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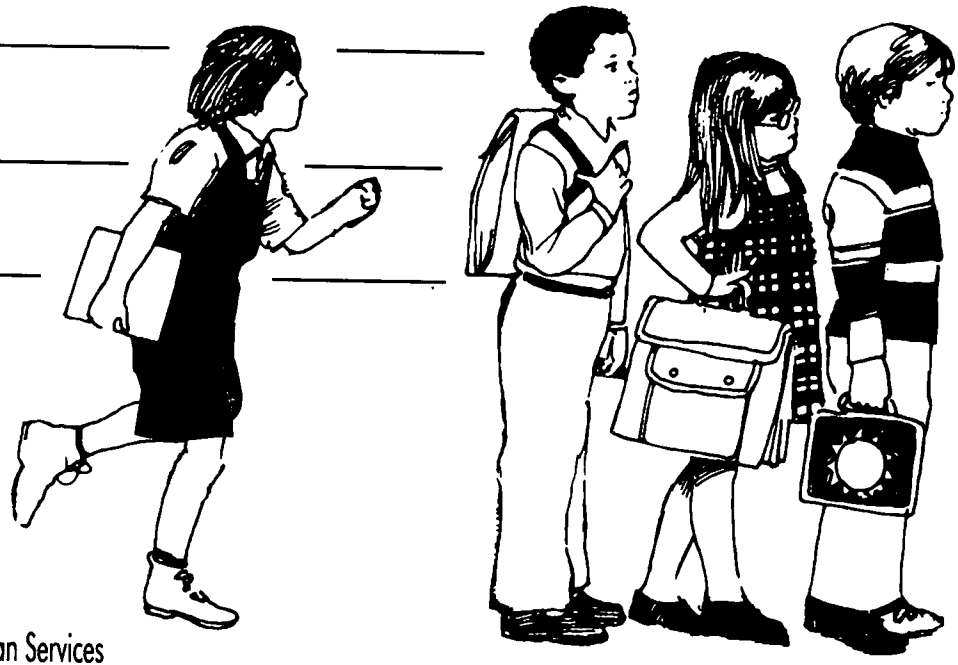
ABSTRACT

Published to provide reliable and current data for public health professionals and other individuals in the public and private sector to inform policymaking, this book compiles secondary data for 50 health status indicators and service needs of America's children. The book provides both a graphic and textual summary of the data and addresses long-term trends where applicable. Some statistics reveal the extent of progress toward "Healthy People 2000" goals or a reduction in the prevalence of unhealthful behaviors, while others reveal burgeoning or escalating health problems of women, children, and youth. Following an introduction that discusses trends and issues in children's health, the book has six sections : (1) "Anniversary Section," which summarizes data over the last 60 years; (2) "Population Characteristics," including children in poverty, working mothers, child care, school dropouts, and family composition; (3) "Health Status," discussing the health issue of infants, children, and adolescents; (4) "Health Services and Utilization," including immunizations, health care financing, physician and hospital care issues; (5) "State-Specific Data," including mortality, birthweight, perinatal and prenatal care, and children per pediatrician; and (6) "City Data," including infant mortality, birthweight, and prenatal care. Contains 50 references. (AMC)

CHILD HEALTH USA '95



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Maternal & Child Health Bureau

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Child Health USA '95

U.S. Department of Health & Human Services
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CONTENTS

FACE

Child Health USA '95 is the seventh annual report on the health status and service needs of America's children. This book is a compilation of secondary data for 50 health status indicators. It provides both a graphical and textual summary of the data and addresses long-term trends where applicable.

Child Health USA is published to provide reliable and current data for public health professionals and other individuals in the private and public sectors. The succinct format of the book is intended to facilitate the use of the information as a snapshot of measures of the health of children in the United States.

Data are presented for infants, children, adolescents, and women of childbearing age. In addition to health status, health services utilization and population characteristics are addressed. This information provides the reader with a multi-dimensional perspective of the health of children in the United States, in accordance with the World Health Organization's definition of health: "A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

Because 1995 marked the 60th anniversary of Title V, the first section of *Child Health USA '95* is devoted to historical data on maternal mortality, late fetal deaths, low birth weight, and infant mortality. The second section presents statistics on *population characteristics* that influence the well-being of children. The third section, entitled *health status*, contains vital statistics and health behavior information for infants, children, and adolescents. The fourth section contains data regarding *health services utilization*. The fifth and sixth sections contain information on selected indicators at the state and city levels.
The Bureau is indebted to the National Center for Health Statistics for its continued collaboration in producing this book. The many sources who also assisted in the collection of data are listed in the reference section beginning on page 70.

Some statistics in *Child Health USA* reveal the extent of progress toward *Healthy People 2000* goals or a reduction in the prevalence of unhealthful behaviors, while others reveal burgeoning or escalating health problems of women, children, and youth. We hope the information provided in this book will be helpful to policy and decision-makers responsible for implementing or expanding programs that affect the health of children in the United States.

Maternal and Child Health Bureau
Health Resources and Services Administration

The year 1995 marked the 60th anniversary of the Nation's maternal and child health legislation, Title V of the Social Security Act. Signed into law in 1935 by President Franklin Delano Roosevelt, Title V remains the longest lasting public health legislation in the history of the United States. However, it is not only longevity that makes the Title V legislation unique. Equally remarkable are its origins and its legacies.

It is significant that Title V was designed not as health legislation, but rather as part of the Social Security Act of 1935. The mission of Title V was then, and remains to this day "...to improve the health and well-being of all the Nation's mothers and children..." including children with special health care needs. In contrast to Medicaid or Medicare, Title V stands alone by its emphasis on a population-based mission and scope.

Throughout its history, Title V has focused on the prevention and early detection of disease and injury. For 60 years, Title V programs across the country have not only provided health care to women and children, but have also built systems to link services and improve accessibility to health care; integrated and coordinated health with other social systems; and forged systems that are centered on individuals, rather than on institutions, in the context of their family, culture, and community.

In the 60 years since the passage of the Title V legislation, the United States has witnessed dramatic improvements in the health of its children, youth, and families due in part to Title V and other government-sponsored public health programs to improve safety, sanitation, nutrition, immunizations and access to health care services. Since 1935, the infant mortality rate has declined more than six-fold. Women today are 78 times less likely to die from maternal mortality than their counterparts of 60 years ago.

In 1995, we continued to see encouraging improvements in the health indicators of the country's children, youth, and families. During the past decade, the nation's infant mortality rate has continued to decline slowly but steadily—even in communities with some of the highest infant mortality rates in the U.S. The country's international ranking for infant mortality, while still dismal, has improved from 24th to 22nd place. The proportion of women receiving prenatal care in the first trimester of pregnancy has continued to climb, as have the proportions of women breast-feeding their infants, and the proportions of children receiving the recommended immunizations by the age of 3. Since 1991, there has been a small but steady decline in the birth rate of teen girls (ages 15 to 19 years)—a trend documented in nearly every state.

There is little doubt that the high priority that government-sponsored maternal and child health programs have given to combating infant mortality, promoting adolescent health, decreasing injury, spearheading an enhanced national effort to immunize preschoolers and fostering healthier families with community development and health service systems integration has had a positive impact.

Many of the efforts to improve maternal and child heath outcomes in communities

nationwide have depended on the innovative partnerships between maternal and child health programs, professional associations, businesses, other government agencies, religious and other nonprofit organizations, and community leaders. In the years to come, the linkages between public and private partners will need to be increasingly strong and far-reaching. Otherwise, many hard-won gains may be lost, and the health of children and families will suffer.

While the statistical trends presented in this document reveal areas of progress, they also illustrate the extent to which some heath risks continue to plague the lives of children and families as they prepare to enter the next millennium. In the United States today, the leading health risk for both children and adults is neither a disease nor a medical condition. It is poverty, which can affect nutrition, access to health care, and living conditions that are conducive to health. Poverty has steadily risen among children during the last three decades. Although children under age 18 represent just 26.2 percent of the total U.S. population, they constitute 38.4 percent of the nation's poor In the United States, a child is born into poverty every 32 seconds. And then there's the tragedy of violence, both at home and in society. In 1994, state child protective services in 48 states determined that 1,012,000 children were victims of child abuse and neglect. It is likely that, above and beyond these figures, large numbers of cases of abuse and neglect go undetected and unreported. More than half of all reports of child maltreatment come from professionals: educators, law enforcement and justice officials, health and social service professionals, and child care providers, while less than 20 percent are reported by the victim's family. These statistics underscore how critically important it is for all professionals who work with children, indeed for all adults, to take responsibility for the health and well-being of the nation's most vulnerable citizens.

Firearms are the second leading cause of death due to injury among adolescents 15 to 19. It is estimated that fifteen children are killed by firearms each day. In the last ten years, the proportion of adolescent deaths due to homicide has increased by 50 percent. In 1993, 65 percent of all firearm deaths in 15 to 19 year olds were linked to homicide, an additional 27 percent involved suicide and 7 percent were unintentional.

AIDS is also taking a terrible toll on children, who are increasingly both affected and infected by HIV/AIDS. Advances in the knowledge, screening and therapy for reducing the transmission of the HIV virus from pregnant women to their infants show some promise for stemming the rates of pediatric AIDS.

Among teenagers, the proportion of AIDS cases in teen girls compared to boys jumped by 25 percent just in the past two years (1993-1995). Girls now comprise 35 percent of all teen AIDS cases, and girls are acquiring AIDS primarily through heterosexual contact.

AIDS has become one of the leading killers of women of reproductive age in the U.S. (many of whom were infected as teenagers), and women comprise the fastest growing group to become infected with HIV.

Thus, it is critical that AIDS education and prevention efforts target both girls and boys.

Researchers estimate that every day approximately 3,000 young people become regular smokers. Many smokers start their habit as teenagers, and a large portion of them continue to smoke throughout the rest of their lives. Sixty-nine percent of adult daily smokers report having tried their first cigarette by age 18. Every year, more than 400,000 people die from diseases caused by tobacco use.

Teen smoking rates decreased in the late 1970s, remained relatively stable during the 1980s, and have resumed a steady increase among 8th, 10th, and 12th graders throughout the 1990s. In 1995, one in three high school seniors said that they had smoked cigarettes in the last 30 days, and 91 percent of 10th graders reported that cigarettes were easy to obtain. The Clinton Administration responded in 1995 by proposing a major tobacco initiative to reduce the access and appeal of tobacco products to youth.

Yet another area in which tobacco use has proven negative effects is during pregnancy. Along with the consequences for the mother's long-term health, smoking in pregnancy, particularly during the first trimester, is one of the scientifically documented risk factors for low birth weight and infant mortality. Thus Title V programs, in conjunction with other government-sponsored activities, have continued to promote smoking-cessation activities for pregnant women and women of reproductive age.

As we prepare to enter the 21st century, it may be well to pay heed to the words of Lillian Wald, who first suggested the formation of a children's bureau (precursor to today's Maternal and Child Health Bureau) at the beginning of this century:

> I ask you to consider whether this call for the children's interest does not imply the call for our country's interest. Can we afford not to take it?

The U.S. has made great progress in improving maternal and child health, yet it still has many objectives to meet. The road to making children a national priority in this country is long, and the way uphill. But it is the direction we must continue to take.

This issue commemorates 60 years of Title V of the Social Security Act, the longest lasting public health legislation in our Nation's history. The goal of the Title V legislation was to promote and improve maternal and child health nationwide.

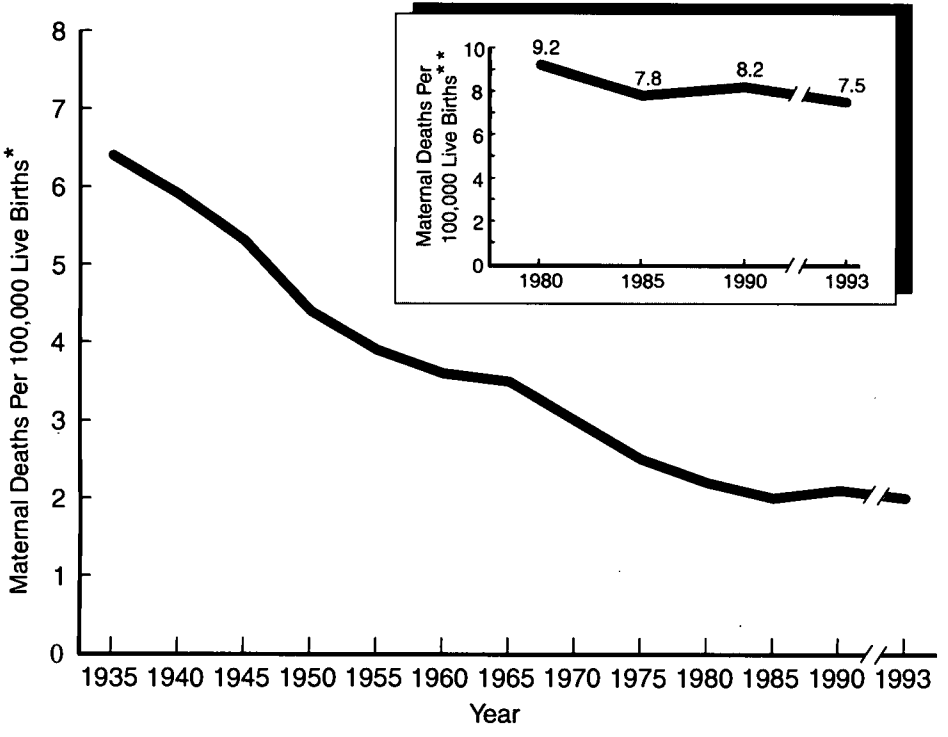
Since the passage of Title V, maternal mortality rates, late fetal death rates, low birth weight percentages and infant mortality rates have all drastically improved. Title V-funded research, training, and demonstration programs continue to address the financial, social, behavioral, and structural barriers to health care faced by many women and children.

Presently, Title V-supported programs provide prenatal care to more than 2 million women and primary health care to more than 11 million children, including almost 1 million children with special health needs.

NOTE: The graphs used in this section are often trend data from 1970 forward. Ethnicity data were not collected until 1979. In order to present statistics from 1970 to 1993, data must be consistent for the entire period. The anniversary pages do not have racial designations because in the early years covered by the graphs, race was not reliably reported.

Maternal Mortality: 1935-1993

Source (I.1): National Center for Health Statistics



* *Data values represented on a log scale.*

** *Actual data values.*

MATERNAL MORTALITY

From 1935 to 1993, the maternal mortality rate dropped from 582 maternal deaths per 100,000 live births to 7.5. Though all causes of maternal mortality declined dramatically over that period, the overall decline was largely due to marked decreases in maternal deaths from infection, toxemia, and hemorrhage.

Significant improvements in the care of women during labor, delivery, and the postpartum period have been made over the last 60 years. Technical improvements (including sterile techniques) in the management of vaginal and cesarean deliveries and the advent of effective antibiotics probably accounted for much of the decrease in maternal mortality. It is also likely that the development of widely used prenatal care protocols contributed to the decline in mortality from chronic or pregnancy-induced conditions.

Although maternal mortality has decreased significantly over the past 60 years, it is still a serious problem. Many of these deaths might be preventable if the health care system worked more effectively.

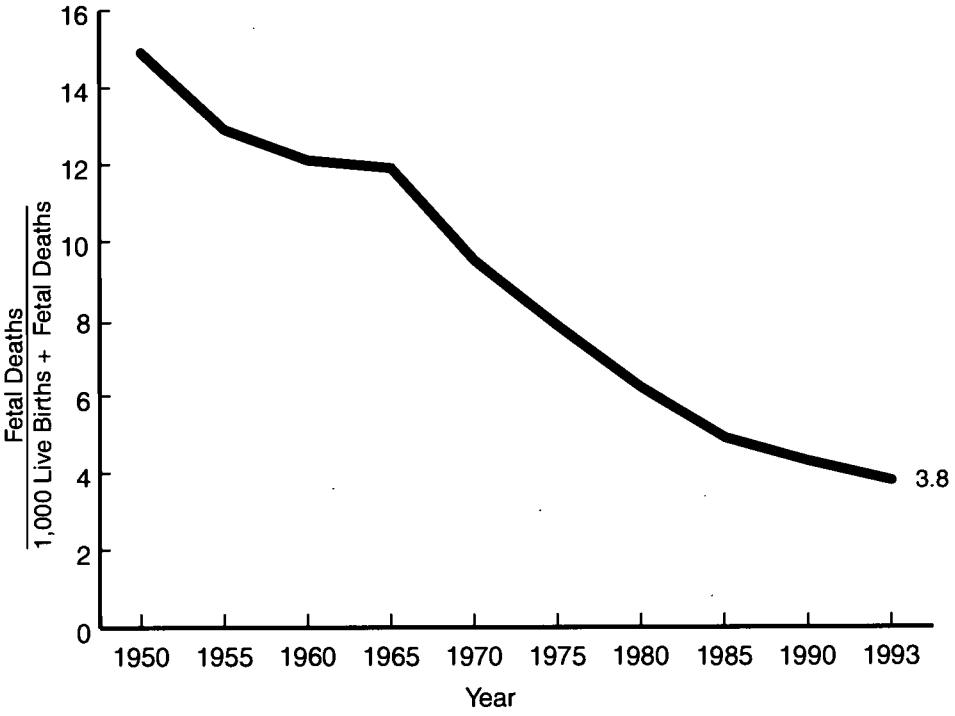
LATE FETAL DEATHS

The rate of fetal deaths decreased from 14.9 per 1,000 live births plus late fetal deaths in 1950 to 3.8 in 1993. Part of the decline in the 1950s and 1960s was due to improvements in obstetric technique.

There is some evidence that late fetal deaths are likely related to maternal nutrition. Smoking during pregnancy also increases the risk of late fetal death. Prenatal care that promotes good nutrition may have a role in preventing late fetal deaths.

Late Fetal Deaths*: 1950-1993

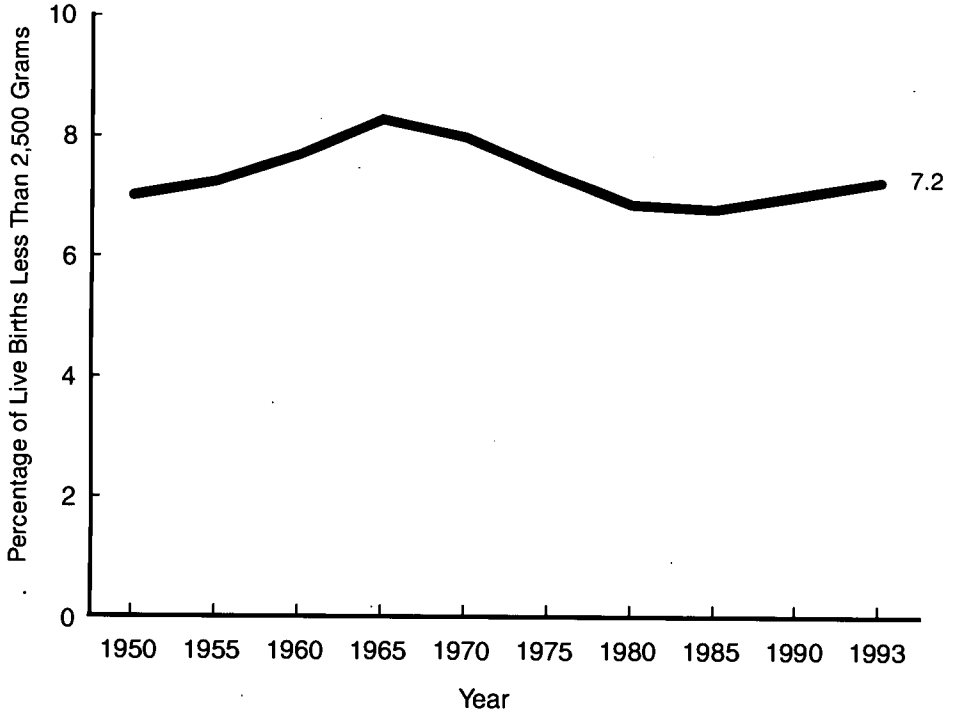
Source (I.2): National Center for Health Statistics



* *More than 28 weeks gestation*

Low Birth Weight*: 1950-1993

Source (I.3): Maternal and Child Health Bureau



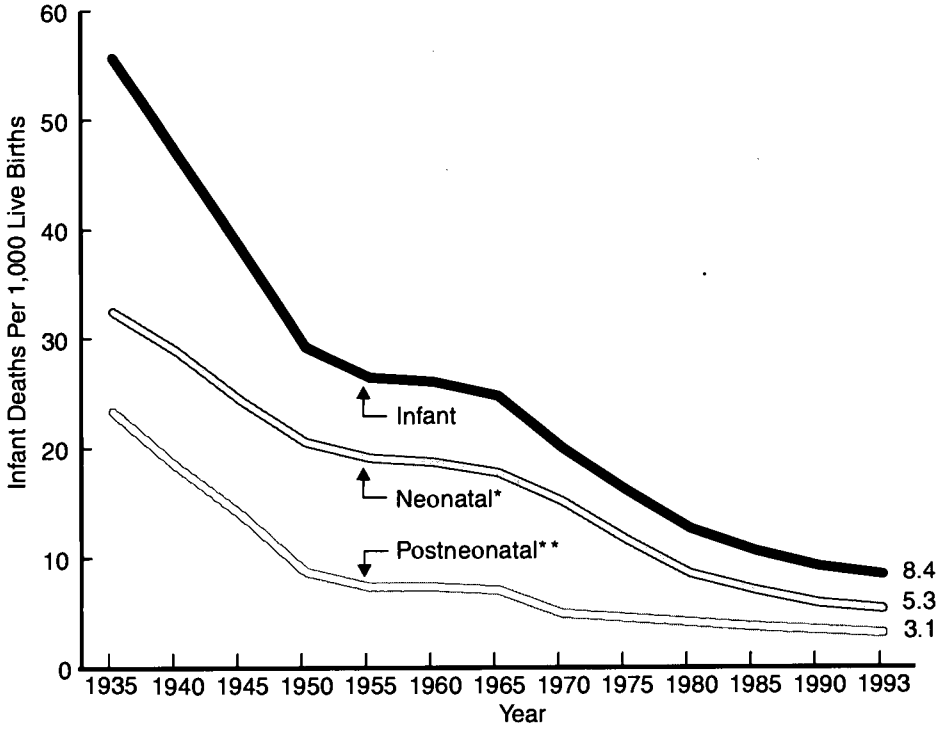
** Less than 2,500 grams (5.5 lbs.).*

LOW BIRTH WEIGHT

The prevalence of low birth weight in the total population increased from 7.0% in 1950 to 8.3% in 1965. The increase in low birth weight prevalence between 1950 and 1965 was partially attributable to improved reporting, especially for the poorer segments of the population. It decreased to a low of 6.8% in 1985. However, the percentage of low birth weight births has been slowly increasing.

