



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 7.5 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 2009, approximately 7.5 million U.S. children under 18 years of age had no health insurance coverage, representing 10.0 percent of the population. More than one-third of children were insured through public programs such as Medicaid and the Children's Health Insurance Program (36.8 percent), and 60.4 percent were covered by private insurance.

Children's insurance status varies by race and ethnicity. In 2009, 74.0 percent and 70.9 percent of non-Hispanic White and non-Hispanic Asian children, respectively, and 70.8 percent of Asian children had private coverage, while the same was true of only 47.1 percent of non-Hispanic Native Hawaiian and Other Pacific Islander children, 43.7 percent of non-Hispanic Black children,

41.8 percent of non-Hispanic American Indian and Alaska Native children, and 36.8 percent of Hispanic children. Over half of non-Hispanic Black, American Indian and Alaska Native, and Native Hawaiian and Other Pacific Islander children were publicly insured.

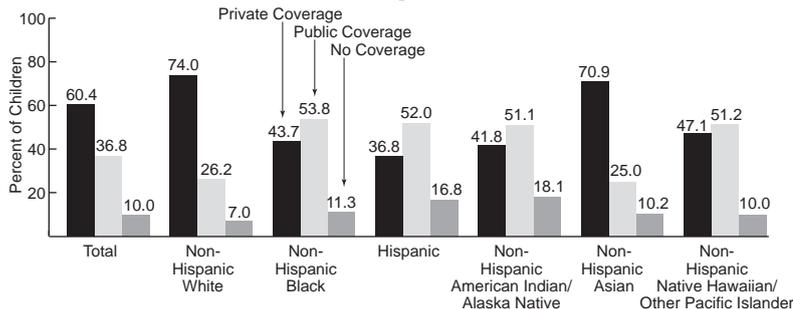
As family income increases, private health insurance coverage among children rises and the proportions of children with public coverage and no coverage decrease. In 2009, children living in households with incomes below 100 percent of the U.S. Census Bureau's poverty threshold (\$21,954 for a family of four in 2009) were most likely to have public coverage (74.8 percent) while similar proportions of poor and near-poor (incomes between 100-199 percent of the

poverty threshold) children were uninsured (15.1 percent and 14.8 percent, respectively). Children with family incomes of 300 percent or more of the poverty threshold were most likely to have private coverage (89.0 percent), and least likely to have public coverage (12.2 percent) or to be uninsured (4.7 percent).

In 1997, the Children's Health Insurance Program (CHIP) 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,* 2009

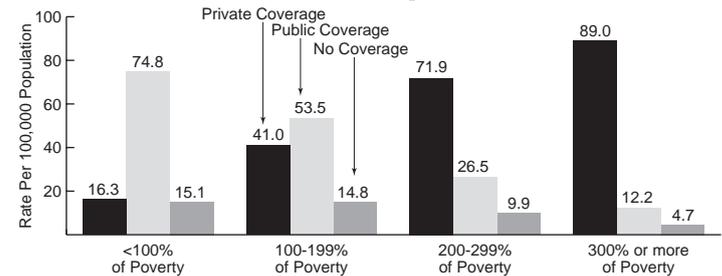
Source (III.1): U.S. Census Bureau, Current Population Survey



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

Health Insurance Coverage Among Children Under Age 18, by Poverty Status* and Type of Coverage,** 2009

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 \$21,954 in 2009. **Totals equal more than 100 percent because children may have more than one source of coverage.

LEVELS OF INSURANCE

While most children have some type of health insurance, it may not always meet their needs. The 2007 National Survey of Children's Health asked parents about their child's health insurance coverage and related costs and benefits. Based on both insurance status and benefits, four levels of insurance were defined: full and adequate coverage; full and inadequate coverage (or underinsurance); gaps in coverage (child had periods of no insurance coverage in the past year); and uninsured (child was never insured in the past year).¹ Overall, 65.7 percent of children were fully insured in 2007, 19.3 percent were underinsured (i.e., covered but did not receive

the level of benefits necessary to meet their needs), 10.4 percent had gaps in coverage, and 4.7 percent were consistently uninsured during the past year.

The proportion of children with different levels of insurance coverage varied by a number of factors. Children aged 0-5 years were most likely to have full and adequate insurance coverage (69.3 percent) compared to children aged 6-11 years (64.0 percent) and aged 12-17 years (63.9 percent; data not shown). Hispanic children were most likely to be uninsured (12.1 percent) and to have gaps in their past-year coverage (16.1 percent). Non-Hispanic White and multiracial children had the highest rates of

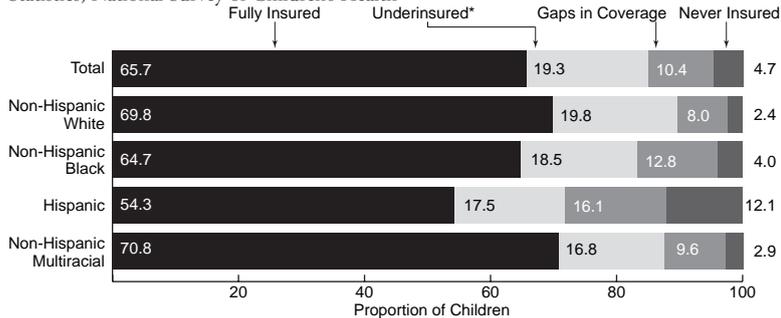
full and adequate insurance coverage (69.8 and 70.8 percent, respectively).

