



## HEALTH SERVICES FINANCING AND UTILIZATION

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 Children's Health Insurance Program (CHIP). Eligibility for public programs is based on a family's income compared to the Federal poverty level. Nearly every state has CHIP programs that help to expand coverage to children who would otherwise be uninsured. Despite the progress achieved through public programs, approximately 7.4 million children remain uninsured in the United States.

This section presents data on the health insurance status and 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 2008, approximately 7.4 million U.S. children under 18 years of age had no health insurance coverage, representing 9.9 percent of the population. This was a decrease from the previous year, when the rate was 11.0 percent. One-third of children were insured through public programs such as Medicaid and the Children's Health Insurance Program, and 63.5 percent were covered by private insurance. The percentage of children covered by public insurance increased over the previous year, while the percentage of children with private insurance decreased.

Children's insurance status varies by race and ethnicity. In 2008, 76.5 percent of non-

Hispanic White children had private coverage, while the same was true of only 47.2 percent of non-Hispanic Black children and 40.6 percent of Hispanic children. Non-Hispanic Black children were the most likely to have public coverage (50.7 percent), and Hispanic children were the most likely to be uninsured (17.2 percent).

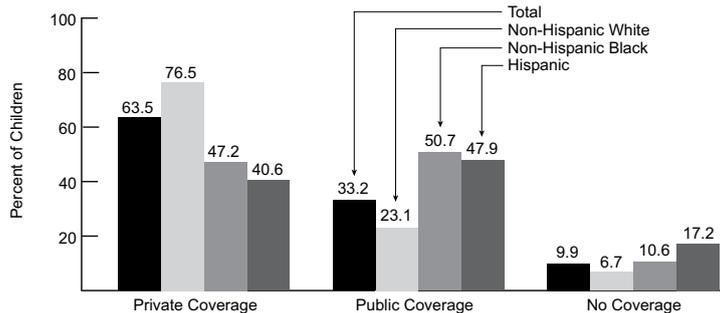
As family income increases, private health insurance coverage among children rises and the proportions of children with public coverage and no coverage decrease. In 2008, children living in households with incomes below 100 percent of the U.S. Census Bureau's poverty threshold (\$22,025 for a family of four in 2008) were most likely to have public coverage (71.5 percent) and to be uninsured (15.7 percent).

Children with family incomes of 300 percent or more of the poverty threshold were most likely to have private coverage (90.5 percent), and least likely to have public coverage (10.8 percent) or to be uninsured (4.3 percent).

In 1997, the Children's Health Insurance Program was created in response to the growing number of uninsured children in low-income working families. 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,\* 2008

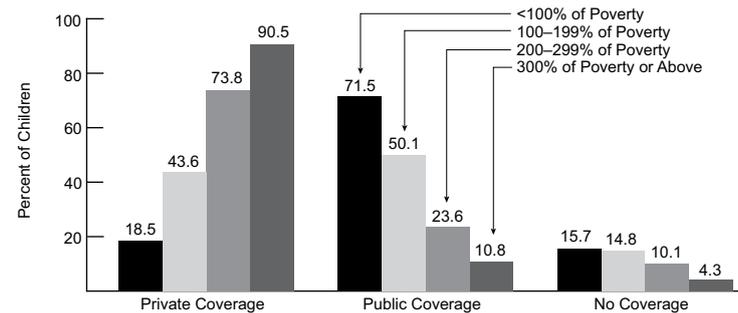
Source (III.1): U.S. Census Bureau, Current Population Survey



\*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,\*\* 2008

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



\*The U.S. Census Bureau uses a set of money income thresholds to determine who is in poverty; the poverty threshold for a family of four was \$22,025 in 2008. \*\*Totals equal more than 100 percent because children may have more than one type of coverage.

## ADEQUACY OF INSURANCE

While most children have some type of health insurance, it may not always be adequate to meet their needs. The 2007 National Survey of Children's Health asked parents of insured children three questions regarding the services and costs associated with their child's health insurance. Insurance was considered adequate if parents answered that it "usually" or "always" met the following criteria: 1) out-of-pocket costs are reasonable; 2) the benefits that are included and the services that are covered meet

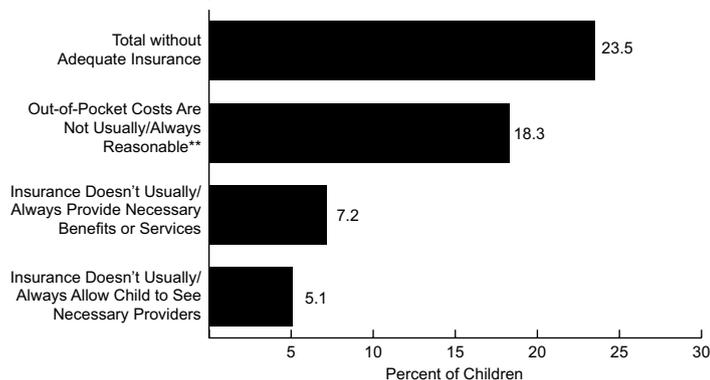
the child's needs; and 3) the family's preferred providers are covered. Overall, 23.5 percent of insured children had insurance that did not meet at least one of these three criteria, and therefore were determined to have insurance that was not adequate.

