

The availability of and access to quality health care directly affects the health of the population. This is especially true of those at high risk due to low socioeconomic status or chronic medical conditions.

Children may receive health coverage through a number of sources, including private insurance, either employer-based or purchased directly, and public programs, such as Medicaid or the State Children's Health Insurance Program (SCHIP; changed to CHIP in 2009). Eligibility for public programs is based on a family's income compared to the Federal poverty level. Nearly every State has SCHIP programs that help expand coverage to children who would otherwise be uninsured. Despite the progress achieved through public programs, approximately 8.1 million children remain uninsured in the United States.

This section presents data on the utilization of health services within the maternal and child population. Data are summarized by source of payment, type of care, and place of service delivery.



HEALTH CARE FINANCING

In 2007, 8.1 million children younger than 18 years of age had no health insurance coverage, representing 11.0 percent of the population. This was a slight drop from the rate of 11.7 percent the previous year. More than 30 percent of children were insured through public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP; changed to CHIP in 2009).

Children's insurance status varies by a number of factors, including race and ethnicity and poverty status. Non-Hispanic White children were more likely than children of other racial/ethnic groups to have private insurance coverage in 2007 (76.9

percent), while fewer than half of non-Hispanic Black and Hispanic children had private coverage during the same period (48.7 and 40.4 percent, respectively). Non-Hispanic Black children were most likely to have public coverage (47.1 percent), and Hispanic children were the most likely to be uninsured (20.0 percent).

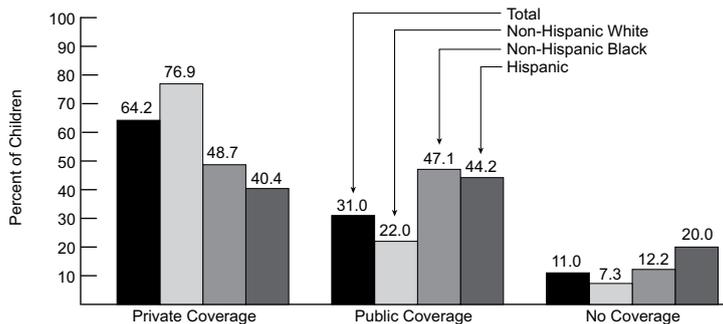
As family income increases, private health insurance coverage among children rises and the proportions of children with public coverage and no coverage decrease. In 2007, children with family incomes below 100 percent of the poverty threshold (\$21,203 for a family of four in 2007) were most likely to have public coverage (70.1

percent) or be uninsured (17.6 percent), and were least likely to have private coverage (17.2 percent). The majority of children with family incomes of 200 to 299 percent and 300 percent or more of poverty were privately insured (72.7 and 90.2 percent, respectively).

In 1997, SCHIP was created in response to the growing number of uninsured children in low-income working families. In 2007, more than 7.1 million children were enrolled in SCHIP. Although designed to cover children with family incomes below 200 percent of the poverty level, many States have expanded eligibility to children with higher family incomes.

Health Insurance Coverage Among Children Under Age 18, by Race/Ethnicity and Type of Coverage,* 2007

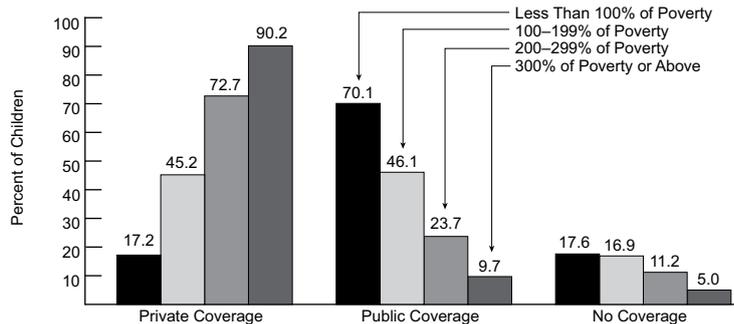
Source (III.1): U.S. Census Bureau, Current Population Survey



*Totals equal more than 100 percent because children may have more than one type of coverage.

Health Insurance Coverage Among Children Under Age 18, by Poverty Status* and Type of Coverage,** 2007

Source (III.1): U.S. Census Bureau, Current Population Survey



*The U.S. Census poverty threshold for a family of four was \$21,203 in 2007.

** Totals equal more than 100 percent because children may have more than one type of coverage.

ADEQUACY OF HEALTH INSURANCE COVERAGE

While the majority of children in the United States have health insurance coverage, it may not always be adequate to meet their health and medical needs. The 2007 National Survey of Children's Health asked parents of insured children three questions about the services and costs associated with their child's health insurance. Parents were asked whether out-of-pocket costs were reasonable, whether the child's health insurance covered services that met the child's needs, and whether

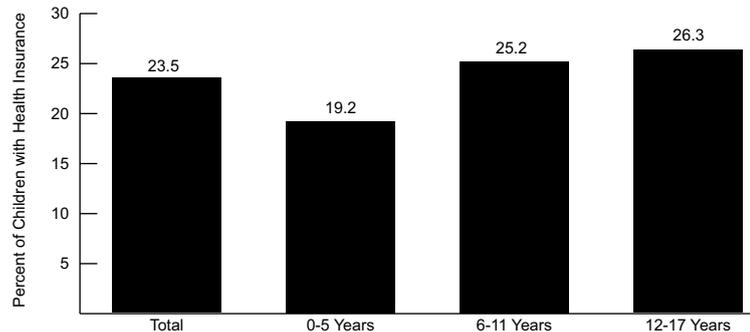
their health insurance allowed them to see the health care providers they needed.

