold increase of reported early syphilis cases when compared to 2000. There were 15 cases reported in 2000 and 44 cases reported in 2001.

The increase of early syphilis was attributed to an outbreak in Topeka and one in Wichita. The Topeka outbreak accounted for 19 cases or 43 percent of all early syphilis in Kansas for 2001 and revolved around commercial sex workers and methamphetamine/cocaine usage.

This outbreak persisted throughout the first half of 2002 before being controlled. There were eight cases in the first half of 2002 and only two cases in the second half, both in August.

The Wichita outbreak, which consisted of 10 early syphilis cases, was linked to crack (cocaine) usage and sex for drugs/money. The outbreak in Wichita did not persist beyond the fall of 2001 (2).

Thirty-nine cases of early syphilis were reported from January 1, 2002 to December 31, 2002. In 2002 the focus of early syphilis control and prevention shifted to Wyandotte County (Kansas City area). In the last three months of 2002, Wyandotte County reported seven early cases of syphilis. Five of these cases were crack users and the other two were sexual partners of crack users. Johnson County, adjacent to Wyandotte County, reported four cases of early syphilis in December alone. Two of these Johnson County cases were methamphetamine/crack users and the other two cases were sexual partners of methamphetamine/crack users.

This outbreak accounted for 28 percent (11 cases) of all the early syphilis cases in Kansas for the year. African Americans and Hispanics accounted for 19 cases and 6 cases of reported early syphilis cases respectively in 2002. Historically, minorities in Kansas and nationwide have been disproportionately impacted by syphilis. This may reflect reporting bias or reflect differences in core syphilis prevalence and social environments. Whites accounted for 14 of the reported early syphilis cases. The male to female ratio of the 39 cases in Kansas for 2002 was 1:0.8 (22/17). Two female cases named female sex partners but no male case named male sex partners. The median age of an individual infected with early syphilis was 34 years of age and the age range was 18 to 60 years of age.

Kansas disease intervention specialists (DIS) made a decisive impact on the course of the disease. Fourteen (36%) of all the new early syphilis cases in Kansas for 2002 were discovered through DIS intervention activities. Thirty-eight individuals at risk for developing syphilis were preventively treated. CDC recommends an aggressive treatment schedule to minimize the spread of disease. DIS investigated 91 sexual contacts and 55 social contacts of the 39 early syphilis cases.

Of the 39 Kansas cases of early syphilis diagnosed, nearly two-thirds (24) were symptomatic (infectious). One goal of the program is to maintain a high percentage of early symptomatic syphilis diagnoses compared to early latent (non-infectious) syphilis diagnoses.

The high percentage of early symptomatic syphilis being found through screening and disease intervention indicates that Kansas is addressing the disease aggressively by finding disease earlier. Continuing this effort should prevent large uncontrolled outbreaks of the kind that have occurred in other areas of the country.

Outbreaks in Topeka and Wichita were minimized by aggressive actions of local DIS with the assistance of DIS from other areas and STD Program management. The actions included intensive disease specific interviews for each case within a week of the report and follow-up interviews for each case within a week of the original interview. Each sexual partner and social contact from each case is thoroughly investigated within a week of initiation.

Additionally, site visits to laboratories, medical centers, hospitals and correctional facilities in the outbreak areas were carried out by DIS to improve intervention and surveillance.

The nature of the Kansas outbreaks is similar to that of other areas of the country in the last few years where syphilis rates soared above the national average. However, relatively quick recognition of potential outbreaks in conjunction with aggressive and persistent disease intervention activities diminished the Kansas outbreaks. These same measures will be conducted in Kansas City during 2003.

*Derek Coppedge
KDHE Bureau of Epidemiology and Disease*

References

- 1 The National Plan to Eliminate Syphilis from the United States, October 1999, Centers for Disease Control and Prevention.
- 2 Reported Early Syphilis Infections in Kansas Between 01-01-2001 and 12-31-2001, Kansas Department of Health and Environment

News Notes

NCHS Data Warehouse on Health of Aging

The National Center for Health Statistics (NCHS) has released new data to the Data Warehouse on Trends in Health and Aging <http://www.cdc.gov/nchs/agingact.htm>.

