

Kansas Health Statistics Report

Kansas Department of Health and Environment – Division of Health – Center for Health and Environmental Statistics – No 26 – August 2005

Sunburns and Sunscreen Usage Among Kansas Women: Results from the 2002-2003 Kansas Women's Health Survey

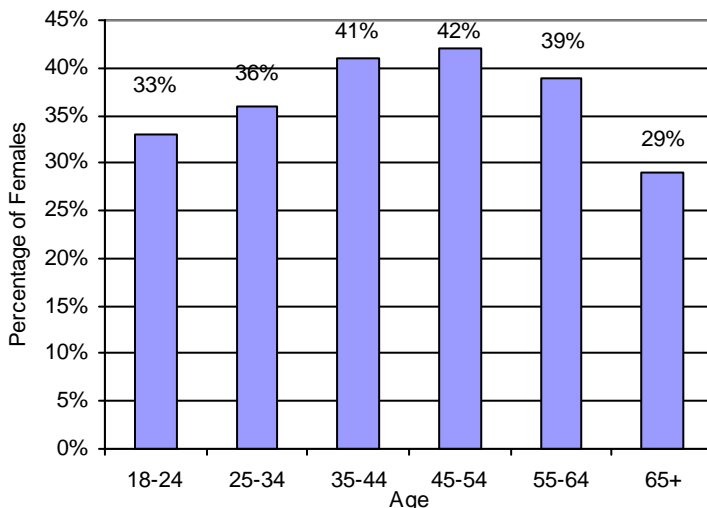
Each year approximately 200 adult Kansas women are diagnosed with melanoma skin cancer (1, 2). Excess exposure to the sun (sunburns) and history of sunburns early in life are risk factors for the development of skin cancer. Other risk factors for sunburns and skin cancer include: individuals with light skin, hair, or eye color; family history of skin cancer; personal history of skin cancer; certain types of moles or a large number of moles; and freckles (3).

Preventive measures for sunburns and skin cancer include limiting exposure to the sun between 10 a.m. and 4 p.m., wearing protective clothing, using sunscreen, and avoiding sunlamps and tanning beds (3). The American Academy of Dermatology recommends that everyone who is out in the sun for more than 20 minutes should use a sunscreen with a Sun Protection Factor (SPF) of at least 15 for basic protection. A sunscreen with SPF 15 will absorb 93 percent of UV light, while a sunscreen with SPF 30 will absorb 97 percent of UV light (4). Data from the 2002-2003 Kansas Women's Health Survey was utilized to examine behaviors related to skin cancer prevention, including sunscreen usage and sunburns among adult women in Kansas.

A random digit-dial health survey among adult Kansas women was conducted in 2002-2003. The survey collected information on health conditions and risk factors including questions on use of sunscreen, SPF of sunscreen, and number of sunburns.

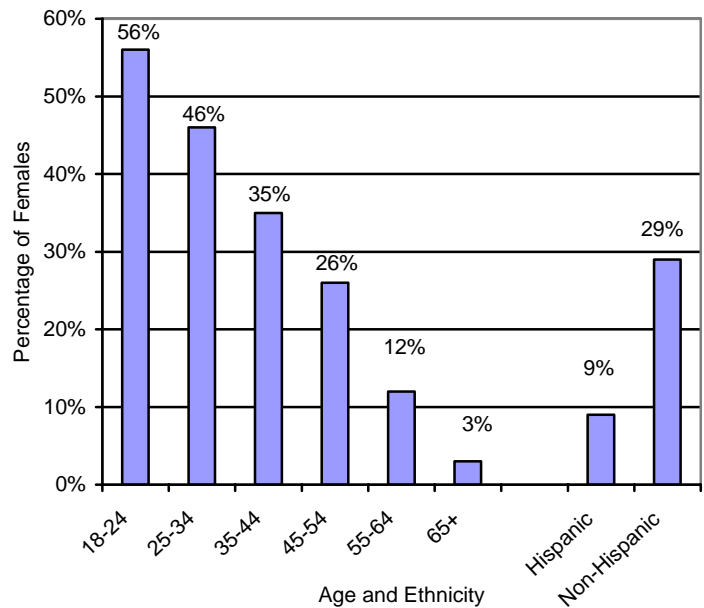
Sunscreen is used always or nearly always by 23 percent of Kansas women who go out in the sun for more than one hour on a sunny day. Among women who use sunscreen of any frequency, 96 percent use a sunscreen with a SPF of at least 15 and 63 percent use a sunscreen with a SPF of at least 30. Figure 1 shows that use of sunscreen differs by age (p-value < 0.01).

