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 7.3 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. This section also provides the latest data on the health care needs and financing of care for children with special health care needs.

HEALTH CARE FINANCING

In 2010, approximately 7.3 million U.S. children under 18 years of age had no health insurance coverage, representing 9.8 percent of the population. This was not statistically different from the previous year (9.7 percent). More than one-third of children were insured through public programs[77] such as Medicaid, the Children's Health Insurance Program, and military health insurance (37.9 percent), and 59.6 percent were covered by private insurance.

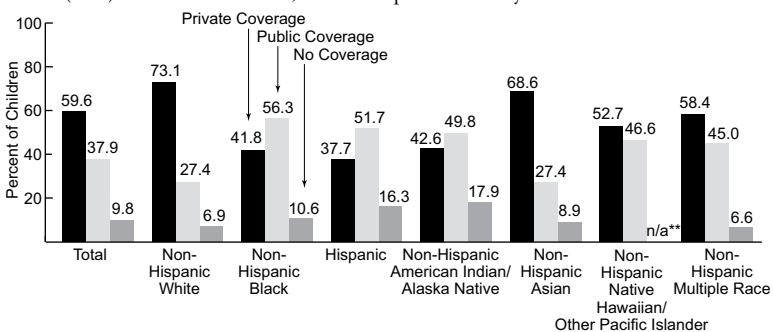
Children's insurance status varies by race and ethnicity. In 2010, 73.1 percent and 68.6 percent of non-Hispanic White and Asian children, respectively, had private coverage, while the same was true for only 52.7 percent of non-Hispanic Native Hawaiian and Other Pacific Islander children, 42.6 percent of non-Hispanic American Indian/Alaska Native children, 41.8 percent of non-Hispanic Black children, and 37.7 percent of Hispanic children. Over half of non-Hispanic Black and Hispanic children were publicly insured (56.3 percent and 51.7 percent, respectively) followed by 49.8 percent of non-Hispanic American Indian/Alaska Native children.

As family income increases, private health insurance coverage among children rises and the proportions of children with public coverage and no coverage decrease. In 2010, children living in households with incomes below 100 percent of the U.S. Census Bureau's poverty threshold ($22,314 for a family of four in 2010) were most likely to have public coverage (73.7 percent) or to be uninsured (15.4 percent); a similar proportion of children living in near-poor households (between 100-199 percent of the poverty threshold) were also uninsured (14.1 percent). Children with family incomes of 400 percent or more of the poverty threshold were most likely to have private coverage (92.2 percent), and least likely to have public coverage (10.5 percent) or to be uninsured (3.5 percent).

In 2009, the Children's Health Insurance Program was reauthorized and states were given incentives to provide coverage to additional children. 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,* 2010

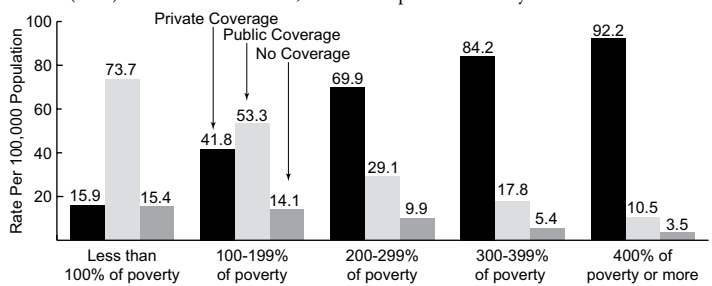
Source (III.1): U.S. Census Bureau, Current Population Survey



*Totals equal more than 100 percent because children may have more than one source of coverage.
**Due to small sample size, estimate did not meet criteria for reliability.

Health Insurance Coverage Among Children Under Age 18, by Poverty Status* and Type of Coverage, 2010**

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



*The U.S. Census Bureau's poverty threshold for a family of four was $22,314 in 2010.
**Totals equal more than 100 percent because children may have more than one source of coverage.

HEALTH CARE FINANCING FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

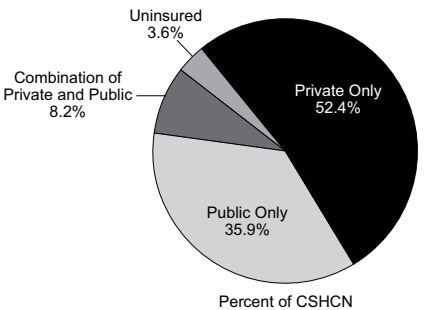
The consistency and adequacy of health insurance can have a significant impact on children's access to needed health care services. This is particularly true for children with special health care needs (CSHCN). In 2009–10, the National Survey of Children with Special Health Care Needs asked parents whether their child had insurance coverage in the past 12 months and, if so, what kind they had. Overall, 90.7 percent of CSHCN were insured for all of the previous 12 months, while the remaining 9.3 percent were uninsured for all or some part of the year (data not shown).

At the time of the interview, 96.5 percent of CSHCN were reported to have some type of insurance: 52.4 percent had private insurance and 35.9 percent had public insurance, 8.2 percent had both private and public insurance, while 3.6 percent were uninsured at the time of the interview. The proportion of CSHCN with private and public insurance coverage changed significantly over the last decade. In 2001, 64.7 percent of CSHCN had private and 21.7 percent had public coverage. This reflects a decline of over 20 percent in the proportion of CSHCN with private coverage and a nearly 60 percent increase in the proportion with public coverage over the decade (data not shown).