Children were considered to have adequate health insurance coverage if their parent answered "usually" or "always" to each of these three questions. Overall, 23.5 percent of currently insured children lacked adequate insurance. Older children were more likely than younger children to lack adequate coverage: 26.3 percent of children aged 12-17 and 25.2 percent of those aged 6-11 years were reported to lack adequate insurance, compared to 19.2 percent of children aged 0-5 years.

The percentage of children lacking adequate health insurance coverage also varied by household income. Currently insured children with incomes below the Federal Poverty Level (FPL) and more than 400 percent of FPL were least likely to lack adequate coverage (20.1 and 21.1 percent, respectively). In comparison, 26.9 percent of children with household incomes of 201-400 percent of FPL and 25.1 percent of those with incomes of 101-200 percent of FPL lacked adequate insurance.

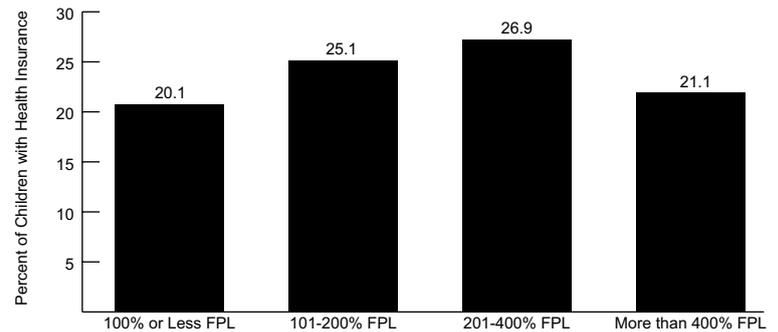
Currently Insured Children Under Age 18 Whose Health Insurance Was Not Adequate, by Age, 2007

Source (I.8): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



Currently Insured Children Under Age 18 Whose Health Insurance Was Not Adequate, by Poverty Status,* 2007

Source (I.8): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*Federal Poverty Level (FPL) was equal to \$20,650 for a family of four in 2007; FPL is set by the U.S. Department of Health and Human Services for determining income eligibility in public assistance programs.

VACCINATION COVERAGE

The Healthy People 2010 objective for immunization is to achieve 90 percent coverage for each of the universally recommended vaccines among young children. In 2007, 77.4 percent of children 19-35 months of age had received each of the vaccines in the recommended 4:3:1:3:3:1 series. This series comprises four doses of diphtheria, tetanus, and pertussis vaccine; three doses of poliovirus vaccine; one dose of measles, mumps, and rubella vaccine; three doses of *Haemophilus influenzae* type b (Hib) vaccine; three doses of the Hepatitis B vaccine; and one dose of varicella (chicken pox) vaccine. Overall, 80.1 percent of young children had received the 4:3:1:3:3 series, which excludes the varicella vaccine.

In recent years, the greatest increase in vaccination rates has occurred with the varicella vaccine, which was added to the recommended schedule in 1996. Since 2000, coverage of varicella vaccine has increased approximately 30 percent. Coverage for most other vaccines has also risen during this time period, generally between 2 and 4 percent.

Racial/ethnic differences in coverage are apparent for most vaccine types. Non-Hispanic Black children have the lowest rates of vaccination with the overall 4:3:1:3:3:1 series, as well as

the lowest rates of vaccination with each of the individual vaccines, except varicella.

Each year, the Centers for Disease Control and Prevention publishes an update of the childhood immunization schedule (see next page). No

new vaccines were added to the schedule in 2009; however, there were a number of changes in the catch-up recommendations for several vaccines and the vaccination guidelines for certain populations of children.

Vaccination Rates among Children Aged 19-35 Months, by Race/Ethnicity, 2007

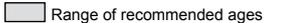
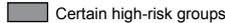
Source (III.2): Centers for Disease Control and Prevention, National Immunization Survey

	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic	Asian
Complete Series 4:3:1:3:3:1 (includes Varicella)	77.4	77.5	75.3	78.0	79.4
Series 4:3:1:3:3 (excludes Varicella)	80.1	81.0	77.5	79.8	80.7
4+ DTaP	84.5	85.3	82.3	83.8	87.5
3+ Polio	92.6	92.6	91.1	93.0	95.0
1+ MMR	92.3	92.3	91.5	92.6	93.9
3+ Hib	92.6	92.6	90.8	93.5	91.0
3+ HepB	92.7	92.5	91.2	93.6	93.8
1+ Varicella	90.0	89.2	89.8	90.6	93.7

