STATISTICAL NEWS

PA Department of Health ◆ Bureau of Health Statistics and Research ◆ Vol. 25 No. 5 ◆ September 2002

Many Osteoporosis Risks Among PA Women

Age, Obesity, Smoking, Lack of Calcium & Exercise Contribute

Approximately one in six Pennsylvania women indicate they have a family history of osteoporosis. Among women over the age of 35, about one in thirteen women have broken a wrist, vertebrae or hip since they were 35 years old. Less than half of women in Pennsylvania have been counseled by a health professional regarding osteoporosis and how to prevent it.

For the past two years, the Behavioral Risk Factor Surveillance System (BRFSS), a statewide sample survey of adult residents, has asked Pennsylvania women about osteoporosis (see data table on page 5). It is estimated that ten million Americans suffer from osteoporosis (porous bone), a disease characterized by structural deterioration of bone tissue leading to fragility and high risk of bone fractures, particularly hip, vertebrae and wrist fractures. Women are three times more likely than men to suffer osteoporosis. All women should be concerned about osteoporosis particularly women past menopause. Women may lose up to 20% of their bone mass in the five to seven years after menopause. Osteoporosis is also more prevalent among whites and Asians, those with a family history of the disease, and the elderly.

Approximately one in six Pennsylvania women indicate they have a family history of osteoporosis.

There is nothing one can do to alter the risks associated with age, race, sex or family history; however, there are some behaviors that are associated with an increased likelihood of osteoporosis. A poor diet lacking in calcium and Vitamin D, lack of exercise, smoking and excessive alcohol all appear to contribute to osteoporosis. The primary defense from osteoporosis is to build strong bones during childhood and adolescence. Women acquire most of their skeletal mass by age 20. Adult women can help prevent osteoporosis by having a balanced diet rich in calcium and Vitamin D, engaging in resistance exercise, not smoking,

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Hospital Utilization Data Show Dramatic Changes

Fewer Beds, Shorter Stays, More Outpatient Surgery Since 1980

Over the past 20 years, the number of beds, inpatient admissions, and average length of stay for Pennsylvania's general acute care hospitals have declined dramatically while the number of outpatient surgeries and specialty inpatient services, such as open-heart surgery, have increased substantially.

When the decade of the 1980s began, there were 227 non-federal, general acute care hospitals with 54,239 licensed beds serving the health care needs of 11.8 million Pennsylvania residents. Today, there are 183 general acute care hospitals with a total licensed capacity of 41,872 beds serving 12.2 million residents. In 1980, there were 4.4 staffed beds and 157.7 inpatient admissions per 1,000 population, compared to 2.8 staffed beds and 132.4 admissions in 2000.

Between 1980 and 2000, dramatic changes occurred in the way health care was financed and delivered. Financing of health care began to shift from a fee-for-service system, in which hospitals and providers were generally paid what they charged for services, to a managed care system in which reimbursement levels were more restrictive. Concurrent with the ascension of man-

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Prostate Cancer Statistics for PA and U.S.

Incidence Higher for Blacks; Mortality Down; Earlier Stage Diagnoses

Prostate cancer accounted for the largest number (10,237) and percentage (29.2) of all invasive cancer cases diagnosed among Pennsylvania male residents in 1999 (the latest year of available statewide cancer incidence data). However, mortality rates for this disease are on the decline as earlier detection has increased. The average annual (1995-99) age-adjusted incidence rate for prostate cancer among black males in Pennsylvania was nearly 75 percent higher than the rate for white males (263.7, compared to 151.1 per 100,000). This supports the fact that black males have been reported to have the highest incidence of prostate cancer in the world.

Since the late 1980s increased basic screening procedures, specifically the prostate-specific antigen (PSA) blood test, have become more prevalent among physicians and clinics. This increase in screening procedures, especially for patients of advanced ages, has affected the number and the stage of cases detected and reported. A review of annual age-adjusted prostate cancer incidence rates for Pennsylvania residents during the years 1989 through 1999 show that rates increased dramatically between 1989 and 1992. The rates then decreased dramatically between 1992 and 1995. Since 1995, the rates have remained somewhat stable. Since the PSA test made it possible to detect prostate cancer much earlier in asymptomatic men, the pattern or trend displayed by the age-adjusted rates appears to be appropriate.

