NCHS Dataline

The National Center for Health Statistics, Centers for Disease Control and Prevention, will hold its next data users conference in Washington, DC, in July 2002. This biennial conference offers researchers, analysts, policy makers, and program officials an opportunity to learn about current and upcoming data resources and the new tools for the application and analysis of NCHS data files. A new classification system has been launched for classifying functional status and disabilities. NCHS released a new analysis of trends in cesareans and vaginal birth after cesareans and closes out the *Healthy People 2000* decade with an assessment of the progress in reducing health disparities.

2002 DATA USERS CONFERENCE

Continuing a series of meetings aimed at those who are current or potential users of NCHS data, the 2002 conference will be held July 15–17 at the Omni Shoreham Hotel in Washington, DC. The conference is organized around a series of plenary sessions on general topics and workshops focused on the data sets from each of the NCHS data systems. There will be presentations by NCHS staff on the structure and content of the data files, emphasizing the aspects of data collection that are essential for the effective utilization of the information. Other presentations will address analytical and statistical issues, and others will show how the information has been used in innovative epidemiological, programmatic, or policy applications.

For more information on the conference or to sign up for a registration packet, contact NCHS at 301-458-INFO or check the CDC website at www.cdc.gov/nchs. There is no registration fee for the three-day conference.

NEW SYSTEM FOR CLASSIFYING FUNCTIONAL STATUS AND DISABILITIES IS LAUNCHED

Representatives from more than 25 countries met in Bethesda, Maryland, on October 21, 2001, to launch a new international system for classifying functional status and disabilities. The announcement of the new classification system was made during the Opening Session of the World Health Organization Collaborating Centers for the International Classification of Diseases, hosted this year by NCHS, which serves as the North American Center. This new system will be implemented worldwide and will result in a better understanding of the extent of disabilities and their impact on the daily lives of citizens in every nation. The new system will be used by those providing medical care, administering social services, advocating for rights and benefits, promoting accessibility, and developing policies and programs.

The new classification system will result in better, more uniform data for research and data analysis. The International Classification of Functioning, Disability and Health (ICF) complements the International Classification of Diseases (ICD), which is used worldwide for coding causes of death and hospitalization. Without these international classifications, comparisons of health data among countries would be impossible. The ICF was approved by the World Health Assembly in May 2001, after a decade-long international revision process in which the United States and 40 other countries were active participants.

The ICF provides a framework and classification scheme for describing a wide range of information about health, including functional status. It is structured around two broad components: (1) body functions and structure; and (2) activities related to tasks and actions by an individual and participation involvement in a life situation, with additional information on severity and environmental factors. Functioning and disability are viewed as a complex interaction between the health condition of the individual and the contextual factors of the environment as well as personal factors. The picture produced by this combination of factors and dimensions is of "the person in his or her world." The ICF is applicable to all people, whatever their health condition. Its language is neutral as to etiology, placing the emphasis on function rather than condition or disease. It also is carefully designed to be relevant across cultures, age groups, and genders, making it highly appropriate for heterogeneous populations. More information on the development and use of the ICF is available at www.cdc.gov/nchs/icd9.

CESAREAN AND VBAC TRENDS REVERSED IN LAST HALF OF 1990S

A new NCHS report tracks trends in rates of cesarean delivery and vaginal births after previous cesarean (VBAC) delivery for 1991–1999. The report shows that

from 1991 to 1996 the cesarean rate declined while the VBAC rate steadily increased. Trends have reversed since 1996, with cesareans now on the rise and the rate of VBACs declining to early 1990 levels.

The US cesarean rate increased 6% from 1996 to 1999 (with preliminary 2000 data showing another 4% increase), after declining 8% from 1991 to 1996. Women in all racial and ethnic groups experienced the increase; however, the earlier decline was more pronounced among white non-Hispanic women.

The VBAC rate increased 33% from 1991 to 1996, then dropped by 17% from 1996 to 1999. The dramatic increase in VBAC rates was experienced by women of all ages and for each major race/ethnic group.