Recommended Immunization Schedule for Children Aged 0-6 Years, United States, 2009

Source (III.3): Department of Health and Human Services, Centers for Disease Control and Prevention

	BIRTH	1MO	2MO	4MO	6MO	12MO	15MO	18MO	19-23MO	2-3YR	4-6YR
Hepatitis B¹	HepB	HepB		see footnote 1		HepB					
Rotavirus²			RV	RV	RV²						
Diphtheria, Tetanus, Pertussis³			DTaP	DTaP	DTaP	see footnote 3	DTaP				DTaP
Haemophilus influenzae type b⁴			Hib	Hib	Hib⁴		Hib				
Pneumococcal⁵			PCV	PCV	PCV		PCV				PPSV
Inactivated Poliovirus			IPV	IPV			IPV				IVP
Influenza⁶							Influenza (yearly)				
Measles, Mumps, Rubella⁷							MMR		see footnote 7		MMR
Varicella⁸							Varicella		see footnote 8		Varicella
Hepatitis A⁹							HepA (2 doses)			HepA Series	
Meningococcal¹⁰											MCV

 Range of recommended ages  Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed vaccines, as of December 1, 2008, for children aged 0 through 6 years. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. Licensed combination vaccines may be used whenever any component of the

combination is indicated and other components are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations, including high-risk conditions: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant

adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

- At birth:**
- Administer monovalent HepB to all newborns before hospital discharge.
 - If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
 - If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).
- After the birth dose:**
- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1 or 2 months. The final dose should be administered no earlier than age 24 weeks.
 - Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg (anti-HBs) after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).

4-month dose:

- Administration of 4 doses of HepB to infants is permissible when combination vaccines containing HepB are administered after the birth dose.

2. Rotavirus vaccine (RV). (Minimum age: 6 weeks)

- Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks or older (i.e., 15 weeks 0 days or older).
- Administer the final dose in the series by age 8 months 0 days.
- If Rotarix® is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)

- The fourth dose may be administered as early as age 12 months, provided at

least 6 months have elapsed since the third dose.

- Administer the final dose in the series at age 4 through 6 years.
- 4. Haemophilus influenzae type b conjugate vaccine (Hib). (Minimum age: 6 weeks)**
- If PRP-OMP (PedvaxHIB® or Convaq® [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
 - TriHIBit® (DTaP/Hib) should not be used for doses at ages 2, 4, or 6 months but can be used as the final dose in children aged 12 months or older.
- 5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])**
- PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
 - Administer PPSV to children aged 2 years or older with certain underlying medical conditions (see MMWR 2000;49[No. RR-9]), including a cochlear implant.
- 6. Influenza vaccine. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])**
- Administer annually to children aged 6 months through 18 years.
 - For healthy nonpregnant persons (i.e., those who do not have underlying medical conditions that predispose them to influenza complications) aged 2 through 49 years, either LAIV or TIV may be used.
 - Children receiving TIV should receive 0.25 mL if aged 6 through 35 months or 0.5 mL if aged 3 years or older.
 - Administer 2 doses (separated by at least 4 weeks) to children aged younger than 3 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.
- 7. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)**
- Administer the second dose at age 4 through 6 years. However, the second dose

may be administered before age 4, provided at least 28 days have elapsed since the first dose.

8. Varicella vaccine. (Minimum age: 12 months)

- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.

9. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- Administer to all children aged 1 year (i.e., aged 12 through 23 months). Administer 2 doses at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA also is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See MMWR 2006;55[No. RR-7].

10. Meningococcal vaccine. (Minimum age: 2 years for meningococcal conjugate vaccine [MCV] and for meningococcal polysaccharide vaccine [MPSV])

- Administer MCV to children aged 2 through 10 years with terminal complement component deficiency, anatomic or functional asplenia, and certain other high-risk groups. See MMWR 2005;54[No. RR-7].
- Persons who received MPSV 3 or more years previously and who remain at increased risk for meningococcal disease should be revaccinated with MCV.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

MENTAL HEALTH TREATMENT

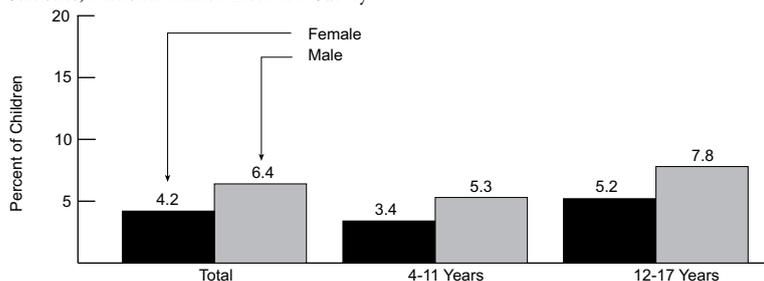
According to parents' reports, 5.3 percent of children aged 4-17 years received treatment for emotional or behavioral difficulties in the past year. This includes treatment, alone or in conjunction with medication, for difficulties with emotions, concentration, behavior, or being able to get along with others. Boys were more likely than girls to have received treatment (6.4 versus 4.2 percent), and older children (aged 12-17 years) were more likely than younger children

(aged 4-11 years) to have received treatment (6.5 versus 4.4 percent; data not shown). Among those children who received treatment for emotional or behavioral difficulties, almost 60 percent were seen at a private practice, clinic, or mental health care center, while nearly 40 percent received treatment through their school. Another one-quarter of children who received treatment did so through a primary care provider, and fewer than 10 percent of children received treatment at some other type of place. (Parents could report more than one place of treatment.)