The...incidence rate for...black males was nearly 75 percent higher than the rate for white males.

The National Cancer Institute's SEER (Surveillance, Epidemiology, End Results) program annually reports age-adjusted cancer incidence rates for the United States, based on data collected from nine population based cancer registries selected to be representative of the United States total population. The annual age-adjusted prostate cancer incidence rates for Pennsylvania have been lower than the comparable SEER rates. However, since 1991 the differences between the annual incidence rates for Pennsylvania and SEER have been decreasing. One possible explanation for the shrinking differences between these rates is that the PSA test may have taken longer to become widely accepted and/or available in Pennsylvania as compared to other areas of the country.

During the eleven-year period of 1989 to 1999, Pennsylvania race-specific incidence rates have been much higher for black males compared to white males. However, the difference in rates between these two race groups has been decreasing since 1996. For white males, the rates peaked in 1992 and then decreased until 1995. Since 1995, the rates have remained fairly stable for white males. As was the case for all males combined, rates among Pennsylvanian white males were lower than comparable SEER rates and the difference in rates between Pennsylvania and SEER has been decreasing in recent years. For black males, the Pennsylvania rates decreased each year after peaking in 1994—corresponding SEER rates remained stable since 1995. With the exception of 1995, 1996 and 1997, Pennsylvania incidence rates for black males were lower than comparable SEER rates.

Prostate cancer is the second most common cause of male cancer deaths in Pennsylvania residents – only lung cancers claim more lives. There were 1,674 resident deaths due to prostate cancer in 2000, the lowest annual number of cases reported between 1990 and 2000. During the eleven-year period of 1990-2000, Pennsylvania's prostate cancer age-adjusted mortality rates have shown a declining trend. SEER also reports total United States cancer mortality rates based on death certificate data, with statistics for 1999 being the most current available. The Pennsylvania mortality rates have been approximately the same as the United States rates for all males between 1990 and 1999.

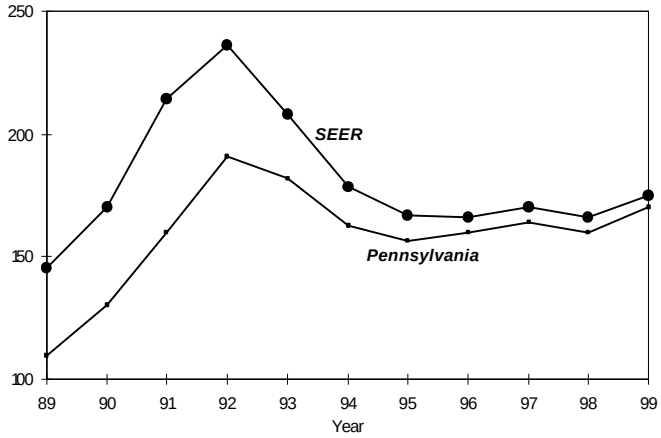
The age-adjusted prostate mortality rates for white Pennsylvanians have followed the same pattern as that for all male deaths during the years of 1990-2000. Among white males, Pennsylvania mortality rates have been approximately the same as comparable U.S. rates. The Pennsylvania rates for black males varied between 65.3 in 2000 and 85.4 in 1996. The U.S. mortality rates have shown a declining trend since 1994 for black males. With exception of 1996, the rates among black Pennsylvanians have decreased since 1993.

An improvement in detecting prostate cancers early is evident when comparing the 1989 prostate cancer stages to the 1999 stages among Pennsylvania residents. Much of this improvement can be attributed to the implementation of the PSA screening test. In 1989, 62.9 percent of the prostate cancer cases were diagnosed in the in situ or localized stage of the disease. By 1999, 76.6 percent of the cases were diagnosed in these early stages. In 1999, 3.6 percent of the cases were diagnosed at the distant stage; down from 16.1 percent in 1989. Regional stage diagnoses also decreased from 12.6 percent in 1989 to 7.4 percent in 1999. When comparing black and white males, the staging distributions in 1999 were similar.