CSHCN without health insurance are less likely to receive the health care they need than those with insurance. CSHCN without current health insurance coverage were less likely than those with insurance to have a usual source of sick care (85.6 percent versus 92.9 percent), to receive all needed dental care (79.2 versus 95.1 percent) and prescription medications (84.1 percent versus 97.9 percent) and to receive all needed mental health services (85.1 versus 94.7 percent).

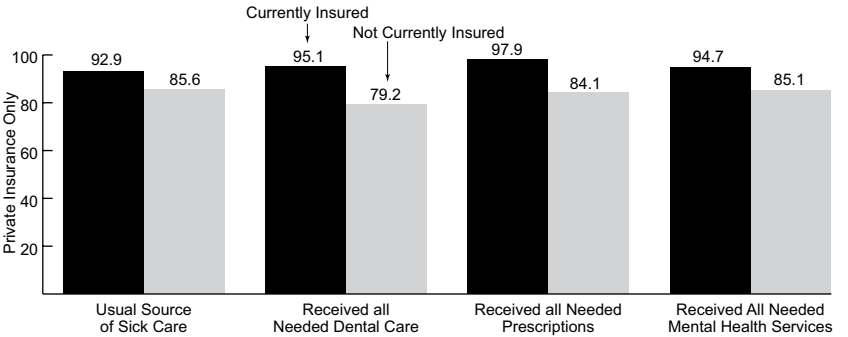
Health Insurance Coverage Among CSHCN at Time of Survey, 2009–10

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 with Special Health Care Needs



Access to Services, by Health Insurance Coverage, Among CSHCN, 2009–10

Source (III.3): 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



VACCINATION COVERAGE

Vaccination is one of the greatest public health achievements of the 20th century, resulting in dramatic declines in morbidity and mortality for many infectious diseases.[78] Childhood vaccination in particular is considered among the most cost-effective preventive services available, as it averts a potential lifetime lost to death and disability.[79]

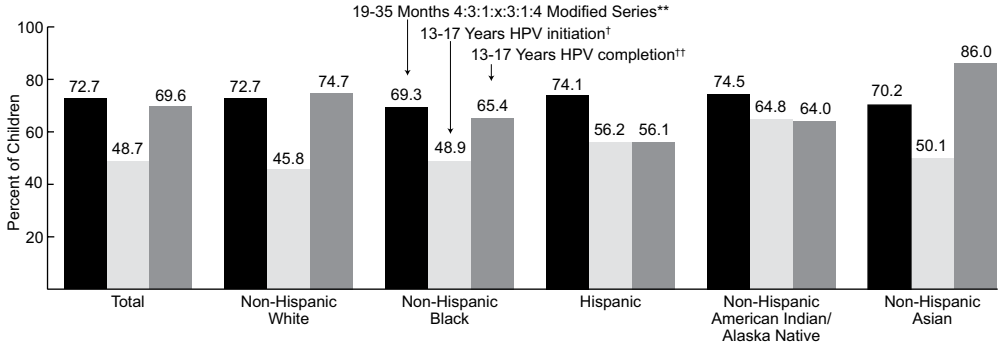
Currently, there are 12 different vaccines recommended by the Centers for Disease Control and Prevention from birth through age 18, many of which require multiple doses for effectiveness as well as boosters to sustain immunity—see the following page for a summary of the vaccination schedule.

In 2010, 72.7 percent of children 19–35 months of age received each of six vaccines in a modified series of recommended vaccines (4:3:1:3:X:1:4). This series includes four doses of diphtheria, tetanus, and acellular pertussis vaccine (DTaP/DT/DTP); 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). Because of changes in measurement of the Haemophilus influenzae type b (Hib) vaccine and the vaccine shortage that occurred during December 2007–June 2009, coverage estimates included here are based on the modified series that excludes the Hib vaccine. Although the 2010 level of vaccine series coverage is below the Healthy People 2020 objective of 80 percent, there were no significant disparities by race and ethnicity.

The human papillomavirus (HPV) vaccine protects against certain strains of HPV that can cause cervical cancer and genital warts and was first recommended in 2006 for females aged 11–12 years and more recently recommended for males of the same age, with catch-up vaccination at later ages for females (13–26 years) and males (13–21 years) who have not completed the 3-dose series.[80] In 2010, only 48.7 percent of females aged 13–17 years had received at least 1 of the 3 necessary doses of HPV vaccine, among whom about two-thirds with adequate time to complete the series had done so (69.6 percent). Hispanic and non-Hispanic American Indian/Alaska Native females were significantly more likely to have initiated HPV vaccination than non-Hispanic White females (56.2 and 64.8 percent versus 45.8 percent, respectively). However, compared to non-Hispanic White females, Hispanic and non-Hispanic Black females were less likely to complete the vaccine series (74.7 percent versus 56.1 and 65.4 percent, respectively), while non-Hispanic Asian females were more likely to do so (86.0 percent). A new requirement of health plans to monitor the proportion of females completing 3 doses by 13 years of age may help to increase HPV vaccination.[81]

Receipt of Selected Vaccinations Among Children, by Recommended Age Group and Race/Ethnicity,* 2010

Source (III.4): Centers for Disease Control and Prevention, National Immunization Survey



*The sample of Native Hawaiian/Pacific Islanders was too small to produce reliable results. **4+ DTaP, 3+ Polio, 1+ MMR, 3+ HepB, 1+ Varicella, 4+ PCV; excludes Hib, due to the 2007-2009 shortage. †1+ HPV among females only.
††3+ doses among females who had at least one HPV dose and at least 24 weeks between the first dose and time of the survey.