In 2005-2006, 5.1 percent of children aged 4-17 years were prescribed medication for emotional or behavioral difficulties in the past year. That includes the 4.4 percent of children who were reported to have been prescribed medication for the symptoms of attention deficit hyperactivity disorder (ADHD). Again, boys were more likely than girls to have been prescribed medication (6.6 versus 3.4 percent), and 12- to 17-year-olds were more likely to be prescribed medication than younger children (6.0 versus 4.3 percent; data not shown).

Receipt of Treatment* for Emotional or Behavioral Difficulties in the Past 12 Months among Children Aged 4-17 Years, by Sex and Age, 2005-2006

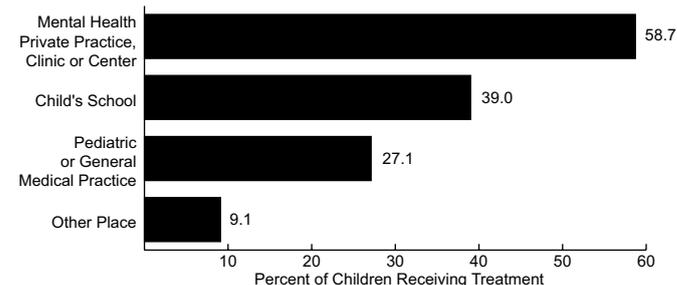
Source (II.11): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Received treatment, other than or in addition to medication, in the past 12 months for difficulties with emotions, concentration, behavior, or being able to get along with others; this includes children who have been prescribed medication and are receiving other types of treatment, but does not include children who have been prescribed medication only.

Place of Treatment* for Emotional or Behavioral Difficulties among Children Aged 4-17 Years who Received Treatment in the Past 12 Months, 2005-2006

Source (II.11): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Treatment, other than or in addition to medication, in the past 12 months for difficulties with emotions, concentration, behavior, or being able to get along with others; this includes children who have been prescribed medication and are receiving other types of treatment, but does not include children who have been prescribed medication only. Parents could report more than one place of treatment.

DENTAL CARE

According to the Centers for Disease Control and Prevention, dental caries (tooth decay) is the single most common chronic disease among children in the United States. Untreated tooth decay causes pain and infections, which may affect children's ability to eat, speak, play, and learn.¹ Dental caries, however, are preventable with proper dental care. For this reason, the American Dental Association recommends that children have their first dental checkup within 6 months of the eruption of their first tooth or at 12 months of age, whichever comes first.

In 2006, only 27.7 percent of children eligible for services under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program received preventive dental services.

In 2007, 73.0 percent of children aged 1-18 years received dental care, including care from dental specialists and dental hygienists, in the past year. Receipt of dental care varied by a number of factors, including race/ethnicity and income. Children with family incomes of 200 percent or more of the poverty threshold were more likely to have received dental care than children living with family incomes below 200 percent of the

poverty threshold (78.9 versus 64.8 percent, respectively).

Non-Hispanic White children aged 1-18 years were more likely than children of other racial/ethnic groups to have received dental care in the past year (76.0 percent), followed by non-Hispanic Black children (71.0 percent) and Hispanic children (67.5 percent; data not shown).

1 Centers for Disease Control and Prevention, Division of Oral Health. Children's Oral Health. <http://www.cdc.gov/OralHealth/topics/child.htm>. Accessed 26 November, 2008.

Receipt of EPSDT Preventive Dental Service among Eligible Children,* Aged Birth–20 Years, 1990–2006**

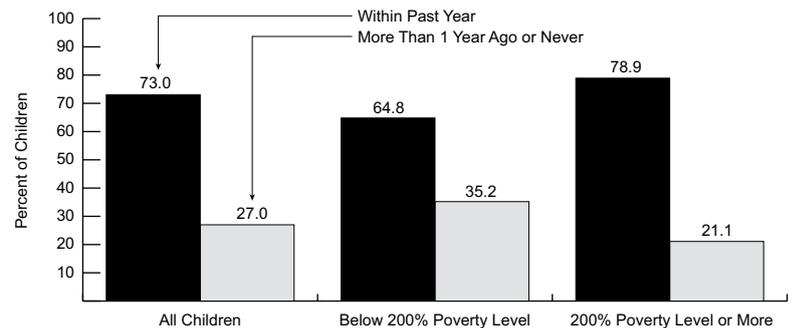
Source (III.4): Centers for Medicare and Medicaid Services, Annual EPSDT Report



*All children on Medicaid are eligible for EPSDT services. **Not all States and Territories reported data in all years.