Underinsurance was most commonly reported among children living in households with incomes 200-399 percent of the Federal poverty level (\$20,650 for a family of four in 2007) and least commonly reported among children living in households with incomes below the poverty line (22.8 versus 14.1 percent). Underinsurance was also more common among children in fair or poor health and those with special health care needs (data not shown).

1 Kogan MD, Newacheck PW, Blumberg SJ, Ghandour RM, Singh GK, Strickland BB, van Dyck PC. Underinsurance among children in the United States. N Engl J Med. 2010 Aug 26;363(9):841-51.

Levels of Insurance Among Children Aged 0-17 Years, by Race/Ethnicity 2007

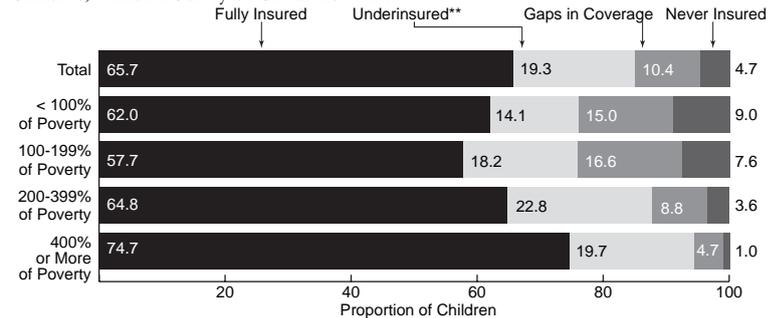
Source (III.2): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*Fully insured but did not receive the level of benefits necessary to meet their needs, based on parent report.

Levels of Insurance Among Children Aged 0-17 Years, by Poverty*, 2007

Source (III.2): 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



*The U.S. Department of Health and Human Services establishes poverty guidelines for determining financial eligibility for Federal programs; the poverty level for a family of four was \$20,650 in 2007.

**Fully insured but did not receive the level of benefits necessary to meet their needs, based on parent report.

VACCINATION COVERAGE

The Healthy People 2020 objective for childhood immunization is to achieve 90 percent coverage for each of the universally recommended vaccines among young children. In 2009, 70.5 percent of children 19–35 months of age received each of six vaccines in a modified series of recommended vaccines (4:3:1:3:1:4). This series includes four doses of diphtheria, tetanus, and pertussis vaccine (DTP/DT/DTaP); three doses of poliovirus vaccine; one dose of measles, mumps, and rubella vaccine (MMR); three doses of the Hepatitis B vaccine (HepB); one dose of the varicella (chicken pox) vaccine; and four doses of the pneumococcal conjugate vaccine (PCV). Estimates presented in previous editions of Child Health USA have focused on receipt of a 7-vaccine series which also included three doses of *Haemophilus influenzae* type b vaccine (Hib). However, because of changes in measurement of the Hib vaccine and the vaccine shortage that occurred from December 2007 to September 2009, coverage estimates included here are based on the modified series that excludes Hib.

For some vaccines, the proportion of children covered varied by poverty status. Children living in households with family incomes below 100 percent of the U.S. Census Bureau's poverty threshold (\$22,025 for a family of four in

2008) had significantly lower rates of vaccine coverage for diphtheria, tetanus, and pertussis (80.1 percent compared to 85.7 percent of children living in households with family incomes above the poverty threshold) as well as for the four recommended doses of pneumococcal conjugate vaccine (74.8 percent versus 83.2 percent). Although no difference was observed in the proportion of children receiving three

doses of the Hepatitis B vaccine by poverty status, coverage for the Hepatitis B birth dose (one dose within the first three days of life) was higher among children living below poverty than for those living at or above poverty (63.2 percent versus 59.4 percent; data not shown). No statistically significant difference was observed in the proportion of children receiving the modified 6-vaccine schedule by poverty status.

Vaccination Rates Among Children Aged 19-35 Months, by Poverty,* 2009

Source (III.3): Centers for Disease Control and Prevention, National Immunization Survey

Vaccine	Total	< 100% Poverty	≥ 100% Poverty
4:3:1:3:x:1:4 Modified Series**	70.5	75.5	78.5
4+DTAP	83.9	80.1	85.7
3+Polio	92.8	92.0	93.3
1+MMR	90.0	88.8	90.6
2+ or 3+Hib***	83.6	90.1	93.1
3+HepB	92.4	92.3	92.7
1+ Varicella	89.6	89.0	90.2
4+ PCV	80.4	74.8	83.2

*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. **Excludes Hib, due to the 2007–2009 shortage. ***Depending on product type received

Recommended Immunization Schedule for Children Aged 0-6 Years, United States, 2011

Source (III.4): Department of Health and Human Services, Centers for Disease Control and Prevention

 Range of recommended ages  Certain high-risk groups

	Birth	1mo	2mo	4mo	6mo	12mo	15mo	18mo	19-23mo	2-3yr	4-6yr
Hepatitis B¹	HepB	HepB		HepB							
Rotavirus²			RV	RV	RV ²						
Diphtheria, Tetanus, Pertussis³			DTaP	DTaP	DTaP	see footnote 3	DTaP				DTaP
Haemophilus influenzae type b⁴			Hib	Hib	Hib ⁴	Hib					
Pneumococcal⁵			PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus⁶			IPV	IPV		IPV					IPV
Influenza⁷						Influenza (yearly)					
Measles, Mumps, Rubella⁸						MMR		see footnote 8			MMR
Varicella⁹						Varicella		see footnote 9			Varicella
Hepatitis A¹⁰						HepA (2 doses)				HepA Series	
Meningococcal¹¹											MCV

This schedule includes recommendations in effect as of December 21, 2010. 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. Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

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).