Recommended Routine Immunizations for Children from Birth Through 18 Years Old, 2012

Source (III.5): Department of Health and Human Services, Centers for Disease Control and Prevention

Age	HepB Hepatitis B	DTaP/Tdap* Diphtheria, tetanus, pertussis (whooping cough	Hib Haemophilus influenzae type b	IPV Polio	PCV Pneumo-coccal conjugate	RV Rotavirus	MMR Measles, mumps, rubella	Varicella Chickenpox	HepA** Hepatitis A	HPV† Human papilloma-virus	MCV†† Meningo-coccal conjugate	Flu‡ Influenza
Birth	✓											
2 months	✓ (1-2 mos)	✓	✓	✓	✓	✓						
4 months		✓	✓	✓	✓							
6 months		✓	✓‡		✓	✓‡						
12 months	✓		✓	✓	✓		✓	✓				
15 months		✓							✓✓			
18 months												✓ Annual dose each Fall or Winter
19-23 months												
4-6 years		✓		✓			✓	✓				
7-10 years												
11-12 years		✓ Tdap								✓✓✓	✓	
13-15 years												
16-18 years											✓	

Note: If your child misses a shot, you don't need to start over, just go back to your child's doctor for the next shot. The doctor will keep your child up-to-date on vaccinations. There are certain health conditions and other situations that might cause some of these vaccines to be recommended at other than routine ages. Talk with your health care provider for more information.

**Tdap vaccine is a combination vaccine that is recommended at age 11 or 12 to protect against tetanus, diphtheria, and pertussis. If your child has not received any or all of the DTaP vaccine series, or if you don't know if your child have received these shots, you child needs a single dose of Tdap when they are 7–10 years old. Talk to your child's health care provider to find out if they need additional catch-up vaccines.*

***Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 to 18 months later.*

†All 11 or 12 year olds—both girls and boys—should receive 3 doses of HPV vaccine to protect against HPV-related disease. Either HPV vaccine (Cervarix® or Gardasil®) can be given to girls and young women; only one HPV vaccine (Gardasil®) can be given to boys and young men.

††Everyone 6 months of age and older—including children, teens, and adults—should get a flu vaccine each fall or winter. Children 6 months through 8 years of age may need two doses, at least 4 weeks apart. Ask your health care provider for more information.

‡6-month doses of Hib and RV may not be necessary depending on the brand of vaccine used. Your health care provider will know how many doses to administer.

For more information, call toll free 1-800-CDC-INFO (1-800-232-4636) or visit http://www.cdc.gov/vaccines

MENTAL HEALTH TREATMENT

In 2010, 2.9 million, or 12.2 percent, of adolescents aged 12 to 17 received past-year treatment or counseling for problems with emotions or behavior (not related to drug or alcohol use) in a specialty mental health setting, including both inpatient and outpatient care (data not shown). Inpatient care includes treatment or counseling from an overnight or longer stay in a hospital, residential treatment center, or foster care or therapeutic foster care home, and outpatient care includes services 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.

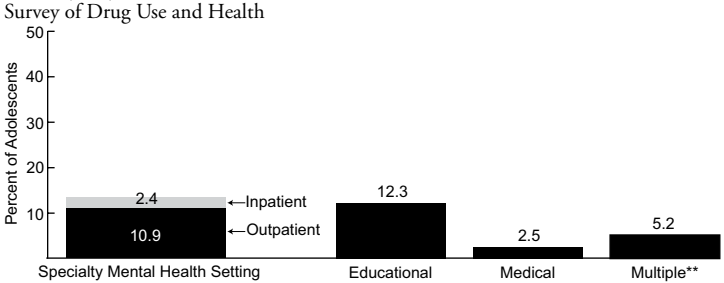
A similar proportion of adolescents received mental health services in an educational setting, including counseling from a school social worker, psychologist, or counselor (12.3 percent), while 2.5 percent received services from a pediatrician or other family doctor in a medical setting; less than 1 percent of adolescents received mental health services in a juvenile justice setting in the past 12 months. Approximately 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 (14.4 percent) than males (10.1 percent) (data not shown). In general, few racial or ethnic differences in service site for past-year treatment were observed. However, non-Hispanic Asian children were least likely to receive services in a specialty mental health setting (3.5 percent) while non-Hispanic Black children were more likely to receive services in an educational setting (15.5 percent) than non-Hispanic White and Hispanic children (11.6 and 11.8 percent, respectively; data not shown).

The most common reported reason for service use was feeling depressed. This was the case for nearly half of adolescents who received services in a specialty mental health 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 30.5 percent of those seeking care in a specialty mental health setting compared to 20.5 and 10.7 percent of those treated in educational and medical settings, respectively.