The frequency with which parents reported problems with insurance adequacy differed for the three criteria. Problems with out-of-pocket costs were most commonly cited, with the parents of 18.3 percent of children reporting that out-of-pocket costs were not usually or always

reasonable. The parents of 7.2 percent of children reported that insurance does not usually or always include benefits and services that meet the child's needs, and the parents of 5.1 percent of children reported that insurance did not usually or always allow the child to see necessary providers. Older children were more likely than younger children to lack adequate coverage, with 26.3 percent of children aged 12–17 years and 25.1 percent of children aged 6–11 years lacking adequate coverage, compared to 19.2 percent of children aged 0–5 years.

### Children Lacking Adequate Health Insurance,\* by Individual Adequacy Criteria, 2007

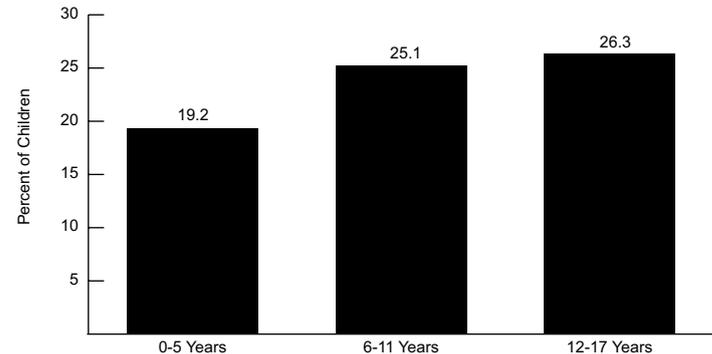
Source (I.7): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



\*Insurance was considered adequate if parents reported that it "usually" or "always" met each of the three criteria. \*\*Among those who reported having out-of-pocket expenses.

### Children Lacking Adequate Insurance Coverage,\* by Age, 2007

Source (I.7): 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



\*Insurance was considered adequate if parents reported that it "usually" or "always" had reasonable out-of-pocket costs, included benefits and services that met the child's needs, and allowed the child to see necessary providers.

## VACCINATION COVERAGE

The Healthy People 2010 objective for childhood immunization is to achieve 90 percent coverage for each of the universally recommended vaccines among young children. In 2008, 68.4 percent of children 19–35 months of age received each of the vaccines in the recommended 4:3:1:3:3:1:4 series. This series includes 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 vaccine; three doses of the Hepatitis B vaccine; one dose of the varicella (chicken pox) vaccine; and four doses of the pneumococcal conjugate vaccine. Overall, 76.1 percent of young children received the 4:3:1:3:3:1 series (which does not include the pneumococcal vaccine), and 78.2 percent received the 4:3:1:3:3 series (which does not include the pneumococcal or varicella vaccines).

In recent years, the greatest increases in vaccination rates have occurred with the pneumococcal and varicella vaccines. Pneumococcal conjugate vaccine was added to the immunization schedule in 2001, and vaccination coverage was first measured in 2005. Since 2005, coverage among young children has increased 50 percent. Varicella vaccine was added to the schedule in the mid-1990s, and since 2000 coverage has increased by 34 percent.

Racial/ethnic differences in coverage are apparent for most vaccine types. Non-Hispanic Blacks have the lowest rate of coverage with the complete 4:3:1:3:3:1:4 series, as well as the lowest rates of vaccination with each of the individual vaccines, except for the varicella and measles, mumps, and rubella vaccines.

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 2010 schedule.

### Vaccination Rates Among Children Aged 19-35 Months, by Race/Ethnicity, 2008

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

	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic Asian
<b>Complete Series 4:3:1:3:3:1:4</b>	68.4	68.2	65.9	68.5	73.5
<b>Series 4:3:1:3:3:1</b>	76.1	75.3	72.7	77.7	82.2
<b>Series 4:3:1:3:3</b>	78.2	77.8	74.2	79.4	84.2
<b>4+DTaP</b>	84.6	85.0	80.1	84.9	92.3
<b>3+ Polio</b>	93.6	93.6	91.5	94.3	96.5
<b>1+ MMR</b>	92.1	91.3	92.0	92.8	94.7
<b>3+ Hib</b>	90.9	90.8	88.6	91.9	92.6
<b>3+ HepB</b>	93.5	93.4	92.1	93.7	97.5
<b>1+ Varicella</b>	90.7	89.8	90.4	91.8	94.2
<b>4+ PCV</b>	80.1	81.4	76.4	78.6	82.3