Infant Mortality Rates: 1935-1993

Source (I.4): Maternal and Child Health Bureau



* *Neonatal: less than 28 days old*
** *Postneonatal: 28 days to 1 year old*

INFANT MORTALITY

The survival of infants in the U.S. has markedly improved over the past 60 years. In 1935, there were 55.7 infant deaths per 1,000 live births; while in 1993, the U.S. infant mortality rate was 8.4. Advances in public health and medical practices—improvements in sanitation, the initiation of childhood immunizations, better medical treatment of infectious and other illnesses, and improvements in maternity and newborn care—all have contributed to the infant mortality decrease.

Although the U.S. infant mortality rate continues to improve and is at an all-time low, the U.S. ranks only 22nd among industrialized nations.

NEONATAL AND POSTNEONATAL MORTALITY

Though there have been substantial decreases in both neonatal and postneonatal mortality in the U.S. over the past 60 years, the relationship between neonatal and postneonatal mortality has not remained constant. Postneonatal mortality declined more rapidly than neonatal mortality from the 1940s through the mid 1960s due to improvements in living conditions and in pediatric care. The gap between neonatal and postneonatal mortality has diminished from the 1970s because of dramatic improvements in perinatal intensive care.

Photo Courtesy of H. Armstrong Roberts

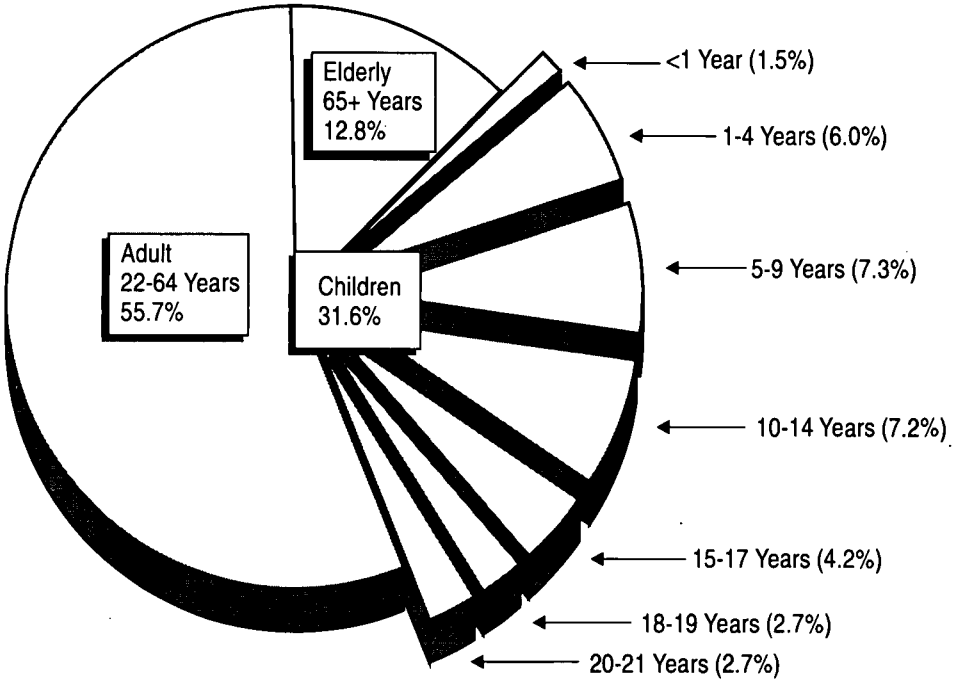
In the collection and presentation of data, socio-demographic characteristics are used to develop a comprehensive and accurate picture of the country's diverse maternal and child population. These characteristics include race and ethnicity, age, and poverty status.

At the national, state, and local levels, policy makers use population information to systematically address health-related issues of mothers and children. By carefully analyzing and comparing data, health workers can often isolate high-risk populations that require specific interventions. Policy makers can then develop effective programs that meet the needs of those populations.

The following section presents data on a number of population characteristics that have an impact on maternal and child health program development and evaluation. These include data on the population distribution by age, poverty status, and living arrangements. Data on school dropout rates and working mothers and child care trends are also included.

U.S. Resident Population by Age Group: 1995

Source (II.1): U.S. Bureau of the Census



POPULATION OF CHILDREN

In 1995, there were almost 83 million children through the age of 21 in the United States, representing 31.6% of the total population.

Between 1980 and 1995, there was a 19.1% increase in the number of children under 5 years of age.

Although there were approximately 27 million more children age 21 or younger in 1995 than in 1950, this age group is declining relative to other age groups in the population.

In 1995, persons aged 65 and over represented 12.8% of the total population. By the year 2000, this group is expected to decrease by 12.6%. The child population is expected to remain at 31.5%.

CHILDREN IN POVERTY

In 1994, there were 14.6 million related children under 18 years of age living in families with income below the federal poverty level. This age group contains 38.4% of all the nation's poor.

Black or Hispanic children are more likely to live in poverty than are white children.

Between 1980 and 1994, the number of children living in poverty increased by almost 3.5 million. In contrast, the number of persons 65 years of age and over living in poverty decreased by 0.2 million.

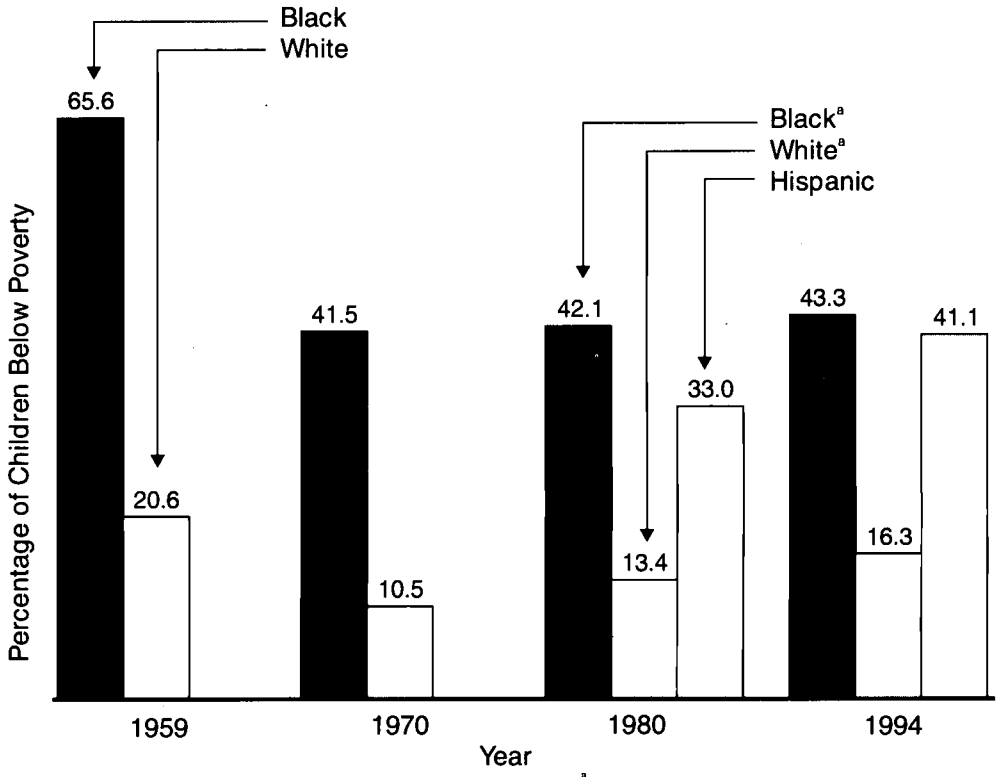
In 1994, a family of four was considered to be living in poverty if its annual income was below $15,141.**

* *Related children in a family include householder's own children and all other children in the household who are related to the householder by blood, marriage, or adoption.*

** *Based on the U.S. Census Bureau's poverty threshold, which is calculated using the Consumer Price Index from the previous calendar year.*

Related Children Under 18 Years of Age* Living in Families Below 100% of Poverty: 1994

Source (II.2): U.S. Department of Commerce

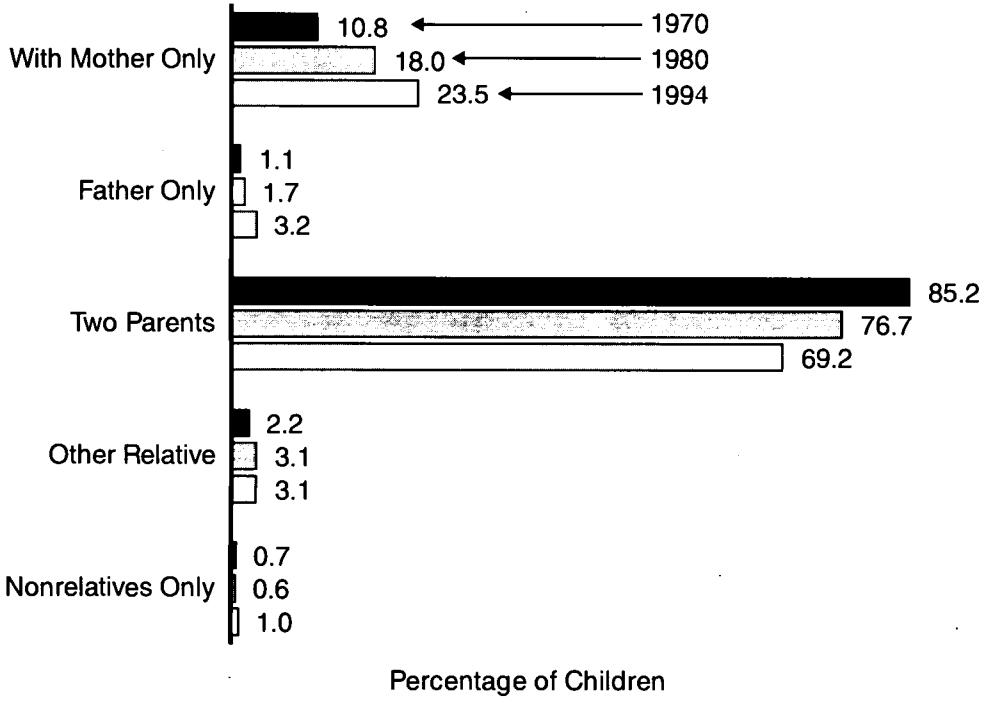


Note: Ethnicity data are not available prior to 1979.

[a] *Includes Hispanic*

Living Arrangements of Children Under 18 Years of Age: 1970-1994

Source (II.3): U.S. Bureau of the Census



FAMILY COMPOSITION

In 1994, 18.6 million children lived in families with only one parent. This group represented 26.7% of children younger than 18 years of age.

Since 1970, the percentage of children living with single parents has more than doubled, from 11.9% to 26.7%. A rise in the divorce rate and the number of never-married parents have contributed to this increase.

In 1994, the vast majority of single-parent families consisted of children living with their mothers. Of children living with only one parent, the proportion living with a single father increased from 9.1% in 1970 to 12.1% in 1994.

White children are less likely to be living with one parent than are black or Hispanic children. The proportions living with one parent in 1994 were 20.9% for white children, 31.8% for Hispanic children, and 57.1% for black children.

Approximately two-thirds of both black children and Hispanic children who live with a single mother are below the federal poverty level.

Note: A parent may be a stepparent or parent by adoption.

WORKING MOTHERS

In 1995, about 62% of all mothers with preschool-aged children (younger than 6 years) were in the labor force, a nearly twofold increase since 1970.

Currently, there are about 10 million working women with preschool-aged children. About 12 million children younger than 6 and 28 million children ages 6-17 have mothers in the labor force.

** Data for 1994 and 1995 are not strictly comparable with data for earlier years due to changes in the survey and the estimation process.*

CHILD CARE

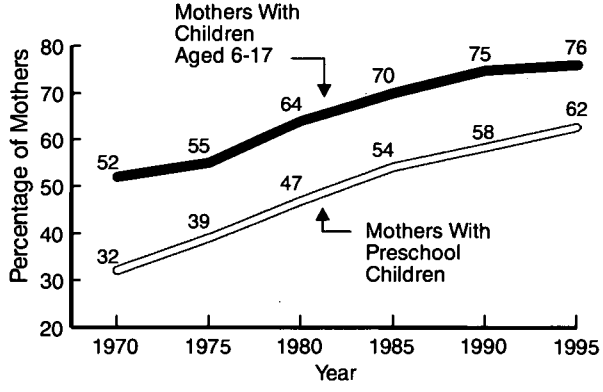
In 1993, 3 out of 10 children younger than age 5 (3.0 million) whose mothers worked outside of the home spent their days in nonresidential day care centers.

The percentage of children receiving child care in their homes decreased from 35.7% to 30.7% from 1991 to 1993.

Women who work full time tend to use day care centers while women who work part time are more likely to use in-home care.

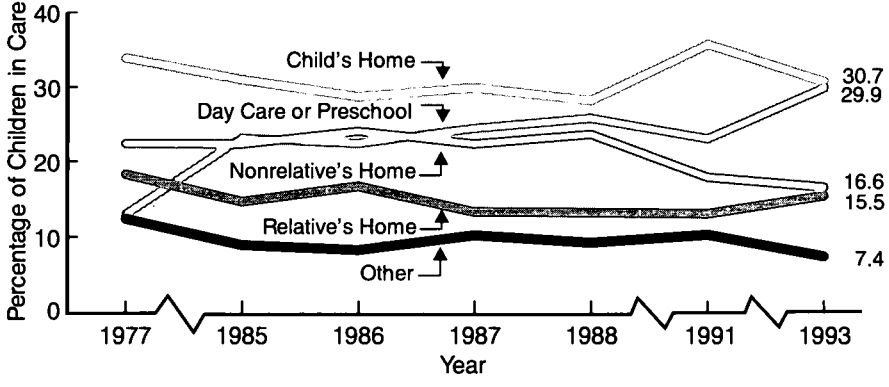
Mothers in the Labor Force*: 1970-1995

Source (II.4): U.S. Bureau of Labor Statistics



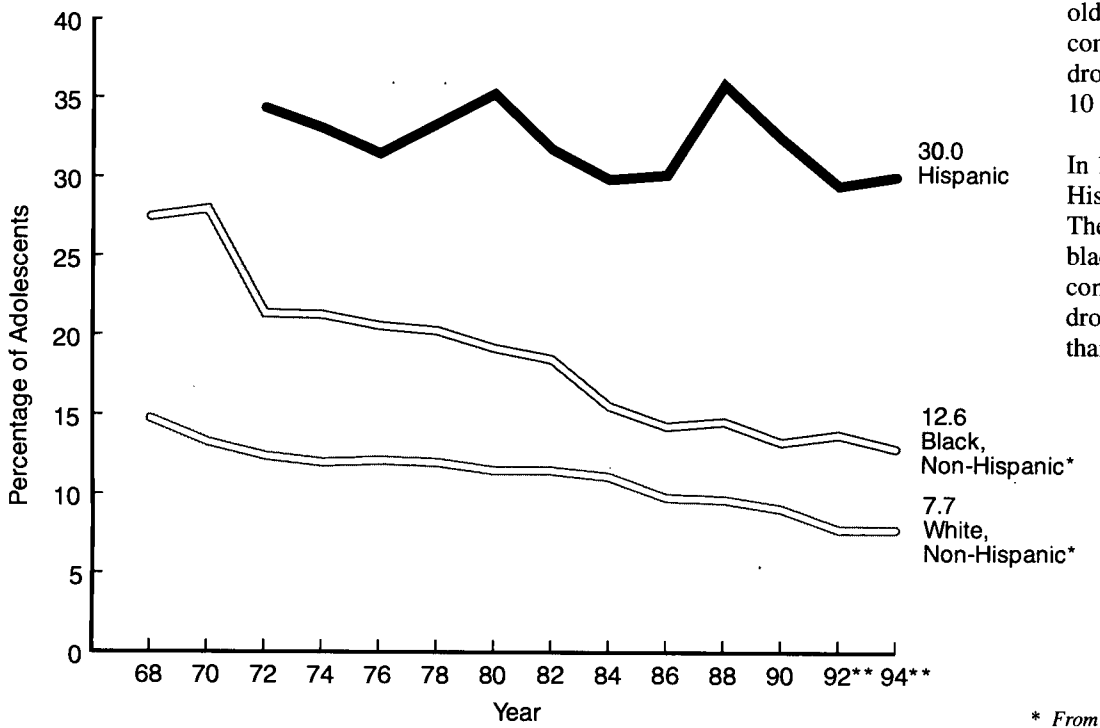
Place of Care for Preschool-Aged Children: 1977-1993

Source (II.5): U.S. Bureau of the Census



Status School Dropout Rates for Adolescents Ages 16-24 by Race/Ethnicity: 1968-1994

Source (II.6): U.S. Department of Education



Note: Status rates measure the proportion of the population who have not completed high school and are not enrolled at one point in time, regardless of when they dropped out.

SCHOOL DROPOUTS

In 1994, more than 3 million 16 to 24 year olds were out of school and had not completed high school. Those who have dropped out of high school represent 1 in 10 young adults (10.5%).

In 1994, almost one third of young Hispanics dropped out of high school. The difference between the dropout rates of black and white young adults has narrowed considerably in the last 25 years, as the dropout rate decreased faster for blacks than for whites.

* *From 1968-71, includes persons of Hispanic origin.*

** *Because of changes in data collection procedures, data may not be comparable with figures for earlier years.*

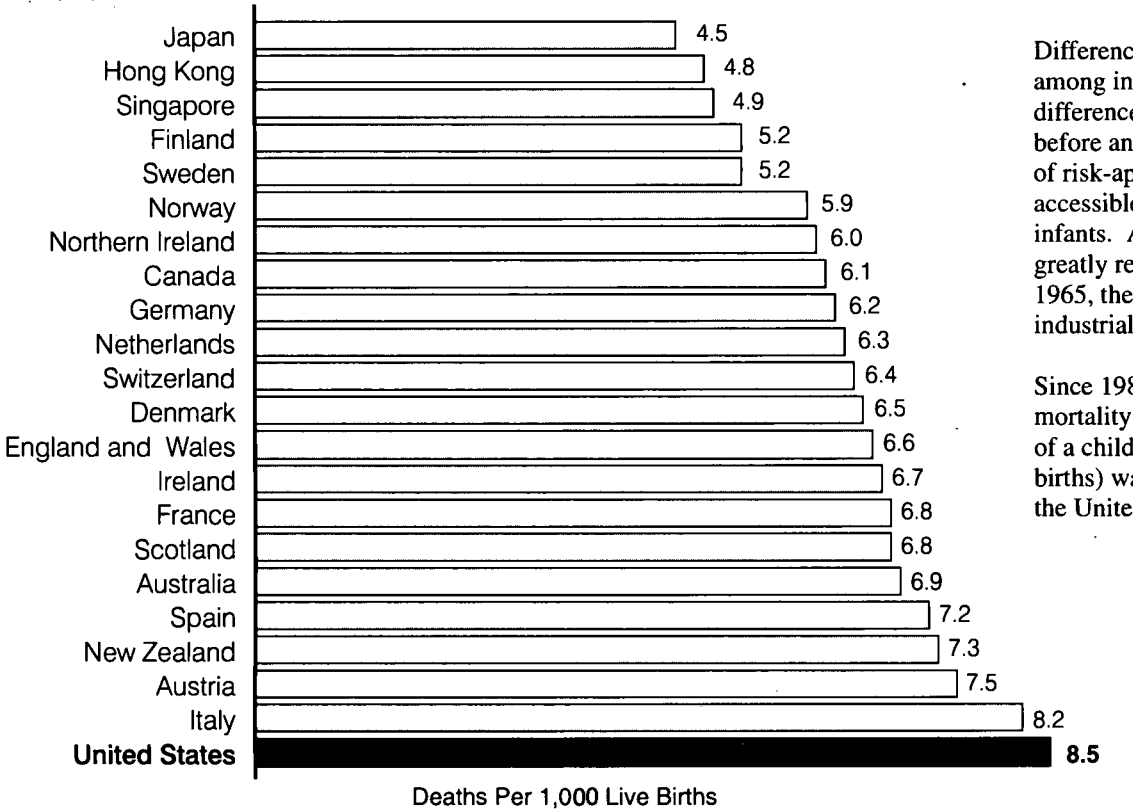
The systematic assessment of the health status of children enables health workers to determine the impact of past and current health intervention and prevention programs. Program planners and policy makers identify trends by examining and comparing data from one year to the next.