Past-Year Mental Health Service Use Among Adolescents Aged 12-17,* by Service Site, 2010

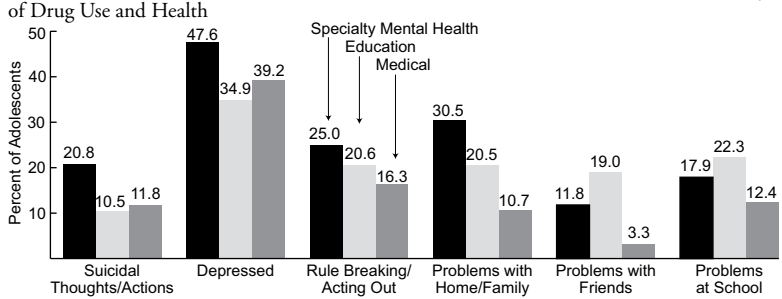
Source (III.6): Substance Abuse and Mental Health Service Administration, National Survey of Drug Use and Health



*Among adolescents who received past-year mental health treatment or counseling for problems with emotions or behavior. **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, 2010**

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

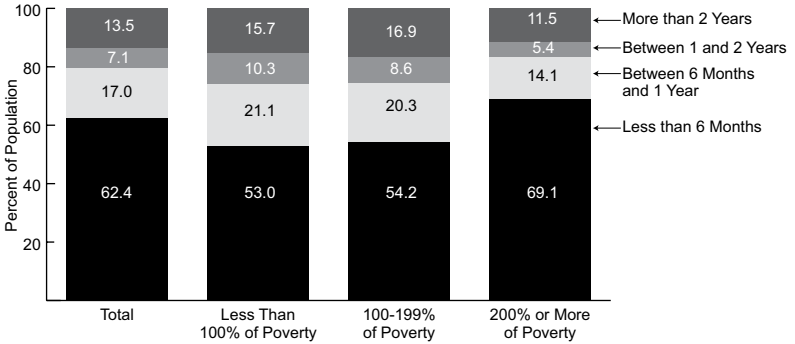
According to the Centers for Disease Control and Prevention, dental caries (tooth decay) is the most common chronic infectious disease among children in the United States.[82] Untreated tooth decay causes pain and infections, which may affect children's ability to eat, speak, play, and learn. Tooth decay, however, is preventable with proper dental care for cleaning, brushing and flossing instruction, sealants, and fluoride treatment. For this reason, the American Academy of Pediatric Dentistry recommends that children have their first dental checkup at the eruption of the first tooth or by age 1,[83] with two visits per year thereafter.[84]

In 2010, 62.4 percent of children aged 2–17 years received dental care in the past 6 months, while 13.5 percent had not received such care in more than 2 years. Receipt of dental care varied by a number of factors, including poverty and insurance status. Children living in households with incomes at or below 100 or 200 percent of the poverty level were less likely than children living in households with incomes above 200 percent of the poverty threshold to have received dental care in the past 6 months (53.0 and 54.2 percent, respectively, compared to 69.1 percent). Uninsured children were about half as likely to have received a dental visit in the past 6 months (30.8 percent) as those with public (58.8 percent) or private insurance (68.9 percent; data not shown).

Similar patterns were observed for unmet dental care needs. Overall, 4.3 million or 6.6 percent of children had unmet dental care needs in 2010. However, the proportion of children with unmet needs was substantially higher among those who were uninsured (26.4 percent) compared to those with either private (4.1 percent) or public (6.1 percent) insurance. With respect to poverty, children living in households below 100 or between 100 and 199 percent of the poverty level were at least twice as likely to have an unmet dental care need in the past year as children at 200 percent or more of poverty (8.7 and 10.4 percent, respectively, compared to 4.3 percent, data not shown).

Time Since Last Dental Visit Among Children Aged 2–17 Years,* by Poverty Status, 2010**

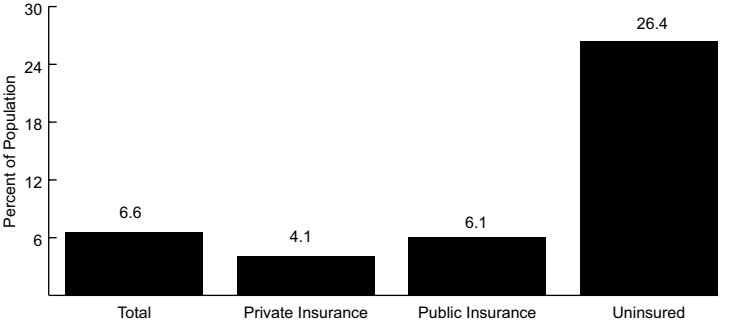
Source (III.7): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



**All estimates are age-adjusted and may not total to 100 due to rounding.*
***Poverty level, defined by the U.S. Census Bureau, was $22,314 for a family of four in 2010.*

Unmet Dental Need* in the Past Year Among Children Aged 2–17 Years, by Insurance Type and Status, 2010

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; all estimates are age-adjusted.*

WELL-CHILD VISITS

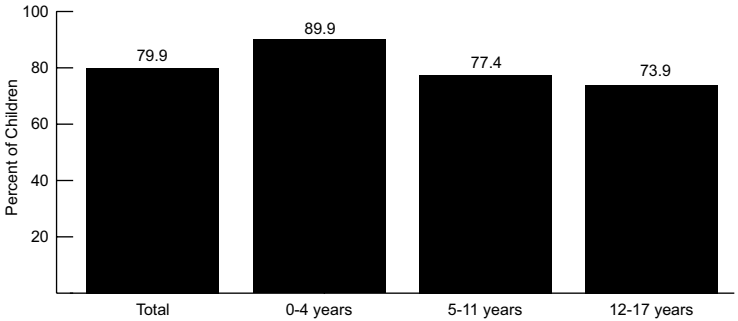
In 2010, 79.9 percent of children under 18 years of age were reported by their parents to have had a preventive, or "well-child," medical visit in the past year when they were not sick or injured. The American Academy of Pediatrics recommends that children have eight preventive health care visits in their first year, three in their second year, and at least one per year from age 3 through adolescence.[85] 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 2010, 89.9 percent of children 4 years of age and younger had received a preventive visit in the past year, compared to 77.4 percent of children 5–11 years of age and 73.9 percent of children 12–17 years of age. Among the oldest adolescents, the rate was even lower (69.0 percent).