## Recommended Immunization Schedule for Children Aged 0-6 Years, United States, 2010

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 B <sup>1</sup>	HepB	HepB				HepB					
Rotavirus <sup>2</sup>			RV	RV	RV <sup>2</sup>						
Diphtheria, Tetanus, Pertussis <sup>3</sup>			DTaP	DTaP	DTaP	see footnote 3	DTaP				DTaP
Haemophilus influenzae type b <sup>4</sup>			Hib	Hib	Hib <sup>4</sup>		Hib				
Pneumococcal <sup>5</sup>			PCV	PCV	PCV		PCV			PPSV	
Inactivated Poliovirus <sup>6</sup>			IPV	IPV			IPV				IPV
Influenza <sup>7</sup>								Influenza (yearly)			
Measles, Mumps, Rubella <sup>8</sup>							MMR		see footnote 8		MMR
Varicella <sup>9</sup>							Varicella		see footnote 9		Varicella
Hepatitis A <sup>10</sup>							HepA (2 doses)			HepA Series	
Meningococcal <sup>11</sup>											MCV

□ Range of recommended ages

■ Certain high-risk groups

This schedule includes recommendations in effect as of December 15, 2009. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Considerations should include provider assessment, patient preference, and the potential for adverse events. Providers should consult the relevant Advisory Committee on Immunization Practices

statement for detailed recommendations: <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) 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. Monovalent HepB vaccine should be used for doses administered before age 6 weeks. 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 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).

- Administration of 4 doses of HepB to infants is permissible when a combination vaccine containing HepB is administered after the birth dose. The fourth dose should be administered no earlier than age 24 weeks.

### 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 0 days or older.
- The maximum age for the final dose in the series is 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 Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- TRIHIB (DTaP/Hib) and Hibrix (PRP-T) should not be used for doses at ages 2, 4, or 6 months for the primary series but can be used as the final dose in children aged 12 months through 4 years.

### 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 2 or more months after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See MMWR 1997;46(No. RR-8).

### 6. Inactivated poliovirus vaccine (IPV) (Minimum age: 6 weeks)

- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.

- If 4 doses are administered prior to age 4 years a fifth dose should be administered at age 4 through 6 years. See MMWR 2009;58(30):829-30.

### 7. Influenza vaccine (seasonal). (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 children aged 2 through 6 years (i.e., those who do not have underlying medical conditions that predispose them to influenza complications), either LAIV or TIV may be used, except LAIV should not be given to children aged 2 through 4 years who have had wheezing in the past 12 months.
- 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 9 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.

- For recommendations for use of influenza A (H1N1) 2009 monovalent vaccine see MMWR 2009;58(No. RR-10).

### 8. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- Administer the second dose routinely 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.

### 9. Varicella vaccine. (Minimum age: 12 months)

- Administer the second dose routinely 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.

### 10. 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 older children who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A is desired.

### 11. Meningococcal vaccine. (Minimum age: 2 years for meningococcal conjugate vaccine [MCV4] and for meningococcal polysaccharide vaccine [MPSV4])

- Administer MCV4 to children aged 2 through 10 years with persistent complement component deficiency, anatomic or functional asplenia, and certain other conditions placing them at high risk.
- Administer MCV4 to children previously vaccinated with MCV4 or MPSV4 after 3 years if first dose administered at age 2 through 6 years. See MMWR 2009; 58:1042-3.

The Recommended Immunization Schedules for Persons Aged 0 through 18 Years are approved by the Advisory Committee on Immunization Practices (<http://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

Some children rely on medication for the treatment of mental or emotional health problems. However, these services may not be accessible to all children who need them. In 2007, the parents of 40 percent of children who needed treatment reported that it was not received.

Unmet need for mental health treatment varied by age, with younger children having higher rates of unmet needs. In 2007, 57.8 percent of children aged 2–5 years who needed mental health care did not receive it, compared to 42.2 percent of children aged 6–11 years and 33.7 percent of children aged 12–17 years. Hispanic

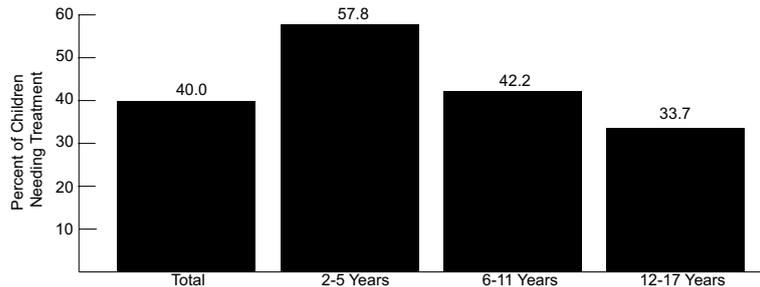
children who needed treatment had the highest rates of unmet need (49.4 percent), followed by non-Hispanic Black children (46.0 percent). More than half of uninsured children who needed treatment did not receive it, compared to 36.6 percent of children with private insurance who needed treatment (data not shown).