In the following section, health status indicators are presented by age group: infant, child, and adolescent. Trend data for the preceding 20 years are presented for selected indicators.

The health status indicators in this section are based on vital statistics and national surveys. Population-based samples are designed to yield data that are representative of the maternal and child population affected by, or in need of, specific health services.

Comparison of National Infant Mortality Rates: 1992

Source (III.1): National Center for Health Statistics



COMPARISON OF NATIONAL INFANT MORTALITY RATES

Differences in the infant mortality rates among industrialized nations reflect differences in the health status of women before and during pregnancy and the quality of risk-appropriate primary health care accessible to pregnant women and their infants. Although the United States has greatly reduced its infant mortality rate since 1965, the nation ranks lower than 21 other industrialized countries.

Since 1980, Japan has had the lowest infant mortality rate in the world. In 1992, the risk of a child dying in infancy (4.5 per 1,000 live births) was 55% lower than that observed in the United States (8.5 per 1,000 live births).

INFANT MORTALITY

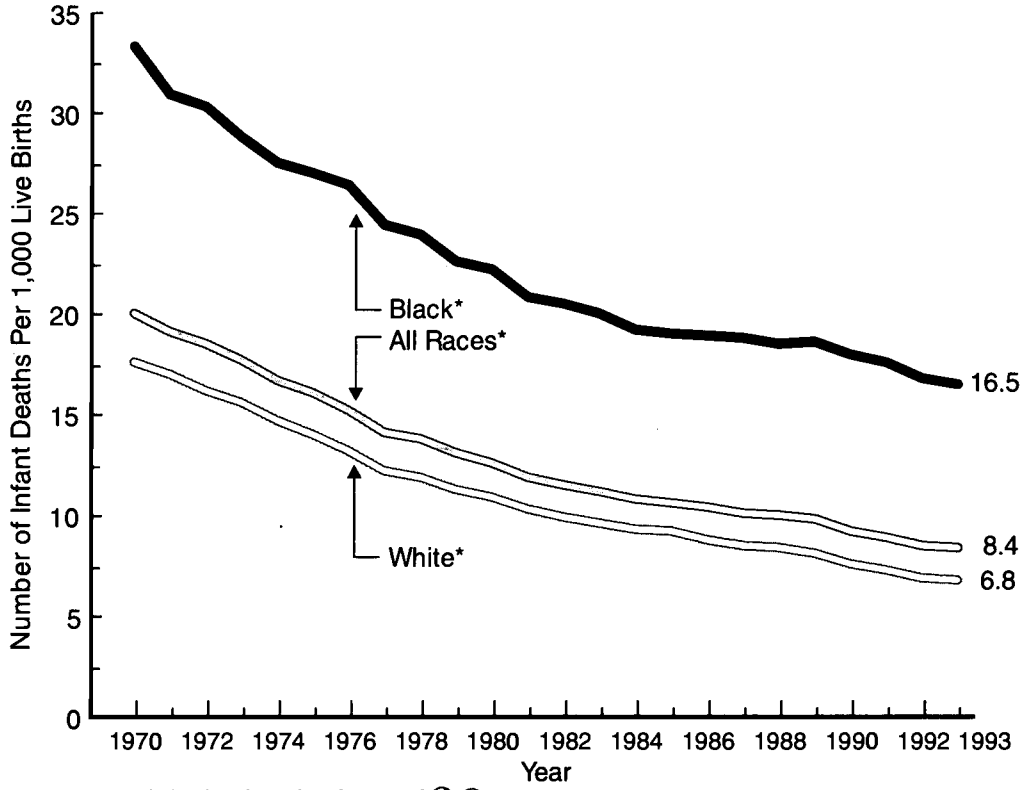
In 1993, 33,466 infants diéd before their first birthday. The infant mortality rate was 8.4 deaths per 1,000 live births. This figure represents a decline of 1% from the rate of 8.5 for the previous year.

The rapid decline in infant mortality, which began in the mid 1960s, slowed for both blacks and whites during the 1980s.

The 1993 infant mortality rate for black infants was 2.4 times the rate for white infants. Although the trend in infant mortality rates among blacks and whites has been on a continual decline throughout the 20th century, the proportional discrepancy between black and white rates has remained unchanged.

U.S. Infant Mortality Rates by Race of Mother: 1970-1993

Source (III.2): National Center for Health Statistics



* *Includes the ethnic classification of Hispanic*

NEONATAL AND POSTNEONATAL MORTALITY

Neonatal

In 1993, 21,174 infants younger than 28 days died; putting the neonatal mortality rate at 529.3 deaths per 100,000 live births. Both the overall mortality rate and rates by leading causes of mortality decreased from 1991 to 1993.

Blacks have the highest rates of neonatal mortality in all categories. Disorders related to short gestation and low birth weight are the primary causes of neonatal mortality for blacks, while congenital anomalies are the leading cause for whites.

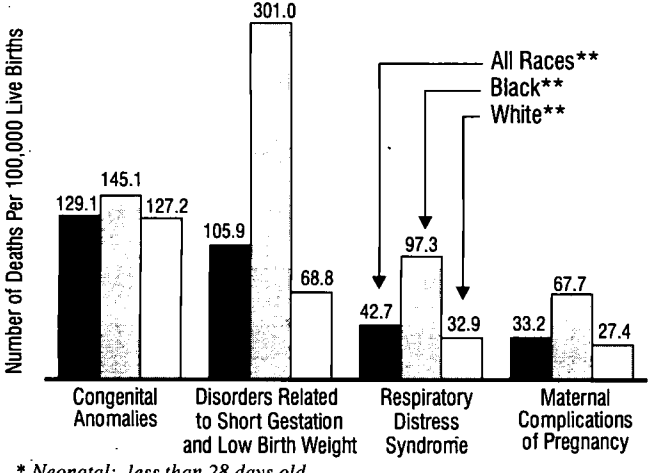
Postneonatal

In 1993, 12,292 infants 28 days to 11 months old died; the postneonatal mortality rate was 307.3 deaths per 100,000 live births, a decrease of 7.1 deaths per 100,000 live births from 1992.

The postneonatal mortality rate for blacks is at least two times that for whites in all leading causes of postneonatal mortality (three tlimes greater when homicide is the cause), with the exception of congenital anomalies.

Leading Causes of Neonatal* Mortality: 1993

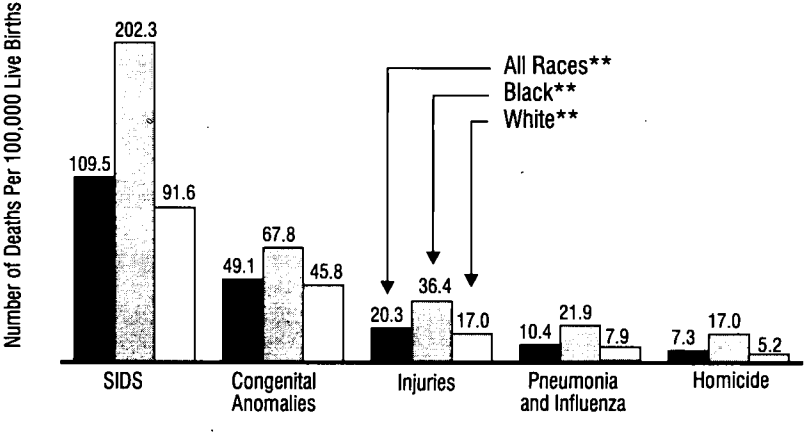
Source (III.3): National Center for Health Statistics



* *Neonatal: less than 28 days old*
** *Includes Hispanic*

Leading Causes of Postneonatal* Mortality: 1993

Source (III.3): National Center for Health Statistics



* *Postneonatal: 28 days to less than one year old*
** *Includes Hispanic*

MATERNAL MORTALITY

During the past several decades, there has been a dramatic decrease in maternal mortality in the United States. Since 1980, however, the rate of decline has slowed.

In 1993, there were 302 maternal deaths which resulted from complications during pregnancy, childbirth, or the postpartum period.

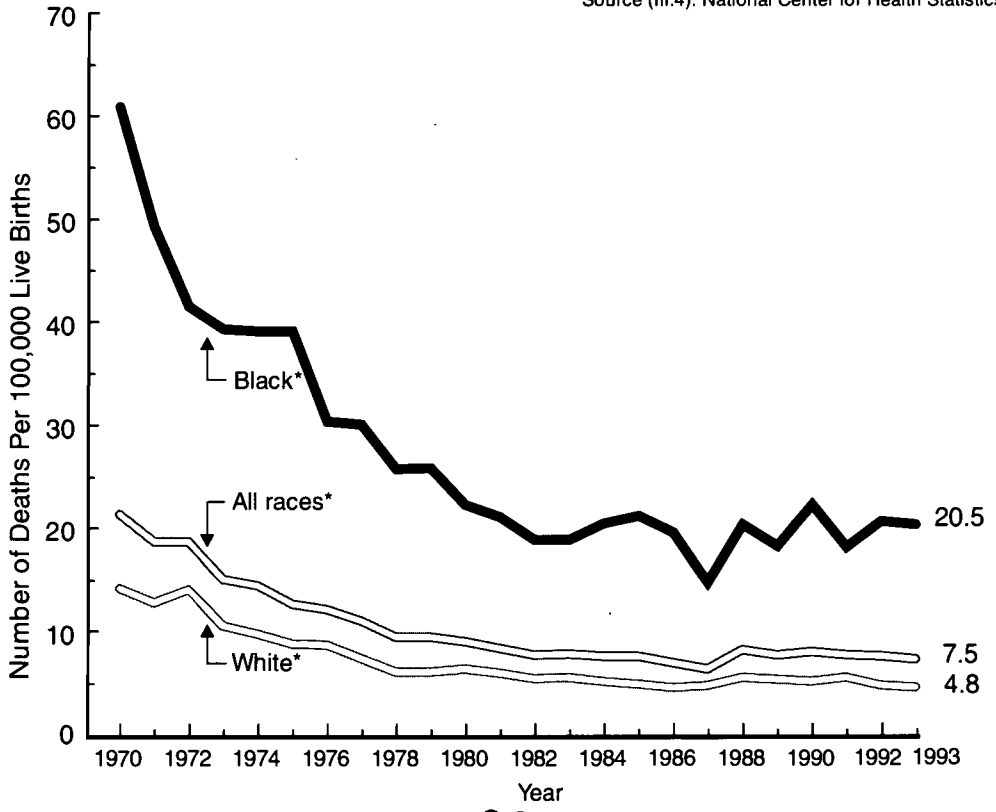
The maternal mortality rate for black women (20.5 per 100,000 live births) is more than four times the rate for white women (4.8 per 100,000 live births).

Regardless of race, the risk of maternal death increases for women over age 30; women 35-39 years old have more than twice the risk of maternal death than those aged 20-24 years.

Note: 1970-1988 data based on race of child; 1989-1993 data based on race of mother.

Maternal Mortality Rates by Race: 1970-1993

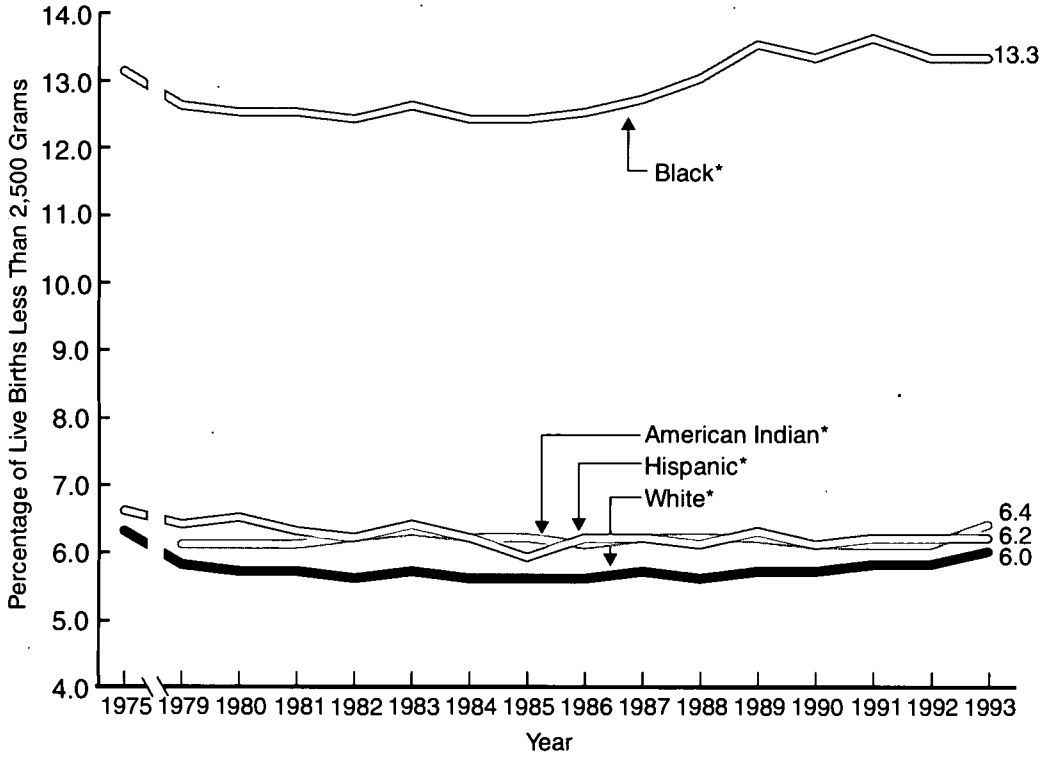
Source (III.4): National Center for Health Statistics



* *Includes the ethnic classification of Hispanic*

Percentage of Low Birth Weight Infants by Race: 1975-1993

Source (III.5): National Center for Health Statistics



* *Includes the ethnic classification of Hispanic*

LOW BIRTH WEIGHT

In 1993, 288,482 babies (7.2% of all live births) were of low birth weight, weighing less than 2,500 grams, or 5.5 pounds, at birth.

The percentage of low birth weight births among all live births rose from a low of 6.8% in 1985 to 7.2% in 1993. From 1992 to 1993, rates among blacks and Hispanics remained stable, while rates among American Indians and whites increased.

Low birth weight is the factor most closely associated with neonatal mortality. Low birth weight infants are more likely to experience long-term disabilities or to die during the first year of life than are infants of normal weight.

Factors associated with increased risk of low birth weight include poverty, low level of educational attainment, and minority status.

Note: 1975-1988 data based on race of child; 1989-1993 data based on race of mother.

INFANT FEEDING

From 1971 to 1982, the percentage of mothers who began breastfeeding in the hospital increased to a high of 62%, but then gradually declined to 51.5% by 1990. Since 1991, however, there has been an increase for black, Hispanic, and white women. The total in-hospital breastfeeding rate for 1994 was 57.4%.

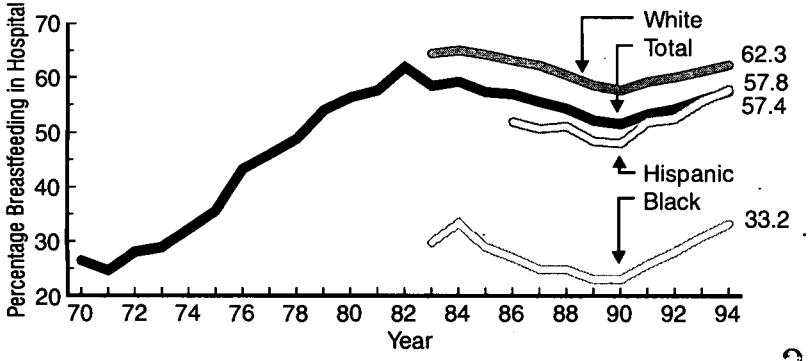
With steeper increases in the rate of breastfeeding for black women, the gap between breastfeeding rates for black and white women narrowed slightly in 1994 but was still nearly twice as high for white women as for black women. The 1994 rates for Hispanic women averaged 8.5% lower than those for white women.

Breastfeeding rates for women of all races decrease substantially between delivery and 5 to 6 months postpartum, the period of breastfeeding recommended as most critical for the infant's health by the Surgeon General of the United States. The 1994 rates at 5 to 6 months postpartum were only 23.9%, 18.9% and 10.3% for white, Hispanic, and black women respectively, representing a decline of 38.4% among whites, 38.9% among Hispanics, and 22.9% among blacks from the rates just after delivery.

Breastfeeding rates were highest among women over 30 years of age, college educated, relatively affluent, women not participating in the Women, Infants, and Children (WIC) dietary supplement program and/or residing in the western United States. Women least likely to breastfeed were younger than 20, employed full-time, low-income (<$10,000/year), black, Hispanic, and/or who lived in the southeastern United States. Also women were less likely to breastfeed their first child.

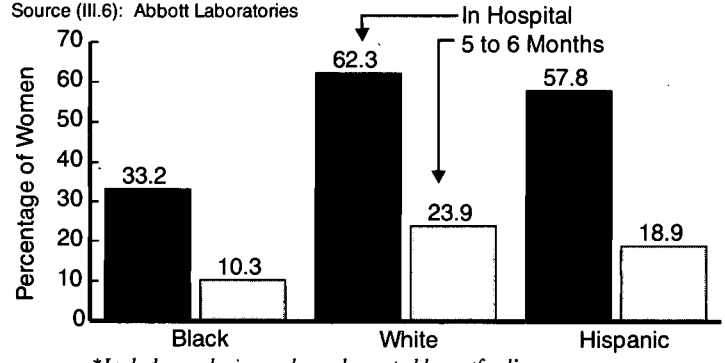
Trends in Breastfeeding by Race: 1970-1994

Source (III.6): Abbott Laboratories



Breastfeeding Rates by Race: 1994*

Source (III.6): Abbott Laboratories



*Includes exclusive and supplemented breastfeeding.

CHILD MORTALITY

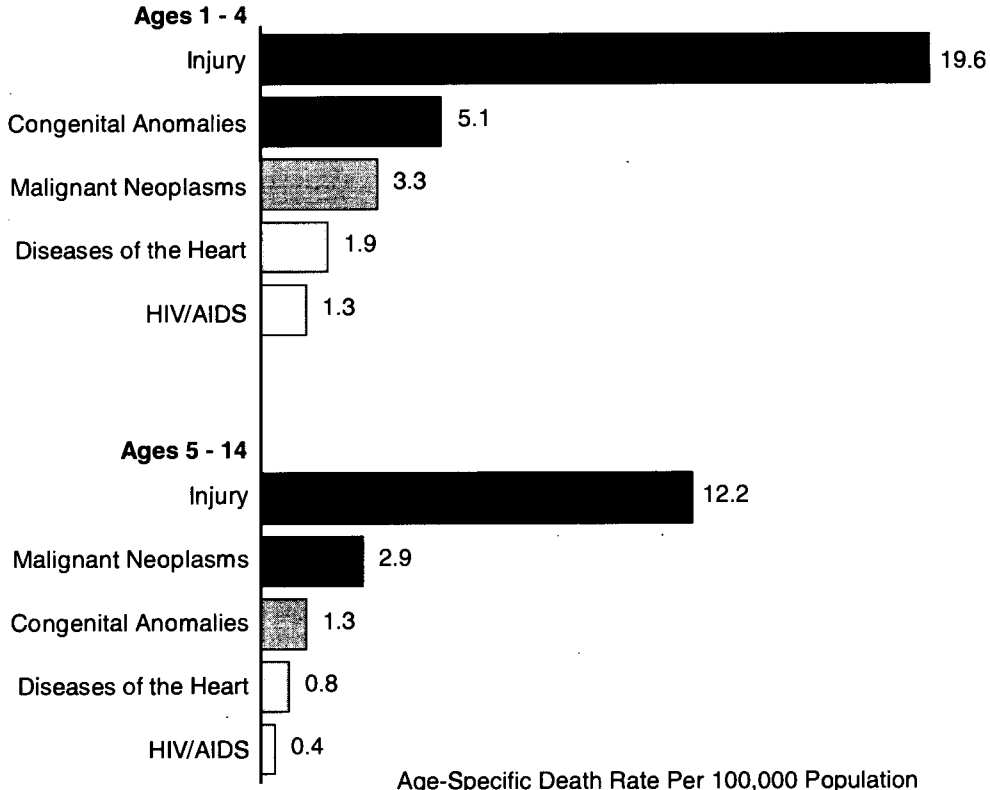
There were 15,724 deaths of children ages 1-14 years in 1993. Injury, of any type and regardless of intent, was the primary cause of death in that age group. Among 1-4 year old children, injuries accounted for 44% of all deaths, followed by deaths due to congenital anomalies (birth defects), malignant neoplasm (tumors), diseases of the heart, and HIV or AIDS.

