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FROM VITAL & HEALTH STATISTICS OF THE NATIONAL CENTER FOR HEALTH STATISTICS

U.S. DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE

Public Health Service
Office of Health Research, Statistics, and Technology

Number 49

April 16, 1979

Office Visits for Family Planning, National Ambulatory Medical Care Survey: United States, 1977¹

According to data collected in the National Ambulatory Medical Care Survey (NAMCS), an estimated 11 million visits to office-based physicians included a family planning service, either as one of the stated purposes of the visit or as an adjunct service when patients visited for other problems.

The NAMCS is a sample survey conducted annually by the Division of Health Resources Utilization Statistics in the National Center for Health Statistics. The estimates in this report are based on information recorded by participating physicians on brief encounter forms (Patient Record, see Advance Data No. 48, April 13, 1979) during sample office visits. A brief description of the sample design and an explanation of the sampling errors associated with selected aggregate statistics may be found in the Technical Notes of this report.

Data on family planning services are also reported from the National Survey of Family Growth (NSFG), based on a sample of currently married women between the ages of 15 to 44 years, with a family planning visit in the last 3 years; and by the National Reporting System for Family Planning Services (NRSFPS), based on reports by a sample of organized family planning service sites.^{2,3} Because of the differences in the

populations sampled, and differences in the definitions and collection procedures, statistics on family planning visits from these several data systems differ. According to NSFG statistics for 1976, an estimated 11,153,000 women in the age range 15-44 years had visited their own physician within the last 3 years for family planning services. Provisional data from NRSFPS for 1976 indicated about 5,427,000 visits by women of all ages to organized family planning clinics.

In NAMCS, patients' principal problems, complaints, or other reasons for visit, expressed as nearly as possible in the patient's own words, are recorded by the physician on the Patient Record. From 1973 to 1976 these reasons for visit were coded according to a symptom classification developed for use at the inception of the survey.⁴ However, this classification scheme did not provide much detail in the area of family planning. The opportunity to obtain more complete information was presented by the 1977 revision of the classification.⁵ The new taxonomy delineated, among other presenting patient problems and complaints, the most commonly presented types of family planning reasons for visiting physicians given by patients.

¹This report was prepared by Beulah K. Cypress, Ph.D., Division of Health Resources Utilization Statistics.

²National Center for Health Statistics: Use of family planning services by currently married women 15-44 years of age, United States, 1973 and 1976, by G.E. Hendershot. *Advance Data from Vital and Health Statistics*, No. 45. DHEW Pub. No. (PHS) 79-1250. Public Health Service. Hyattsville, Md. Feb. 7, 1979.

³National Center for Health Statistics, Provisional Data from the National Reporting System for Family Planning Services, January 1976-December 1976, (mimeo).

⁴National Center for Health Statistics: The National Ambulatory Medical Care Survey: Symptom classification, by S. Meads and T. McLemore. *Vital and Health Statistics*. Series 2-No. 63. DHEW Pub. No. (HRA) 74-1337. Health Resources Administration. Washington. U.S. Government Printing Office, May 1974.

⁵National Center for Health Statistics: *A reason for visit classification for ambulatory care*, by D. Schneider, L. Appleton, and T. McLemore. *Vital and Health Statistics*. Series 2-No. 78. DHEW Pub. No. (PHS) 79-1352. Public Health Service. Washington. U.S. Government Printing Office. In press.

This permitted a clearer identification of family planning visits than was possible in earlier national surveys of ambulatory care in physicians' offices. Also in 1977 for the first time, "family planning" was included in the therapeutic services listed on the Patient Record.

In NAMCS, a family planning therapeutic service is defined as services, counseling, or advice which might enable patients to determine the number and spacing of their children. It includes both contraception and infertility services. Information from this item was used to estimate the number of visits which included family planning services even though the physician did not record that as the patient's reason for visiting the physician.