Figure 1. Percentage of Females Who Use Sunscreen Always or Nearly Always, 2003 Women's Health Survey



Three out of ten women (28%) had a sunburn during the past 12 months. Occurrence of sunburn differed by age group and ethnicity (Figure 2). Average number of sunburns among all women during the past 12 months was two. Average number of sunburns differed significantly among women who used sunscreen always or nearly always compared to women who used sunscreen sometimes, seldom, or never (1.94 burns vs. 2.45 burns respectively, p-value < 0.01).

Figure 2. Percentage of Females with Sunburn by Age and Ethnicity, 2003 Women's Health Survey



Use of sunscreen always or nearly always reduces the number of sunburns among Kansas women. All women should be encouraged to use sunscreen regularly.

Public health efforts in Kansas regarding sunburn prevention in women should target all those at increased risk for sunburn and skin cancer, with particular efforts to reach those under age 35 and Non-Hispanics.

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2004 Kansas Vital Statistics Counts Released

The Center for Health and Environmental Statistics has published preliminary counts of births, deaths, marriages, and marriage dissolutions by county for 2004. The data are contained in table 5 on page 7. Population-based rates, trend data, and other analyses will be in the *Annual Summary of Vital Statistics*, published later this year.

Popular Baby Names Listed

After almost a decade in the top spot, Jacob has been replaced by Aiden as the most popular boys' name given to newborns by Kansas parents in 2004 (Table 1).

The trend for Celtic and English boys' names continues with names such as Aiden, Conner, Dylan, Kaden, and Logan included in the top 25. Emma has hung on for another year as the top name for girls. Kaitlyn, Abigail, Emily, and Madison join Emma in the top five. This information was prepared by the Kansas Department of Health and Environment's Center for Health and Environmental Statistics. The lists are derived from birth certificate information which the Center's Office of Vital Statistics keeps on file.

Table 1. Top 25 Names Given to Babies Born in Kansas, 2004

Rank	Girls	Count	Boys	Count
1	Emma	265	Aiden	311
2	Kaitlyn	250	Jacob	293
3	Abigail	248	Kaden	292
4	Emily	238	Ethan	249
5	Madison	236	Michael	222
6	Hannah	190	Caleb	215
7	Grace	187	Andrew	196
8	Olivia	182	Alexander	190
9	Brianna	177	Matthew	184
10	Hailey	176	William	184
11	Makayla*	170	Tyler	180
12	Riley	163	Jackson	178
13	Alexis	160	Braden	176
14	Elizabeth	152	Nicholas	174
15	Kaylee	152	Joshua	173
16	Mackenzie	149	Conner*	169
17	Sarah	147	Dylan	163
18	Lauren	137	Jayden	153
19	Alyssa	132	Nathan*	150
20	Kylie	132	Ryan*	149
21	Sophia*	129	Zachary	149
22	Katherine	128	Logan	147
23	Madeline	127	John*	147
24	Anna	126	Austin	144
25	Sydney*	124	Samuel	143

* Names that moved into the top 25 from the previous year

Dropping off the list of 25 most popular girls' names were Chloe, Samantha and Taylor. Joining the list were Makayla, Sophia, and Sydney. Leaving the list of 25 most popular boys' names were Christian, Christopher, Jonathan, and Joseph. Joining the list were Conner, John, Nathan, and Ryan.

Popular baby names are one of the more regularly requested items produced by the center's Office of Health Care Information. While the list reflects popular culture and names frequently used in the media, other information from birth certificates and other vital records stored with the center's Office of Vital Statistics is used to gauge health trends in the state.

The popular baby names lists are available on the KDHE Web site at: <http://www.kdhe.state.ks.us/hci>

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Kansas Immunization Rates Rise

More Kansas children are being immunized, according to a Centers for Disease Control and Prevention (CDC) report. The recent National Immunization Survey (NIS) data show Kansas immunization rates have improved for the third consecutive year.

Immunization rates for 2004 for the 4:3:1 series (four doses of DTaP - Diphtheria, Tetanus, and Pertussis; three doses of polio vaccine, and one dose measles-mumps-rubella vaccine) have increased from 74 percent in 2002 to 80.6 percent in 2004. This is a nearly 9 percent increase in rates and resulted in approximately 5,700 more Kansas children immunized in 2004 than in 2002 for the 4:3:1 series.

Rates for 2004 for the 4:3:1:3:3 series (includes 4:3:1 vaccines plus Hepatitis B and Haemophilus influenzae type b) have increased to 77.5 percent, up from 66.8 percent in 2002. This marks a 16 percent increase and resulted in approximately 9,500 more children being immunized in 2004 than in 2002 for the 4:3:1:3:3 series. Immunization rates nationally are also steadily improving. The NIS data reflects rates for children ages 19 to 35 months.