Doses following the birth dose:

- The second dose should be administered at age 1 or 2 months. Monovalent HepB should be used for doses administered before age 6 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.
- Infants who did not receive a birth dose should receive 3 doses of HepB on a schedule of 0, 1, and 6 months.
- The final (3rd or 4th) dose in the HepB series 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.

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.

- Hibrix 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.
- A PCV series begun with 7-valent PCV (PCV7) should be completed with 13-valent PCV (PCV13).
- A single supplemental dose of PCV13 is recommended for all children aged 14 through 59 months who have received an age-appropriate series of PCV7.
- The supplemental dose of PCV13 should be administered at least 8 weeks after the previous dose of PCV7. See MMWR 2010;59(No. RR-11).
- Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant.

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

- If 4 or more doses are administered prior to age 4 years an additional dose should be administered at age 4 through 6 years.
- The final dose in the series should be administered on or after the fourth birthday and at least 6 months following the previous dose.

7. Influenza vaccine (seasonal). (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- For healthy children aged 2 years and older (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.
- Administer 2 doses (separated by at least 4 weeks) to children aged 6 months through 8 years who are receiving seasonal influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

- Children aged 6 months through 8 years who received no doses of monovalent 2009 H1N1 vaccine should receive 2 doses of 2010-2011 seasonal influenza vaccine. See MMWR 2010;59(No. RR-8):33-34.

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

- The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.

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

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

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

- Administer 2 doses at least 6 months apart.
- HepA is recommended for children aged older than 23 months 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 conjugate vaccine, quadrivalent (MCV4). (Minimum age: 2 years)

- Administer 2 doses of MCV4 at least 8 weeks apart to children aged 2 through 10 years with persistent complement component deficiency and anatomic or functional asplenia, and 1 dose every 5 years thereafter.
- Persons with human immunodeficiency virus (HIV) infection who are vaccinated with MCV4 should receive 2 doses at least 8 weeks apart.
- Administer 1 dose of MCV4 to children aged 2 through 10 years who travel to countries with highly endemic or epidemic disease and during outbreaks caused by a vaccine serogroup.
- Administer MCV4 to children at continued risk for meningococcal disease who were previously vaccinated with MCV4 or meningococcal polysaccharide vaccine after 3 years if the first dose was administered at age 2 through 6 years.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The National Survey of Children with Special Health Care Needs (CSHCN) asked the parents of CSHCN whether their child had insurance in the past 12 months and what kind of insurance they had. Overall, 91.2 percent of CSHCN were reported to have been insured for all of the previous 12 months, while the remaining 8.8 percent were uninsured for all or some part of the year. At the time of the interview, almost 97 percent of CSHCN were reported to have some type of insurance: 59.1 percent had private insurance provided through an em-

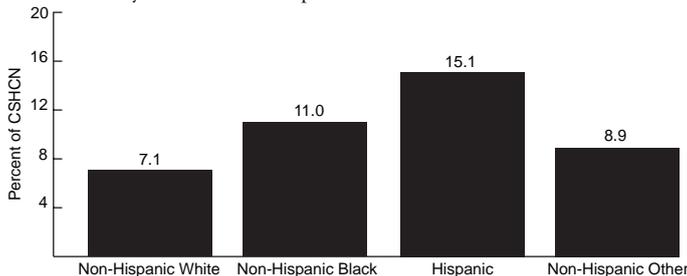
ployer or obtained directly from an insurance company and 28.1 percent had public insurance, such as Medicaid, the Children's Health Insurance Program (CHIP), or military health care. Another 7.4 percent of CSHCN had both private and public insurance, and 3.5 percent were uninsured at the time of the interview (data not shown).

The percentage of CSHCN without insurance in 2005-06 varied by race/ethnicity and family income. Hispanic CSHCN were most likely to have been uninsured at some point during the prior year (15.1 percent), followed by non-Hispanic Black children (11.0 per-

cent), non-Hispanic CSHCN of other races (8.9 percent) and non-Hispanic White children (7.1 percent). CSHCN living in poor and near poor families—or those with family incomes below 100 percent of the Federal poverty level (\$19,350 for a family of four in 2005) and between 100 and 199 percent of the Federal poverty level—were most likely to be uninsured at some point in the prior year (14.2 and 14.1 percent, respectively). In contrast, the same was true for 7.1 percent of CSHCN living in families with incomes 200-399 percent of poverty and 2.9 percent of CSHCN living in households with family incomes of 400 percent or more of poverty.