In about half of the 11 million family planning visits patients expressed a reason for visiting the physician which was related to family planning. In the other half, reasons other than family planning were given but, in addition to other medical care, some kind of family planning therapeutic service was rendered during the visit (table 1). It is not known whether some patients were reluctant to say that family planning was their reason for the visit or whether the subject,

possibly related to the presenting problem, arose during the course of the visit. But for the purpose of estimating the extent of utilization of private physicians for family planning services, these encounters were considered "family planning" visits.

It was postulated that teenagers might be less inclined than older patients to cite family planning as a reason for going to the physician's office. Apparently this was not the case since differences between the proportions of teenagers' visits in which they cited a reason and those in which they simply received a service were not statistically significant. On the other hand, patients 45 years and over were less likely to give than not give family planning as a reason when they received a family planning service during the visit. This may or may not indicate that for this group of patients family planning was probably incidental to their purpose in visiting the physician.

PATIENT SEX, RACE, AND AGE

The ratio of about 13 visits by women to one visit by men was not unexpected (table 2). However, the fact that about 791,000 family planning visits to physicians were made by men provides a new perspective on the traditionally female-oriented approach to discussion of family planning visits. Because of the paucity of data on family planning visits by men, most published reports have dealt exclusively with visits by women. Unpublished data from NRSFPS reveal only about 39,000 visits by men in some 4,800 organized family planning service sites during 1976.³ While the NAMCS visit rate of about 10 visits by men for each 1,000 males over 15 years in the population is quite low compared to that of females (about 122 per 1,000), this may mark the beginning of a trend and bears scrutiny in the future.

Available data sources indicate that white patients tend to visit private physicians for family planning services at a higher rate than black patients, while black patients visit organized family planning clinics at a higher rate than white patients do. Of the white female respondents in NSFG with a family planning visit in the last 3 years, 86 percent reported visiting a private physician; but only 63 percent of the

Table 1. Number and percent distribution of office visits for family planning with a family planning reason for visit or with a family planning therapeutic service included, by patient age and sex: United States, 1977

Age and sex	Family planning visits	
	Reason for visit stated	Therapeutic service included
Total	5,662	5,341
<u>Age</u>	Percent distribution	
All ages	100.0	100.0
15-19 years	11.6	10.1
20-34 years	76.3	68.9
35-44 years	10.0	10.2
45 years and over	*2.0	10.8
<u>Sex</u>		
Female	90.8	94.9
Male	9.2	5.1

Table 2. Number, percent distribution, and rate of office visits for family planning, by patient sex, race, and age: United States, 1977

Sex, race, and age	Number in thousands	Percent distribution	Visit rate per 1,000 ¹
Total	11,003	100.0	68.9
Sex			
Female	10,213	92.8	121.6
Male	791	7.2	10.5
Race			
White	9,998	90.9	71.3
Black and all other	1,006	9.1	51.9
Age			
15-19 years	1,199	10.9	57.1
20-34 years	8,000	72.7	158.9
35-44 years	1,110	10.1	48.4
45 years and over	695	6.3	10.6

¹Based on the civilian noninstitutionalized population 15 years and over.

black respondents reported the location as the physician's office.² On the other hand, organized family planning clinics which reported to NRSFPS showed an enrollment rate of roughly 144 per 1,000 black women 15-44 years of age in the population, compared with only about 44 per 1,000 white women of the same age.³ The NAMCS data also disclosed a differing utilization pattern by race with white women visiting at a rate of 71 per 1,000, compared with 52 per 1,000 black and other women. The reader should note that the NAMCS *visit* rate includes initial and return visits, some of which may be by the same patient; but the NRSFPS enrollment rate is based on an unduplicated count of patients.

Most family planning visits to office-based physicians were made by patients of both sexes in the age range 20-34 years (73 percent), representing an average of about 159 visits for each 1,000 persons of that age in the United States (table 2). Patients aged 15-19 years accounted for about 11 percent of the total with a visit rate of about 57 per 1,000. (Visit rates by age groups

are higher when calculated for women only. A forthcoming series report on "Office Visits by Women" will include family planning data for these groups.)