Receipt of preventive medical care also varies by several other factors, including type of insurance and race and ethnicity. In 2010, only 55.6 percent of uninsured children had received a well-child visit in the past year, compared to about 80 percent of those with public or private insurance (79.4 and 83.3, respectively; data not shown). With respect to race and ethnicity, non-Hispanic children of more than one race and non-Hispanic Black children were most likely to have received a well-child visit in the past year (87.1 and 83.3 percent, respectively), followed by non-Hispanic White (80.5 percent), non-Hispanic Asian (76.4), and Hispanic children (75.4). Non-Hispanic American Indian/Alaskan Native children had the lowest reported rate of preventive care in the past year (63.2 percent).

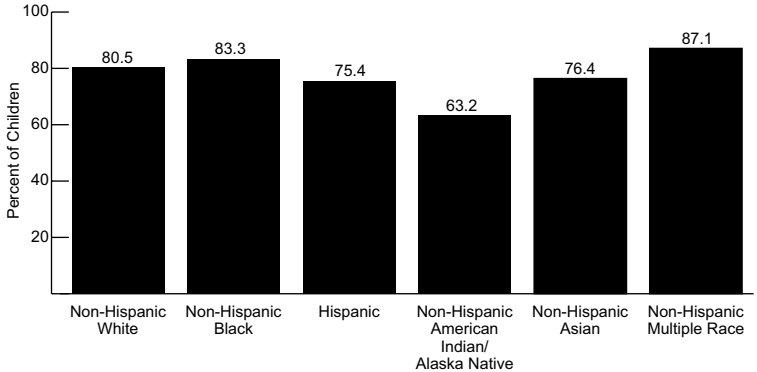
Receipt of Preventive Health Care in the Past Year Among Children Under Age 18, by Age, 2010

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, 2010**

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



**All estimates are age-adjusted. **The sample of Native Hawaiian/Pacific Islander children was too small to produce reliable results.*

HEALTH CARE VISITS

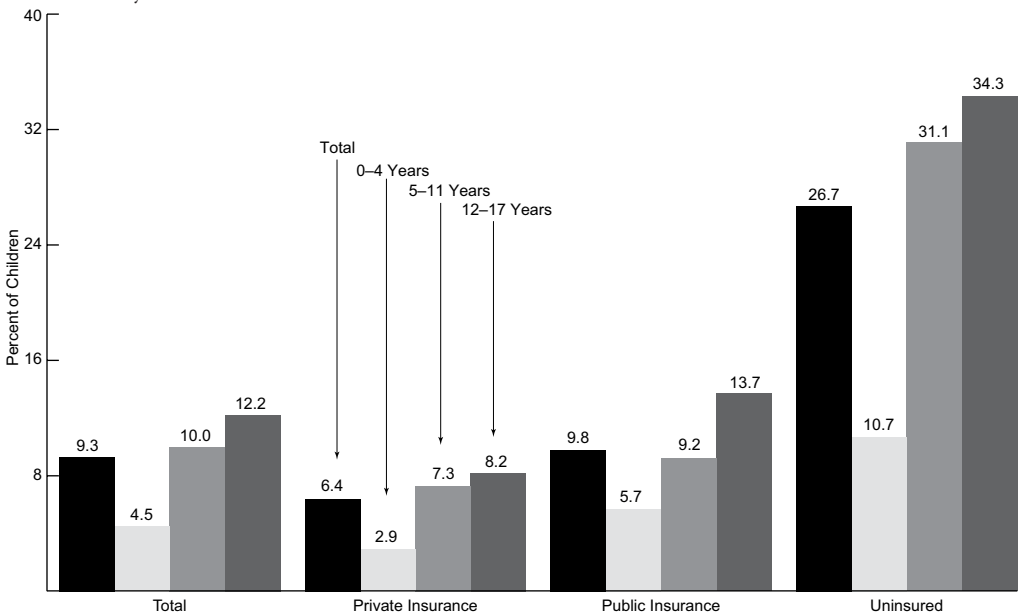
In 2010, 9.3 percent of children under 18 years of age had not seen a physician or other health care professional in the past year for either sick or routine care (not including overnight hospitalization, emergency department visits, home health care, or dental care). Older children were more likely than younger children to go 12 months without seeing a health care provider. More than 12 percent of children aged 12–17 years (12.2 percent) had not seen a health care provider in the past year, compared to only 4.5 percent of children under 5 years of age.

Health care visits also vary by insurance type and status. In 2010, more than one in four children without health insurance (26.7 percent) had not seen a physician or other health professional in the past year, compared to 9.8 percent with public insurance and 6.4 percent of privately insured children. Across all age groups, uninsured children were most likely to have gone without a health visit in the past year, while privately insured children were the least likely. Across all insurance groups, older children were more likely than those less than 5 years old to have not seen a health care professional. Thus, having no past-year visit ranged from 2.9 percent among privately insured children under 5 years of age to 34.3 percent among uninsured children aged 12–17 years—a ten-fold difference.