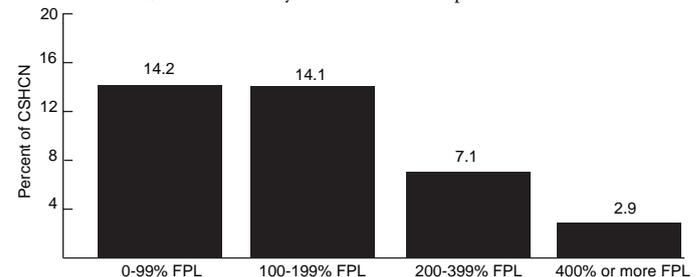
Percent of CSHCN Ever Uninsured in the Past 12 Months, by Race/Ethnicity, 2005-06

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 with Special Health Care Needs



Percent of CSHCN Ever Uninsured in the Past 12 Months, by Poverty Level,* 2005-06

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 with Special Health Care Needs



*The U.S. Department of Health and Human Services establishes poverty guidelines for determining financial eligibility for Federal programs; the poverty level for a family of four was \$19,350 in 2005.

MENTAL HEALTH TREATMENT

In 2009, 2.9 million, or 12.0 percent of adolescents aged 12 to 17 received past-year treatment or counseling for problems with emotions or behavior (not including problems caused by drug or alcohol use) in a specialty mental health setting, including both inpatient¹ and outpatient² care (data not shown). A similar proportion of adolescents received mental health services in an educational setting³ (12.1 percent) while 2.5 percent received services from a pediatrician or other family doctor in a medical setting, and less than 1 percent received mental health services in a juvenile justice setting. About 5 percent of adolescents received mental health services in both a specialty mental health setting and either an educational or a medical setting.

A greater proportion of females received specialty mental health services (14.0 percent) than males (10.1 percent; data not shown). Few racial and ethnic differences in service site for past-year treatment were observed with two notable exceptions: Asians were less likely to receive services in a specialty mental health setting compared to non-Hispanic White and Black children (6.6 percent versus 12.8 and 12.2 percent, respectively) and non-Hispanic Black children were more likely to receive services in an educational setting (16.4 percent) than children of other racial/ethnic groups (data not shown).

The most commonly reported reason for service use was feeling depressed. This was true for nearly half of adolescents who received services in either a specialty mental health or medical

setting, and over one-third of those who received services in an educational setting. Overall, reasons for treatment or counseling varied by service site. For example, problems with home/family was reported as the reason for seeking services by 27.8 percent of those seeking care in a specialty mental health setting compared to 17.8 and 11.9 percent of those treated in educational and medical settings, respectively.

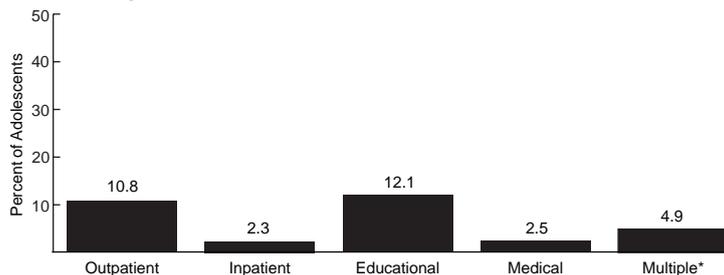
1 Includes treatment/counseling from an overnight or longer stay in a hospital, residential treatment center, or foster care or therapeutic foster care home.

2 Includes treatment/counseling from a private therapist, psychologist, psychiatrist, social worker, or counselor; mental health clinic or center; partial day hospital or day treatment program; or in-home therapist, counselor, or family preservation worker.

3 Includes treatment/counseling from a school social worker, school psychologist, or school counselor.

Past-Year Mental Health Service Use Among Adolescents Aged 12-17, by Service Site, 2009

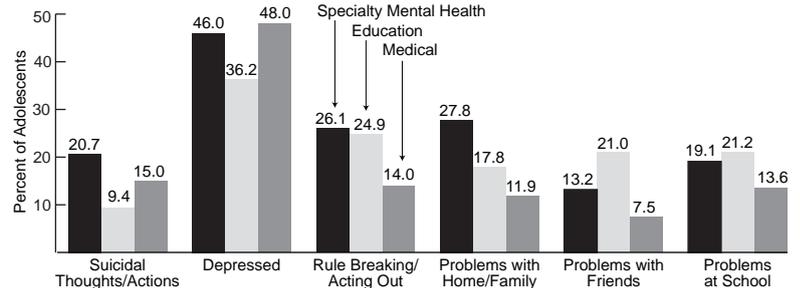
Source (III.6): Substance Abuse and Mental Health Service Administration, National Survey of Drug Use and Health



*Inpatient or Outpatient services in addition to services received in either an educational or medical setting.

Selected Reasons* for Mental Health Service Use Among Adolescents Aged 12-17,** by Service Site, 2009

Source (III.6): Substance Abuse and Mental Health Service Administration, National Survey of Drug Use and Health



*Respondents could report multiple reasons. **Among adolescents who received past-year mental health treatment or counseling.

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.¹ Tooth decay, 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.²

In 2009, 78.4 percent of children aged 2–17 years received dental care in the past year while 15.0 percent had not received such care in more than 2 years. Receipt of dental care varied by

a number of factors, including insurance status and poverty. Over 80 percent of children with private health insurance coverage received past-year dental care, as did 76.6 percent of children with public insurance, and only 51.6 percent of uninsured children. Poor and near poor children, or those living in households with incomes at or below 100 or 200 percent of the U.S. Census Bureau's poverty threshold (\$22,025 for a family of four in 2008), were less likely than children living in households with incomes above 200 percent of the poverty threshold to have received past-year dental care (71.5 and 75.6 percent, respectively, compared to 82.2 percent; data not shown).