Injuries comprised 52% of all deaths among 5-14 year old children, followed by malignant neoplasm, congenital anomalies, diseases of the heart, and HIV or AIDS.

Childhood mortality rates have declined substantially over the past several decades. However, the decline has plateaued in recent years and, in both age groups, mortality in 1993 was slightly higher than mortality in 1992.

Leading Causes of Death in Children Ages 1-14: 1993

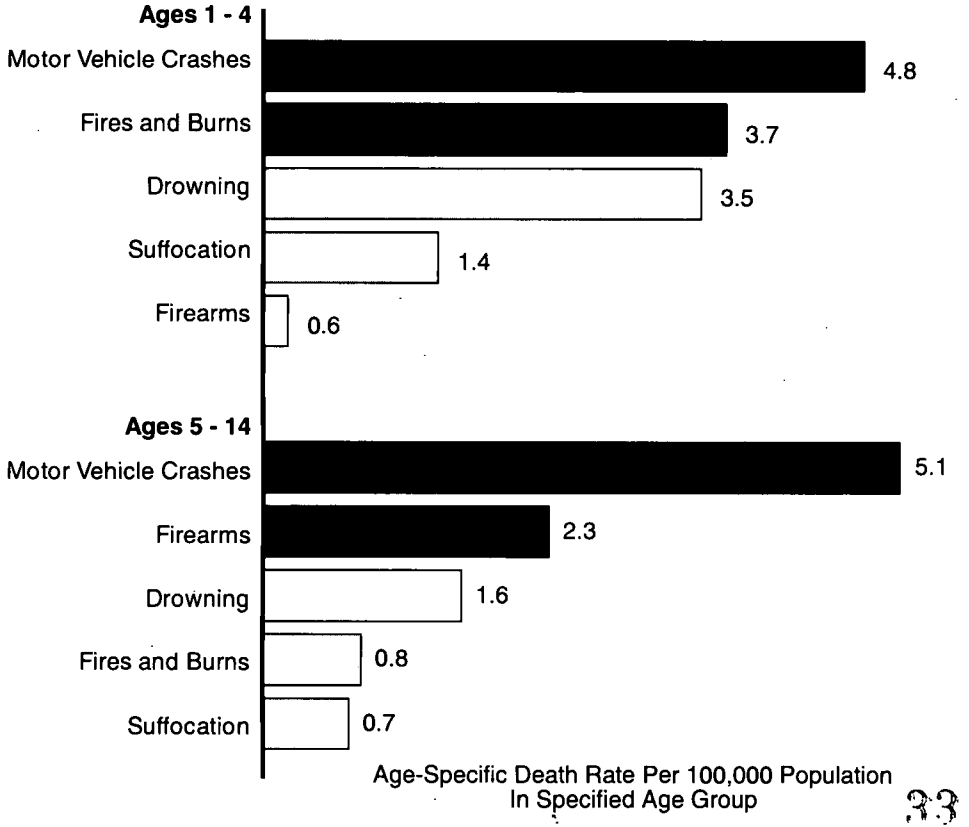
Source (III.7): National Center for Health Statistics



Age-Specific Death Rate Per 100,000 Population In Specified Age Group

Childhood Deaths Due to Injury by Cause and Age: 1993

Source (III.8): National Center for Health Statistics



CHILDHOOD DEATHS DUE TO INJURY

In 1993, injuries caused the deaths of 3,093 1-4 year old children and 4,502 5-14 year old children.

Among 1-4 year old children, motor vehicle crashes, fire, and drowning were the leading causes of injury death. Motor vehicle crashes were the leading cause of injury death among 5-14 year old children, followed by firearm and drowning deaths. Almost 55% of firearm deaths among 5-14 year old children were homicides.

HOSPITALIZATION

In 1993, there were 3.4 million hospital discharges of children 1 through 21 years old, or four discharges per 100 children during the year.

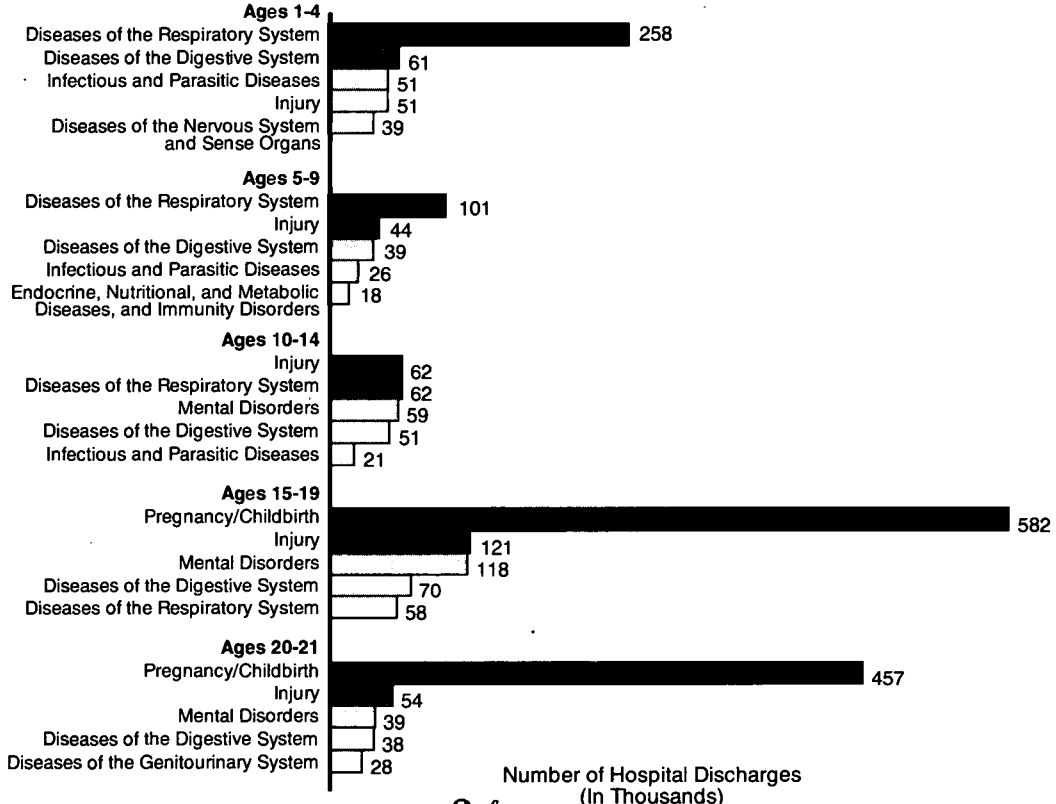
Diseases of the respiratory system were the major cause of hospitalization of children 1-9 years of age and accounted for 36% of their discharges.

Hospital discharge rates decrease with age until age 9 and then increase during later adolescence.

While injuries are the leading cause of death for children older than 1 year, this category accounted for only 11% of the hospital discharges of children 1-14 years in 1993. Pregnancy and childbirth related hospitalizations accounted for 70% of discharges of young women ages 15-21.

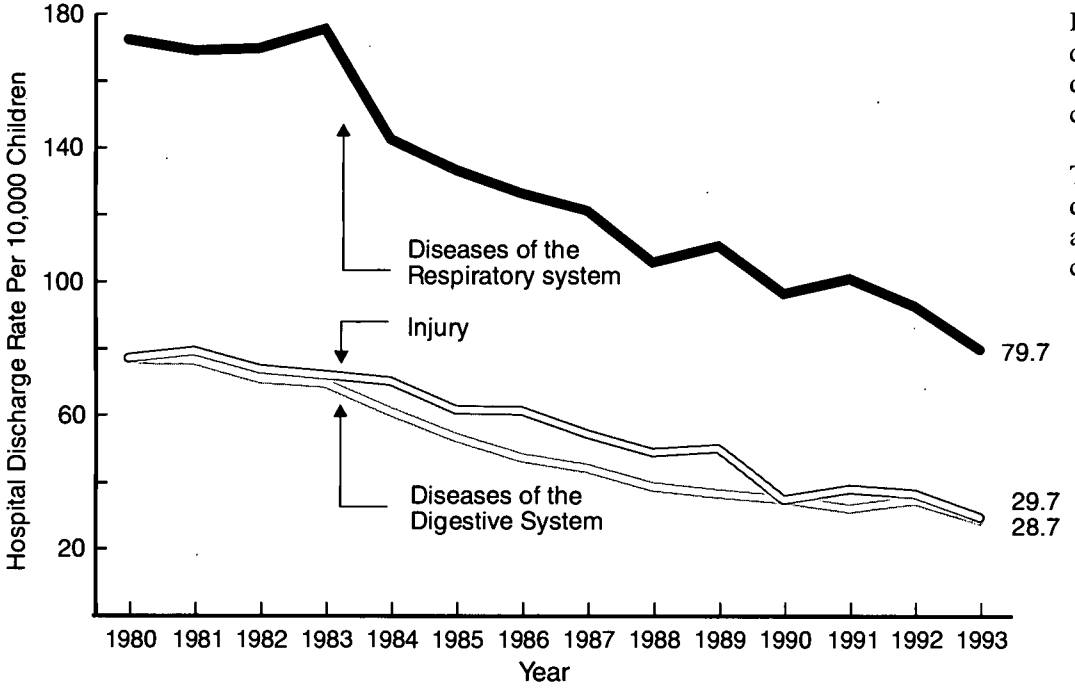
Major Causes of Hospitalization, by Age: 1993

Source (III.9): National Center for Health Statistics



Discharge Rate of Patients 1-14 Years Old for Selected Diagnoses: 1980-1993

Source (III.10): National Center for Health Statistics



HOSPITAL DISCHARGE TRENDS

Since 1980, there has been a 55% decrease in overall hospital discharge rates for children aged 1-14 years.

Between 1980 and 1993, there was a 54% decline in the hospital discharge rate for diseases of the respiratory system in children aged 1-14 years.

Three diagnostic categories (digestive disease, respiratory disease, and injury) accounted for 51% of the discharges of children aged 1-14 years in 1993.

LEAD EXPOSURE

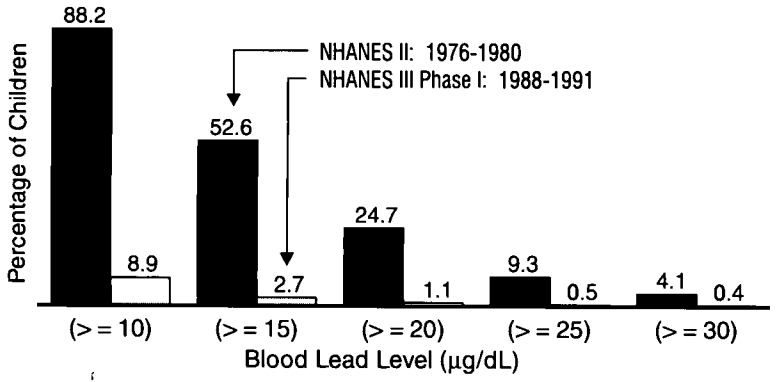
Reductions in childhood lead exposure are a major public health success story. The percentage of children with elevated blood lead levels declined substantially from 1976 to 1991, and average blood lead levels dropped from 15 micrograms per deciliter (µg/dL) to .6 µg/dL. Despite this success, 1.7 million American children still have elevated blood lead levels. This is about 9% of all children under 6 years old. Nationally, about 36% of the children in the U.S. who are poor, black, and live in inner cities, have elevated blood levels. This compares to about 4% of non-Hispanic white children who are neither poor nor live in the inner city.

The most serious remaining sources of lead exposure are deteriorated lead-based paint in older housing, as well as dust and soil contaminated by leaded paint and residues from past auto emissions of leaded gasoline. The Environmental Protection Agency initiated a phase-out of leaded fuel in the 1970s. The manufacture of residential paint with lead was phased out over several decades and finally eliminated in 1978.

The Centers for Disease Control and Prevention (CDC) is currently updating its 1991 guidelines on lead screening and treatment of children with lead poisoning. Although data indicate that lead exposure has substantially declined, children in inner cities continue to be disproportionately affected. The new guidelines will help improve the use of screening tools, expand prevention activities among children who need them most, and help assure that prevention approaches are appropriate to local conditions.

Percentage of Children 1-5 Years Old With Elevated* Blood Lead Levels: 1976-1991

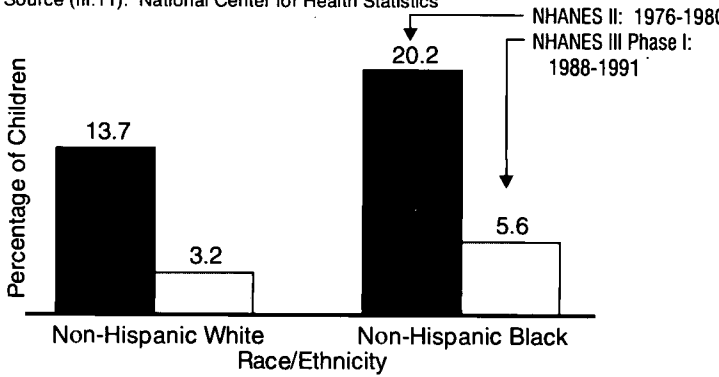
Source (III.11): National Center for Health Statistics



Elevated blood lead level: at or more than 10 µg/dL

Mean Blood Lead Levels (µg/dL) in Children Ages 1-5, by Race/Ethnicity: 1976-1991

Source (III.11): National Center for Health Statistics



PEDIATRIC AIDS

As of December 31, 1995, 6,948 cases of AIDS in children younger than 13 years old had been reported in the U.S. This total includes 800 newly reported cases in 1995.

Pediatric cases of AIDS represent approximately 1.4% of all cases reported. The majority of pediatric AIDS cases result from transmission before or during birth, with a disproportionate number of cases occurring in black and Hispanic children.

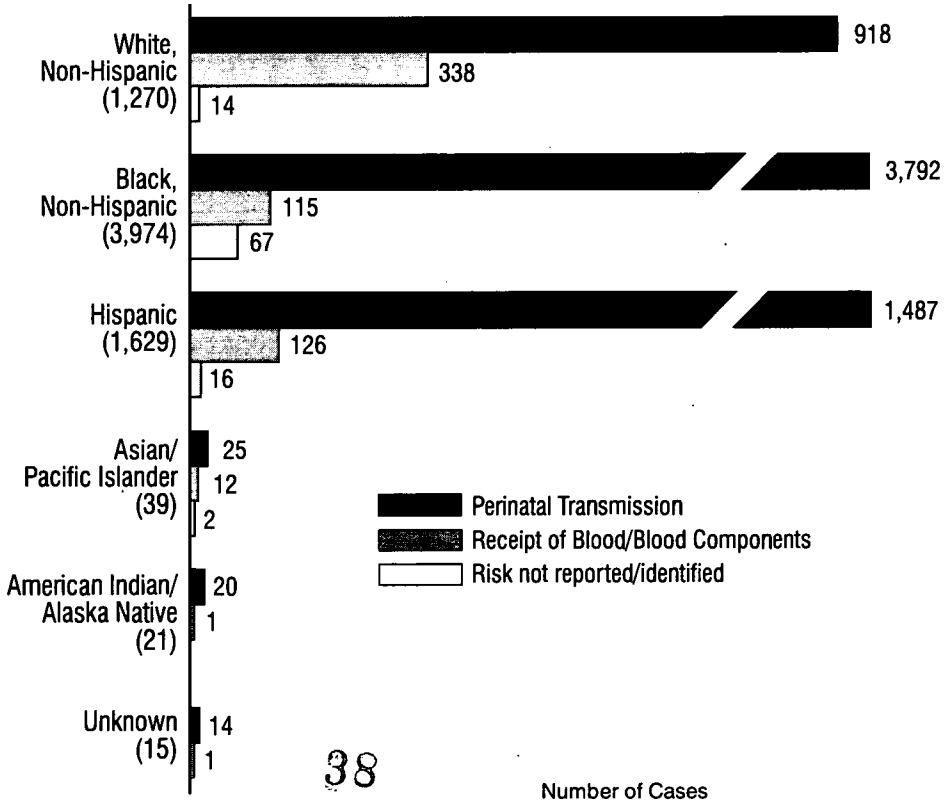
NOTES:

Perinatal Transmission - Child's biologic mother had:
- *Injecting drug use*
- *Sex with injecting drug user*
- *Sex with bisexual male*
- *Sex with person with hemophilia*
- *Sex with transfusion recipient with HIV infection*
- *Sex with person with HIV infection, risk not specified*
- *Receipt of blood transfusion, blood components, or tissue*
- *Has HIV infection, risk not specified*

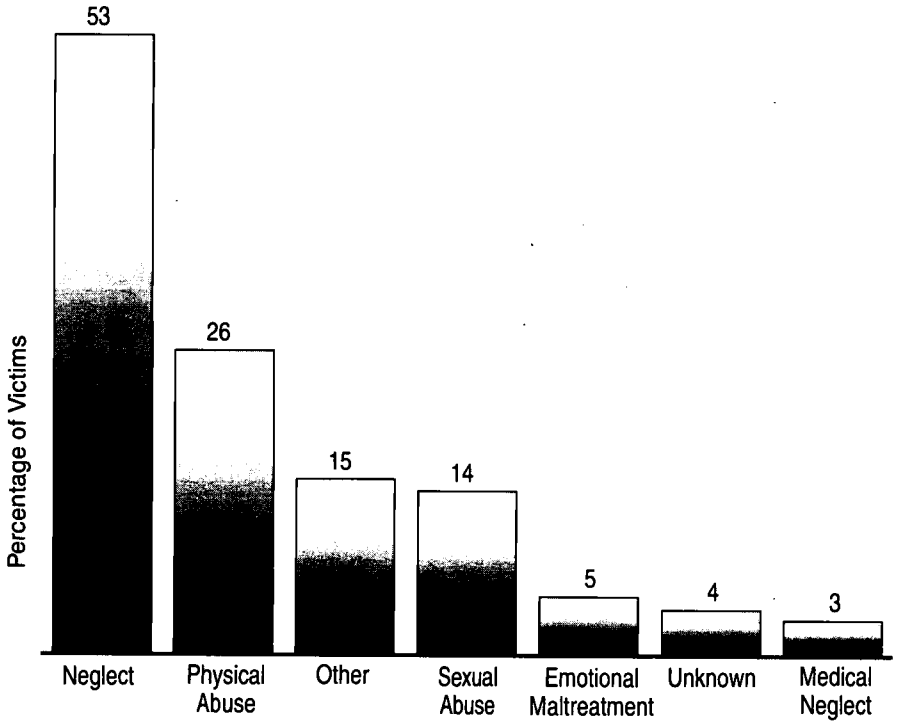
Receipt of Blood/Blood Components:
- *Received clotting factor for hemophilia/coagulation disorder*
- *Received blood transfusion, blood components, or tissue*

Pediatric AIDS Cases by Race/Ethnicity and Exposure Category: 1981-1995

Source (III.12): Centers for Disease Control and Prevention



Percentage of Child Abuse and Neglect Victims, by Type of Maltreatment: 1994
Source (III.13): National Center on Child Abuse and Neglect



Note: Because some states report more than one type of abuse, the total does not equal 100%.

39

CHILD ABUSE AND NEGLECT

Investigations by state child protective services agencies in 48 states determined that 1,012,000 children were victims of substantial or indicated child abuse and neglect in 1994.

About 27% of all victims of child maltreatment were 3 years old or younger, and another 20% were between the ages of 4 and 6. Just over one-fifth of victims were youth ages 13-18.

Types of maltreatment children suffered were neglect 53%, physical abuse 26%, sexual abuse 14%, and other types of maltreatment including medical neglect and emotional maltreatment (27%). Forty-three states reported that 1,111 children died as a result of maltreatment in 1994.