Some children rely on medication for mental or emotional health problems. In 2007, 6.2 percent of children received medication for Attention Deficit Hyperactivity Disorder (ADHD) or other problems with emotions, concentration, or behavior. Multiracial children were most likely to receive medication (8.3 percent),

followed by non-Hispanic White children (7.3 percent); children of other races, such as Asian/Pacific Islanders and American Indian/Alaska Natives, were least likely to receive medication (2.5 percent). The use of medication also varies by insurance status. Children with public insurance were two times more likely than children with private insurance and almost four times more likely than children with no insurance to receive medication for ADHD, emotions, concentration, or behavior (data not shown).

### Children Aged 2–17 Years Who Needed but Did Not Receive\* Mental Healthcare/Counseling in the Past Year, by Age, 2007

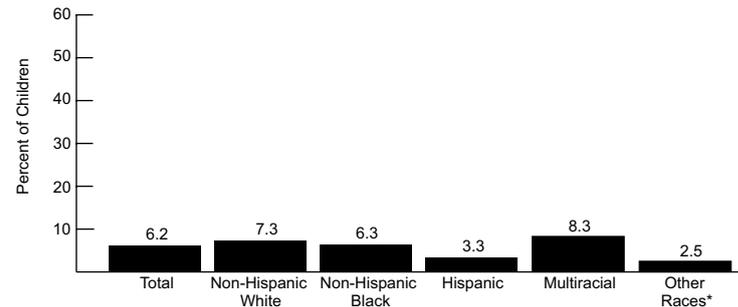
Source (I.7): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



\*Both need for treatment and receipt of treatment are based on parent report.

### Children Aged 2–17 Years Currently Taking Medication for Attention Deficit Hyperactivity Disorder (ADHD), Emotions, Concentration, or Behavior, by Race/Ethnicity, 2007

Source (I.7): 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



\*Includes Asian/Pacific Islanders and American Indian/Alaska Natives.

## DENTAL CARE

According to the Centers for Disease Control and Prevention, dental caries (tooth decay) is the 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.<sup>1</sup> Dental caries, however, is 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 the first tooth or at 12 months of age, whichever comes first.

In 2008, only 31.7 percent of children eligible for services under the Medicaid Early and

Periodic Screening, Diagnosis, and Treatment (EPSDT) program received preventive dental services. This is similar to the previous year's rate, but an improvement over the rate of 27.7 percent in 2006.

In 2008, 73.9 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 poverty level. Children living in households with incomes above 200 percent of the U.S. Census Bureau's poverty threshold (\$22,025 for a family of four in 2008) were more likely than children living in households with incomes

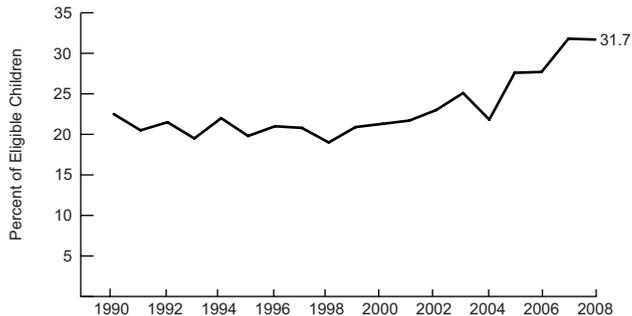
below 200 percent of the poverty threshold to have received dental care in the past year (78.9 percent versus 66.8 percent).

Non-Hispanic White children were more likely than children of other racial/ethnic groups to have received dental care in the past year (76.4 percent), followed by non-Hispanic Black children (73.9 percent) and Hispanic children (66.7 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 February 2010.*

### Receipt of EPSDT Preventive Dental Service Among Eligible Children,\* Aged Birth–20 Years, 1990–2008

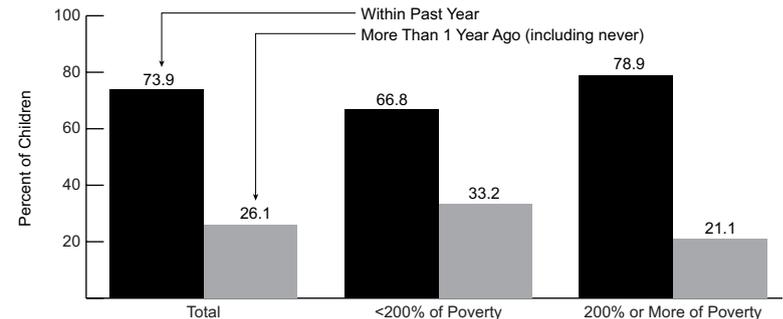
Source (III.4): Centers for Medicare and Medicaid Services, Annual EPSDT Report



\*All children on Medicaid are eligible for EPSDT services.