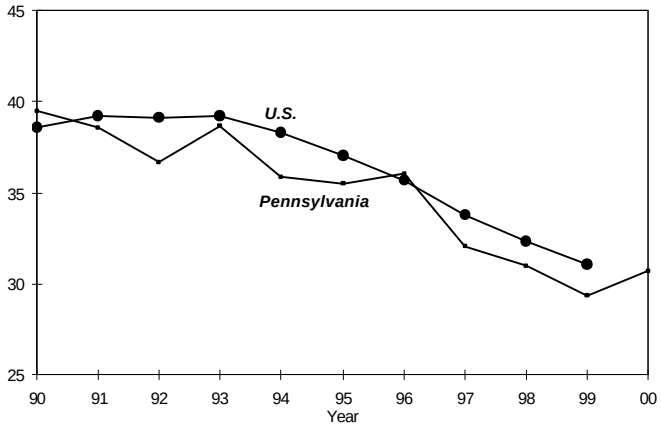
Data tables and charts displaying the statistics mentioned in this article appear on the opposite page.

Please contact the Bureau of Health Statistics and Research at 717-783-2548 with any questions regarding the data presented in this article. Additional cancer incidence and mortality statistics are available on our web pages at ***www.health.state.pa.us/stats***.

Age-Adjusted Invasive Prostate Cancer Incidence Rates Pennsylvania Residents and SEER Data, 1989-1999



Age-Adjusted Prostate Cancer Mortality Rates Pennsylvania Residents and United States, 1990-2000



Age-Adjusted Invasive Prostate Cancer Incidence Rates by Race

	All Cases		Whites		Blacks	
Year	PA	SEER	PA	SEER	PA	SEER
1989	109.9	145.1	106.6	145.6	143.2	191.4
1990	130.4	170.4	126.3	172.0	191.2	220.5
1991	159.7	214.0	153.5	215.4	241.2	284.2
1992	191.1	235.9	184.7	236.4	277.3	320.5
1993	182.2	207.8	174.2	202.1	286.9	333.6
1994	162.6	178.6	153.0	172.3	293.8	301.6
1995	156.7	167.0	146.7	161.3	287.9	269.5
1996	160.2	166.3	148.9	161.1	269.0	266.8
1997	163.9	169.9	152.9	164.9	266.8	266.2
1998	159.6	166.0	149.3	160.8	251.7	265.6
1999	169.9	174.8	159.6	167.8	245.4	265.6
1995-99	161.7	168.9	151.1	163.2	263.7	266.8

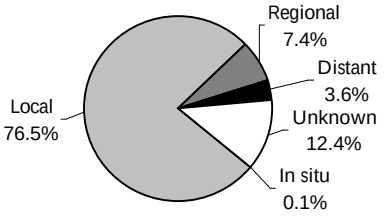
NOTE: All rates are per 100,000 and age-adjusted to 2000 U.S. standard million

Age-Adjusted Prostate Cancer Mortality Rates by Race

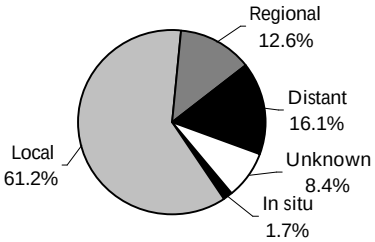
	All Deaths		Whites		Blacks	
Year	PA	US	PA	US	PA	US
1990	39.5	38.6	37.0	35.7	84.5	77.7
1991	38.6	39.2	36.8	36.5	68.5	77.6
1992	36.7	39.1	33.9	36.2	84.1	78.9
1993	38.7	39.2	36.1	36.2	79.8	80.7
1994	35.9	38.3	33.6	35.5	74.2	78.6
1995	35.5	37.0	33.4	34.2	70.3	76.6
1996	36.0	35.7	32.9	32.8	85.4	77.0
1997	32.1	33.8	29.8	31.1	68.4	72.3
1998	31.0	32.3	28.8	29.6	66.0	70.6
1999	29.3	31.1	27.1	28.6	65.5	67.8
2000	30.7	NA	29.0	NA	65.3	NA
1995-99	32.5	33.9	30.2	31.2	70.4	72.8