In 1994, state child protective services agencies received and referred for investigation an estimated 2 million reports alleging the maltreatment of 2.9 million children. More than half of all reports alleging maltreatment (53%) came from professionals, including educators, law enforcement and justice officials, medical professionals, social service professionals and child care providers. Only one in five reports came from either the victim or a family member of the victim.

DENTAL CARIES

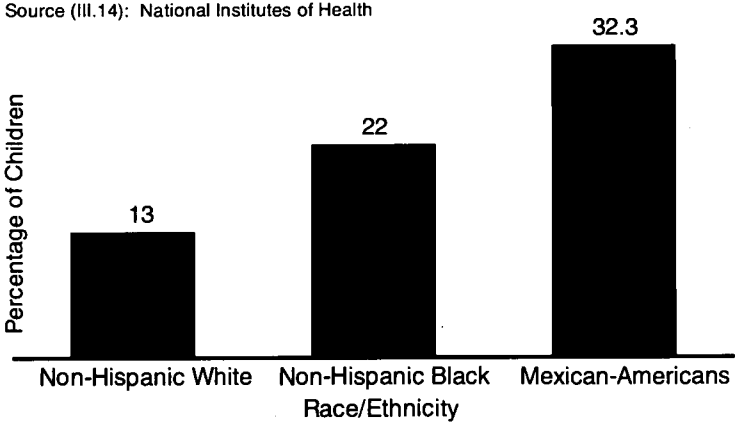
From 1988 to 1991, on the average, children 2-4 years of age had 1.2 decayed and filled primary surfaces. Only 25% of children ages 5-17 with at least one permanent tooth accounted for about 80% of the group with filled permanent teeth.

Differences in caries prevalence were found among racial and ethnic subpopulations, and caries patterns for the primary and permanent teeth differed also. Mexican-American children ages 2-4 had the highest prevalence of caries in their primary teeth (32.3%), compared to 22% of non-Hispanic black children and 13% of non-Hispanic white children. Mexican-Americans also had the highest mean number of filled decayed surfaces on primary teeth. These statistics demonstrate that Mexican-American children are receiving dental care, but the high caries prevalence suggests an apparent lack of caries prevention in this subpopulation.

Mexican-American children ages 5-17 also had the highest prevalence of caries in permanent teeth (48.6%) compared to 44.3% of non-Hispanic whites and 39.4% of non-Hispanic blacks.

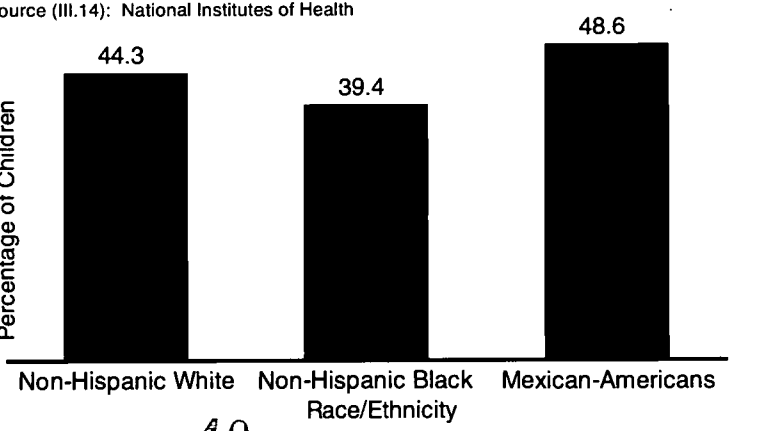
Percentage of Children Ages 2-4 with Dental Caries in Primary Teeth, by Race/Ethnicity: 1988-1991

Source (III.14): National Institutes of Health



Percentage of Children Ages 5-17 with Dental Caries in Permanent Teeth, by Race/Ethnicity: 1988-1991

Source (III.14): National Institutes of Health



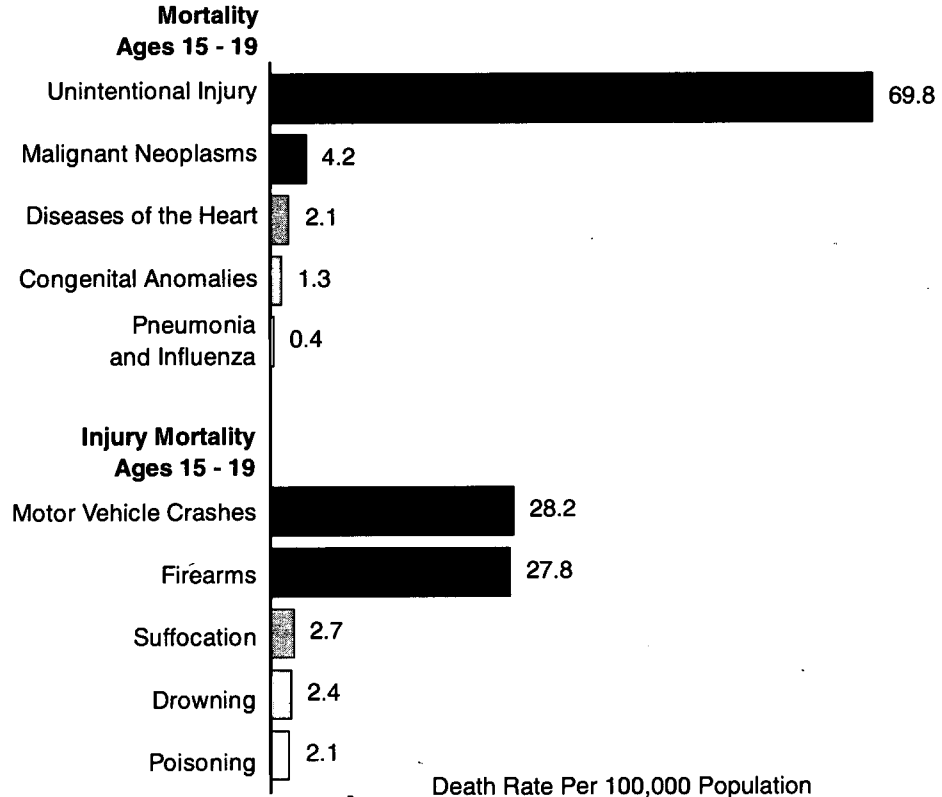
ADOLESCENT MORTALITY

In 1993, there were 14,997 deaths of adolescents aged 15-19 years. In that age group, injury was the leading cause of death. The 12,047 injury deaths accounted for 80% of all deaths among 15-19 year olds in 1993. Malignant neoplasm (tumor) was the next leading cause of death, accounting for 4.8% of all deaths among 15-19 year olds. Mortality among teenagers declined substantially between 1960 and the early 1980s. There was a moderate increase in mortality among 15-19 year olds in the mid to late 1980s. The death rate among that age group has been stable since then.

Motor vehicles and firearms were the leading causes of injury mortality among 15-19 year olds in 1993. Each category accounted for approximately 40% of all injury deaths among teenagers. The next three leading causes of injury death—suffocation, drowning, and poisoning—each accounted for 2% to 3% of all injury deaths among 15-19 year olds. Motor vehicle mortality among teenagers has declined by approximately 15% over the past decade. Conversely, adolescent mortality from firearms has more than doubled over that same period.

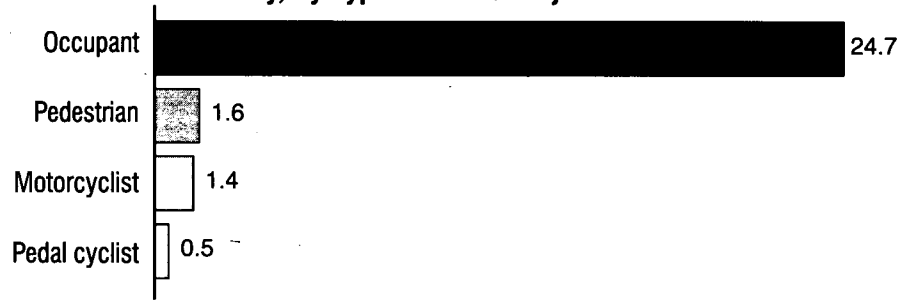
Leading Causes of Death in Adolescents 15-19 Years of Age: 1993

Source (III.15): National Center for Health Statistics

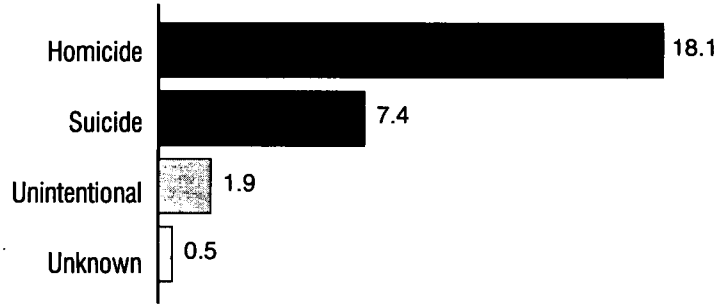


Motor Vehicle Crashes and Firearms Mortality Among Adolescents, Ages 15-19: 1993
Source (III.16): National Center for Health Statistics

Motor Vehicle Traffic Mortality, by Type of Person Injured



Firearm Mortality, by Intent



Death Rate Per 100,000 Population
In Specified Age Group

43

ADOLESCENT DEATHS DUE TO INJURY

In 1993, motor vehicle traffic crashes caused the death of 4,876 15-19 year olds. Almost 90% of those deaths were of motor vehicle occupants, either passengers or the driver. Deaths of pedestrians, motorcyclists, and pedal cyclists accounted for the remainder of motor vehicle mortality among teenagers. Data from the National Highway Traffic Safety Administration suggest that alcohol was involved in 20-25% of motor vehicle deaths among teenagers.

In 1993, 4,794 15-19 year olds were killed by firearms in the U.S. Homicide accounted for 3,118 or 65% of firearm deaths among teenagers. Approximately 27% of firearm deaths were suicide, while 7% were considered to be unintentional. Over the past decade, the proportion of firearm deaths due to homicide has increased by approximately 50%.

TEEN PREGNANCY AND ABORTION RATES

In 1991, there were 997,190 pregnancies among women less than 20 years of age. Pregnancy outcomes included 531,591 live births (53.3%) and 326,620 induced abortions (32.8%).

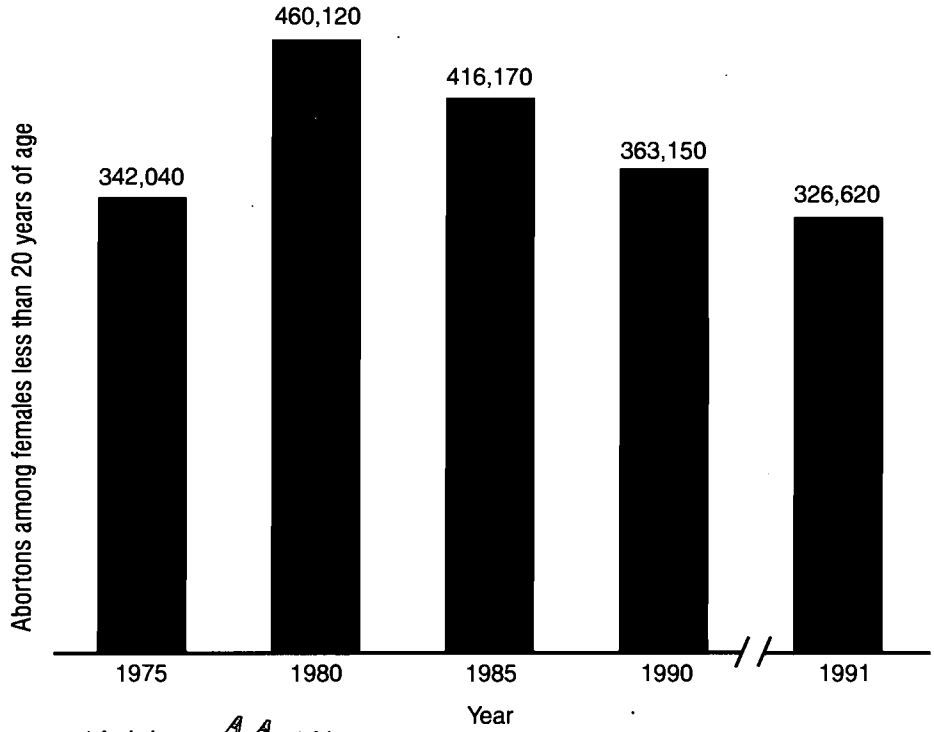
Although the number of abortions among females less than 20 increased sharply from 1975 to 1980, the rate has decreased steadily from 1980-1991. For the first time since 1986, there was a small but steady decline in the teen birth rate from 1991 to 1993. This trend has been documented in nearly every state.

Researchers consistently find four broad factors that predict sexual intercourse at an early age, adolescent pregnancy, and nonmarital childbearing among teenagers: early school failure, early behavior problems, poverty, and family problems/family dysfunction.

NOTE: Data represent a woman's age at the time a pregnancy ended. More pregnancies were experienced by teenagers than were reported because most of the 19-year-olds who became pregnant had their births or abortions at age 20 and thus were not counted.

Abortion Trends Among Women Less Than 20 Years of Age*: 1975-1991

Source (III.17): The Alan Guttmacher Institute



** Includes women ages ≤ 14*

SEXUAL ACTIVITY

The number of students reporting ever having had sexual intercourse increased with age. Males in all grades had the highest prevalence of sexual experience.

Over 50% of students in 12th grade reported having had sexual intercourse during the preceding three months. The prevalence rate of sexual activity increased significantly from grades 9 through 12 among females, while it increased significantly from grades 10 through 12 among males.

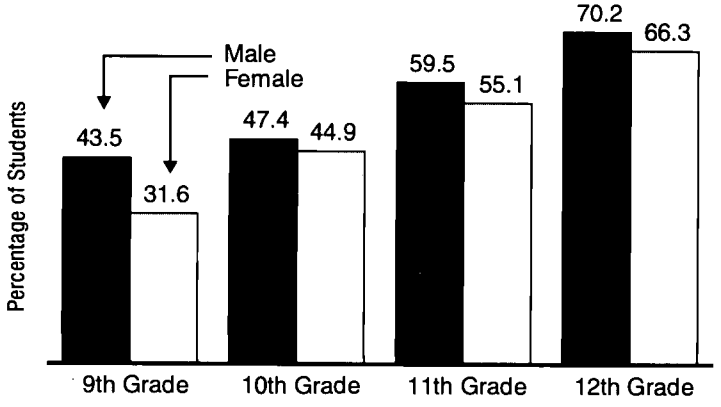
CONDOM USE

More than 50% of sexually active 9th through 12th graders reported condom use during last sexual intercourse. Males were significantly more likely than females to have reported that a condom was used.

While sexual activity increased by grade for all students, condom use decreased by grade. Only 46.5% of sexually active 12th graders reported condom use, compared with 61.6% of sexually active 9th graders.

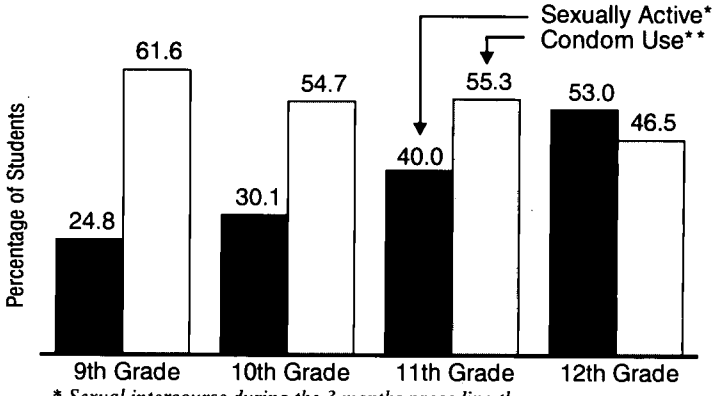
Percentage of High School Students Who Have Ever Had Sexual Intercourse, by Grade: 1993

Source (III.18): Centers for Disease Control and Prevention



Sexual Activity and Condom Use in High School Students: 1993

Source (III.18): Centers for Disease Control and Prevention



* *Sexual intercourse during the 3 months preceding the survey.*

** *Among sexually active students at last sexual intercourse.*

ADOLESCENT CHILDBEARING

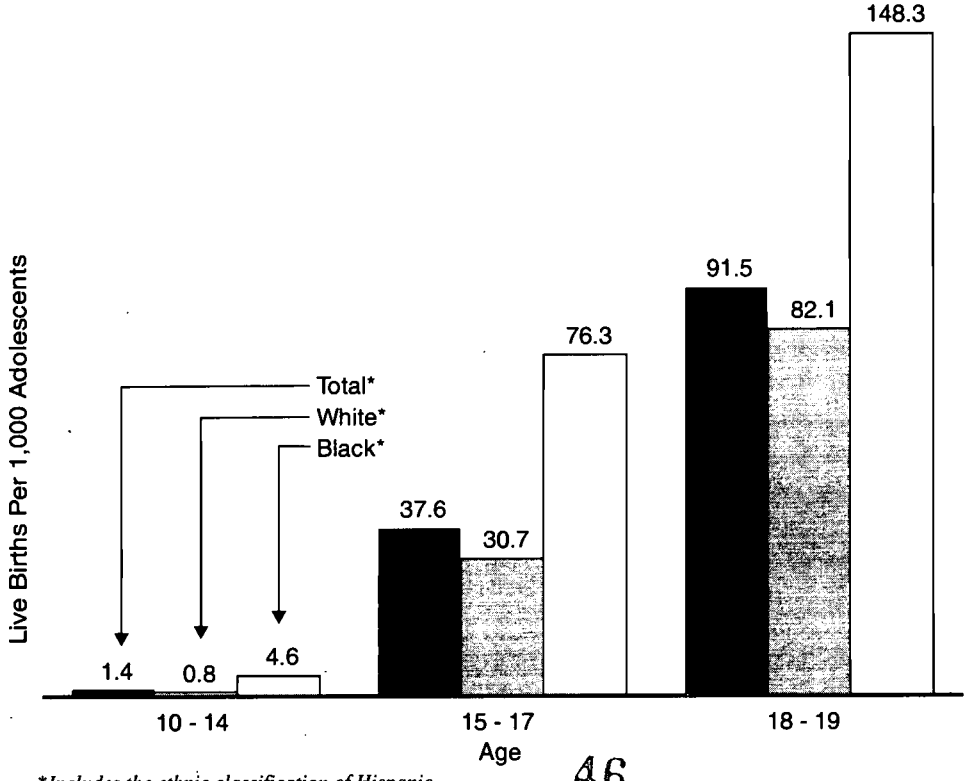
In 1994, the live birth rate per 1,000 women was 1.4 for teenagers aged 10-14, 37.6 for those 15-17, and 91.5 for those 18-19 years old.

In 1994, there were 69,028 live births among black females younger than 18 years of age, which represented 10.8% of all births to black women. There were 132,366 births to white females under 18, which represented 4.2% of all births to white women.

In 1994, approximately 59 million women were of childbearing age (15-44 years) in the United States.

Live Births by Age and Race of Mother: 1994

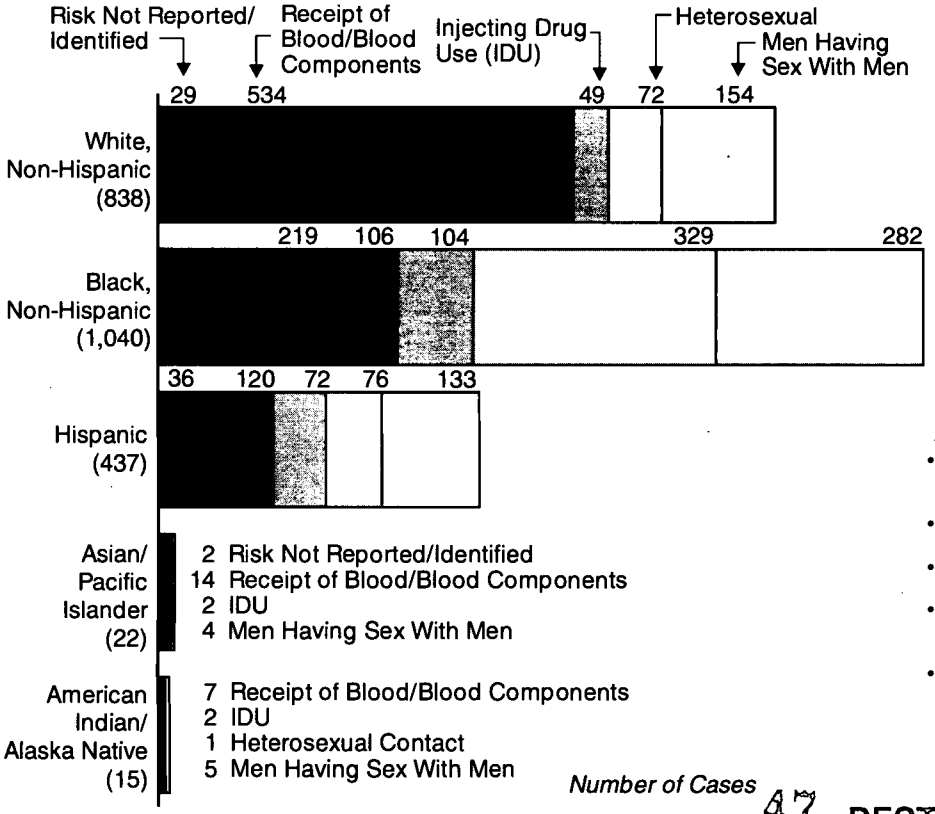
Source (III.19): National Center for Health Statistics



*Includes the ethnic classification of Hispanic

Adolescent AIDS Cases by Race/Ethnicity and Exposure Category for Ages 13-19: 1981-1995

Source (III.20): Centers for Disease Control and Prevention



ADOLESCENT AIDS

As of December 31, 1995, 2,354 cases of AIDS were reported in adolescents aged 13-19 years. This total includes 405 newly reported cases in 1995.