### Receipt of Dental Care\* Among Children Aged 1–18 Years, by Poverty Level,\*\* 2008

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 U.S. Census Bureau uses a set of money income thresholds to determine who is in poverty; the poverty threshold for a family of four was \$22,025 in 2008.

## PREVENTIVE HEALTH CARE VISITS

In 2008, 75.8 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. Well-child visits offer an opportunity not only to monitor children’s health and provide

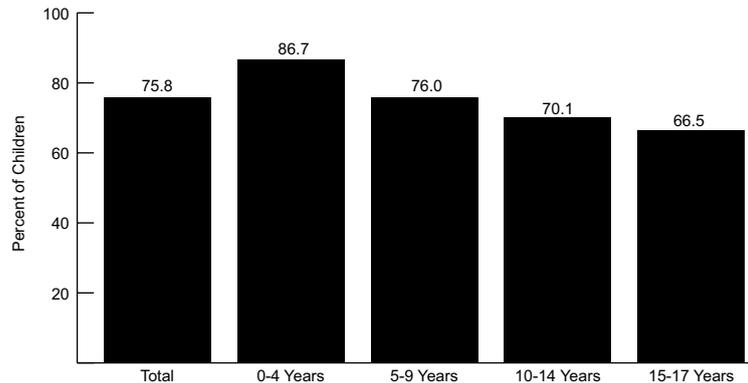
immunizations, but also to assess a child’s behavior and development, discuss nutrition, and answer parents’ questions.

The proportion of children receiving well-child visits declines with age. In 2008, 86.7 percent of children 4 years of age and younger received a preventive visit in the past year, compared to 76.0 percent of children 5–9 years of age, 70.1 percent of children 10–14 years of age, and 66.5 percent of children 15–17 years of age.

Receipt of preventive medical care also varies by race and ethnicity. In 2008, non-Hispanic Black children were the most likely to have received a well-child visit in the past year (81.1 percent), followed by non-Hispanic White children (75.7 percent). Hispanic children were least likely to have received preventive care in the past year (72.6 percent).

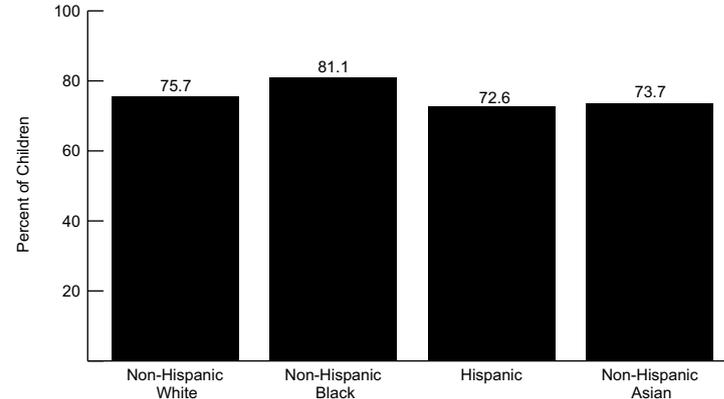
### Receipt of Preventive Health Care in the Past Year Among Children Under Age 18, by Age, 2008

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, 2008

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



## LACK OF HEALTH CARE

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 2008, 10.9 percent of children under 18 years of age had not seen a physician or other health care professional in the past year for either sick or routine care (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 5.0 percent of children under 5 years of age.

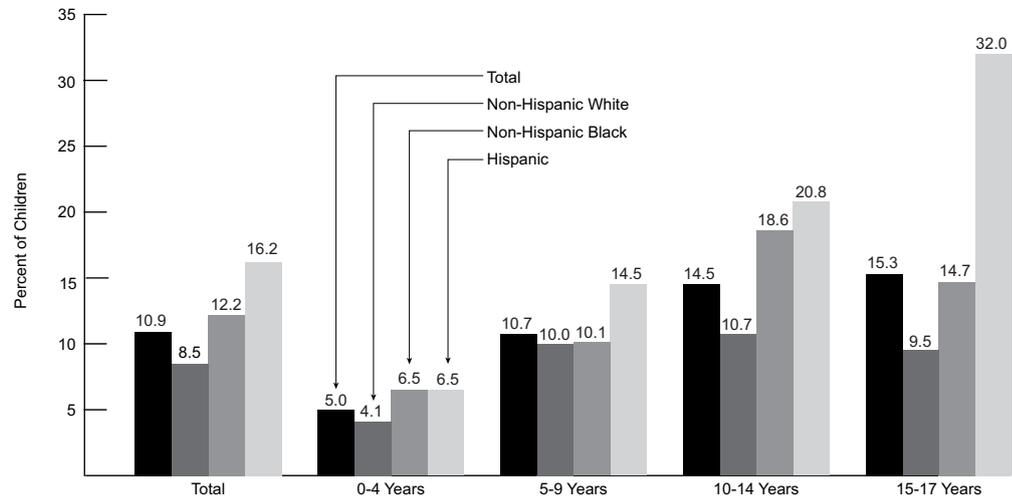
Health care visits also varied by race/ethnicity. In 2008, over 16 percent of Hispanic children had not seen a physician or other health care professional in the past year, compared to 8.5 percent of non-Hispanic White children and 12.2 percent of non-Hispanic Black children. Within every age group, Hispanic children were the least likely to have seen a health care provider, and non-Hispanic White children were the most likely to have seen one.