NA = not available

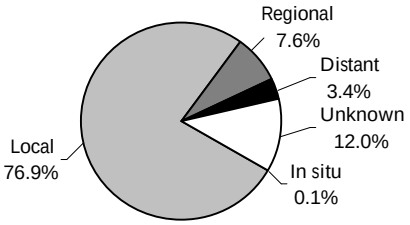
Prostate Cancer, Percent Distribution of Stage at Diagnosis, PA Residents, All Cases (1989 and 1999) and By Race (1999)



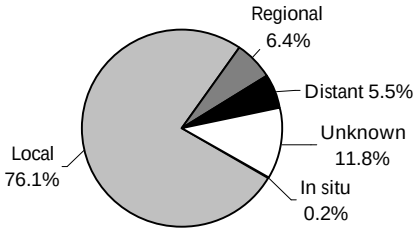
All Residents 1999



All Residents 1989



Whites 1999



Blacks 1999

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Hospital Utilization Data...

aged care and its increasing share of the health care industry marketplace, the Balanced Budget Act of 1997 resulted in further reduced payments to hospitals and providers, particularly for Medicaid and Medicare. As a result, an occupied inpatient bed was no longer the revenue producer it once was, and hospitals began to operate under increasingly tighter profit margins. Many hospitals closed and others consolidated or merged in order to survive.

Facilities that were able to weather the fiscal storm had to alter the way in which they delivered services by shifting utilization to less costly outpatient settings. Advances in medical equipment technology made this shift in utilization much more feasible, and the lapse of the Certificate of Need program (CON) in December of 1996 allowed hospitals to construct outpatient and day surgery centers. The lapsing of CON also allowed hospitals to expand into higher-level inpatient specialty services, such as open-heart surgery, which are generally higher reimbursed services.

Analyses of data obtained from the Bureau of Health Statistics and Research's annual survey of hospitals from fiscal year 1980/81 through 2000/01 addresses some of these trends for general acute care (non-federal) facilities. Please note that, beginning in fiscal year 1993/94, the Bureau's annual hospital survey stopped collecting information on long-term care beds. In order to compare data from years prior to 1993/94, long-term care information was deleted from the entire analyses.

The average (hospital) stay was just over eight days in 1980/81 and is now just over five days.

Beds and Average Daily Inpatient Population:
Over the past 20 years, the number of licensed inpatient beds has decreased by 22.8 percent, and staffed beds by 35.6 percent. Staffed bed occupancy rates in the early 1980s were at or near 80 percent, falling to the mid-60 percent range during the mid to late 1990s. The average daily inpatient population (occupancy rate x staffed beds) was 43,174 in 1980/81, compared to 23,114 in 2000/01 – a drop of 46.4 percent. Chart 1 on the right reflects these changes.

Average Length of Stay:
The average length of an inpatient stay has also declined. The average stay was just over eight days in 1980/81, and is now just over five days (see Chart 2 on the right).

Although we do not have the necessary data (discharges and discharge days) to calculate an average length of stay for specific inpatient units, we can approximate that average by dividing the number of admissions for that unit into the total patient days of care. In 1980/81, the length of stay for medical/surgical patients was 10.1 days, compared to 5.0 days in 2000/01. Obstetric unit length of stay went from nearly 4 days to 2.5.