KDHE has made numerous changes in its Immunization Program, including implementing several recommendations of the Governor's Blue Ribbon Task Force that studied ways to improve immunization rates.

Steps include:

- A 10-county pilot project called Immunize and Win a Prize which was aimed at Medicaid children and successfully resulted in increased immunization rates in every county, some increases as high as 55 percent,
- Expansion of the Immunize and Win a Prize program statewide to provide an incentive for parents to ensure their child is fully immunized, and to assist those families struggling with financial issues surrounding immunizations,
- Requirement of Hepatitis B and varicella (chicken pox) vaccine for school entry,
- Recommendation of an accelerated immunization schedule for DTaP (Diphtheria, Tetanus, and Pertussis) to ensure more children complete the series by allowing children to receive the fourth DTaP dose at 12 months, rather than 15-18 months,
- Use of the KDHE WIC program to identify immunization status of children in the program, and
- Implementation of a statewide immunization registry to ensure parents and health care providers know a child's immunization schedule so the child can be fully immunized.

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Cancer Control Plan under Review

The Kansas Cancer Partnership, through a series of state-wide public meetings, has unveiled the Kansas Comprehensive Cancer Control and Prevention Plan.

The meetings provided an opportunity for interested individuals to hear about the plan and provide feedback on the goals and initiatives proposed to help reduce Kansas' cancer incidence and mortality.

Cancer is the second leading cause of death in the state. Each year nearly 12,000 Kansans are diagnosed with cancer and 5,000 die from the disease. The plan calls for increasing education, information, and communication about cancer in Kansas.

The plan focuses on six priority cancers and identifies approaches to addressing the burden of cancer including: preventing some cancers from occurring, screening to detect cancer at its earliest stages, treating cancer with the most comprehensive/high quality treatment, and addressing survivorship and end of life issues for cancer patients.

The plan calls for the following actions:

- increased education, information, and communication regarding prevention and screening,
- improved access to treatment and coordinated services to help newly diagnosed patients,
- informing policymakers and legislators of issues regarding health insurance for poor and uninsured; coverage for medical advocacy services; and coverage for expenses involving clinical trials,
- improved data collection and access to data to help target cancer prevention and screening efforts, and
- establishing pilot projects in communities focusing on education and information; surveillance and data collection; identification of resources and risk reduction factors.

A copy of the Kansas Comprehensive Cancer Control and Prevention Plan is available at <http://www.kdhe.state.ks.us/bhp/index.html>.

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Kansas Perinatal Periods of Risk Analysis Compares Two Time Periods, 1994-1998 and 1999-2003

Infant mortality is an important measure of health, both nationally and in Kansas. The disparity in infant mortality rates between whites and blacks persists. In Kansas, when comparing 1994-1998 and 1999-2003, the total fetal/infant mortality rate has decreased in both the white and black populations, but the rate for blacks still remains approximately two times higher than the white rate. One method to identify opportunities and prioritize interventions to reduce fetal/infant mortality is the Perinatal Periods of Risk (PPOR) approach (1).

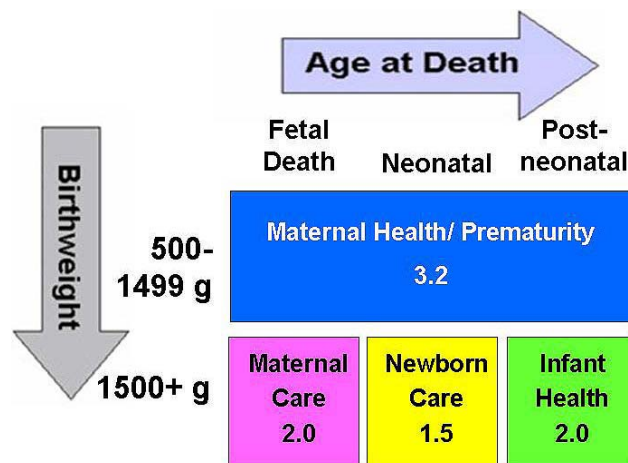
The PPOR approach was originally developed for use in developing and developed countries through the work of the Centers for Disease Control and Prevention (CDC) to monitor and investigate fetal-infant mortality. Since 1997, in partnership with CDC, the March of Dimes, HRSA/Maternal and Child Health Bureau and over 20 major cities, CityMatCH has led national efforts to validate, enhance, and adapt this approach for use in urban U.S. communities.

The Kansas Perinatal Council, a subcommittee of the Perinatal Association of Kansas, decided to provide leadership and guidance for a PPOR initiative in Kansas. They have provided

oversight of the state level analysis, and encouragement to local communities in their assessment activities.