Similar patterns were observed for unmet dental care needs. Overall, 7.1 percent of children

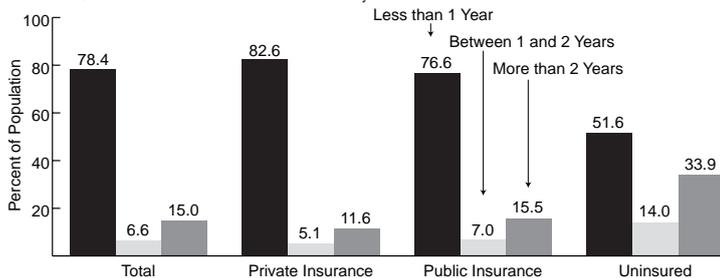
had unmet dental care needs in 2009. However, the proportion of children with unmet needs was substantially higher among those who were uninsured (27.8 percent) compared to those with either private (4.4 percent) or public (6.7 percent) insurance. Similar proportions of poor and near poor children, about 10 percent, had unmet dental needs compared to 4.5 percent of children living in households with incomes above 200 percent of the poverty threshold (data not shown).

1 Centers for Disease Control and Prevention, Division of Oral Health. *Children's Oral Health*. Available at: <http://www.cdc.gov/OralHealth/topics/child.htm>. Accessed April 2011.

2 American Dental Association. *For the patient: baby's first teeth*. *JADA* 2002;133:255.

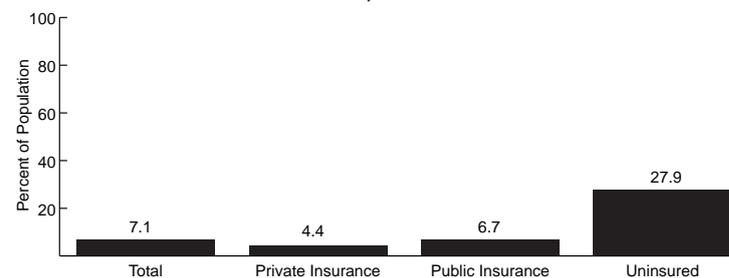
Time Since Last Dental Contact Among Children Aged 2-17 Years, by Insurance Status and Type, 2009

Source (III.7): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Unmet Dental Need* Among Children Aged 2-17 Years in Past 12 Months, by Insurance Status and Type, 2009

Source (III.7): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*Based on parent report that services were needed but were not affordable.

WELL-CHILD VISITS

In 2009, 78.0 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 be-

havior and development, discuss nutrition, and answer parents’ questions.

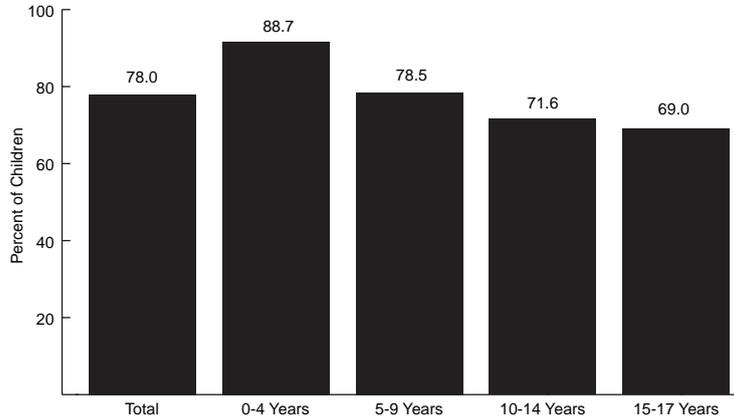
The proportion of children receiving well-child visits declines with age. In 2009, 88.7 percent of children 4 years of age and younger received a preventive visit in the past year, compared to 78.5 percent of children 5–9 years of age, 71.6 percent of children 10–14 years of age, and 69.0 percent of children 15–17 years of age.

Receipt of preventive medical care also varies by race and ethnicity. In 2009, non-Hispanic

Black children were significantly more likely to have received a well-child visit in the past year (83.6 percent) than non-Hispanic White and Hispanic children (77.6 percent and 74.9 percent, respectively). Non-Hispanic American Indian/Alaskan Native children had the lowest reported rate of preventive care in the past year (72.1 percent), but this was not statistically different than estimates for other racial/ethnic groups.

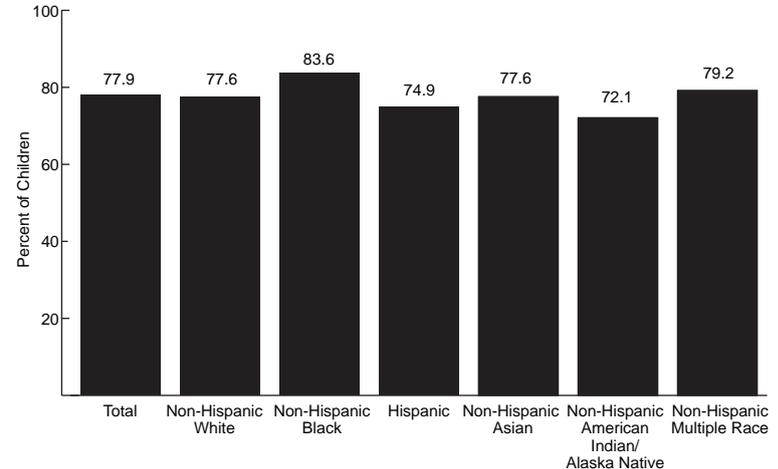
Receipt of Preventive Health Care in the Past Year Among Children Under Age 18, by Age, 2009

Source (III.8): 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, 2009

Source (III.8): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



HEALTH CARE VISITS

In 2009, 10.1 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. Nearly 15 percent of children aged 15–17 years had not seen a health care provider in the past year, compared to less than 5.0 percent of children under 5 years of age.