The proportion of children going without health care also varied by poverty level. In 2008, 13.3 percent of children living in households with incomes below 100 percent

of the U.S. Census Bureau's poverty threshold (\$22,025 for a family of four in 2008) had not seen a physician or other health professional in the past year, compared to 5.1 percent of children living in households with incomes of 400 percent or more of the poverty threshold (data not shown).

### Child Reported to Have Not Seen a Physician or Other Health Care Professional\* in the Past 12 Months, by Age and Race/Ethnicity, 2008

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.

## USUAL PLACE FOR SICK CARE

In 2008, a doctor's office or health maintenance organization (HMO) was the usual place for sick care (not including routine or preventive care) for 72.7 percent of children in the United States, a proportion that varies by poverty status and race/ethnicity. Children living in households with incomes above the U.S. Census Bureau's poverty threshold (\$22,025 for a family of four in 2008) were more likely to visit a doctor's office or HMO for sick care than children living in households with incomes below the poverty threshold (78.3 percent versus 55.6 percent). Children living in households with incomes below the poverty threshold were more likely than children living in households with

higher incomes to go to a clinic or health center (40.8 percent versus 20.3 percent).

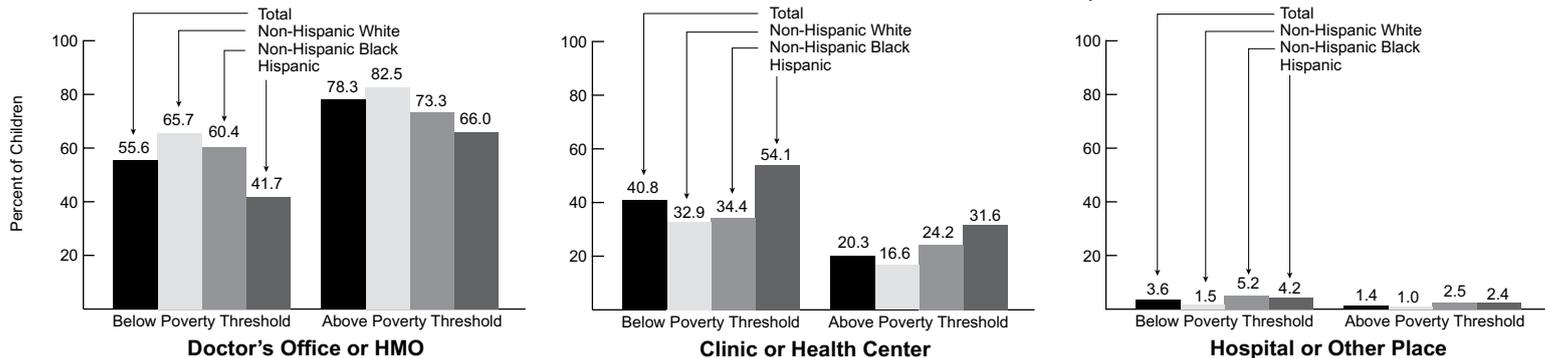
Among children living in poverty, 65.7 percent of non-Hispanic White children received sick care at a doctor's office or HMO, compared to 60.4 of non-Hispanic Black children and 41.7 percent of Hispanic children. Regardless of income, Hispanic children were more likely than non-Hispanic children to receive sick care at a clinic or health center. Among Hispanic children living in poverty, 54.1 percent received care at a clinic or health center, compared to 34.4 percent of their non-Hispanic Black counterparts and 32.9 percent of their non-Hispanic White counterparts. Among children living in families with incomes above the poverty thresh-

old, 31.6 percent of Hispanics, 24.2 percent of non-Hispanic Blacks, and 16.6 percent of non-Hispanic Whites received sick care at a clinic or health center.

Although only a small proportion of children used a hospital emergency room, hospital outpatient department, or other place as their primary source of sick care, it was more common among children living in families with incomes below the poverty threshold than among children with family incomes above the poverty threshold (3.6 percent versus 1.4 percent). Regardless of income, this was generally more common among non-Hispanic Black and Hispanic children than among non-Hispanic Whites.