GEOGRAPHIC DISTRIBUTION

Proportions of family planning visits did not differ significantly among the four geographic regions when sampling variability was taken into account (table 3), approximating the regional proportions of all NAMCS visits. Similarly, visits in metropolitan areas exceeded those in nonmetropolitan areas, reflecting the high concentration of physicians' offices in metropolitan areas.

Table 3. Number, percent distribution, and rate of office visits for family planning, by geographic region and metropolitan or nonmetropolitan area: United States, 1977

Region and area	Number in thousands	Percent distribution	Rate per 1,000
Total	11,003	100.0	68.9
Region			
Northeast	2,589	23.5	70.6
North Central	2,485	22.6	58.0
South	3,553	32.3	68.1
West	2,377	21.6	85.0
Area			
Metropolitan	9,019	82.0	82.7
Nonmetropolitan	1,984	18.0	39.2

PHYSICIAN SPECIALITY

Most family planning visits (65 percent) occurred in the offices of obstetrician-gynecologists, with an additional 26 percent made to general and family practitioners (GFP) (table 4). Male patients chiefly visited GFP's and urologists. The patient's age did not appear to make a difference in the choice of physician by specialty.

Table 4. Number and percent distribution of office visits for family planning by most visited physician specialty, according to patient age and sex: United States, 1977

Age and sex	Number in thousands	Total	Physician specialty			
			General and family practice	Obstetrics and gynecology	Urological surgery	All other specialties
All ages	11,003	100.0	25.8	64.8	3.1	6.3
<u>Age</u>			Percent distribution			
15-19 years	1,199	100.0	37.5	58.5	0.0	* 4.0
20-34 years	8,000	100.0	23.1	69.3	*3.5	* 3.0
35-44 years	1,110	100.0	*28.0	*58.8	*4.6	8.6
45 years and over	695	100.0	*32.7	*32.6	*1.6	*33.1
<u>Sex</u>						
Female	10,213	100.0	24.8	69.8	* 0.1	* 5.3
Male	791	100.0	*38.3	-	*42.0	*19.7

PATIENT'S REASON FOR VISIT

About 93 percent of the 5.7 million visits by patients who specifically stated they were visiting for family planning or related reasons fell chiefly in three major groups: those who visited for counseling, examinations, and general advice; those who required insertion, removal, or checkup of contraceptive devices; and those who visited for the prescription or renewal of contraceptive medication (table 5). (Predict-

ably, it was observed that teenagers were proportionately more likely to visit for contraceptive medication than they were for a contraceptive device.)

Surgical sterilization of patients of both sexes was performed during the visits for a relatively small number of patients. Of the estimated 240,000 such visits, about 80 percent were for vasectomies. Patients electing sterilization ranged from 20 to 44 years of age.

Patients who visited seeking abortions or for whom abortions were performed during

Table 5. Number and percent distribution of office visits with a family planning reason for visit by reason category: United States, 1977

Reason category and NAMCS code ¹	Number in thousands	Percent distribution
Total	5,662	100.0
Family planning, N.O.S. ² X500	2,085	36.8
Contraceptive device ³ X510	1,604	28.3
Contraceptive medication X505	1,569	27.7
Other reasons for visit ⁴ X515, X520, X525, X530	405	7.1

¹Based on a reason for visit classification developed for use in NAMCS (see reference 5).

²Includes counseling, examinations, and general advice regarding; birth control, N.O.S.; unwanted pregnancy; contraceptive, N.O.S.; sterilization; infertility; genetics; contraception followup, N.O.S.

³Includes IUD insertion, removal, or checkup; diaphragm insertion, removal, or checkup.

⁴Includes evaluation for and arrangement for abortion, wants abortion, sterilization (this visit), abortion (this visit), and artificial insemination.