Other highlights of the report show that:

- In 1999, there were 862,068 births by cesarean delivery for a rate of 22.0 per 100 births, compared with a rate of 22.6 in 1991.
- Cesarean rates are lowest for teenage mothers and increase steadily with maternal age. The 1999 cesarean rate for mothers in their 30s and 40s was approximately double that for teenagers.
- In 1999, a total of 97,680 births were delivered by VBAC. VBAC rates were highest for teenagers and lowest for older mothers.
- Cesarean rates for all regions and nearly all states increased from 1996 to 1999, but throughout the 1990s, cesarean rates were highest in the South and lowest in the Midwest and West.
- Cesarean deliveries were consistently higher for women having their first child than for women having a second or third birth.
- Cesarean rates were higher for women with medical risk factors or complications of delivery. However, even for women with risk factors and labor complications, cesarean rates declined during the first half of the decade and then have increased since 1996. Throughout the 1990s, cesareans were more frequently performed for women with diabetes, genital herpes, hypertension, eclampsia, incompetent cervix, and uterine bleeding.

The report, *Trends in Cesarean Birth and Vaginal Birth After Previous Cesarean, 1991–99*,[1] is based on birth certificates filed in state vital statistics offices and reported to CDC's National Center for Health Statistics through the National Vital Statistics System. The report examines trends in cesarean and VBAC rates by age, race, ethnicity, education of mother, medical risk factors, and complications of delivery for the nation and by state. It provides important information to monitor current patterns and changes in childbirth and delivery in America. The report can be downloaded or viewed without charge from the CDC website.

DESPITE OVERALL GAINS, DISPARITIES IN HEALTH REMAIN

Despite considerable overall advances in health over the past decade, a new NCHS analysis shows that significant disparities in health persist among racial and ethnic groups in America. Tracking 17 key health indicators, the report (which presents data for *Healthy People 2000*) shows that infant mortality, teen births, heart disease death rates, and other key measures improved substantially for most population groups during the 1990s. However, the report also demonstrates that while many of the indicators showed some reduction in disparities, others showed increases in disparities.

This report presents national trends in racial- and ethnic-specific rates for 17 health status indicators established as part of the *Healthy People 2000* process. The indicators reflect various aspects of health including infant mortality, teen births, prenatal care, and low birthweight; as well as death rates for all causes, and for heart disease, stroke, lung and breast cancer, suicide, homicide, motor vehicle crashes, and work-related injuries. Infectious diseases such as tuberculosis and syphilis are also included. The percent of children in poverty and the percent of the population living in communities with poor air quality round out the set of measures developed to allow comparisons among national, state, and local areas on a broad set of health indicators.

One of the goals of *Healthy People 2000* was to reduce disparities in health. Notable progress was made in reducing the gap in syphilis case rates and stroke death rates. However, for about half of the indicators the disparities improved only slightly, and disparities actually widened substantially for work-related injury deaths, motor vehicle crash deaths, and suicide.

While no single group scored best on all of the indicators, Asians/Pacific Islanders had the most favorable rates on eight of the indicators. A notable exception is the markedly high rates for tuberculosis. In 1998, the tuberculosis case rate for Asians/Pacific Islanders was 15 times the rate for white non-Hispanics.

White non-Hispanics also generally fared well, with the most favorable rates for prenatal care, homicide, tuberculosis, and percent of children in poverty.

All racial and ethnic groups experienced improve-

ment in rates for 10 of the indicators. For four additional indicators there was improvement in rates for all groups except American Indians/Alaska Natives. Female breast cancer death rates improved except for American Indian/Alaska Native and Asian/Pacific Islander women. The percent of low birthweight infants improved only for black non-Hispanics. The percent of children under 18 years of age living in poverty improved for all groups except Asians/Pacific Islanders.

From 1990 to 1998, rates for American Indians/Alaska Natives failed to decline—or actually increased—on six of the indicators, including low birthweight, suicide death rates, and all cause death rates.

A notable success was seen in the drop in syphilis case rates. The two groups with the highest rates of syphilis in 1990, black non-Hispanics and Hispanics, had the greatest declines—about 90% from 1990 to 1998. This cut by more than half the relative difference in the rate for black non-Hispanics and Asians/Pacific Islanders, who had the lowest rates.

Healthy People 2010 is now in place and—building on the work of the *Healthy People 2000* initiatives—has identified a set of Leading Health Indicators which will be tracked nationwide and in states and communities. *Healthy People 2010* calls for the elimination of disparities in health among all population groups. *Trends in Racial and Ethnic-Specific Rates for the Health Status Indicators: United States, 1990–1998*[2] is available on the NCHS website.

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http://www.cdc.gov/cancer/nbccedp/info-bc.htm

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