The new release contains new and updated tables: "Help in Instrumental Activities of Daily Living, United States, 1992-2000, Selected Years" and "Help in Activities of Daily Living, United States, 1992-2000, Selected Years" from the Home Health and Hospice Care Survey, "Hospital Discharge Rates by First-Listed Diagnosis, United States, 1970-2000" from the National Hospital Discharge Survey, and "Nursing Home Residents Receiving Assistance in Activities of Daily Living by Bed-/Chairfast Status, United States, 1977-1999, Selected Years" from National Nursing Home Survey.

The Warehouse is a user-friendly Web-based data archive developed by the NCHS with support from the National Institute on Aging. It's specifically designed to show trends in health-related behaviors, health status, health care utilization, functional status and disability, and health care expenditures of the older population.

National Center for Health Statistics

Working Families' Health Insurance Coverage, 1997-2001

The Center for Studying Health System Change reports that between 1997 and 2001 the most dramatic change in health insurance coverage of Americans in working families was a growth in public insurance enrollment. Among non-elderly people in working families who lacked access to employer coverage, enrollment in public programs rose from 17% to 21%, and among those who declined employer coverage, enrollment in public programs jumped 13 percentage points from 34% in 1997 to 47% in 2001.

Another significant change was a 10.3 percent increase in enrollment of children from low-income working families in public programs. In 2001, 31.3% of children from low-income working families were enrolled in public programs compared to 21% in 1997. There was also a slight decline in the percentage of uninsured Americans in working families during this time, with 13.0% uninsured in 1997 and 11.6% uninsured in 2001.

The proportion of Americans in working families with employer-sponsored health insurance remained statistically un-

changed with 76.8% covered in 1997 and 77.5% covered in 2001. The report is at <http://www.hschange.com/CONTENT/463/>.

Center for Studying Health System Change

Health Statistics for U.S. Children

In its *Summary Health Statistics for U.S. Children: National Health Interview Survey, 1998*, the National Center for Health Statistics reports that most U.S. children under 18 years of age enjoyed excellent or very good health (84%). However, 12% of children had no health insurance coverage, and 6% of children had no usual place of medical care. Twelve percent of children had been diagnosed with asthma sometime during their life.

An estimated 8% of children 3-17 years of age had a learning disability, and an estimated 6% of children had Attention Deficit Disorder (ADD). Lastly, 11% of children in single mother families had two or more visits to an emergency room in the past year compared with 6% of children in two-parent or single-father families. The report is available at <http://www.cdc.gov/nchs/nhis.htm>.

*Debra L. Blackwell, Ph.D. and Luong Tonthat
National Health Interview Survey Statistics*

Small Employers Respond to Premium Increases

Findings from a recent report by the Center for Studying Health System Change (HSC) indicate that the rapid increase in insurance premiums that affected all firms in 2000 and 2001 was especially evident in small firms, producing an average 14.5% increase in premium costs to workers in firms with fewer than 50 employees. While conducting site visits to 12 nationally representative metropolitan areas, HSC found that in order to avoid the sting of rising health insurance costs, most small employers have made dramatic changes in the coverage they offer employees.

Small employers in all 12 sites increased cost sharing, eight decreased employer premium contribution, six changed products, plans, and/or carriers, five reduced eligibility, and three sites reduced services covered. The complete report is available at <http://www.hschange.com/CONTENT/479/>.

Center for Studying Health System Change

The Office of Health Care Information of the Kansas Department of Health and Environment's Center for Health and Environmental Statistics produces *Kansas Health Statistics Report* to inform the public about the availability and uses of health data. Material in this publication may be reproduced without special permission as long as *Kansas Health Statistics Report*, KDHE Center for Health and Environmental Statistics is listed as the source. Comments, questions, address changes and articles on health data intended for publication may be sent to OHCI, 1000 SW Jackson, Suite 130 Topeka, KS, 66612-1354, Kansas.Health.Statistics@kdhe.state.ks.us, or 785-296-8627, Roderick L. Bremby, Secretary KDHE; Lorne A. Phillips, PhD, State Registrar and Director CHES; Greg Crawford, Editor.

264-39
Office of Health Care Information
Center for Health and Environmental Statistics
Kansas Dept. of Health & Environment
1000 SW Jackson, Suite 130
Topeka, KS 66612-2221

**PRST STD
US Postage
Paid
Topeka, KS
Permit No. 157**