Whites comprised 36% of the AIDS cases among adolescents. Of these, 64% were exposed to HIV primarily through receipt of clotting factor for hemophilia/coagulation disorder or as a result of blood transfusions. Eighteen percent of whites aged 13-19 years were exposed to HIV through male-to-male sexual contact.

Forty-four percent of adolescent AIDS cases were among black, non-Hispanics. Twenty-seven percent of blacks aged 13-19 were exposed to HIV through male-to-male sexual contact.

NOTES:

- *Receipt of Blood/Blood components:*
  Received clotting factor for hemophilia/coagulation disorder
  Received blood transfusion, blood components, or tissue
- *The category "Men Who Have Sex with Men" includes men who have sex with men and also inject drugs*
- *Race is unknown for two persons in this age group; both are in the category "Risk Not Reported/Identified"*
- *Heterosexual contact includes sex with: an injecting drug user; a person with hemophilia; a transfusion recipient infected with HIV; an HIV-infected person, risk not specified; a bisexual male (females only)*
- *On January 1, 1993, the AIDS case definition for adults and adolescents, aged 13 years and older, was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/μL or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.*

ADOLESCENT AIDS

Males comprised 65% of the 2,354 AIDS cases among adolescents aged 13-19 years. These young men were exposed to HIV primarily through receipt of clotting factor for hemophilia/coagulation disorder or as a result of blood transfusions. Thirty-eight percent of males aged 13-19 years were exposed to HIV through sexual contact with other males.

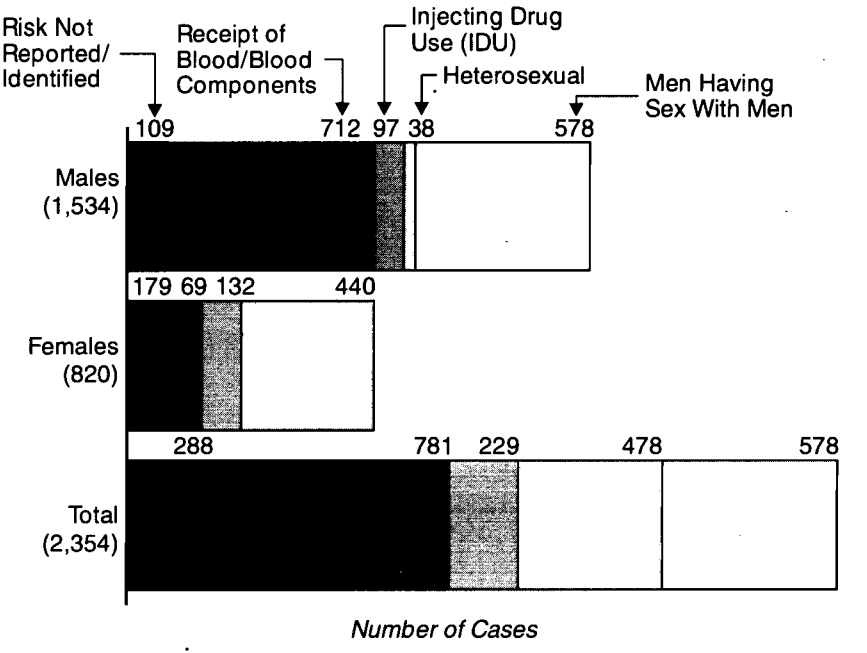
Thirty-five percent of adolescent AIDS cases were among females. Of those, 54% acquired HIV infection through heterosexual contact. Twenty-four percent had sex partners who were injecting drug users, while 16% were injecting drug users themselves.

NOTES:

- *Receipt of Blood/Blood components: Received clotting factor for hemophilia/coagulation disorder Received blood transfusion, blood components, or tissue*
- *The category "Men Who Have Sex with Men" includes men who have sex with men and also inject drugs*
- *Heterosexual contact includes sex with: an injecting drug user; a person with hemophilia; a transfusion recipient infected with HIV; an HIV-infected person, risk not specified; a bisexual male (females only)*
- *On January 1, 1993, the AIDS case definition for adults and adolescents, aged 13 years and older, was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/μL or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.*

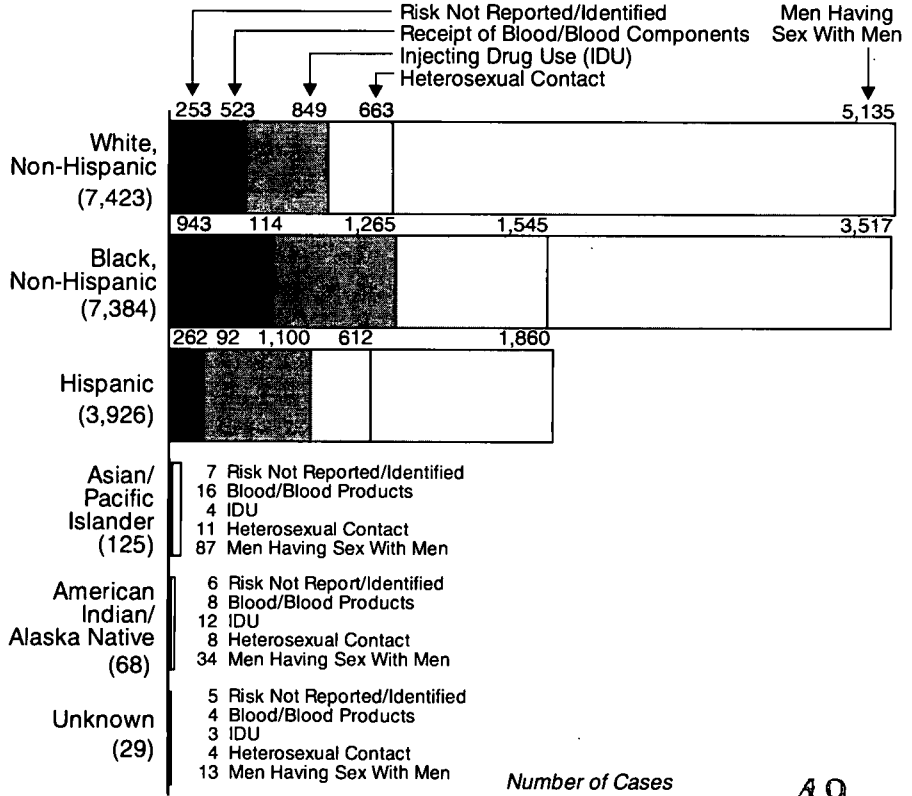
Adolescent AIDS Cases by Gender and Exposure Category for Ages 13-19: 1981-1995

Source (II.21): Centers for Disease Control and Prevention



Young Adult AIDS Cases by Race/Ethnicity and Exposure Category for Ages 20-24: 1981-1995

Source (III.22): Centers for Disease Control and Prevention



YOUNG ADULT AIDS

As of December 31, 1995, 18,955 cases of AIDS were reported in young adults aged 20-24 years. This total includes 2,432 newly reported cases in 1995.

Across all racial/ethnic groups, men who have sex with men is the major exposure category associated with known AIDS cases in young adults. Young adult women (24% of known AIDS cases in this age group) are exposed to HIV primarily through injecting drug use (31%) or through sex with an injecting drug user (25%).

Due to the long latency period (median of 10 years to severe opportunistic infections), the majority of young adults with AIDS were most likely infected during adolescence.

NOTES:

- *Receipt of Blood/Blood components:*
  Received clotting factor for hemophilia/coagulation disorder
  Received blood transfusion, blood components, or tissue
- *The category "Men Who Have Sex with Men" includes men who have sex with men and also inject drugs*
- *Heterosexual contact includes sex with: an injecting drug user; a person with hemophilia; a transfusion recipient infected with HIV; an HIV-infected person, risk not specified; a bisexual male (females only)*
- *On January 1, 1993, the AIDS case definition for adults and adolescents, aged 13 years and older, was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/μL or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.*

SUBSTANCE ABUSE

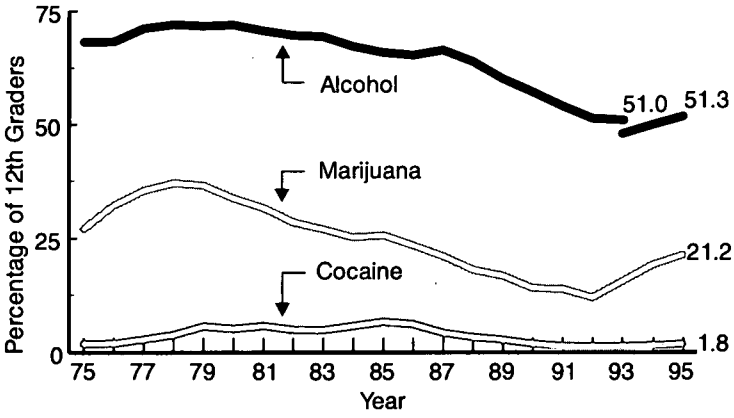
Drug use among U.S. secondary school students rose again in 1995, continuing a trend that began in 1991 among 8th grade students, and in 1992, among 10th and 12th graders. Beliefs about the harmfulness of drugs have proven to be important determinants of use.

Although alcohol use rates decreased steadily from 1987 to 1993, use has increased for the past two years. Alcohol is still the most widely used substance among 12th graders. In 1995, over 51% of 12th graders reported using alcohol within the 30 days prior to the survey.

In 1995, the use of marijuana continued the strong resurgence that began in the early 1990s. The percentage of 12th graders reporting daily use increased from 1.9% to 4.6% between 1992 and 1995. The use of cocaine continued to increase slightly.

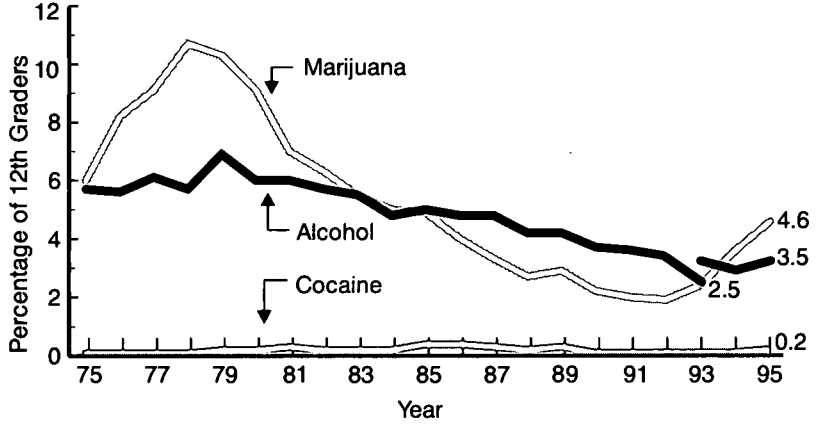
Long-Term Trends in Thirty-Day Prevalence of Use of Various Types of Drugs for Twelfth Graders: 1975-1995

Source (III.23): The Monitoring the Future Study, University of Michigan



Long-Term Trends in Thirty-Day Prevalence of **Daily** Use of Various Types of Drugs for Twelfth Graders: 1975-1995

Source (III.23): The Monitoring the Future Study, University of Michigan



NOTE: As of 1993, half of the surveys included a new question on alcohol: "On how many occasions, if any, have you had an alcoholic beverage to drink—more than just a few sips?" By 1994, all of the surveys incorporated this question. The syntax before 1993 was, "On how many occasions, if any, have you had alcohol to drink?"

CIGARETTE SMOKING

Trends in Thirty Day Prevalence

The University of Michigan's Institute for Social Research has found that cigarette smoking rose again in 1995 among American youth. This is the fourth year in a row that cigarette smoking increased for 8th and 10th graders, and the third year in a row for high school seniors. One in three high school seniors said that they had smoked cigarettes 30 days prior to the survey.

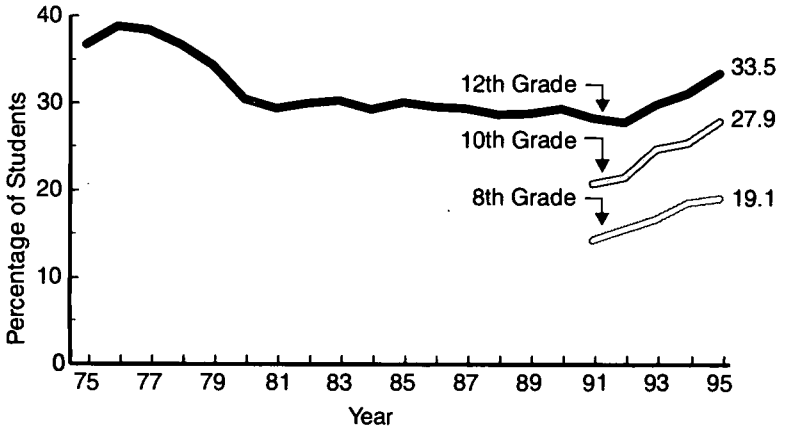
Increased smoking rates will have severe, lifelong consequences for this generation because a large proportion of those who initiate smoking in adolescence will continue to smoke for the rest of their lives. Hundreds of thousands of each graduating class may die prematurely as a result of cigarette smoking.

Trends in Attitudes

Among American youth, both disapproval and perceived risk of cigarette smoking have been declining over the past several years, while the prevalence of smoking has increased. Three-fourths (76%) of 8th graders say they can get cigarettes fairly easily; by 10th grade, over 90% say cigarettes are easily attainable.

Long-Term Trends in Thirty-Day Prevalence of Cigarette Smoking for 8th, 10th, and 12th Graders, 1975-1995

Source (III.24): The Monitoring the Future Study, The University of Michigan



Trends in Attitudes About Smoking One or More Packs of Cigarettes Per Day for 10th Graders: 1991-1995

Source (III.24): The Monitoring the Future Study, The University of Michigan

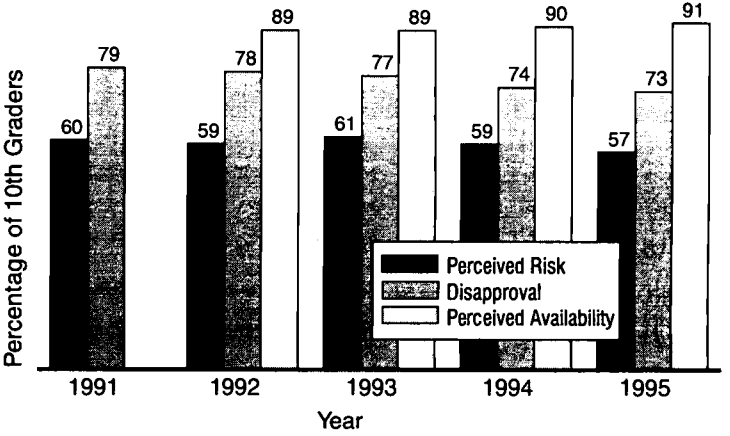


Photo Courtesy of Bruce Stromberg/The Children's Hospital of Philadelphia

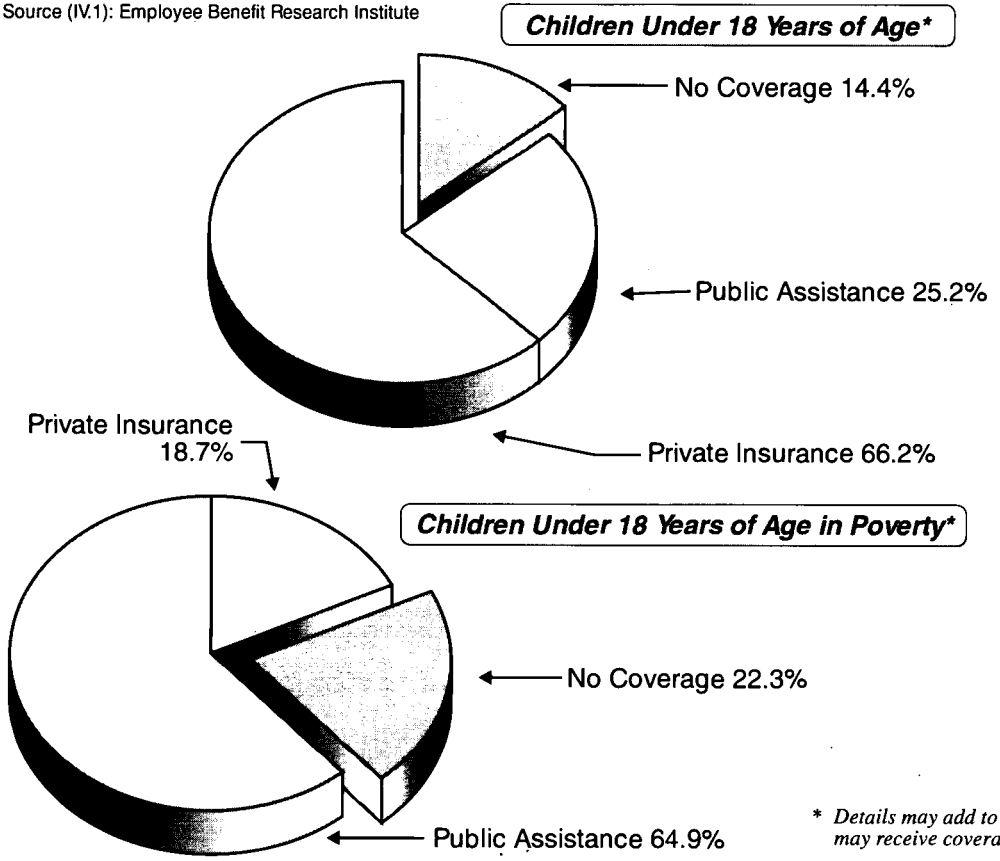
The availability of and access to quality health care directly affect the health of mothers and children; especially those at high risk due to medical or low socio-economic status. To date, there is no universal health care coverage for women and children in the United States. It is estimated that over 14% of children younger than 18 had no health insurance coverage in 1994.

As states implement alternative service delivery environments such as Medicaid managed care, monitoring and quality assurance will become increasingly important.

The following section presents both national and state data on the utilization of health services within the maternal and child population. The most current data are summarized by source of payment, type of care, and place of service delivery. Data are stratified by age, ethnicity, and income.

Health Insurance Coverage: 1994

Source (IV.1): Employee Benefit Research Institute



HEALTH CARE FINANCING

A 1996 report from the Employee Benefit Research Institute indicated that 14.4%, or 10.0 million children younger than 18 years of age, had no insurance coverage in 1994.

Some 25.2% of children were publicly insured, primarily through Medicaid, and 66.2% were covered by private insurance.

Of children younger than 18 whose families lived in poverty, 64.9% were publicly insured and 18.7% had private coverage. However, 22.3% of children in poverty had no health coverage in 1994.