Receipt of Dental Care* among Children Aged 1–18 Years, by Poverty Level,** 2007

Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Includes visits to specialists and dental hygienists. **The poverty threshold, as determined by the Census Bureau, was equal to \$21,203 for a family of four in 2007.

TIMING OF HEALTH CARE VISITS

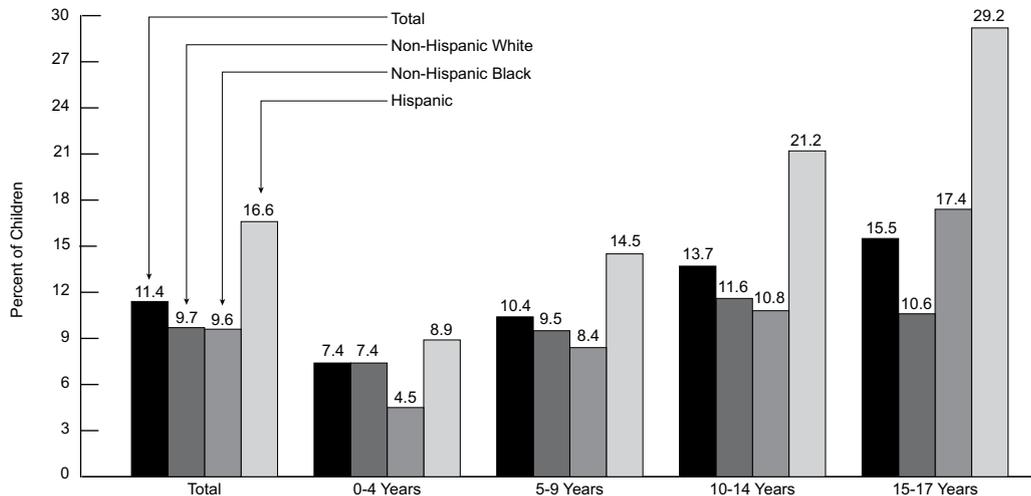
The American Academy of Pediatrics recommends that children have eight preventive health care visits in their first year, three in their second year, and at least one per year from middle childhood through adolescence. In 2007, 11.4 percent of children under 18 years of age had not seen a physician or other health care professional in the past year (not including overnight hospitalization, emergency department visits, home health care, or dental care). Older children were more likely than younger children to go 12 months without seeing a health care provider. More than 15 percent of children aged 15-17 years had not seen a health care provider in the past year, compared to 7.4 percent of children under 5 years of age.

Health care visits also varied by race/ethnicity: in 2007, nearly 17 percent of Hispanic children had not seen a physician or other health professional in the past year, compared to 9.7 percent of non-Hispanic White children and 9.6 percent of non-Hispanic Black children. Within every age group Hispanic children were the least likely to have seen a health care provider, and non-Hispanic Black children were the most likely to have seen one, except for within the 15- to 17-year-old age group. Across all racial/ethnic and age groups,

Hispanic children aged 15-17 years were the most likely to have gone without a health care visit in the past year (29.2 percent).

Children Reported to Have Not Seen a Physician or Other Health Care Professional* in the Past 12 Months, by Age and Race/Ethnicity, 2007

Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Does not include overnight hospitalizations, emergency department visits, home health care, and dental care.

PREVENTIVE HEALTH CARE VISITS

In 2007, nearly 74 percent of children under 18 years of age were reported by their parents to have had a preventive, or “well-child”, medical visit in the past year. The American Academy of Pediatrics recommends that children have eight preventive health care visits in their first year, three in their second year, and at least one per year from middle childhood through adolescence.

Young children were more likely than children of other ages to have a well-child visit: 82.7 percent of children aged 4 years and younger had a visit in the past year, compared to 75.8 percent of children aged 5-9 years, 69.1 percent of children aged 10-14 years, and only 63.3 percent of children aged 15-17 years.

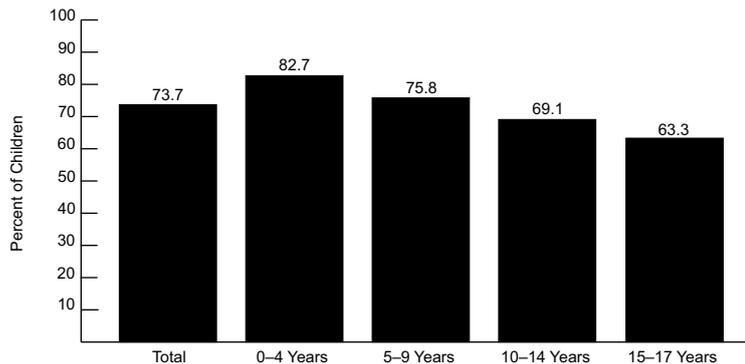
The proportion of children receiving preventive medical care also varies by race and ethnicity. In 2007, non-Hispanic Black children were the most likely to have had a well-child visit in the

past year (79.8 percent), followed by non-Hispanic White children (74.1 percent). Hispanic children were least likely to have had preventive care (68.5 percent).