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Chart 1
Number of Licensed and Staffed Beds and Average Daily Inpatient Population, Pennsylvania General Acute Care Hospitals, Selected Fiscal Years, 80/81-00/01

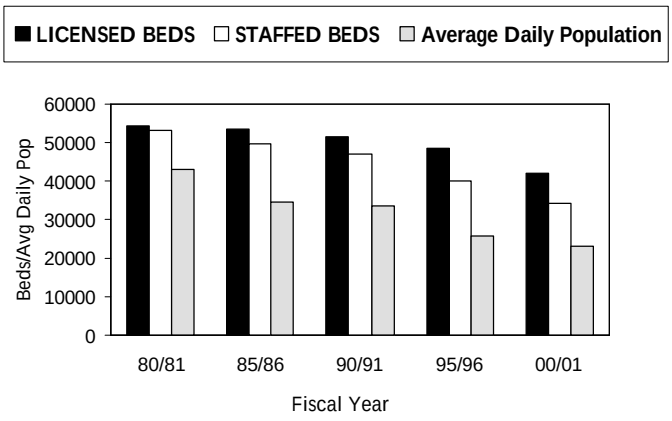


Chart 2
Average Length (in days) of Inpatient Stay, Pennsylvania General Acute Care Hospitals Fiscal Years, 80/81-00/01

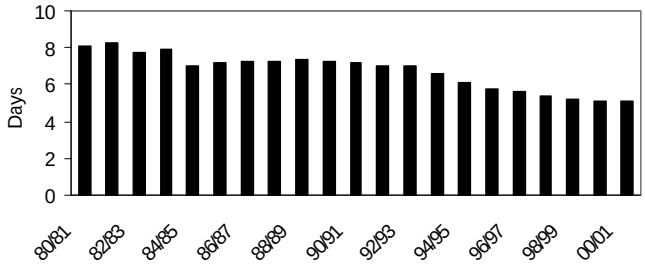
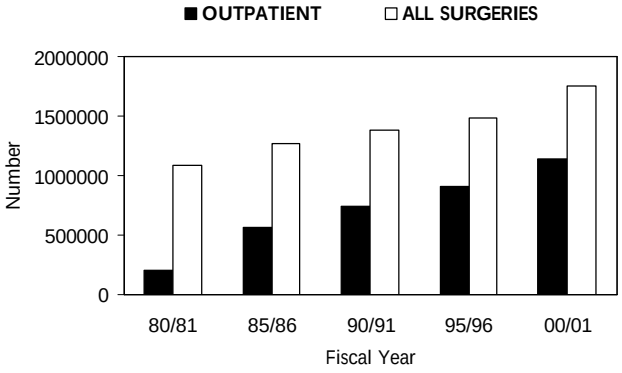


Chart 3
Number of Outpatient Surgeries and All Surgeries, Pennsylvania General Acute Care Hospitals Selected Fiscal Years, 80/81-00/01



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Osteoporosis Risks...

and avoiding excessive alcohol consumption. For some women, bone density testing and medication may be appropriate.

The data table on the right shows only about 18% of Pennsylvania women consume at least three servings of dairy products a day and that figure drops to 12% among women aged 65+. However, older women tend to take more calcium supplements than younger women (53% for ages 65+, compared to 22% for those aged 18-44). Unfortunately, almost 27% of adult Pennsylvania women do not engage in any leisure time physical activity, 23% are smokers, and another 23% are obese.

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If you think that you may be at risk, you should discuss bone density testing with your physician. The Pennsylvania Department of Health partners with health systems to provide free bone density testing during the Farm Show in Harrisburg every year and provides low cost testing for post-menopausal women during May which is osteoporosis month, again in partnership with health systems. For additional information on available testing and any concerns regarding osteoporosis, call the Department's toll free number at 1-877-PA-HEALTH or try the National Institutes of Health online resource center on osteoporosis at ***www.osteo.org***.