PPOR data analysis consists of two phases. Phase I examines data relating to the four mortality components (Figure 3) – maternal health/prematurity, maternal care, newborn care and infant health – for various populations and uses a reference group to estimate excess mortality. The maternal health/prematurity cell includes fetal and infant deaths weighing 500-1499 grams. The maternal care cell includes fetal deaths weighing over 1499 grams. The newborn care cell includes live born infants who died <28 days and weighed over 1499 grams. The infant health cell includes live born infants who weighed over 1499 grams and died 28-364 days after birth.

Figure 3. PPOR Map of Fetal-Infant Mortality, Kansas, 1999-2003 *



* Rates/1,000 Live Births and Fetal Deaths

Methodology

For PPOR analysis, the study population was identified by linking certificates of death for a given year (death cohort) with the corresponding birth certificate. Data analysis included live births and infant deaths with a birth weight of 500 grams or greater and fetal deaths of at least 24 weeks gestation with a birth weight of 500 grams or more. Terminations are excluded. The rates (per 1,000 live births and fetal deaths) were then compared to a Kansas reference group (see below) to calculate the excess mortality. Data analysis was conducted using SAS, version 9.1.

The integrity and reliability of data-based analysis and reporting depend, in large part, on the quality of the underlying data. If the percentage of infant deaths certificates that cannot be matched with birth certificates is too great, infant mortality rates may be lowered substantially simply due to missing records. Among the linked data set shown in Table 2, the infant death data was analyzed for missing values such as birth weight, gestational age, mother's race/ethnicity, age and education level. The percent of missing data was less than two percent for all the variables analyzed except ethnicity, which had less than 10 percent missing data.

Table 2. Infant Deaths with Matching Linked Birth Certificates by Year

Years	Infant deaths	No. with Matching Birth Certificate	Percent Linked
1994-1998	1,377	1,329	96.5
1999-2003	1,376	1,333	96.9

Data source: Center for Health & Environmental Statistics

For calculating numbers and rates for the cells in the matrix (Figure 3), five years were combined. This was necessary for reliability due to small numbers - particularly for stratified analysis. For this reason, the PPOR workgroup recommends at least 60 cases in the matrix and 10 cases in each cell. Due to small numbers of fetal/infant deaths in the Native Americans, Asians, and Native Hawaiians or other Pacific Islanders populations, these races were not included in the stratified analysis; data analysis was restricted to white and black races, and Hispanic and non-Hispanic ethnicity.

PPOR analysis includes calculation of excess deaths through comparison to a reference group – a population that usually represents better or optimal pregnancy outcomes. The PPOR workgroup recommends using white non-Hispanic women age 20 or older with more than 12 years of education. For Kansas the internal reference group includes white non-Hispanic women age 20 or older with more than 12 years of education residing in the five urban counties (Douglas, Shawnee, Sedgwick, Johnson, and Wyandotte counties) years 1999 through 2003.

Results

PPOR analysis at the state level (Table 3) shows an 11.3 percent decrease in total fetal/infant death rate when comparing 1994-1998 and 1999-2003. The death rate in the white population decreased by 10.9 percent, while the death rate in the black population decreased by 6.3 percent. In the Hispanic population the fetal/infant death rate increased to 8.5/1,000, similar to the non-Hispanic population. The Maternal Health/ Prematurity cell represents the greatest opportunity for intervention for all race/ethnicity groups shown. The Kansas black population has the highest death rates – greatest opportunity for intervention in all the cells of the matrix.

Table 3. PPOR Analysis at the State Level ^{1,2}

	Total Fetal/Infant Deaths		Maternal Health/ Prematurity		Maternal Care		Newborn Care		Infant Health	
			500-1499 Grams		1500 Grams and Greater				Post Neonatal	
			N	Rate	N	Rate	N	Rate		
Kansas										
1994-1998	1816	9.7	663	3.5	451	2.4	304	1.6	398	2.1
1999-2003	1694	8.6	622	3.2	394	2.0	294	1.5	384	2.0
White										
1994-1998	1535	9.2	544	3.3	383	2.3	280	1.7	328	2.0
1999-2003	1421	8.2	505	2.9	335	1.9	254	1.5	327	1.9
Black										
1994-1998	230	16.0	103	7.2	53	3.7	19	1.3	55	3.8
1999-2003	212	15.0	91	6.5	45	3.2	30	2.1	46	3.3
Non-Hispanic										
1994-1998	1520	9.9	542	3.5	375	2.4	257	1.7	346	2.2
1999-2003	1374	8.6	503	3.1	313	2.0	243	1.5	315	2.0
Hispanic										
1994-1998	125	7.8	52	3.2	30	1.9	16	1.0	27	1.7
1999-2003	207	8.5	75	3.1	60	2.5	24	1.0	48	2.0