Receipt of preventive medical care also varies by poverty status. In 2007, 74.3 percent of children with family incomes above the poverty threshold (\$21,203 for a family of four in 2007) had a well-child visit in the past year, compared to 70.7 percent of children with family incomes below the poverty threshold (data not shown).

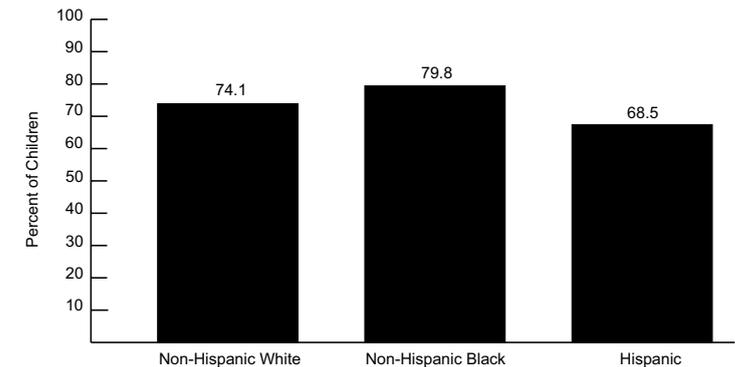
Receipt of Preventive Health Care in the Past Year Among Children Under Age 18, by Age, 2007

Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Receipt of Preventive Health Care in the Past Year Among Children Under Age 18, by Race/Ethnicity, 2007

Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



USUAL PLACE FOR SICK CARE

In 2007, a doctor's office or health maintenance organization (HMO) was the usual place for sick care (not including routine or preventive care) for 74.8 percent of children in the United States, a proportion that varies by poverty status and race/ethnicity. Children with family incomes above the poverty threshold (\$21,203 for a family of four in 2007) were more likely to visit a doctor's office or HMO for sick care than children with family incomes below the poverty threshold.

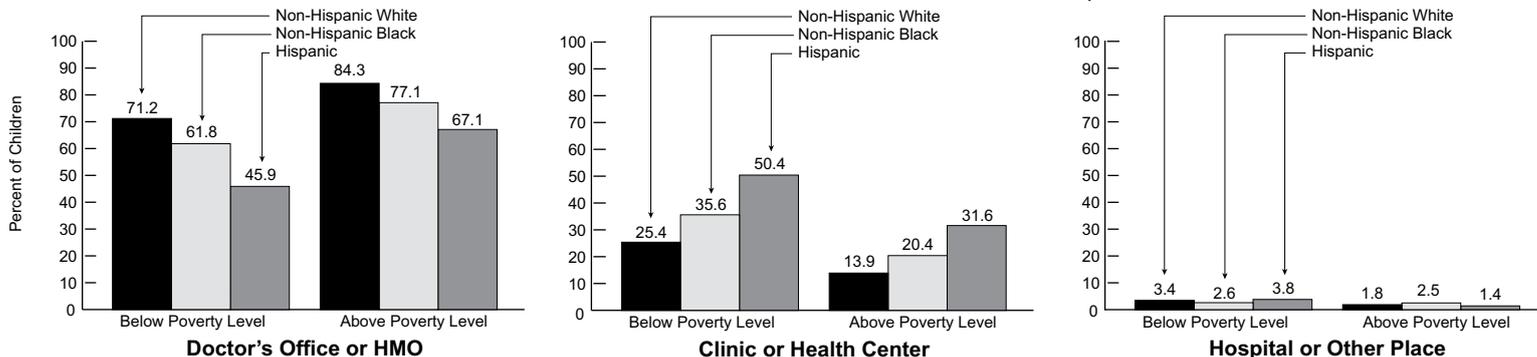
Among children with family incomes below the poverty threshold, 71.2 percent of non-Hispanic

White children received sick care at a doctor's office or HMO, compared to 61.8 percent of non-Hispanic Black children and 45.9 percent of Hispanic children. Hispanic children were more likely than non-Hispanic children to receive sick care at a clinic or health center, with over 50 percent whose family incomes were below poverty and more than 30 percent whose family incomes were above poverty receiving care at such a location. Comparatively, only 25.4 percent of low-income and 13.9 percent of higher-income non-Hispanic White children received care from clinics or health centers.

Only a small proportion of children used a hospital emergency room, hospital outpatient department, or some other source as their primary source of sick care. Children with family incomes below the poverty threshold were more likely than children with family incomes above the poverty threshold to do so. For instance, 3.8 percent of Hispanic children and 3.4 percent of non-Hispanic White children with family incomes below the poverty threshold received sick care from these sources, compared to 1.4 percent and 1.8 percent, respectively, of those with family incomes above the poverty threshold.

Place of Physician Contact,* by Poverty Status** and Race/Ethnicity, 2007

Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*The place where the child usually goes when sick; does not include routine or preventive care visits. **The U.S. Census Bureau poverty threshold for a family of four was \$21,203 in 2007.