Percent of Selected Osteoporosis Risk Factors Among Adult Pennsylvania Women PA BRFSS Survey, 2001

	%	95% CI*
• Health care professional counseled woman about osteoporosis and how to prevent it.		
Total	39.6	±2.4
Non-Hispanic White	41.3	±2.6
Non-Hispanic Black	27.9	±8.0
• Women who have a family history of osteoporosis		
Total	16.3	±2.0
Non-Hispanic White	18.1	±2.3
Non-Hispanic Black	3.1	±5.2
• Has broken a wrist, hip, or vertebrae since age 35 (women age 35+).		
Total	7.7	±1.5
Non-Hispanic White	8.3	±1.6
Non-Hispanic Black	2.7	±4.6
• Consume at least 3 servings of dairy products daily.		
Total	17.5	±2.2
18 - 44	21.6	±3.8
45 - 65	15.6	±3.1
65+	11.5	±3.6
• Take calcium supplements.		
Total	36.8	±2.5
18 - 44	21.7	±3.6
45 - 65	47.3	±4.2
65+	53.4	±4.9
• Get sufficient calcium. (supplements or 3+ dairy foods daily)		
Total	46.6	±2.5
18 - 44	36.3	±3.9
45 - 65	54.6	±4.1
65+	56.9	±4.8
• Engage in no leisure time physical activity	26.6	±2.1
• Are current smokers	22.9	±2.1
• Excessively use alcohol (average more than 1 drink a day)	3.8	±1.1
• Women who are obese	22.8	±2.2

*95% confidence interval

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Hospital Utilization Data...

Surgeries:
During the 1980/81 hospital survey reporting period, there were 1,094,985 surgeries performed in general/acute care facilities – 18.5 percent of which were performed on an outpatient basis. During the 2000/01 survey period, 65.2 percent of the 1,758,560 total surgeries were performed in the outpatient setting.

There has also been a major shift in medical procedures performed in the outpatient setting. During the 1980/81 period, 4.6 percent of all cardiac catheterizations were performed on an outpatient basis; 7.4 percent in 1985/86; 12.6 percent in 1990/91; 28.6 percent in 1995/96; and 40 percent by 2000/2001. See Chart 3 on page 4.

Open-Heart Surgery:
During the five years (1990/91-1994/95) prior to the lapsing of CON in December 1996, approximately 40 general/acute care facilities performed, on average, 24,117 open-heart surgeries per year. During the five years (1996/97-2000/01) after CON, approximately 54 facilities provided open-heart surgery services, performing an average 27,208 surgeries per year.

If you have any questions about the data presented here, or if you need further information, please contact the Bureau at 717-783-2548. Hospital utilization data for the last five annual reporting periods (1996/97 through 2000/01) can be accessed on the Health Statistics web pages at ***www.health.state.pa.us/stats/*** (select Health Facilities).

Drug-Induced Death Statistics for PA and U.S.

Data Are Similar With "Overdoses" Accounting for Majority of Deaths

In 1999, a total of 2,391,399 deaths occurred in the United States, based on information reported on death certificates completed by funeral directors, physicians, medical examiners, and coroners. 19,102 (0.8%) were attributed to drug-induced causes, based on International Classification of Diseases (ICD-10) coding. Similarly, 1999 Pennsylvania death certificate data indicate that 1,027 of 129,430 resident deaths (0.8%) were also attributed to drug-induced causes.

The data table below presents a comparison of drug-induced death data for 1999 for the United States and Pennsylvania. An explanation of each underlying cause-of-death classification category follows.

Mental and Behavioral Disorders due to Psychoactive Substance Use: These codes imply a chronic disorder. 1999 data show that 5.5% of all drug-induced deaths of Pennsylvania residents and 11.8% of all drug-induced deaths nationally were attributed to mental and behavioral disorders due to psychoactive substance use (excludes alcohol).