1 Includes only fetal/infants deaths where mother's race or ethnicity is given.

2 Rate/1,000 live births and fetal deaths.

Data source: Center for Health & Environmental Statistics

Excess deaths are calculated through comparison to the internal reference group. Table 4 shows the excess fetal/infant deaths rates by Perinatal Periods of Risk components. The black population has the highest excess death rate in all the cells. For the black population, the greatest opportunity for intervention is in the maternal health /prematurity cell and the infant health cell. The Hispanic population has a lower rate of excess deaths than the standard population in the newborn care component.

Table 4. Rate per 1,000 of Excess Fetal/Infant Deaths by Perinatal Periods of Risk Components, 1999-2003

Group	Fetal-Infant Mortality	Maternal Health/ Prematurity	Maternal Care	Newborn Care	Infant Health
All	2.4	1.0	0.5	0.0	1.0
White	2.0	0.7	0.4	0.0	0.9
Black	8.8	4.3	1.7	0.6	2.3
Non-Hispanic	2.4	0.9	0.5	0.0	1.0
Hispanic	2.3	0.9	1.0	(0.5)	1.0

Conclusion

Further analysis (phase II) is needed to have a better understanding of the fetal/infant deaths. Phase I PPOR analysis points toward appropriate interventions. The Kansas population showed the greatest need in the maternal health and prematurity component. Interventions for this cell include preconceptional health, improving health behaviors, and perinatal care. Interventions for the other components include prenatal care, high risk referral, and obstetric care for the maternal care cell; perinatal management, neonatal care, and pediatric surgery for the newborn care cell and; sleep position, breast feeding, and injury prevention for the infant health cell.

Reference

1. <http://www.citymatch.org>

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Increase in Obesity Surgery Seen in Kansas

In recent years there has been a sharp increase in the number of people undergoing surgery to promote weight loss by restricting food intake or interrupting the digestive process. According to the National Health and Nutrition Examination Survey (NHANES), 30 percent of adult Americans were obese in 2000 (Body Mass Index [BMI] greater than 30.0) compared to 23 percent in 1994 (1).

The economic impact of obesity on the U.S. health care system is significant and growing. Direct medical costs include preventive, diagnostic, and treatment services. Indirect costs include morbidity and mortality costs, where morbidity costs are defined as the value of income lost from decreased productivity, restricted activity, absenteeism, and bed days. Obesity-related medical expenditures in Kansas in 2003 were estimated at \$657 million; Medicare provided \$138 million and Medicaid financed \$143 million (2). This is a compelling reason for public officials and individuals to monitor the growing incidence of obesity and the growing popularity of surgical solutions.

The 1991 National Institutes of Health Consensus Conference on Gastrointestinal Surgery for Severe Obesity recognized three types of severe obesity management procedures (3):

- Vertical Banded Gastroplasty – procedures designed to restrict food intake by limiting gastric volume by one of several stapling techniques;

- Gastric Bypass and Laparoscopic Gastric Bypass – procedures which combine gastric restriction with emptying of semisolid gastric contents in the jejunum; and
- Laparoscopic placement of an adjustable gastric band (“Lap-Band”) which permits a variable restriction of the stomach and also is completely reversible.

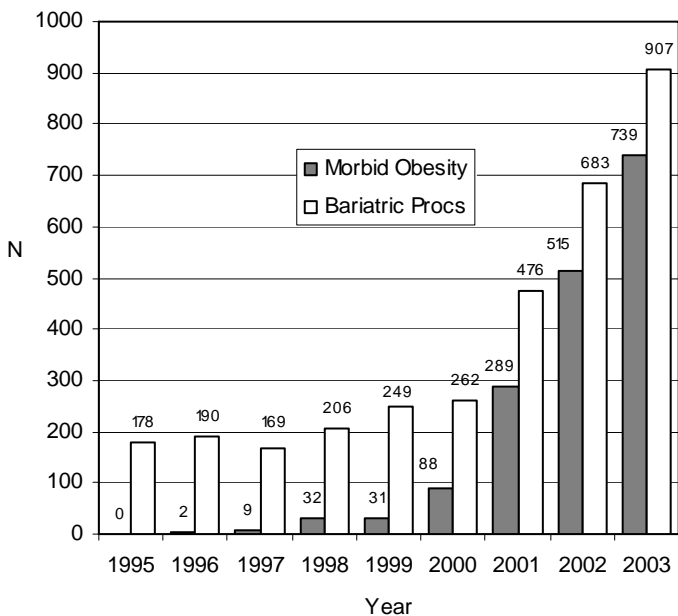
Currently, surgical treatments for obesity are recommended only for people with a BMI of 40 or more – generally indicating about 100 pounds overweight for men and about 80 pounds for women – or a BMI between 35 and 39.9 and who have at least one accompanying weight-related comorbidity, including hypertension, diabetes, and coronary artery disease.