The proportion of children going without health care also varies by poverty level and race and ethnicity. In 2010, children living in households with incomes below the poverty level or between 100–199 percent of poverty were about twice as likely as those at 200 percent or more of poverty to have not seen a physician or other health professional in the past year (12.5 and 13.3 percent, respectively, compared to 6.5 percent). About 7 percent of non-Hispanic White children lacked a health care visit (6.8 percent) compared to 10–14 percent of children of other racial/ethnic groups (data not shown).

No Contact with a Health Care Professional* in the Past Year Among Children Under Age 18, by Age and Insurance Type and Status, 2010

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; all total estimates are age-adjusted.

USUAL PLACE FOR SICK CARE

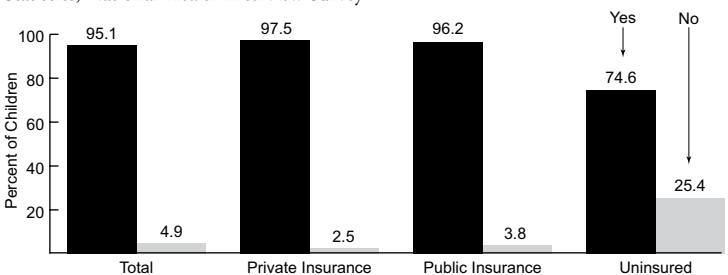
Having a usual place or source of health care is an important indicator of care continuity that has been linked to improvements in care quality, preventive care utilization, and health status.[86] In 2010, the majority of children were reported by their parents to have a usual place of health care when they are sick or need of health advice (95.1 percent); however, about a quarter of uninsured children (25.4 percent) did not have a usual place of care.

Receiving regular primary and preventive care in a doctor's office or clinic can help to avoid unnecessary hospitalizations and emergency room visits. In 2010, among children with a usual source of care, 74.3 percent of children used a doctor's office or health maintenance organization (HMO) as their usual place of care, 23.6 percent used a clinic or health center, and 2.1 percent usually used other places, including emergency rooms and hospital outpatient departments; however, this varied greatly by poverty status. Children with household incomes below the poverty level were more than three times as likely to use a clinic or health center as a usual source of care than children living at 400 percent or more of poverty (38.4 versus 12.3 percent). Conversely, 86.9 percent of children living at 400 percent or more of poverty used a doctor's office or HMO as a usual source of care, compared to 58.5 percent of children living in households with incomes below the poverty threshold.

The location where children usually received care also varied by race and ethnicity and insurance type and status. Clinics and health centers were more likely to serve as a usual place of care for American Indian/Alaska Native (52.9 percent), Native Hawaiian/Other Pacific Islander (45.1 percent), and Hispanic children (39.0 percent) compared to about 25 percent or less of children of other racial/ethnic groups (data not shown). Despite being rare overall, about one-tenth (9.5 percent) of uninsured children usually relied on hospital emergency and outpatient departments and other sources of care.

Usual Place of Care* Among Children Under Age 18, by Insurance Type and Status, 2010

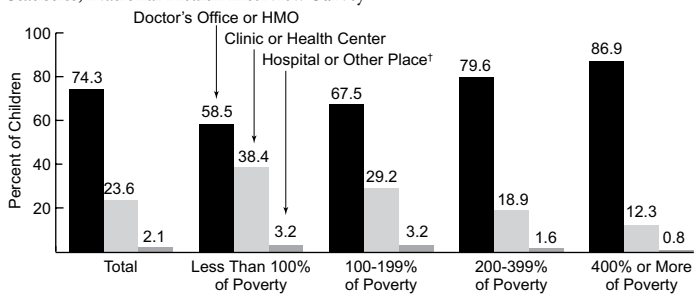
Source (III.7): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



Has a place where the child is usually taken when sick or in need of health advice; all estimates are age-adjusted.

Location of Usual Place of Care* Among Children Under Age 18, by Poverty Status, 2010**

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



*The place where the child is usually taken when sick or in need of health advice; all estimates are age-adjusted; percentages may not total to 100 due to rounding. **Poverty level, defined by the U.S. Census Bureau, was $22,314 for a family of four in 2010. †Includes emergency room, hospital outpatient department, some other place, and not using one place most often.*

EMERGENCY DEPARTMENT UTILIZATION

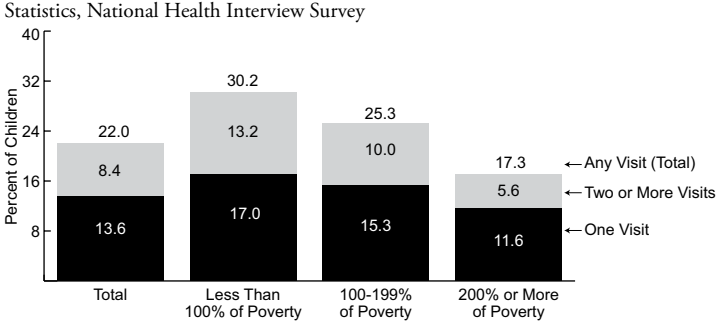
In 2010, 22.0 percent of children had at least one visit to a hospital emergency department (ED) in the past year and 8.4 percent had multiple visits. Children younger than 5 years of age were more likely to have had a past-year ED visit (28.1 percent) than children aged 5–11 years or 12–17 years (20.4 percent and 19.0 percent, respectively; data not shown).