NOTE: N.O.S. = not otherwise specified.

Table 6. Number and percent distribution of office visits which included a family planning therapeutic service but not a family planning reason for visit, by most common principal reason for visit: United States, 1977

Principal reason for visit and NAMCS code ¹	Number in thousands	Percent distribution
Total	5,341	100.0
Gynecological examination X225	964	18.1
Postpartum examination X215	902	16.9
Prenatal examination, routine X205	787	14.7
Symptoms referable to the genitourinary system S640-S829	668	12.5
Pap smear X365	* 336	6.3
All other reasons for visit residual	1,684	31.5

¹Based on a reason for visit classification developed for use in NAMCS (see reference 5).

the visit were relatively rare in physicians' offices.

It was posited that for the 5.3 million visits in which patients received a family planning therapeutic service without having directly expressed family planning as their reason for visit, the primary reasons would cover the broad array of problems usually found in office medical practice (e.g., respiratory or circulatory problems). However, those visits were more likely to be associated with reasons involving certain examinations and care of genitourinary problems than they were with reasons related to other problems. The types of care sought by patients who also received family planning therapeutic services are listed in table 6. It is of interest to note that 15 percent of these visits were for routine prenatal examinations and 17 percent for postpartum examinations, indicating that family planning was likely to be a consideration both during pregnancy and following delivery.

DIAGNOSTIC AND THERAPEUTIC SERVICES

Compared to NAMCS visits for all reasons, patients visiting for family planning received proportionately more Pap tests, blood pressure checks, clinical laboratory tests, and general examinations (table 7).

The rate of Pap tests performed during family planning visits in physicians' offices (about 46 percent) was similar to that of the organized family planning clinics measured by NRSFPS.³ However, blood pressure checks were proportionately more frequent during clinic visits (about 78 percent) than they were during physician visits estimated in NAMCS (about 58 percent).

Patient age was apparently not a determining factor in the physician's provision of services, since for each service shown in table 7 the differ-

Table 7. Number of NAMCS visits and number and percent of family planning office visits for patients 15 years and over, by most common diagnostic and therapeutic service: United States, 1977

Most common diagnostic and therapeutic service	All NAMCS visits	Family planning visits
Total	466,296	11,003
	Percent of visits	
Limited examination and/or history . .	57.6	49.5
General examination and/or history . .	20.2	36.2
Pap test	6.5	45.8
Clinical laboratory test	22.4	33.9
Blood pressure check	40.0	58.2
Drugs (prescription and nonprescription)	54.5	42.8
Diet counseling	7.2	7.7
Medical counseling	20.9	22.1

ences in the proportions by age were not statistically significant. However, the patient's reason for visit may have influenced the use of some services during some visits. General examinations, Pap tests, and clinical laboratory tests were proportionately more frequent when patients visited for contraceptive medication

than when a contraceptive device was involved (table 8). However, Pap tests are usually performed at a visit prior to the insertion of a contraceptive device and, thus, such tests may have been included in a visit with a different reason. Differences in the proportions of other services were not statistically significant.

Table 8. Number and percent of visits for contraceptive medication and for contraceptive device, by selected diagnostic services: United States, 1977

Diagnostic service	Contraceptive medication	Contraception device
Total	1,569	1,604
	Percent of visits	
Limited examination and/or history	49.1	66.3
General examination and/or history	37.4	*14.6
Pap test	66.9	*24.0
Clinical laboratory test	36.0	*14.4
Blood pressure check	57.9	36.6

SYMBOLS	
Data not available-----	---
Category not applicable-----	...
Quantity zero-----	-
Quantity more than 0 but less than 0.05-----	0.0
Figure does not meet standards of reliability or precision-----	*