1999 DRUG-INDUCED DEATHS (Underlying causes of death, based on ICD-10 codes)	United States Data		Pennsylvania Residents	
MENTAL & BEHAVIORAL DISORDERS				
Opioids (e.g. morphine, heroin, etc.)	251		3	
Cannabinoids (e.g. marijuana)	5		0	
Sedatives/hypnotics	3		0	
Cocaine	444		9	
Other stimulants	26		0	
Hallucinogens	3		0	
Tobacco	321		12	
Volatile solvents (e.g. glue sniffing)	2		0	
Multiple drug use	1,198		32	
TOTAL	2,253	11.8%	56	5.5%
ACCIDENTAL POISONING				
Nonopioid analgesics, antipyretics, and antirheumatics (e.g. aspirin)	168		5	
Antiepileptics, sedatives/hypnotics, antiparkinsonism & psychotropic drugs (e.g. tranquillizers)	671		13	
Narcotics & hallucinogens (e.g.cocaine)	6,009		188	
Other drugs acting on the autonomic nervous system	21		0	
Other & unspecified drugs	4,286		488	
TOTAL	11,155	58.4%	694	67.6%
INTENTIONAL SELF-POISONING (SUICIDE)				
Nonopioid analgesics, antipyretics, and antirheumatics	173		5	
Antiepileptics, sedatives/hypnotics, antiparkinsonism & psychotropic drugs	859		16	
Narcotics & hallucinogens	380		15	
Other drugs acting on the autonomic nervous system	22		1	
Other & unspecified drugs	1,747		101	
TOTAL	3,181	16.7%	138	13.4%
ASSAULT (HOMICIDE)				
Assault by drugs, medicaments and biological substances	40	0.2%	7	0.7%
UNDETERMINED INTENT				
Nonopioid analgesics, antipyretics, and antirheumatics	38		0	
Antiepileptics, sedatives/hypnotics, antiparkinsonism & psychotropic drugs	231		3	
Narcotics & hallucinogens	1,425		50	
Other drugs acting on the autonomic nervous system	4		0	
Other & unspecified drugs	775		79	
TOTAL	2,473	12.9%	132	12.9%
TOTAL DRUG-INDUCED DEATHS	19,102	100%	1,027	100%

Accidental Poisoning by and Exposure to Noxious Substances Classified as Drugs: The ICD coding system does not distinguish between legal or illegal drug use. Accidental poisoning by narcotics and hallucinogens would generally include cases described as a "drug overdose." These categories are not specific to individual substances, such as heroin, for example, which is why it is not possible to provide data about overdose deaths for specific drugs based on underlying cause of death data. One of the more commonly used categories is accidental poisoning by "other and unspecified drugs." When multiple drugs or a combination of drugs and alcohol are found to be present, the underlying cause of death will be coded as "other and unspecified drugs." 1999 data show that 67.6% of all drug-induced deaths of Pennsylvania residents and 58.4% of all drug-induced deaths nationally were attributed to accidental poisoning by drugs.

Other ICD-10 codes used to classify drug-induced deaths include intentional self-poisoning (suicide) by exposure to drugs; assault (homicide) by drugs; and, poisoning by exposure to drugs with undetermined intent.

Drug-induced causes exclude accidents, homicides, and other causes indirectly related to drug use. Also excluded are newborn deaths associated with mother's drug use.

In the future, Bureau staff will be studying appropriate use of available drug-induced death statistics and other sources.

Update: Healthy People 2010 Objectives

Focus Area 5 - Diabetes: ***5-05 - Reduce the diabetes death rate.***

All Deaths and by Sex:
The age-adjusted death rate for diabetes (as an underlying or contributing cause) among all residents has not changed much between 1996 and 2000. However, the 2000 rate was the highest figure recorded during the five-year period.

There were 12,827 resident deaths in 2000 either due directly to diabetes or with diabetes mentioned as a contributing cause, resulting in an age-adjusted rate of 86.3 per 100,000 2000 U.S. standard million population. In 1996, there were 12,363 such deaths for a rate of 86.1.

The age-adjusted death rate among female residents also has not shown much of a change between 1996 (76.5) and 2000 (76.7). However, the rate among male residents has been slightly on the increase since 1998. The 2000 rate for males was 100.4, compared to 98.9 in 1999 and 98.0 in 1998.

Pennsylvania's age-adjusted death rates for diabetes for all residents and by sex are much higher than the Healthy People 2010 objective and the rate for males has been on the increase recently.