* *Details may add to more than 100% because individuals may receive coverage from more than one source.*

VACCINATION COVERAGE LEVELS

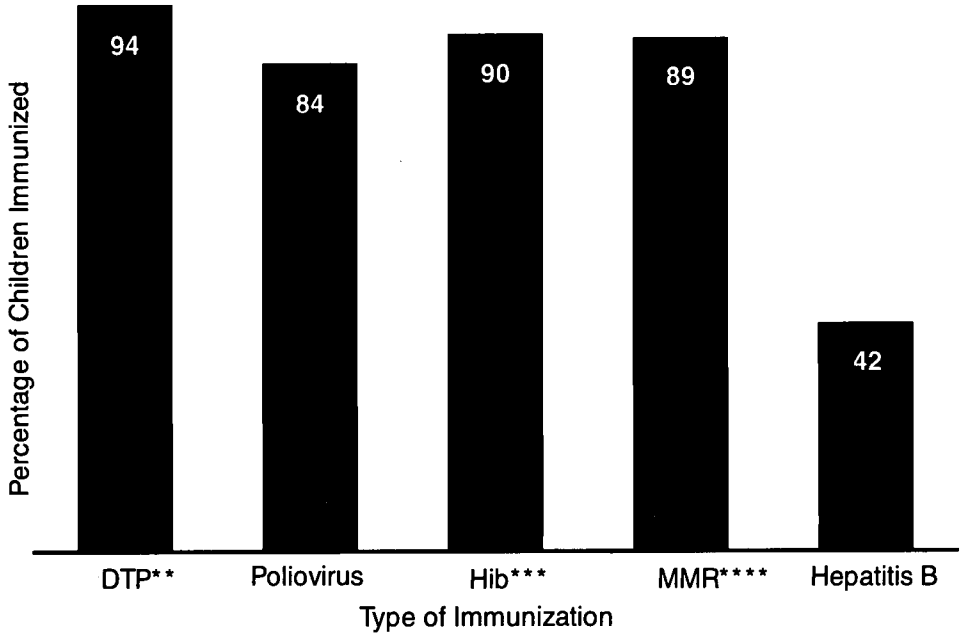
The National Immunization Survey is a single survey providing state and national estimates of vaccination coverage levels among children aged 19-35 months. All children included in the survey were born after October 1990. CDC implemented the NIS in April 1994 as one element of the five-part Childhood Immunization Initiative.

Vaccination coverage estimates are the highest ever recorded in the United States. However, more than one million children still lack one or more doses of the recommended vaccines. Coverage for the Hepatitis B vaccine was not incorporated into the vaccination schedule until 1990.

Coverage levels varied substantially nation-wide. States in the Middle Atlantic, South Atlantic, and West North Central regions (with the exception of South Dakota and Nebraska) had the highest coverage levels (>75%), while Mountain and Pacific states (with the exception of Arizona and Colorado) had the lowest coverage levels (61-74%).

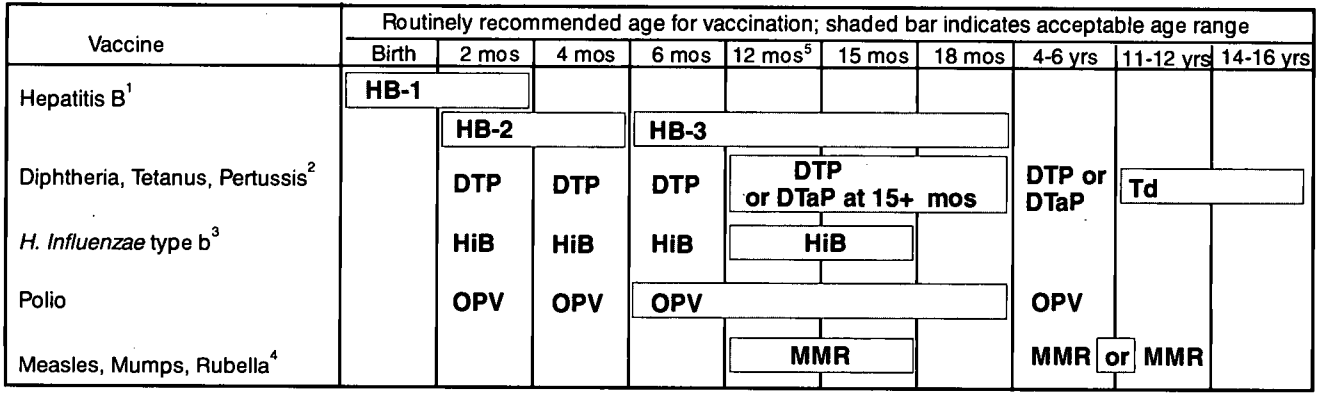
Vaccination Coverage Levels Among Children Aged 19-35 Months, by Selected Vaccines: 1994-1995*

Source (IV.2): Centers for Disease Control and Prevention



*Data are from April 1994 through March 1995
**DTP: Diphtheria and Tetanus toxoids and pertussis vaccine, ≥3 doses
***Hib: Haemophilus infuenzae type b ≥3 doses
****MMR: measles-mumps-rubella ≥1 dose

Recommended Childhood Immunization Schedule, United States, 1995*



** Approved by the Advisory Committee on Immunization Practices (ACIP), the Committee on Infectious Diseases (COID), the American Academy of Pediatrics (AAP), the AAP Executive Board, and the Commission on Public Health and Scientific Affairs (CoPHSA), American Academy of Family Physicians (AAFP).*

[1] All pregnant women should be screened for HBaAg in an early prenatal visit; infants born to HBaAg-positive mothers should receive immunoprophylaxis for hepatitis B with 0.5 ml Hepatitis B Immune Globulin (HBIG) within 12 hours of birth, and 0.5 ml of either Merck Sharpe & Dohme vaccine (Recombivax HB) or of Smith Kline Beecham vaccine (Engerix-B) at a separate site. In these infants, the second dose of vaccine is recommended at 1 month of age and the third dose at 6 months of age. For infants of HBaAg-negative mothers, the second dose of Hepatitis B vaccine may be administered between 1 and 4 months of age, provided at least one month has elapsed since receipt of the first dose. The third dose is recommended between 6 and 15 months of age.

[2] The fourth dose of DTP may be administered as early as 12 months of age, provided at least 6 months have elapsed since DTP3. Combined DTP-Hib products may be used when these two vaccines are to be administered simultaneously. DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is licensed for use for the 4th and/or 5th dose of DTP vaccine in children 15 months of age or older and may be preferred for these doses in children in this age group.

[3] Three H. influenzae type b conjugate vaccines are available for use in infants; HbOC [Hib TITER] (Lederle Praxis); PRP-T [ActHIB; OmniHIB] (Pasteur Merieus, distributed by Smith Kline Beecham; Connaught); and PRP-OMP [PedvaxHIB] (Merck Sharp & Dohme). Children who have received PRP-OMP at 2 and 4 months of age do not require a dose at 6 months of age. After the primary infant Hib conjugate vaccine series is completed, any licensed Hib conjugate vaccine may be used as a booster dose at age 12-15 months.

[4] The second dose of MMR vaccine should be administered EITHER at 4-6 years of age OR at 11-12 years of age.

[5] Vaccines recommended in the second year of life (12-15 months of age) may be given at either one of two visits.

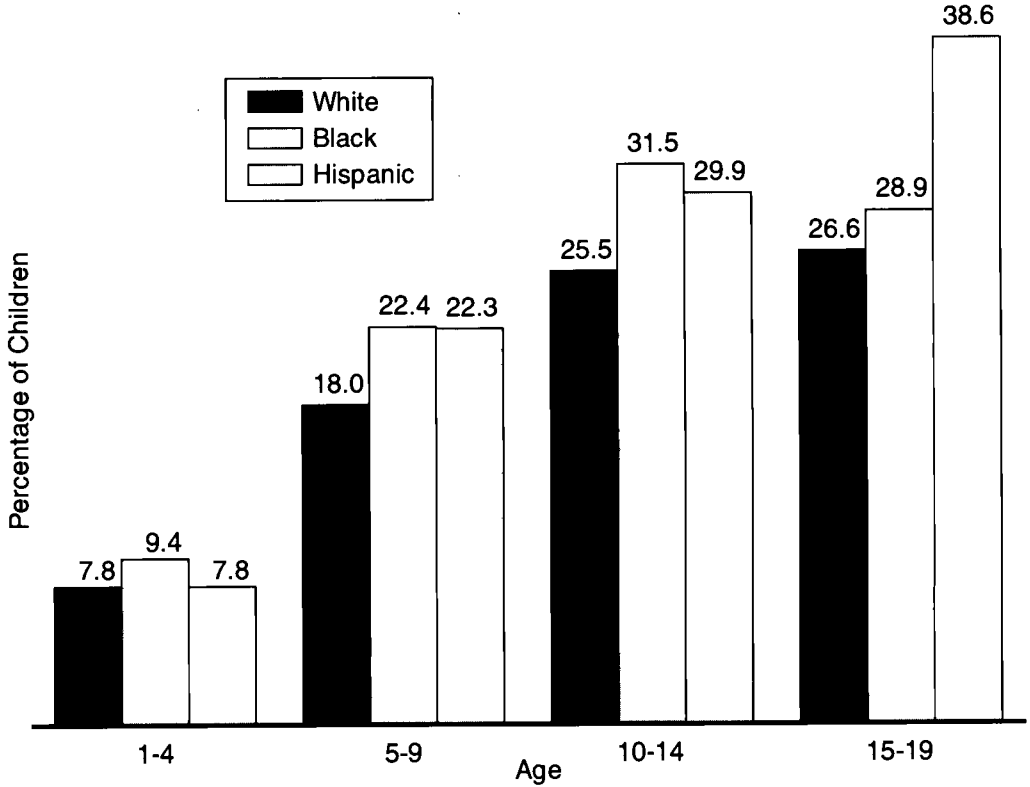
PHYSICIAN VISITS

In 1994, nearly 20.7% of children younger than 20 years of age, or 15.5 million children, were not seen by a physician in the past year. In all age groups, a higher percentage of black children than white children had not been seen by a physician in the past year.

During 1994, 7.8% of white, 9.4% of black, and 7.8% of Hispanic origin children ages 1-4 were not seen by a physician.

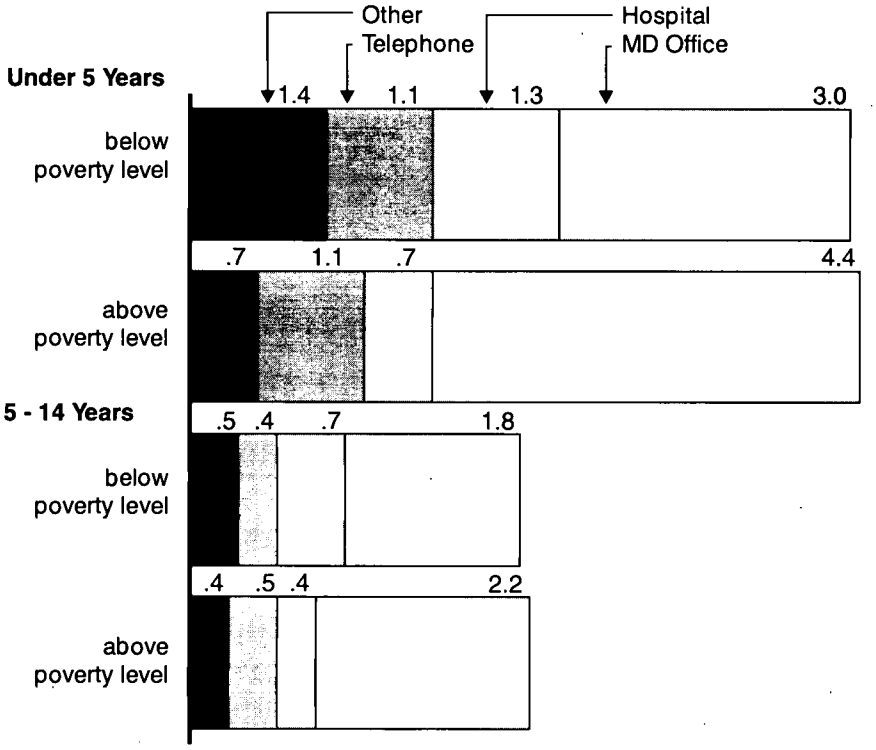
Percentage of Children with No Physician Visits in the Past Year, by Age and Race/Ethnicity: 1994

Source (IV.3): National Center for Health Statistics



Place of Physician Contact by Age and Poverty Status: 1994

Source (IV.4): National Center for Health Statistics



PLACE OF PHYSICIAN CONTACT

Among children who saw a physician during the past year, children younger than 5 years old averaged more physician contacts than school-age children.

Children whose family income was above the poverty level used more physician services than children in poverty.

Children in poverty were more likely to see physicians in hospitals and other places and less likely to see physicians in offices than children above poverty.

However, from 1993 to 1994, the number of physician contacts per child in a physician's office increased for children aged 1-14 years in poverty, while it decreased for children younger than 5 years old in poverty.

HOSPITAL UTILIZATION

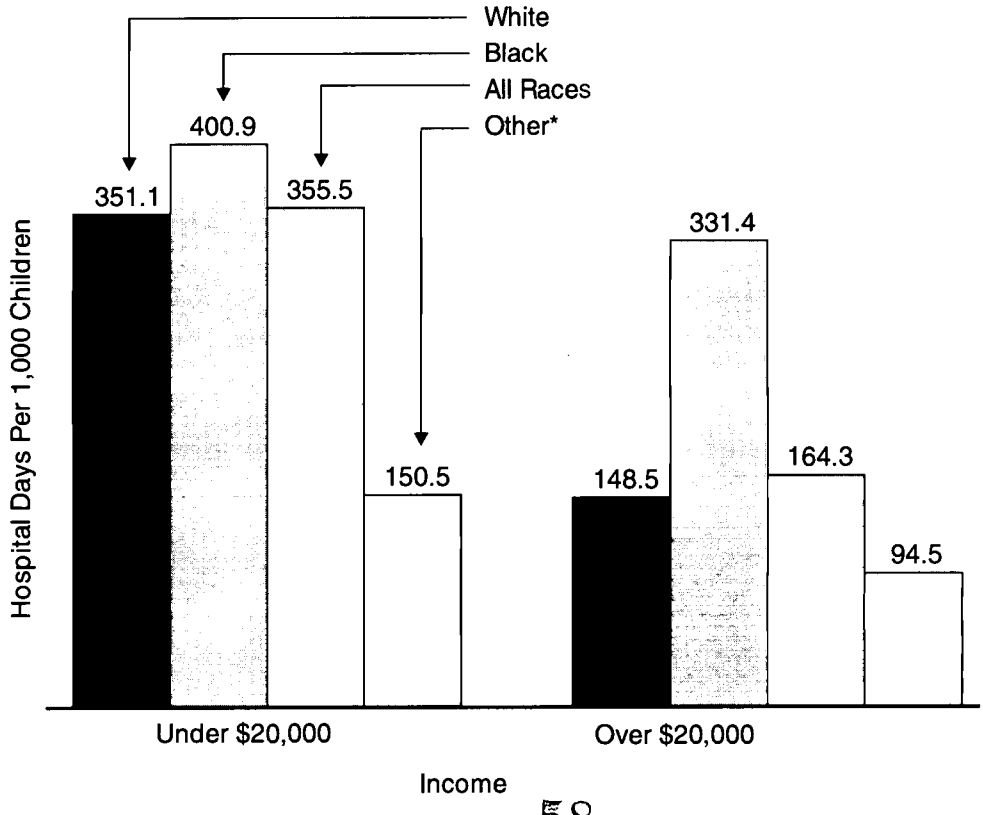
In 1994, children younger than age 18 in families with incomes less than $20,000 averaged 1.5 times more hospital days per 1,000 children than children from higher income families.

Regardless of income status, black children younger than 18 years of age had the highest number of hospital days per 1,000 children.

**Other includes:*
Indian (American)
Eskimo
Aleut
Chinese
Filipino
Hawaiian
Korean
Vietnamese
Japanese
Asian Indian
Samoan
Guamanian
Other Asian Pacific Islanders
Other Race
Multiple Race
Unknown

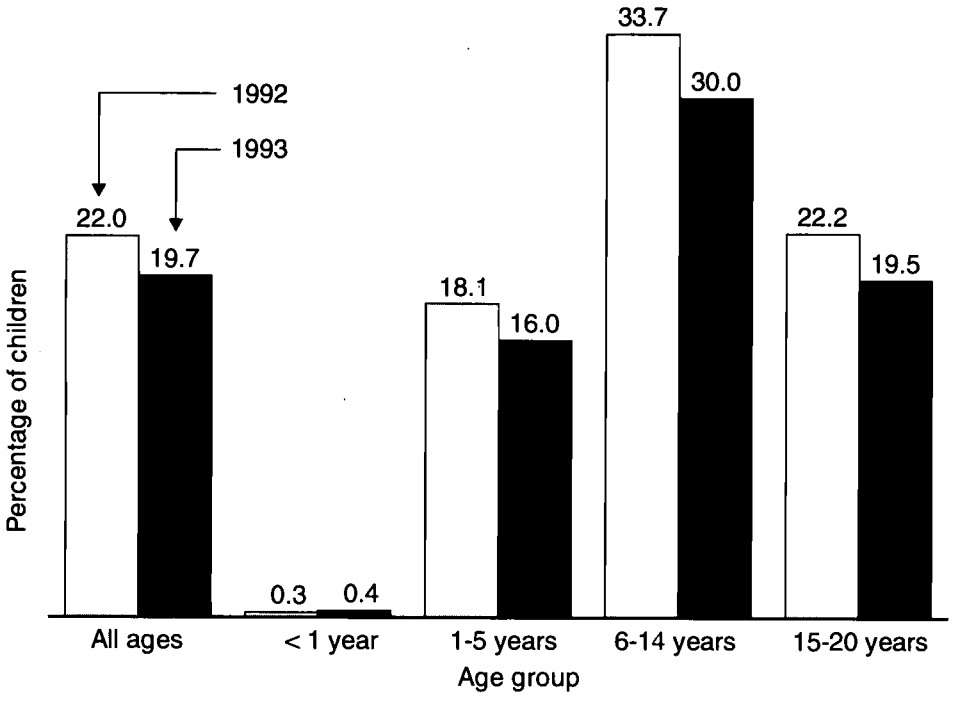
Hospital Utilization by Income and Race: 1994

Source (IV.5): National Center for Health Statistics



Percentage of EPSDT* Children Who Received Preventive Dental Services: 1992-1993

Source (IV.6): Office of Inspector General



Early and Periodic Screening, Diagnosis, and Treatment

ACCESS AND UTILIZATION OF PREVENTIVE DENTAL SERVICES

Few children receive EPSDT dental services; the extent of the problem varies significantly from state to state. In 1993, only 1 in 5 (4.2 million out of 21.2 million) eligible Medicaid-enrolled children received preventive dental services. This was a 2.3% decrease from the 1992 rate of 1 in 4.5 children.

In 1993, three fourths of the states provided preventive dental services to fewer than 30 percent of all eligible children, while none of the states provided services to 50 percent. The Department of Health and Human Services' Healthy People 2000 Objective is "to increase to at least 90 percent the proportion of all children entering school programs for the first time who have received an oral health screening, referral, and follow-up for necessary diagnostic, preventive, and treatment services."

The proportion of eligible Medicaid-enrolled children receiving preventive dental services decreased for all age groups from 1992 to 1993. Although the American Academy of Pediatric Dentists recommends that dentists examine all children before their first birthday, only a small fraction of Medicaid children receive these services.

SERVICE UTILIZATION BY CHILDREN WITH CHRONIC CONDITIONS

Physician Utilization

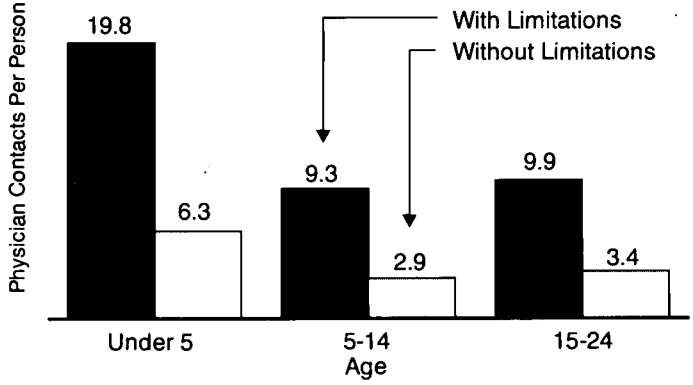
In 1994, children who were limited in activities had three times as many physician contacts as children without chronic conditions. The number of physician contacts per person for ages 15 to 24 remained stable from 1993 to 1994, while it decreased for all others.

Hospital Utilization

Children with chronic conditions spend about 10 times as many days in the hospital as children without activity limitations.

Physician Utilization by Children with Chronic Activity Limitations, by Age: 1994

Source (IIV.7): National Center for Health Statistics



Hospital Utilization by Children with Chronic Activity Limitations, by Age: 1994 (Excluding Deliveries)

Source (IV.7): National Center for Health Statistics

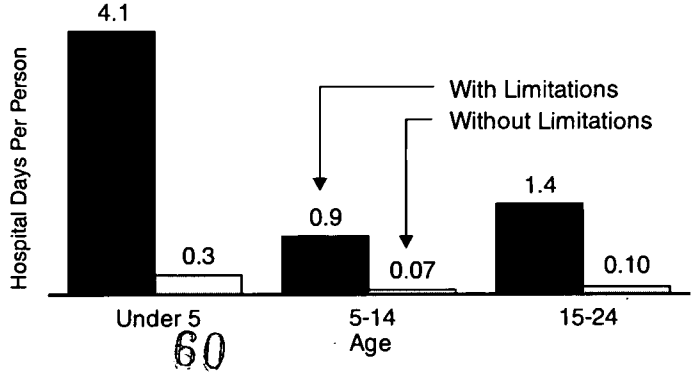


Photo Courtesy of the Hospital for Sick Children

PRENATAL CARE

Early Prenatal Care

Overall, 80% of all mothers received prenatal care in the first trimester of pregnancy in 1994.