TECHNICAL NOTES

SOURCE OF DATA: The information presented in this report is based on data collected in the National Ambulatory Medical Care Survey (NAMCS) during 1977. The target population of NAMCS encompasses office visits within the conterminous United States made by ambulatory patients to physicians who are principally engaged in office practice. The National Opinion Research Center, under contract to the National Center for Health Statistics, was the organization responsible for the survey's field operations. **SAMPLE DESIGN:** NAMCS utilizes a multistage probability design that involves samples of primary sampling units (PSU's), physician practices within PSU's, and patient visits within practices. For 1977 a sample of 3,000 non-Federal office-based physicians was selected from master files maintained by the American Medical Association and American Osteopathic Association. The physician response rate for 1977 was 77.5 percent. Sample physicians were requested to complete Patient Records (brief encounter forms) for a systematic random sample of office visits taking place within their practice during a randomly assigned weekly reporting period. During 1977, 51,044 Patient Records were completed by sample physicians.

SAMPLING ERRORS: The standard error is primarily a measure of the sampling variability that occurs by chance because only a sample, rather than the entire universe is surveyed. The relative standard error of an estimate is obtained by dividing the standard error of the estimate by the estimate itself and is expressed as a percent of the estimate. Relative standard errors of selected aggregate statistics are shown in table I. The standard errors appropriate for estimates percentages of visits are shown in table II.

DEFINITIONS: An *ambulatory patient* is an individual presenting himself for personal health services who is neither bedridden nor currently admitted to any health care institution on the premises.

An *office* is a place that the physician identifies as a location for his ambulatory practice. Responsibility over time for patient care and professional services rendered there generally resides with the individual physician, rather than an institution.

Table I. Approximate relative standard error of estimated number of office visits, NAMCS 1977

Estimated number of office visits in thousands	Relative standard error in percent
500.....	29.0
600.....	26.5
1,000.....	20.7
2,000.....	14.9
5,000.....	9.9
10,000.....	7.6
20,000.....	6.1
50,000.....	4.9
100,000.....	4.5
500,000.....	4.1

Example of use of table: An aggregate estimate of 75,000,000 visits has a relative standard error of 4.7 percent or a standard error of 3,525,000 visits (4.7 percent of 75,000,000).

Table II. Approximate standard errors of percentages of estimated number of office visits, NAMCS 1977

Base of percentage number of visits in thousands	Estimated percentage					
	1 or 99	5 or 95	10 or 90	20 or 80	30 or 70	50
	Standard error in percentage points					
500.....	2.9	6.3	8.6	11.5	13.2	14.4
600.....	2.6	5.7	7.9	10.5	12.0	13.1
1,000.....	2.0	4.4	6.1	8.1	9.3	10.2
2,000.....	1.4	3.1	4.3	5.7	6.6	7.2
5,000.....	0.9	2.0	2.7	3.6	4.2	4.5
10,000.....	0.6	1.4	1.9	2.6	2.9	3.2
20,000.....	0.5	1.0	1.4	1.8	2.1	2.3
50,000.....	0.3	0.6	0.9	1.1	1.3	1.4
100,000.....	0.2	0.4	0.6	0.8	0.9	1.0
500,000.....	0.1	0.2	0.3	0.4	0.4	0.5

Example of use of table: An estimate of 30 percent based on an aggregate of 15,000,000 visits has a standard error of 2.5 percent. The relative standard error of 30 percent is 8.3 percent (2.5 percent ÷ 30 percent).

A *visit* is a direct personal exchange between an ambulatory patient and a physician or a staff member working under the physician's supervision for the purpose of seeking care and rendering health services.

A *physician* is a duly licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) currently in office-based practice who spends time in caring for ambulatory patients. Excluded from NAMCS are physicians who are hospital based; physicians who specialize in anesthesiology, pathology, or radiology; physicians who are federally employed; physicians who treat only institutionalized patients; physicians employed full time by an institution; and physicians who spend no time seeing ambulatory patients.

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DHEW Publication No.
(PHS) 79-1250

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