Between 1997 and 2004, the number of operations nationwide nearly tripled to 63,100, or about 0.6 percent of those eligible using the BMI standard. Between 1998 and 2002 nationwide the hospital death rate for bariatric surgery declined by 64 percent (4). It appears that the perception that bariatric surgery is safe and effective is growing along with the increase in number of people who can be classified as candidates for the surgery.

An examination of community hospital inpatient discharge data acquired from the Kansas Hospital Association (patients with length of stay greater than 24 hours) from 1995 through 2003 reveals a sizeable increase in the number of operations involving restrictions on stomach size.

Figure 4 shows the number of patients undergoing bariatric procedures performed in Kansas from 1995 to 2003 for all diagnoses along with those whose surgery was directly associated with a diagnosis of clinically severe obesity (Morbid Obesity ICD-9 CM code 278.01). Before 1997, the number of inpatient admissions with a diagnosis of clinically severe obesity who were admitted for stomach restrictive surgery was virtually zero. Between 2000 and 2003 the number of bariatric procedures performed on obese patients rose from 88 to 739 – a more than 8-fold increase. More than one in five adult Kansans are obese (BMI greater than 30), but the number with BMI greater than 35 is not known (5).

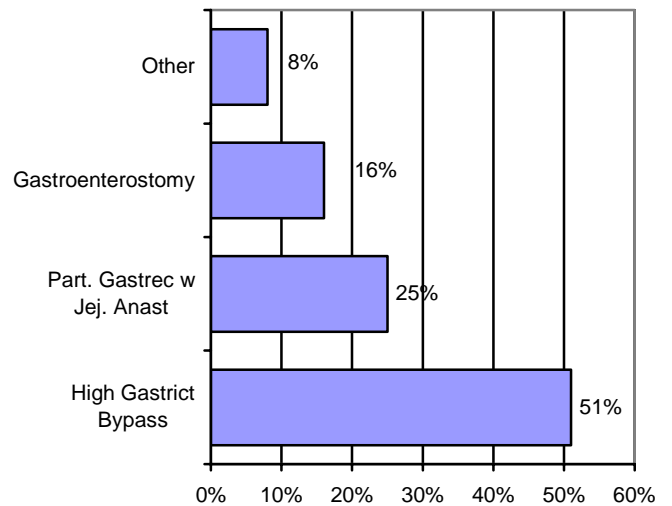
Figure 4. Bariatric Procedures in Kansas, 1995 - 2003



Among the various procedures that have been approved for weight reduction the most common procedure in Kansas that required an overnight hospital stay has been “High Gastric Bypass,”

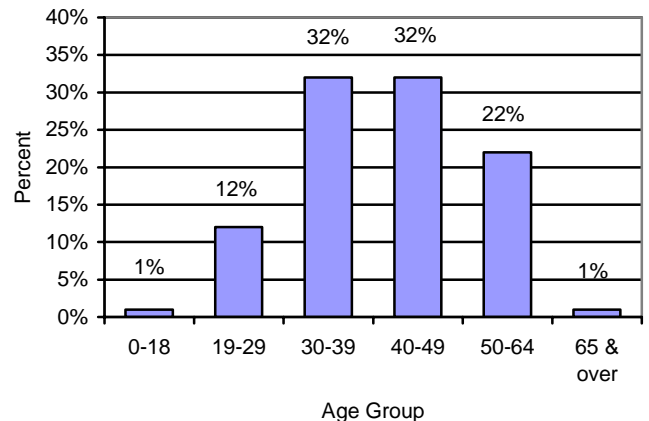
a type of stomach stapling (Figure 5). Other common procedures were Partial Gastrectomy with Anastomosis to Jejunum and Other Gastroenterostomy. All of these procedures involve gastrectomy, or incision of the stomach. Nationwide, the Lap-Band procedure, which does not require gastrectomy, has recently become very popular. Available Kansas community hospital inpatient data contains no record of this procedure having been performed since it currently is only available at specialty hospitals (see website of Association for Morbid Obesity Support: <http://www.obesithelp.com/morbidobesity>).