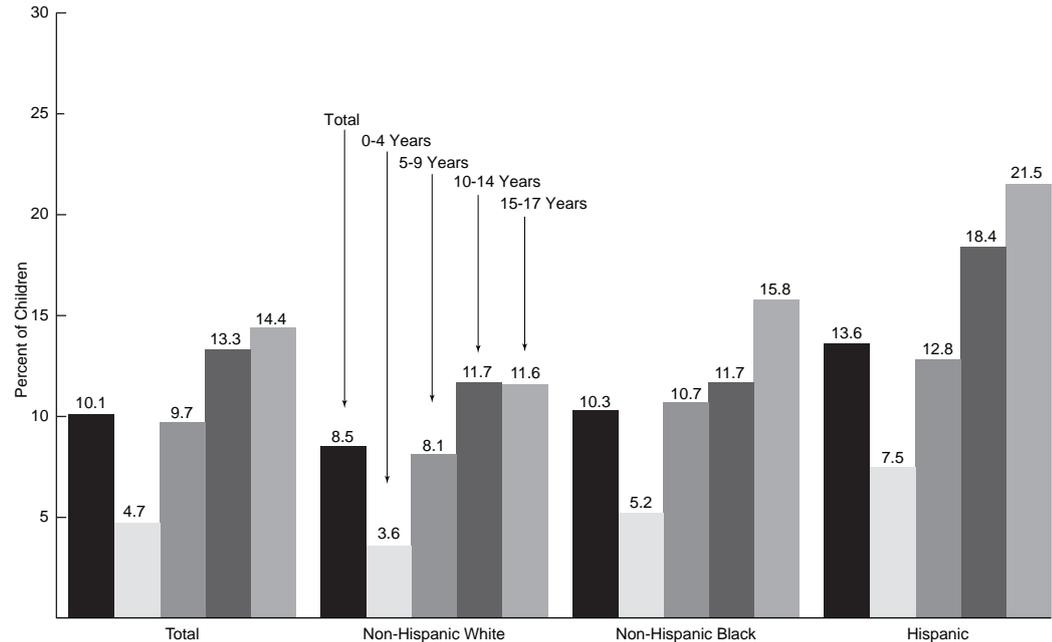
Health care visits also varied by race/ethnicity. In 2009, 13.6 percent of Hispanic children had not seen a physician or other health professional in the past year, compared to 8.5 percent of non-Hispanic White children and 10.3 percent of non-Hispanic Black children. Across all age groups, Hispanic 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; however, not all observed differences were statistically significant. Differences were most pronounced among older children: Among children aged 15–17, 11.6 percent of non-Hispanic White children had not seen a health professional in the past year compared to 21.5 percent of Hispanic children.

The proportion of children going without health care also varied by poverty level. In 2009, 13.2 percent of children living in households with incomes below 100 percent of the U.S. Census Bureau's poverty threshold (\$21,954

for a family of four in 2009) had not seen a physician or other health professional in the past year, compared to 5.4 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, 2009

Source (III.8): 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 2009, a doctor's office or health maintenance organization (HMO) was the usual place for sick care (not including routine or preventive care) for 74.5 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 (\$21,954 for a family of four in 2009) 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 (78.6 percent versus 57.3 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 (39.4 percent versus 19.9 percent).

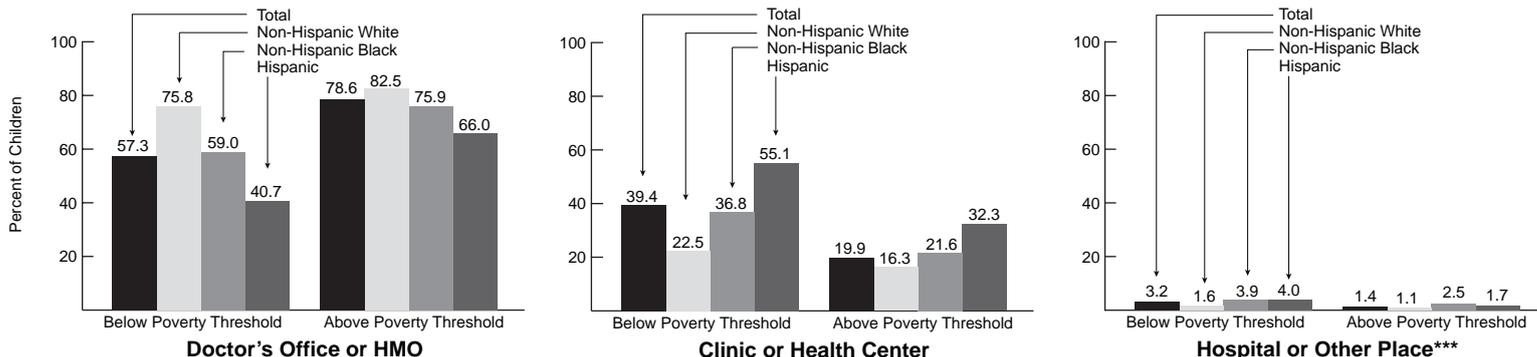
Among children living in poverty, 75.8 percent of non-Hispanic White children received sick care at a doctor's office or HMO, compared to 59.0 percent of non-Hispanic Black children and 40.7 percent of Hispanic children. Regardless of income, Hispanic children were more likely than non-Hispanic children to receive sick care at a clinic or health center. Among Hispanic children living in poverty, 55.1 percent received care at a clinic or health center, compared to 36.8 percent of their non-Hispanic Black counterparts and 22.5 percent of their non-Hispanic White counterparts. Among chil-