## Place of Physician Contact,\* by Poverty Status\*\* and Race/Ethnicity, 2008

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 uses a set of money income thresholds to determine who is in poverty; the poverty threshold for a family of four was \$22,025 in 2008.

## MEDICAL HOME

According to the American Academy of Pediatrics, children's medical care should be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. These characteristics of high-quality health care can be combined into the concept of the medical home. The 2007 National Survey of Children's Health made an effort to measure whether children's health care is meeting the medical home standard. For this purpose, the survey included questions on the following: 1) whether the child has at least one personal doctor or nurse and a usual source of sick care; 2) whether the child has no problems gaining referrals to specialty care and access to therapies

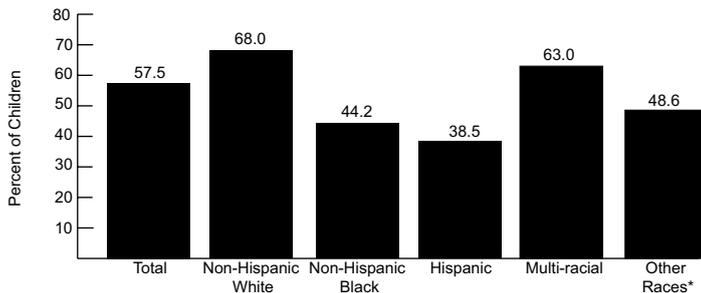
or other services or equipment; 3) whether the family is very satisfied with the level of communication among their child's doctors and other programs; 4) whether the family usually or always gets sufficient help coordinating care when needed, and receives effective care coordination; 5) whether the child's providers usually or always spend enough time with the family, listen carefully to concerns, are sensitive to values and customs, provide needed information, and make the family feel like a partner in the child's care; and 6) whether an interpreter is usually or always available when needed. If a child's care met all of these criteria, according to the parent, then the child was defined as having a medical home.

Overall, the care received by 57.5 percent of children met this medical home standard. This varied substantially by race and ethnicity: 68.0 percent of non-Hispanic White children received care from a medical home, compared to 63.0 percent of multiracial children, 44.2 percent of non-Hispanic Black children, 38.5 percent of Hispanic children, and 48.6 percent of children of other races.

Receipt of care from a medical home also varied by insurance status. Children with private insurance were most likely to receive care from a medical home (66.5 percent), followed by children with public insurance (45.4 percent). Children who were not currently insured were least likely to have a medical home (35.7 percent).

### Children with a Medical Home, by Race/Ethnicity, 2007

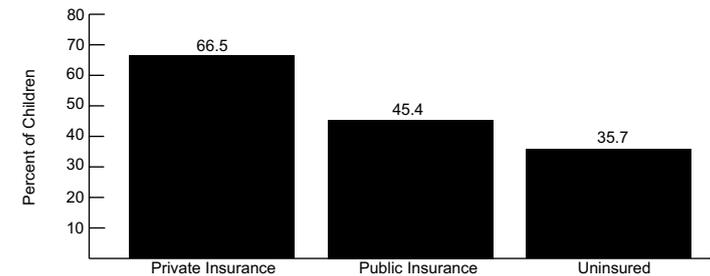
Source (III.5): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



\*Includes Asian/Pacific Islanders and American Indian/Alaska Natives.

### Children with a Medical Home, by Type of Insurance, 2007

Source (III.5): 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



## EMERGENCY DEPARTMENT UTILIZATION

In 2008, more than 20 percent of children had at least one visit to a hospital emergency department (ED). Children living in households with incomes below the U.S. Census Bureau's poverty threshold (\$22,025 for a family of four in 2008) were more likely than children living in households with incomes above the poverty threshold to have visited the ED. Just over one-quarter of children living in poverty made one to three ED visits during the year, compared to fewer than 20 percent of children living in households with incomes above poverty. Similarly, 3.0 percent of children from lower-income

households made four or more visits to the ED, compared to 1.0 percent of children from higher-income households.

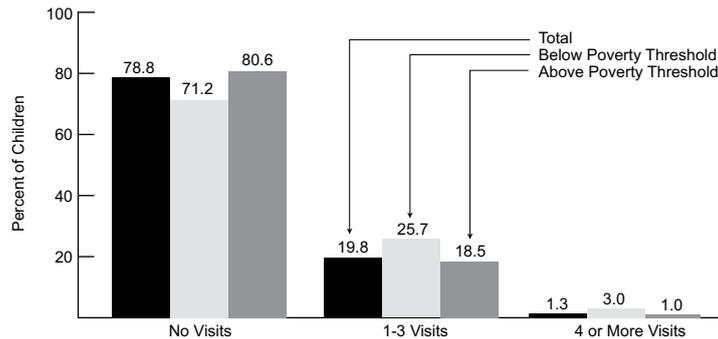
Emergency department utilization also varies by age: 26.6 percent of children under 5 years of age made 1–3 visits to the ED in 2008, compared to 15.4 percent of children aged 10–14 years. Children under 5 years of age were also the most likely to make four or more ED visits (2.1 percent). There were also racial/ethnic differences in ED utilization: 23.3 percent of non-Hispanic Black children made 1–3 visits to the ED in 2008, compared to 19.8 percent of Hispanic children and 18.9 percent of non-Hispanic White children (data not shown).