Figure 5. Bariatric Surgery by Procedure Type



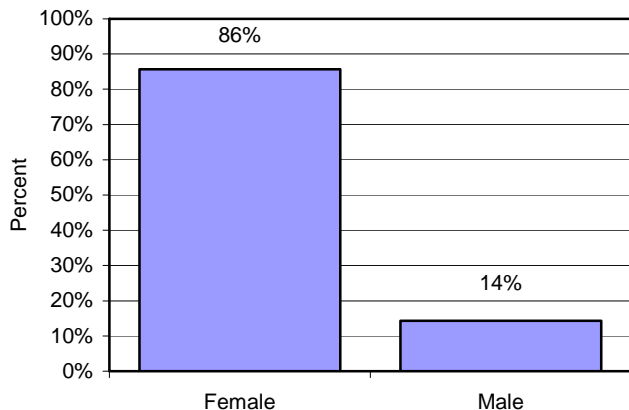
Bariatric surgery is typically selected by middle-aged patients. Figure 6 shows that over 90 percent of patients with a diagnosis of morbid obesity who elected to have bariatric surgery were ages 19-64; about 64 percent were ages 30-49.

Figure 6. Bariatric Surgery by Age Group, 1995-2003



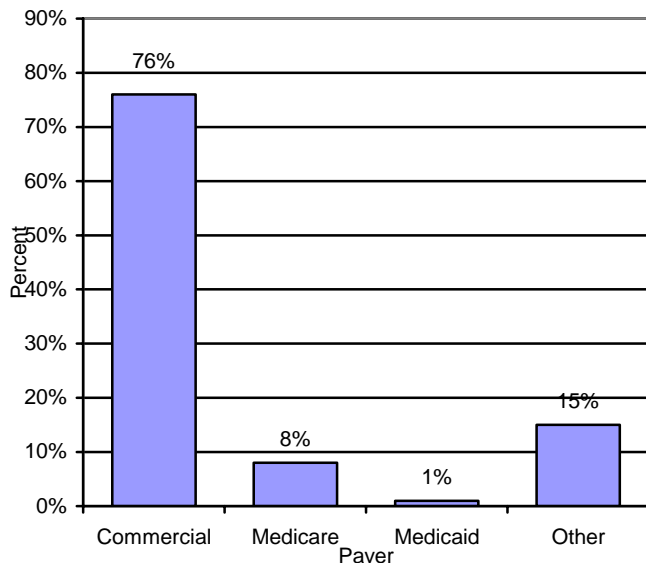
Women elected bariatric surgery in much greater numbers than men; about 86 percent of obese patients choosing bariatric surgery were women (Figure 7).

Figure 7. Bariatric Surgery by Sex 1995 - 2003



Bariatric surgery costs were most often paid by commercial insurers; all commercial carriers were listed as the primary payor in 76 percent of discharges; Medicare was the primary payor in 8 percent of discharges; and Medicaid paid for one percent. The remaining 15 percent of bariatric surgeries were paid by various sources including self and other government payors (Figure 8). Charges for these procedures can be as high as \$30,000 or more if complications arise.

Figure 8. Bariatric Surgery by Payer, 1995-2003



Conclusion

As bariatric procedures become more popular as a treatment method for the morbidly obese, and more payers become pressured to pay for these treatments, further studies must be conducted. There are significant concerns for attaining weight reduction and quality of life for patients after the surgery.

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PA Health Care Cost Containment Council Reports on Hospital-Acquired Infections

Undertaking a controversial and difficult study, beginning January 1, 2004, the Pennsylvania Health Care Cost Containment Council (PHC4) began collecting information from hospitals on infections patients acquire (also known as nosocomial infections) while in the hospital. There is increased concern about these infections, which can result in compromised quality of care, increased hospital stays, increased cost, and untimely death. PHC4 initiated their study and reported it publicly to provide accurate data to providers, purchasers, and consumers of health care and to raise awareness so that attention can be paid to preventing these infections where possible.

While PHC4 suspects underreporting of acquired-infection cases, these findings were startling. Of the 11,668 patients identified having an acquired infection, 15.4 percent died, compared to 2.4 percent who died from complications that did not involve an acquired infection. In addition, an estimated additional \$2 billion in hospital charges and 205,000 hospital days were reported from these conditions. PHC4 hopes this study will result in a "Call to Action" regarding hospital-acquired infections, encourage health care providers to implement procedures to prevent these conditions, improve quality of care and inform consumers about potential hazards from hospital stays.

For more information, see <http://www.phc4.org> for a research brief and a more detailed report.