Emergency department utilization also varies by poverty and race and ethnicity. In 2010, almost one-third of children living in households with incomes below the poverty level had visited an ED in the past year (30.2 percent), compared to 17.3 percent of children living in households at 200 percent or more of the poverty level. Children in poverty were more than twice as likely to have had multiple ED visits as non-poor children living at 200 percent or more of poverty (13.2 versus 5.6 percent, respectively). With respect to race and ethnicity, non-Hispanic Black and Hispanic children were most likely to have visited an ED (26.9 and 23.1 percent, respectively) while Asian children were least likely to have done so (14.9 percent). Compared to the overall average, Asian children had a similar proportion of multiple ED visits but a lower proportion of single visits, whereas non-Hispanic Black children had a higher proportion of both single and multiple visits.

According to the 2009 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 (19.7 percent of visits), followed by cough (7.6 percent), and vomiting (4.5 percent).[86] The three most common primary diagnoses treated in ED visits among both males and females were acute upper respiratory infections (10.8 percent, combined), fever of unknown origin (6.6 percent, combined), and otitis media (middle ear infection) and Eustachian tube disorders (5.1 percent, combined), followed by unspecified viral and chlamydial infection for females (3.2 percent) and open wound of head (4.1 percent) for males. Asthma ranked as the seventh most common diagnosis for males (3.4 percent) compared to the thirteenth most common diagnosis for females (1.9 percent, data not shown).[86]

Visits to the Emergency Department in the Past Year Among Children Under Age 18,* by Poverty Status, 2010**

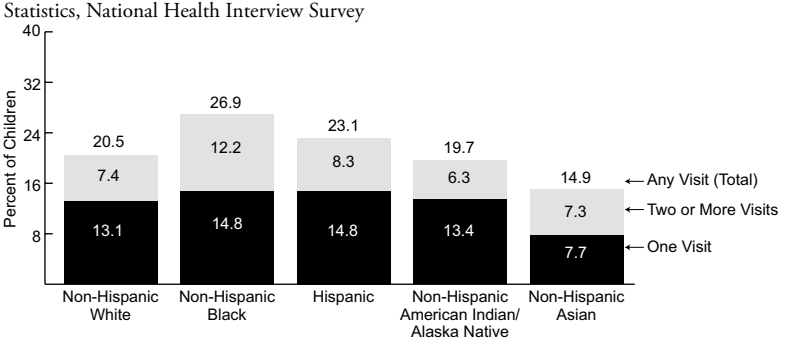
Source (III.7): Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey



*All estimates are age-adjusted. **Poverty level, defined by the U.S. Census Bureau, was $22,314 for a family of four in 2010.*

Visits to the Emergency Department in the Past Year Among Children Under Age 18,* by Race/Ethnicity, 2010**

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



*All estimates are age-adjusted. **The sample of Native Hawaiian/Pacific Islander children was too small to produce reliable results.*

PRENATAL CARE

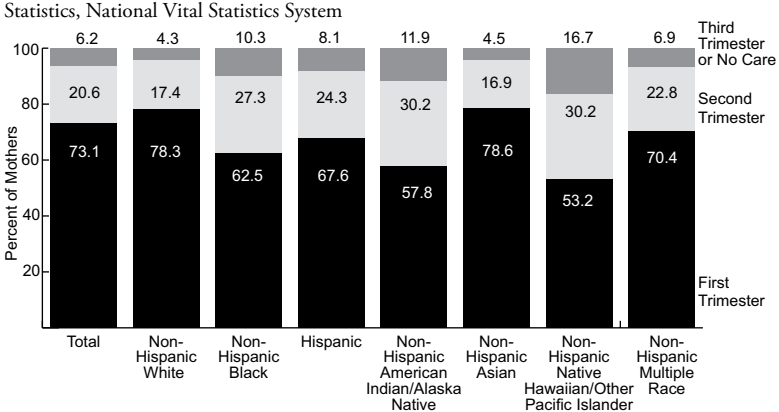
Prenatal care—especially care beginning in the first trimester—allows health care providers to identify and manage a pregnant woman's risk factors and health conditions and to provide expectant parents with relevant health care advice. In 2010, in the 33 States that had implemented the 2003 revision to the standard birth certificate as of January 1st and collected prenatal care information in the same format,[87] 73.1 percent of women giving birth were determined to have received prenatal care in the first trimester, while 6.2 percent of women began prenatal care in the third trimester or did not receive any prenatal care.

The timing of prenatal care initiation differs by race/ethnicity. Non-Hispanic Asian and non-Hispanic White mothers were most likely to begin prenatal care in the first trimester (78.6 and 78.3 percent, respectively) and least likely to begin prenatal care in the third trimester or not all (4.5 and 4.3 percent, respectively). The lowest rates of early prenatal care—received within the first trimester—were observed among non-Hispanic Native Hawaiian and Other Pacific Islander and non-Hispanic American Indian/Alaska Native mothers (53.2 and 57.8 percent, respectively), followed by non-Hispanic Black mothers (62.5 percent). These same racial and ethnic groups also had the highest rates of receiving late (third trimester) or no prenatal care (16.7, 11.9, and 10.3 percent, respectively).