According to the 2006 National Hospital Ambulatory 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 treated in 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).<sup>1</sup>

*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 Department Among Children Under Age 18, by Poverty Status,\* 2008

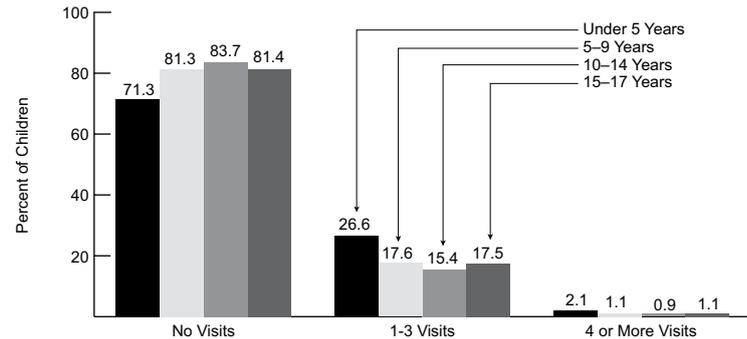
Source (1.7): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



\*The U.S. Census Bureau uses a set of money income thresholds to determine who is in poverty; the poverty threshold for a family of four was \$22,025 in 2008.

### Visits to the Emergency Department Among Children Under Age 18, by Age, 2008

Source (1.7): 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 2007, in the 23 reporting areas (States and territories) that used the revised birth certificate, 70.8 percent of women giving birth were determined to have received prenatal care in the first trimester. In the areas using the unrevised birth certificate, 82.0 percent of women were reported to have entered prenatal care in the first trimester.

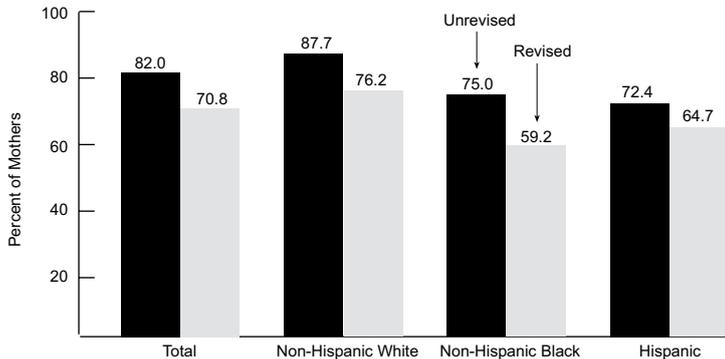
Early prenatal care utilization differs by race/ethnicity. In 2007, non-Hispanic White women were most likely to receive first trimester prenatal care—this is the case using both revised and

unrevised birth certificate data (76.2 percent and 87.7 percent, respectively). Non-Hispanic Black and Hispanic women are less likely to receive first trimester prenatal care.

In 2007, 7.1 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 3.9 percent. In both the unrevised and revised reporting areas, non-Hispanic Black and Hispanic women were more likely than non-Hispanic White women to receive late or no prenatal care.

### Receipt of First Trimester Prenatal Care, by Race/Ethnicity and Birth Certificate Revision\*, 2007

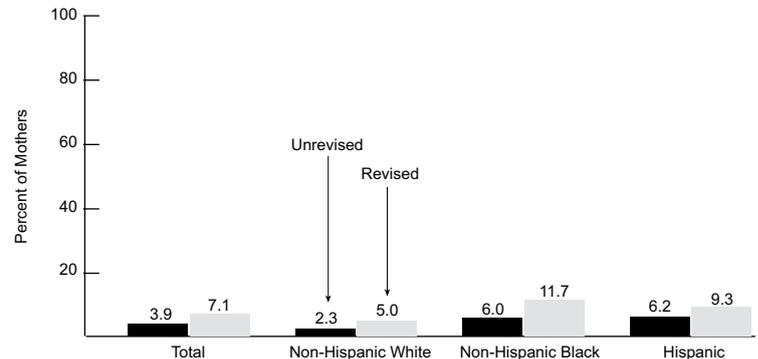
Source (II.2): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



\*“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 1, 2007; “Revised” data are for the 23 reporting areas that had implemented the 2003 Revision.

### Receipt of Late\* or No Prenatal Care, by Race/Ethnicity and Birth Certificate Revision\*\*, 2007

Source (II.2): 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 1, 2007; “Revised” data are for the 23 reporting areas that had implemented the 2003 Revision.