dren living in families with incomes above the poverty threshold, 32.3 percent of Hispanics, 21.6 percent of non-Hispanic Blacks, and 16.3 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 (3.2 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** and Race/Ethnicity, 2009

Source (III.8): 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 \$21,954 in 2009. ***Includes Hospital Emergency Room, Outpatient Department or some other place.

MEDICAL HOME

According to the American Academy of Pediatrics, children's medical care should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.¹ Together, these characteristics of care form the medical home model. The 2007 National Survey of Children's Health measured if a child's health care met the standards of a medical home during the previous 12 months. For this purpose, the survey included questions on the following: 1) whether the child has a 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 commu-

nication 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.

In 2007, the care received by 57.5 percent of children met this medical home standard. This varied substantially by household income: 39.4 percent of children in households with incomes

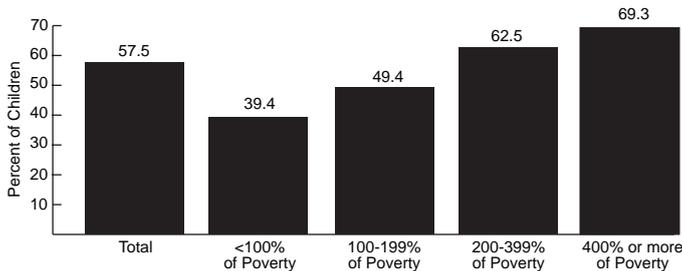
at less than 100% of the Federal poverty level (\$20,650 for a family of four in 2007) had a medical home, compared to 69.3 percent of children in households at or above 400% of the of the Federal poverty level.

Receipt of care from a medical home also varied by parent-reported health status. Children in excellent or very good health were the most likely to receive care in a medical home (61.8 percent), followed by children in good health (36.5 percent). Children in fair or poor health were the least likely to have a medical home (25.3 percent).

1 American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee. The medical home. Pediatrics. 2002;110(1 pt 1):184-186

Children with a Medical Home, by Poverty*, 2007

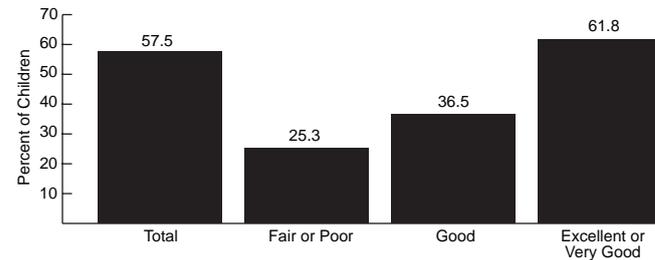
Source (III.9): Health Resources and Services Administration, Maternal and Child Health Bureau and Centers for Disease Control and Prevention, National Center for Health Statistics, National Survey of Children's Health



*The U.S. Department of Health and Human Services establishes poverty guidelines for determining financial eligibility for Federal programs; the poverty level for a family of four was \$20,650 in 2007.

Children with a Medical Home, by Parent-Reported Health Status, 2007

Source (III.10): 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 2009, more than 20.8 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 (\$21,954 for a family of four in 2009) were more likely than children living in households with incomes above the poverty threshold to have visited the ED in the past year. One-quarter of children living in poverty made 1–3 ED visits during the year, compared to 18.5 percent of children living in households with incomes above poverty. Similarly, 2.2 percent of children from low-income households made four or more visits to the ED, compared to 1.0 per-

cent of children from higher-income households.

Emergency department utilization also varied by age: 24.5 percent of children under 5 years of age made 1–3 visits to the ED in 2009, compared to 17.6 percent of children aged 15–17 years. Children under 5 years of age were also the most likely to make four or more ED visits (2.3 percent). There were also racial/ethnic differences in ED utilization: 24.6 percent of non-Hispanic Black children made 1–3 visits to the ED in 2009 compared to 19.0 percent of Hispanic children and 18.8 percent of non-Hispanic White children (data not shown).