By Race and Hispanic Origin:
Black residents have much higher age-adjusted death rates for diabetes (as an underlying or contributing cause), compared to white and Hispanic residents. The 2000 rate for blacks was 121.5 per 100,000 U.S. standard million population, compared to 84.6 for whites and 91.6 for Hispanics.

During the five-year period of 1996-2000, the age-adjusted death rates for whites, blacks, and Hispanics displayed no evident trends. However, the rates for whites and Hispanics were higher in 1999 and 2000, especially among Hispanics. In addition, the 2000 rates for whites and Hispanics were the highest recorded between 1996 and 2000.

The Healthy People 2010 national objective is for an age-adjusted death rate of 45 per 100,000. The rates for Pennsylvania's whites, Hispanics and, especially, blacks are much higher than the 2010 goal and show no signs of declining.

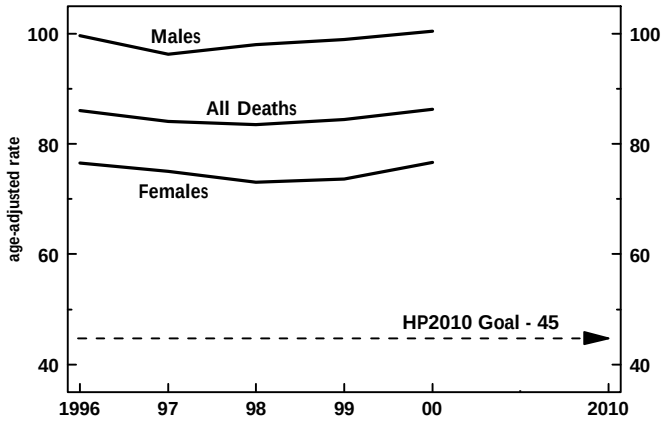
Diabetes Age-Adjusted Death Rates*
By Sex, Race, and Hispanic Origin
Pennsylvania Residents, 1996-2000

	1996	1997	1998	1999	2000
All Deaths	86.1	84.1	83.5	84.4	86.3
Males	99.6	96.3	98.0	98.9	100.4
Females	76.5	75.0	73.1	73.6	76.7
Whites	83.4	81.5	80.9	81.7	84.6
Blacks	122.9	117.0	119.2	118.5	121.5
Hispanics**	88.8	88.2	71.9	77.4	91.6

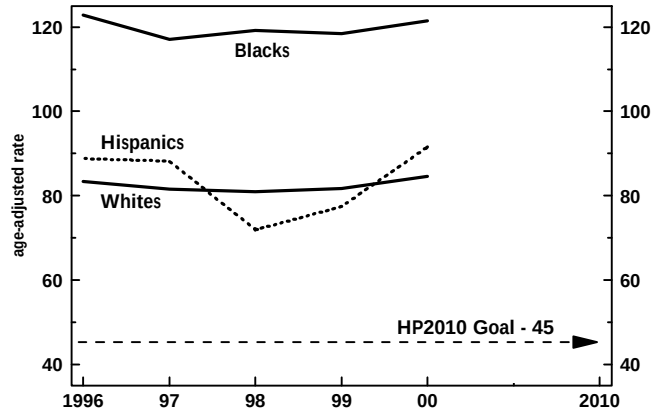
*per 100,000 2000 U.S. standard million population
**Hispanic can be of any race
NOTE: For deaths listing diabetes as an underlying or contributing cause

2010 Target: 45 deaths per 100,000

Diabetes Age-Adjusted Death Rates*
All Deaths and by Sex
Pennsylvania Residents, 1996-2000



By Race & Hispanic Origin, Pennsylvania, 1996-2000**



HP2010 State and County Data on the Web

To access the Department of Health's web page of Healthy People 2010 statistics for the state and counties, go to *www.health.state.pa.us/stats*. The latest available statistics as well as trend data are shown. You can view data for the state, all counties, a specific demographic element (age, sex, race, etc.) or just for a specific county. Complete data sets for the state and counties can be downloaded. There is also a link to the national HP2010 web site.

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The Department of Health is an equal opportunity provider of grants, contracts, services and employment.

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Secretary of Health

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