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News Notes

Prescription Expenditures

Americans spent a total of \$151 billion on outpatient prescriptions in 2002 - an amount nearly 2.5 times greater than the \$65 billion spent in 1996. This figure does not include any over-the-counter remedies or drugs prescribed in hospitals, nursing homes, or other institutions. The top 10 list of costliest drugs, with a combined pricetag of nearly \$30 billion, was led by Lipitor®, the cholesterol-lowering drug, at a cost of \$5.9 billion. Competitors Zocor® and Pravachol® also made the top 10, as did anti-ulcer drugs Prevacid® and Prilosec®, and anti-depressants Paxil® and Zoloft®.

The information is reported in the Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Statistical Brief 60: Top 10 Outpatient Prescription Medicines Ranked by Utilization and Expenditures for the Community Population, 2002, statistical brief.

Agency for Healthcare Research and Quality

Table 4. 2004 Kansas Vital Statistics Counts *

County of Residence	Live Births	Deaths	Marriages	Marriage Dissolutions
Kansas	39,553	23,720	19,174	8,759
Allen	156	175	74	20
Anderson	92	96	56	33
Atchison	245	187	116	54
Barber	48	76	31	24
Barton	319	320	213	72
Bourbon	219	193	115	69
Brown	133	141	81	25
Butler	772	548	417	174
Chase	46	22	33	5
Chautauqua	49	61	42	20
Cherokee	237	253	109	72
Cheyenne	26	36	8	12
Clark	26	33	14	4
Clay	91	103	73	31
Cloud	99	152	56	29
Coffey	101	101	66	116
Comanche	24	31	11	4
Cowley	426	417	271	187
Crawford	525	421	227	174
Decatur	16	43	17	8
Dickinson	208	212	147	53
Doniphan	71	77	59	20
Douglas	1,257	530	709	249
Edwards	38	49	21	13
Elk	44	51	28	11
Ellis	365	239	203	98
Ellsworth	42	78	44	52
Finney	804	177	271	116
Ford	631	253	253	112
Franklin	375	231	207	134
Geary	495	182	513	210
Gove	24	31	12	4
Graham	26	38	18	6
Grant	128	53	46	26
Gray	102	45	33	6
Greeley	23	27	8	5
Greenwood	80	109	62	22
Hamilton	38	26	18	9
Harper	57	105	47	21
Harvey	386	367	237	65
Haskell	86	35	39	3
Hodgeman	18	35	9	5
Jackson	178	103	87	37
Jefferson	196	160	113	51
Jewell	21	50	26	15
Johnson	7,651	2,827	2,641	402
Kearny	70	25	21	8
Kingman	76	121	54	34
Kiowa	36	31	26	3
Labette	261	308	106	88
Lane	13	26	11	9
Leavenworth	909	522	474	229
Lincoln	35	39	29	7
Linn	122	87	62	12
Logan	26	32	22	11

County of Residence	Live Births	Deaths	Marriages	Marriage Dissolutions
Lyon	510	291	242	49
Marion	138	181	87	28
Marshall	128	136	74	35
McPherson	366	328	226	105
Meade	55	45	27	7
Miami	420	237	198	41
Mitchell	61	97	52	22
Montgomery	495	468	298	124
Morris	59	69	35	16
Morton	48	41	20	13
Nemaha	122	150	60	21
Neosho	224	192	151	64
Ness	30	41	20	15
Norton	50	84	32	31
Osage	180	183	100	71
Osborne	31	74	25	11
Ottawa	73	68	40	11
Pawnee	60	82	63	40
Phillips	53	63	37	12
Pottawatomie	294	171	129	49
Pratt	112	128	89	43
Rawlins	16	48	10	11
Reno	835	599	527	343
Republic	46	83	30	15
Rice	137	138	51	40
Riley	823	323	514	202
Rooks	55	74	40	11
Rush	34	49	20	10
Russell	77	110	63	28
Saline	780	494	415	244
Scott	65	38	39	15
Sedgwick	7,757	3,686	3,619	2,601
Seward	526	135	182	87
Shawnee	2,484	1,560	1,181	530
Sheridan	33	27	18	7
Sherman	73	76	33	18
Smith	32	65	25	15
Stafford	40	62	35	9
Stanton	44	25	14	10
Stevens	84	47	46	25
Sumner	286	276	188	74
Thomas	100	96	64	28
Trego	30	54	21	13
Wabaunsee	89	60	38	7
Wallace	14	9	10	10
Washington	60	91	52	17
Wichita	46	35	17	7
Wilson	119	131	72	47
Woodson	32	58	20	19
Wyandotte	2,785	1,452	1,139	229

* Residence Data are presented for births and deaths
 Occurrence Data are presented for Marriages and Marriage
 Dissolutions

Source: Kansas Department of Health and Environment

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