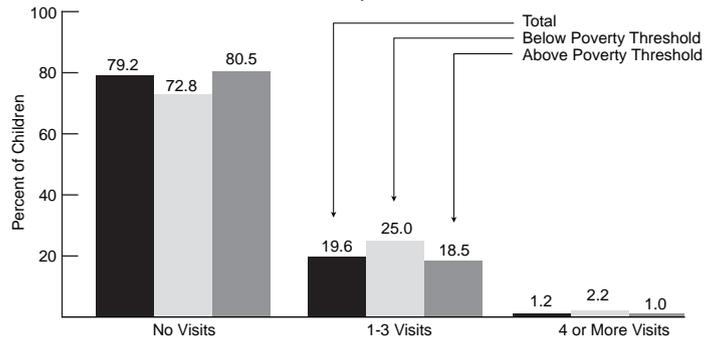
According to the 2007 National Hospital Ambulatory Medical Care Survey, the most

common reason for a visit to the emergency department among children under 15 years of age was fever (15.8 percent), followed by cough (6.1 percent), and vomiting (6.7 percent). The two most common primary diagnoses treated in ED visits among both males and females were acute upper respiratory infections (9.8 percent, combined), otitis media (middle ear infection) and Eustachian tube disorders (7.0 percent, combined), followed by unspecified viral and chlamydial infection among females (2.3 percent) and open wound of head (2.9 percent) among males.¹

1 Niska RW, Bhuiya F, Xu J. National Hospital Ambulatory Medical Care Survey: 2007 emergency department summary. National Health Statistics Reports, No. 26; 2010 Aug.

Visits to the Emergency Room Among Children Under Age 18, by Poverty,* 2009

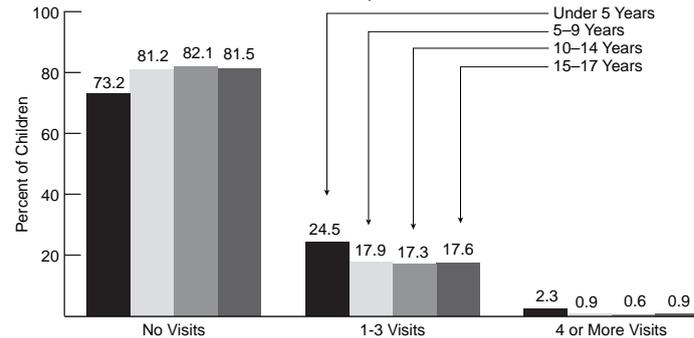
Source (III.8): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*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 \$21,954 in 2009.

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

Source (III.8): 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 in 2003, which are gradually being adopted by the states, make comparisons over time impossible. As of January 1, 2008, 27 states had implemented the revised birth certificate representing 65 percent of all U.S. births.¹

In 2008, in the 27 reporting areas that used the revised birth certificate, 71.0 percent of women giving birth were determined to have received prenatal care in the first trimester, while 7.0 percent of women began prenatal care in the third trimester or did not receive any prenatal care. Early prenatal care utilization differs by race/ethnicity. Non-Hispanic Asian and non-Hispanic White women were most likely to receive prenatal care beginning in the first trimester (77.9 and 76.7 percent, respectively). Non-Hispanic American Indian/Alaska Native women and non-Hispanic Native Hawaiian and Other Pacific Islander women were least

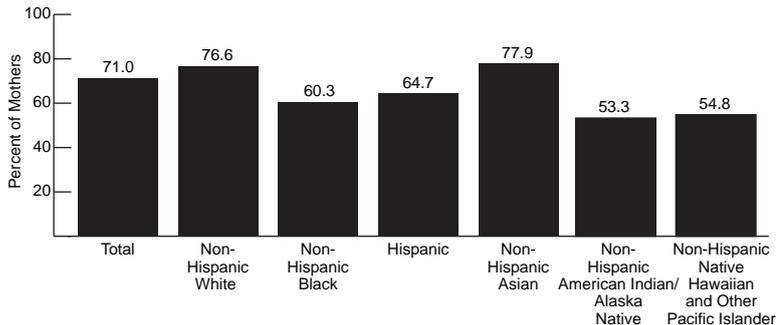
likely to receive first trimester care (53.3 and 54.8 percent, respectively).

Timing of prenatal care initiation also varied by maternal age. Teen-aged mothers were least likely to receive timely prenatal care, with less than one-third of those under the age of 15 and about half of those aged 15-19 years initiating prenatal care in the first trimester (32.9 percent and 54.3 percent, respectively). In comparison, over 70 percent of mothers-to-be aged 25 years and older received early prenatal care.

1 Martin JA, Hamilton BE, Sutton PD, et al. Births: Final data for 2008. National vital statistics reports; vol 59 no 1. Hyattsville, MD: National Center for Health Statistics. 2010.

Receipt of First Trimester Prenatal Care,* by Maternal Race/Ethnicity, 2008

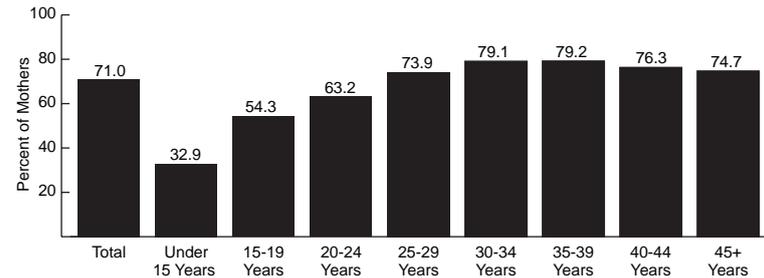
Source (III.11): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*In the 27 reporting areas (States and territories) that used the revised birth certificate.

Receipt of First Trimester Prenatal Care,* by Maternal Age, 2008

Source (III.11): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*In the 27 reporting areas (States and territories) that used the revised birth certificate.