Timing of prenatal care initiation also varies by maternal education, with early prenatal care entry increasing with greater educational attainment. For example, in 2010, first trimester prenatal care was obtained by only 57.6 percent of mothers with less than a high school diploma, compared to 86.7 percent of mothers with a bachelor's degree or higher. Conversely, only 2.5 percent of mothers with a bachelor's degree received late or no prenatal care, compared to 11.6 percent of mothers with less than a high school diploma.

Timing of Prenatal Care Initiation,* by Maternal Race/Ethnicity, 2010

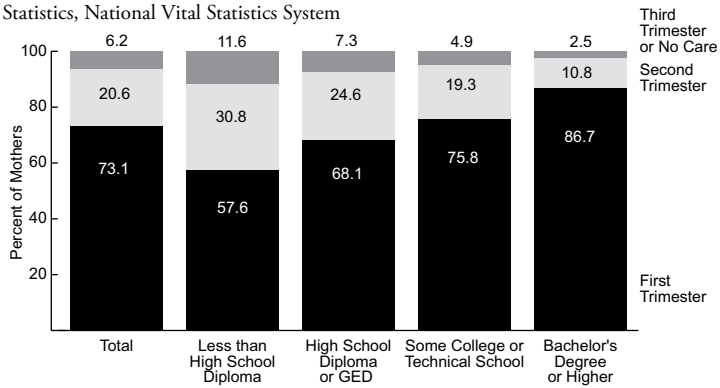
Source (III.9): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data are from 33 states that implemented the 2003 revision of the birth certificate as of January 1, 2010, representing 67% of all US births; percentages may not total to 100 due to rounding.

Timing of Prenatal Care Initiation,* by Maternal Education, 2010

Source (III.9): Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System



*Data are from 33 states that implemented the 2003 revision of the birth certificate as of January 1, 2010, representing 67% of all US births; percentages may not total to 100 due to rounding.

HRSA SERVES CHILDREN

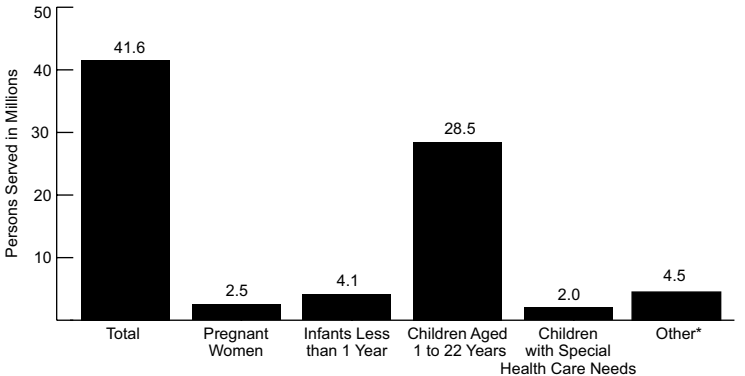
The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary Federal agency responsible for improving access to health care services for people who are uninsured, isolated or medically vulnerable. The agency is made up of 6 bureaus and 10 offices. One of these bureaus, the Maternal and Child Health Bureau (MCHB) takes the lead in promoting the physical and mental health, safety and well-being of the Nation's maternal and child health (MCH) population, which includes all women, infants, children and their families.

To support its mission, MCHB oversees Federal funding to States authorized under Title V of the Social Security Act. Title V authorizes appropriations to States to improve the health of mothers and children, including children with special health care needs (CSHCN). Each year, States report on the numbers of people served by Title V-funded programs. In 2010, programs overseen by MCHB and funded through Title V served over 41 million people within the MCH population, the majority of whom were children under the age of 22 years. Additionally, Federal programs administered by MCHB serve subsets of the MCH population, such as children with autism, sickle cell diseases, traumatic brain injury and epilepsy.

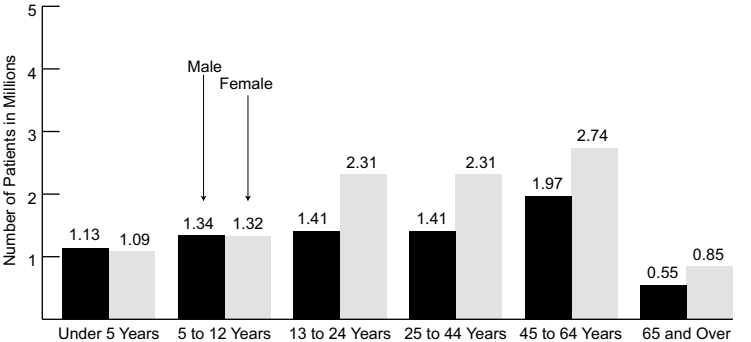
Overseen by the Bureau of Primary Care, HRSA-supported health centers seek to provide comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations. In 2011, over 20 million people were provided with medical, dental, mental health, substance abuse or other services across 1,128 locations. Children aged 0 to 18 years accounted for 33.5 percent of those served by community health centers, with women representing a majority of users (58.7 percent; data not shown).

Number of Persons Served, in Millions, Through the Title V Maternal and Child Health Block Grant, 2010

Source (III.10): Health Resources and Services Administration, Title V Information System



*"Others" usually represents services to reproductive-age women.

Number of Patients, in Millions, Served in HRSA-Funded Community Health Centers by Age and Sex, 2011

Source (III.11): Health Resources and Services Administration, Uniform Data System