EMERGENCY DEPARTMENT UTILIZATION

In 2007, more than 20 percent of children had at least one visit to a hospital emergency department (ED). Children with family incomes below the poverty threshold (\$21,203 for a family of four in 2007) were more likely than children with family incomes above the poverty threshold to have visited the ED. Just over 26 percent of children from low-income families made one to three ED visits during the year, compared to fewer than 18 percent of children from higher-income families. Similarly, 2.8 percent of children from low-income families made four or more visits to the

ED, compared to 1.1 percent of children from higher-income families.

Emergency department utilization also varies by age: 22.4 percent of children under 5 years of age made 1-3 visits to the ED in 2007, followed by children aged 15-17 years (20.3 percent). Children under 5 years of age were also the most likely to make 4 or more visits to the ED (2.7 percent), followed by children aged 5-9 years (1.0 percent). Racial/ethnic differences in utilization were also apparent, with non-Hispanic Black children most likely to make 1-3 and 4 or more visits to the ED (data not shown).

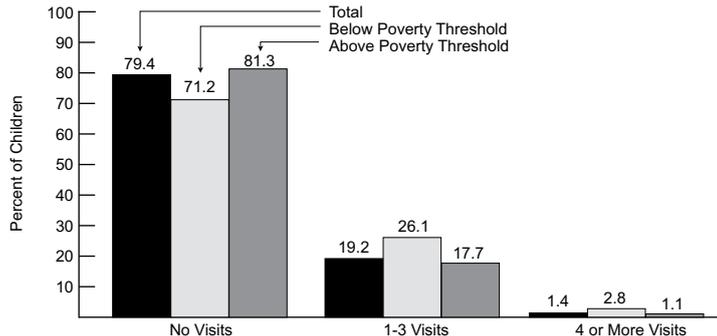
According to the 2006 National Hospital Am-

bulatory Medical Care Survey, the most common reason for a visit to the emergency department among children under 15 years of age was fever (15.1 percent), followed by cough (6.6 percent), and vomiting (5.5 percent). The most common primary diagnoses as the result of ED visits were acute upper respiratory infections (9.2 percent), otitis media (middle ear infection) and Eustachian tube disorders (6.6 percent), and fever of unknown origin (5.8 percent; data not shown).¹

1 Pitts SR, Niska RW, Xu J, Burt CW. National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary. National Health Statistics Reports, No. 7; 2008 Aug.

Visits to the Emergency Room/Emergency Department Among Children Under Age 18, by Poverty Status,* 2007

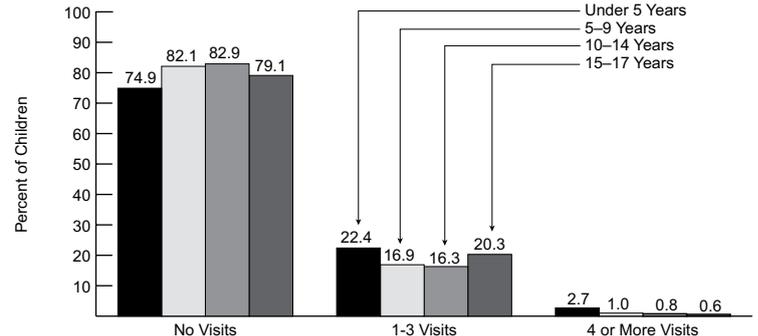
Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey

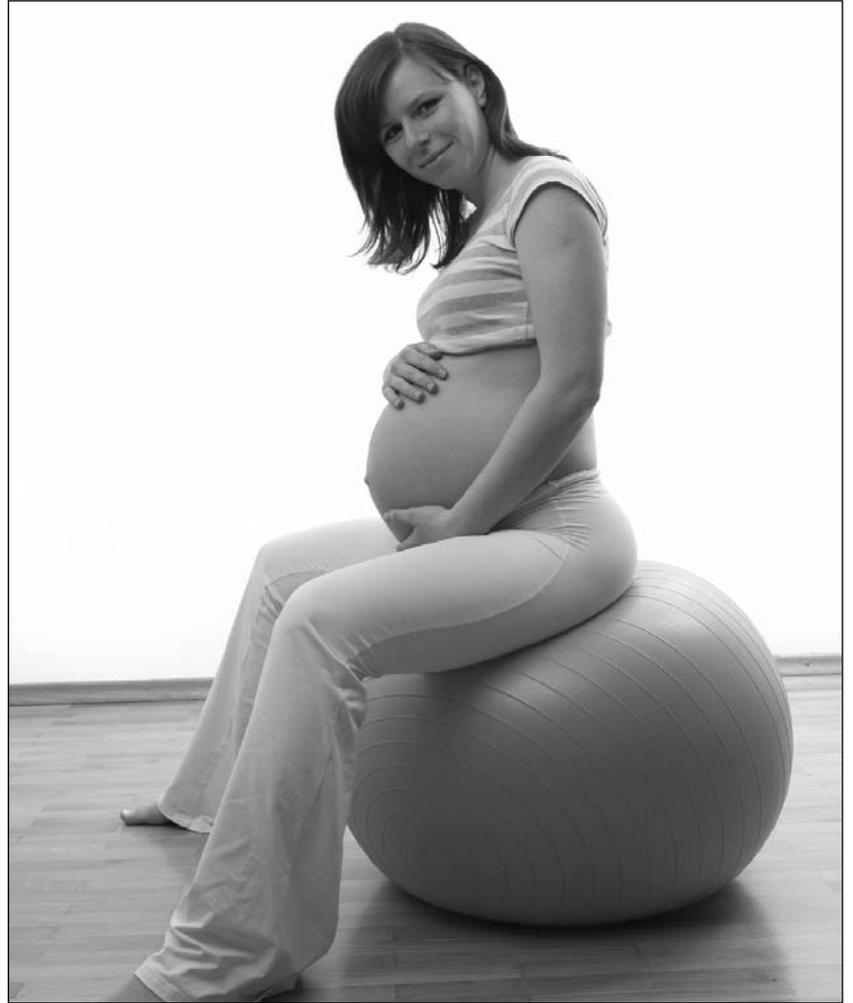


*The U.S. Census Bureau poverty threshold for a family of four was \$21,203 in 2007.

Visits to the Emergency Room/Emergency Department Among Children Under Age 18, by Age, 2007

Source (III.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey





PRENATAL CARE

Prenatal care—especially care beginning in the first trimester—allows health care providers to identify and manage a woman’s risk factors and health conditions and to provide expectant parents with relevant health care advice. The reported rate of first trimester prenatal care utilization has been increasing fairly steadily since the early 1990s; however, changes made to the standard birth certificate, which are gradually being adopted by the states, make comparisons over time impossible.

In 2006, in the 18 reporting areas (States and territories) that use the revised birth certificate, 69.0 percent of women giving birth were determined to have received prenatal care in the first trimester. In the 34 areas using the unrevised birth certificate, 83.2 percent of women were reported to have entered prenatal care in the first trimester.

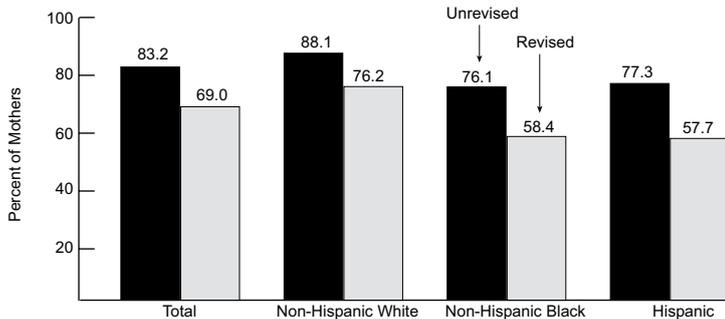
Early prenatal care utilization differs by race/ethnicity. In 2006, non-Hispanic White women were most likely to receive first trimester prenatal care—this is the case using both revised and unrevised birth certificate data (76.2 percent and

88.1 percent, respectively). Non-Hispanic Black and Hispanic women are less likely to receive first trimester prenatal care.

In 2006, 7.9 percent of women in the areas using the revised birth certificate began prenatal care in the third trimester or did not receive any prenatal care; in areas using the unrevised birth certificate, the rate was 3.6 percent. In both the unrevised and revised reporting areas, non-Hispanic Black and Hispanic women were more than twice as likely as non-Hispanic White women to receive late or no prenatal care.

Receipt of First Trimester Prenatal Care, by Race/Ethnicity and Birth Certificate Revision*, 2006

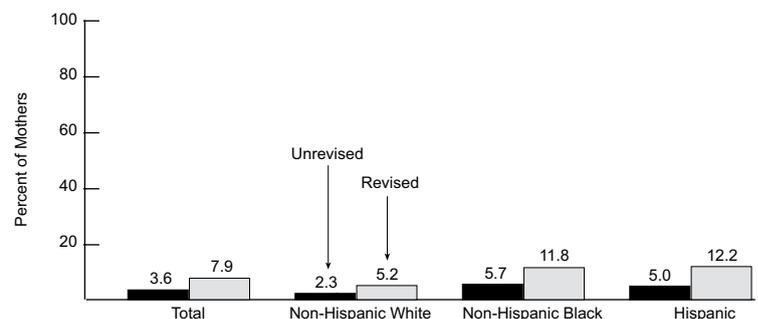
Source (I.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*“Unrevised” data are for all reporting areas that had not implemented the 2003 Revision of the U.S. Certificate of Live Birth as of January 2006, including California (which had implemented a partial revision); “Revised” data are for all reporting areas that had implemented the 2003 Revision, not including California.

Receipt of Late* or No Prenatal Care, by Race/Ethnicity and Birth Certificate Revision**, 2006

Source (I.5): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Care beginning in the third trimester of pregnancy.

**“Unrevised” data are for all reporting areas that had not implemented the 2003 Revision of the U.S. Certificate of Live Birth as of January 2006, including California (which had implemented a partial revision); “Revised” data are for all reporting areas that had implemented the 2003 Revision, not including California.