There is substantial racial disparity in the timely receipt of prenatal care. In 1994, 83% of white mothers, as compared to 68% of black mothers, received early prenatal care.

Women younger than 20 years of age are less likely than older women to receive early prenatal care.

No Prenatal Care

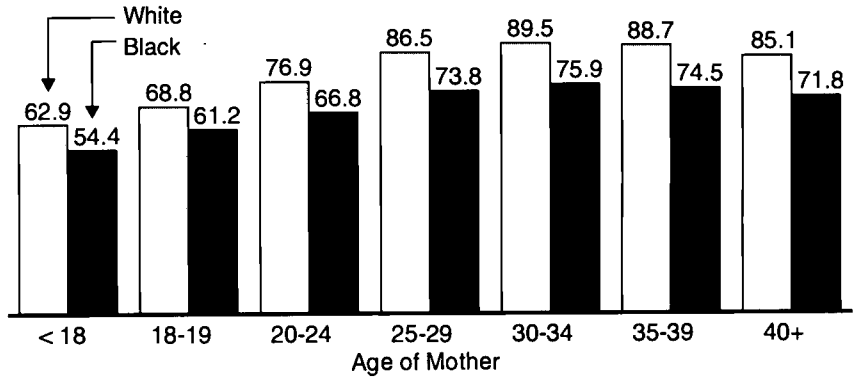
Every year from 1983 to 1991, 6% of infants were born to mothers who initiated care during the third trimester or received no prenatal care. However, that figure dropped to 4% in 1994.

Regardless of age, black women are less likely to receive prenatal care than are white women.

Risk factors for not receiving prenatal care include being less than 18 years of age, unmarried status, low educational attainment and being in a minority group.

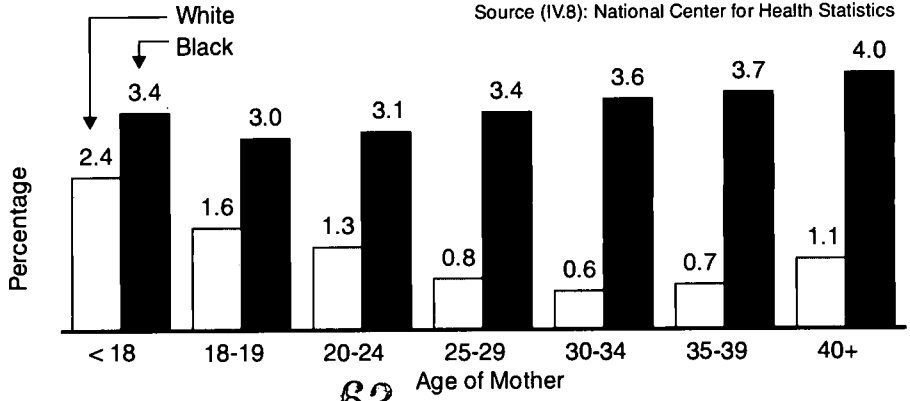
Percentage of Women with Early Prenatal Care, by Age and Race of Mother: 1994

Source (IV.8): National Center for Health Statistics



Percentage of Women with No Prenatal Care, by Age and Race of Mother: 1994

Source (IV.8): National Center for Health Statistics



Infant and Neonatal Mortality Rates, by Race of Mother and State, 1993, and Perinatal Mortality Rates, by Race of Mother and State: 1992

Source (V.1): National Center for Health Statistics

State	Infant Mortality [1]			Perinatal Mortality [2]			Neonatal Mortality [3]		
	All*	White	Black	All*	White	Black	All*	White	Black
UNITED STATES	**8.4**	**6.8**	**16.5**	**8.5**	**7.2**	**15.4**	**5.3**	**4.3**	**10.7**
ALABAMA	10.3	7.9	15.1	11.0	8.4	16.1	6.6	5.0	9.8
ALASKA	8.2	6.3	**	6.3	5.7	**	4.6	3.7	**
ARIZONA	7.6	6.9	22.1	7.6	7.1	11.8	4.9	4.5	13.3
ARKANSAS	10.0	9.1	13.4	9.7	8.2	14.4	5.8	5.1	8.7
CALIFORNIA	6.8	6.3	15.6	7.3	6.9	14.6	4.2	3.8	9.7
COLORADO	7.9	7.4	17.0	7.4	7.1	13.5	4.2	4.0	8.5
CONNECTICUT	7.1	5.8	15.6	8.4	6.9	17.9	5.0	4.1	11.6
DELAWARE	8.8	5.7	19.9	8.7	6.8	14.4	6.4	4.2	14.5
DISTRICT OF COL.	17.4	**	20.6	17.5	**	20.0	12.2	**	14.5
FLORIDA	8.6	6.6	15.3	9.0	7.4	14.2	5.6	4.2	10.0
GEORGIA	10.4	7.2	16.3	10.8	7.3	16.7	6.8	4.5	10.9
HAWAII	7.2	3.8	**	5.7	5.0	**	5.3	**	**
IDAHO	7.2	7.0	**	7.9	8.0	**	3.6	3.6	**
ILLINOIS	9.9	7.1	19.6	9.9	7.8	17.4	6.3	4.6	12.5
INDIANA	9.2	8.0	18.3	9.5	8.4	18.4	5.5	4.9	11.1
IOWA	6.9	6.4	22.9	7.6	7.3	**	4.1	3.8	**
KANSAS	8.8	7.5	23.5	7.8	7.2	14.1	5.5	4.7	14.5
KENTUCKY	8.2	7.6	14.3	7.5	7.0	12.6	5.1	4.7	8.7
LOUISIANA	10.8	7.4	15.6	9.1	7.4	11.7	6.8	4.5	10.0
MAINE	6.8	6.9	**	6.8	6.5	**	4.4	4.5	**
MARYLAND	9.8	6.3	17.6	9.9	7.3	15.6	6.8	4.3	12.2
MASSACHUSETTS	6.2	5.7	11.4	7.1	6.6	12.3	4.5	4.0	8.7
MICHIGAN	9.5	7.1	18.8	8.6	6.9	15.9	6.2	4.6	12.5
MINNESOTA	7.5	7.1	14.1	7.2	6.7	16.4	4.6	4.4	7.8
MISSISSIPPI	11.5	8.4	14.7	12.3	8.2	16.8	7.1	5.3	9.1
MISSOURI	8.4	7.1	14.8	8.0	6.8	14.0	5.2	4.4	8.9
MONTANA	7.4	6.9	**	7.0	6.8	**	4.5	4.4	**
NEBRASKA	9.1	8.3	26.2	6.8	6.4	**	5.3	4.8	**
NEVADA	6.7	6.2	14.0	6.1	5.6	11.5	3.4	3.3	**
NEW HAMPSHIRE	5.6	5.7	**	5.7	5.5	**	3.6	3.7	**
NEW JERSEY	8.3	6.1	17.5	8.6	6.8	16.5	5.5	4.2	11.2
NEW MEXICO	8.4	7.3	**	6.1	5.9	**	4.6	4.3	**
NEW YORK	8.4	6.6	15.4	9.9	8.1	17.0	5.7	4.6	10.3
NORTH CAROLINA	10.5	7.7	17.1	10.6	7.9	16.8	7.3	5.2	12.3
NORTH DAKOTA	7.9	7.9	**	7.7	7.3	**	4.6	4.8	**
OHIO	9.2	7.6	17.9	8.8	7.7	14.8	6.0	5.0	11.5
OKLAHOMA	8.8	8.3	16.4	9.0	8.6	12.5	4.5	3.9	10.9
OREGON	7.2	7.0	**	6.5	6.4	**	3.7	3.6	**
PENNSYLVANIA	8.6	6.6	19.7	9.2	7.8	16.9	5.8	4.7	12.5
RHODE ISLAND	7.3	7.1	**	8.2	7.6	**	4.9	4.9	**
SOUTH CAROLINA	10.1	6.7	15.7	10.7	7.4	16.2	6.8	4.4	10.9
SOUTH DAKOTA	9.5	7.6	**	8.9	8.3	**	4.9	4.2	**
TENNESSEE	9.4	6.7	17.9	8.6	6.5	15.2	5.5	3.8	11.0
TEXAS	7.5	6.5	14.6	7.4	6.7	12.1	4.5	4.0	8.5
UTAH	6.0	6.0	**	6.0	6.1	**	3.0	3.1	**
VERMONT	6.7	6.7	**	7.0	7.1	**	4.6	4.5	**
VIRGINIA	8.7	6.7	14.9	8.3	6.2	15.0	5.8	4.4	10.2
WASHINGTON	6.4	6.0	17.8	6.3	6.0	15.5	3.2	3.1	9.2
WEST VIRGINIA	8.6	8.1	**	8.7	8.7	**	5.8	5.7	**
WISCONSIN	7.9	7.0	16.0	7.5	6.8	12.1	4.7	4.2	9.1
WYOMING	7.9	7.9	**	7.3	7.1	**	4.6	4.7	**

* *Rates include races other than black and white.*

** *Fewer than 20 deaths, rates not shown.*

1. *Rates are deaths less than one year per 1,000 live births in specified group.*
2. *Rates are fetal deaths ≥ 28 weeks and infant deaths < 7 days per 1,000 live births and specified fetal deaths.*
3. *Rates are deaths under 28 days per 1,000 live births in specified group.*

Percentage of Low Birth Weight* Infants, Women Receiving First Trimester Prenatal Care, and Births to Women Under 18, by Race of Mother and State: 1993

Source (V.2): National Center for Health Statistics

State	Percentage Low Birth Weight			Percentage With Early Prenatal Care			Percentage of Births to Women <18			
	All	White	Black	All	White	Black	All	White	Black	Hispanic
UNITED STATES	**7.2**	**6.0**	**13.3**	**78.9**	**81.8**	**66.0**	**5.1**	**4.0**	**10.5**	**7.2**
ALABAMA	8.7	6.6	12.6	80.1	86.8	67.6	7.5	5.0	12.4	5.3
ALASKA	4.9	4.5	9.4	83.3	85.9	85.6	3.9	2.9	5.3	**
ARIZONA	6.7	6.4	13.4	69.9	71.5	64.5	5.9	5.6	10.5	8.8
ARKANSAS	8.2	6.9	12.5	73.8	78.4	58.5	7.5	5.5	14.2	4.5
CALIFORNIA	6.0	5.4	12.6	76.8	76.7	74.3	4.8	4.8	7.9	6.6
COLORADO	8.4	8.0	14.9	79.5	80.5	67.4	4.7	4.5	9.5	10.4
CONNECTICUT	6.9	6.0	12.3	88.0	90.0	74.3	3.4	2.7	7.3	10.8
DELAWARE	7.8	5.8	14.2	82.2	86.5	67.9	5.1	3.3	11.3	9.5
DISTRICT OF COL.	14.6	5.7	16.7	54.9	81.1	50.5	8.1	1.4	9.7	5.8
FLORIDA	7.5	6.1	12.1	80.2	84.1	67.4	5.5	3.8	11.2	4.8
GEORGIA	8.7	6.3	13.0	78.7	84.7	68.4	6.7	4.5	11.0	5.5
HAWAII	6.8	5.2	11.9	74.5	78.7	71.0	3.4	1.3	**	6.5
IDAHO	5.3	5.2	**	78.0	78.5	77.8	4.8	4.7	**	8.3
ILLINDIS	8.1	5.9	15.3	79.3	83.6	64.8	5.3	3.3	12.4	6.4
INDIANA	7.0	6.2	12.9	79.1	81.1	62.8	5.1	4.1	12.7	6.9
IOWA	5.7	5.5	12.6	86.8	87.4	72.3	3.8	3.5	12.8	7.4
KANSAS	6.6	6.0	12.8	83.7	85.2	71.5	4.5	3.8	11.7	8.1
KENTUCKY	7.1	6.6	12.5	81.2	82.7	66.5	6.5	5.9	13.0	5.0
LOUISIANA	9.3	6.2	13.5	77.4	85.9	66.4	8.1	4.5	12.9	4.1
MAINE	5.4	5.4	**	88.0	88.2	87.7	3.4	3.3	**	**
MARYLAND	8.5	5.9	13.7	85.3	91.2	73.5	4.2	2.2	8.5	3.9
MASSACHUSETTTS	6.2	5.7	10.6	88.0	89.7	77.2	3.0	2.5	6.7	9.9
MICHICAN	7.6	5.9	14.3	81.8	85.6	67.0	4.8	3.2	11.1	8.7
MINNESOTA	5.5	5.0	11.9	82.9	85.6	57.0	3.0	2.3	12.7	9.2
MISSISSIPPI	10.1	6.7	13.7	74.9	84.9	64.5	9.5	5.3	13.9	**
MISSOURI	7.5	6.3	13.4	81.5	85.1	64.8	5.4	4.0	12.4	7.5
MONTANA	6.0	5.9	**	80.5	82.7	76.6	4.5	3.6	**	**
NEBRASKA	5.9	5.5	12.0	83.2	84.7	66.6	3.5	2.9	10.4	7.5
NEVADA	7.4	6.5	15.4	73.1	74.8	58.7	5.1	4.5	11.3	6.6
NEW HAMPSHIRE	5.0	4.9	**	88.5	88.6	74.0	2.0	2.0	**	**
NEW JERSEY	7.6	6.1	13.5	81.6	86.1	62.9	3.3	2.0	8.7	6.6
NEW MEXICO	7.3	7.3	12.5	63.9	66.8	59.3	7.4	7.5	11.6	10.5
NEW YORK	7.7	6.2	13.0	74.6	79.3	59.0	3.8	2.9	7.4	6.4
NORTH CAROLINA	8.6	6.6	13.4	80.7	86.8	66.7	6.1	4.0	11.0	5.2
NORTH DAKOTA	5.3	5.3	**	82.8	84.1	86.5	2.9	2.3	**	**
OHIO	7.5	6.3	13.9	83.7	86.6	68.9	5.2	4.0	11.6	9.0
OKLAHOMA	6.7	6.1	12.3	74.3	77.4	58.9	6.3	5.2	11.7	8.9
OREGON	5.2	5.1	11.4	79.5	80.0	68.2	4.6	4.4	13.2	7.7
PENNSYLVANIA	7.4	6.0	14.6	80.8	84.9	58.7	4.2	3.0	11.0	11.7
RHODE ISLAND	6.5	5.9	10.8	89.2	90.8	76.3	4.3	3.6	9.3	9.2
SOUTH CAROLINA	9.3	6.7	13.6	73.5	82.5	59.1	6.6	4.2	10.5	4.5
SOUTH DAKOTA	5.5	5.3	**	79.9	83.4	80.3	3.9	2.7	**	**
TENNESSEE	8.8	7.0	14.4	81.2	85.4	68.2	6.5	4.9	11.7	4.9
TEXAS	7.1	6.2	13.1	71.9	72.7	65.1	6.6	6.1	10.8	8.5
UTAH	5.9	5.9	8.7	85.7	86.6	72.7	3.9	3.8	7.2	9.3
VERMONT	5.7	5.6	**	85.1	85.4	**	2.6	2.6	**	**
VIRGINIA	7.3	5.6	12.3	82.8	87.4	70.1	4.1	2.7	8.5	3.9
WASHINGTON	5.2	4.9	11.3	80.7	81.8	70.4	4.0	3.8	8.8	7.9
WEST VIRGINIA	7.2	7.0	12.1	79.2	79.9	60.6	6.6	6.4	11.6	**
WISCONSIN	6.1	5.2	13.7	82.2	86.0	60.9	3.8	2.5	13.5	9.2
WYOMING	7.3	7.3	**	81.2	81.9	71.7	4.8	4.7	**	8.4

** Less than 2,500 grams (5 lb. 8 oz.).*

*** Fewer than 20 occurrences.*

Number of Children Under Age 18 per Pediatrician, 1994, and Number of Children per Child Health Physician, 1994

Source (V.3): American Academy of Pediatrics

State	Total Number of Children Under Age 18	Children per Pediatrician [1]	Children per Child Health Physician [2]
UNITED STATES	**67, 351,411**	**1,689**	**1,206**
ALABAMA	1,115,653	2,412	1,573
ALASKA	192,377	2,346	1,382
ARIZONA	1,080,989	1,982	1,350
ARKANSAS	648,132	2,735	1,439
CALIFORNIA	8,364,377	1,582	1,139
COLORADO	957,849	1,797	1,167
CONNECTICUT	757,880	1,067	912
DELAWARE	175,810	1,465	1,073
DISTRICT OF COL.	111,286	437	384
FLORIDA	3,109,531	1,526	1,066
GEORGIA	1,895,638	2,064	1,460
HAWAII	301,581	1,228	963
IDAHO	334,001	4,755	2,092
ILLINOIS	3,065,261	1,647	1,198
INDIANA	1,521,948	2,788	1,541
IDWA	734,925	3,343	1,687
KANSAS	684,462	2,501	1,420
KENTUCKY	994,253	2,128	1,347
LOUISIANA	1,268,048	2,104	1,512
MAINE	314,764	2,193	1,310
MARYLAND	1,236,265	935	786
MASSACHUSETTS	1,375,134	918	805
MICHIGAN	2,541,933	2,187	1,579
MINNESOTA	1,230,449	2,110	1,167
MISSISSIPPI	778,188	3,103	1,883
MISSOURI	1,364,012	1,893	1,428
MONTANA	236,507	3,362	1,689
NEBRASKA	441,162	2,456	1,305
NEVADA	357,758	2,964	1,869
NEW HAMPSHIRE	286,055	1,727	1,188
NEW JERSEY	1,871,014	1,032	881
NEW MEXICO	487,416	2,043	1,319
NEW YORK	4,393,891	954	827
NORTH CAROLINA	1,717,467	1,857	1,254
NORTH DAKOTA	175,107	2,793	1,316
OHIO	2,901,507	1,828	1,317
OKLAHOMA	873,131	3,004	1,754
OREGON	790,254	2,347	1,440
PENNSYLVANIA	2,873,175	1,668	1,155
RHODE ISLAND	228,650	1,222	1,009
SOUTH CAROLINA	980,696	2,356	1,433
SOUTH DAKOTA	206,557	3,968	1,606
TENNESSEE	1,297,351	1,746	1,221
TEXAS	5,258,335	2,320	1,577
UTAH	692,455	2,578	1,809
VERMONT	148,477	1,442	1,000
VIRGINIA	1,620,367	1,593	1,111
WASHINGTON	1,402,142	1,951	1,143
WEST VIRGINIA	454,071	2,264	1,367
WISCONSIN	1,350,783	2,238	1,350
WYOMING	142,377	4,168	1,796

1. Pediatricians are considered to be in direct patient care if their major professional activity is office-based, or if they are full-time hospital staff members.

2. The number of child health providers is calculated by adding the total number of pediatricians to one-fourth of the family/general practitioners.

Medicaid Recipients Under Age 21 and Percentage of Pediatricians Currently Participating in Medicaid and the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), 1993

Source (V.4): American Academy of Pediatrics

State	Medicaid Recipients Under Age 21	Percentage of Pediatricians Currently Participating in Medicaid	Percentage of Pediatricians Currently Participating in EPSDT
UNITED STATES	**17,634,534**	**85.1**	**56.9**
ALABAMA	281,991	88.4	57.8
ALASKA	38,586	81.4	78.5
ARIZONA	256,502	77.2	64.9
ARKANSAS	173,918	95.8	91.5
CALIFORNIA	2,496,224	78.1	61.6
COLORADO	161,221	84.6	70.9
CONNECTICUT	167,594	87.0	44.7
DELAWARE	42,816	89.8	40.5
DISTRICT OF COL.	62,543	79.1	25.5
FLORIOA	995,422	83.1	49.2
GEORGIA	525,168	84.4	36.9
HAWAII	58,665	85.8	75.7
IDAHO	60,357	94.8	81.6
ILLINOIS	778,662	84.5	41.6
INDIANA	315,794	95.2	53.4
IOWA	149,855	94.8	66.3
KANSAS	134,528	80.7	70.9
KENTUCKY	304,407	89.2	27.4
LOUISIANA	433,958	87.9	35.9
MAINE	82,749	97.4	89.2
MARYLANO	234,309	75.1	73.5
MASSACHUSETTS	376,198	92.1	68.7
MICHIGAN	624,531	92.0	26.9
MINNESOTA	223,042	92.1	77.9
MISSISSIPPI	267,998	90.6	53.7
MISSOURI	324,912	80.6	60.7
MONTANA	47,177	100.0	87.1
NEBRASKA	97,166	98.1	90.0
NEVAOA	49,578	94.6	62.5
NEW HAMPSHIRE	41,506	94.5	87.3
NEW JERSEY	408,850	82.4	47.3
NEW MEXICO	145,684	91.8	87.1
NEW YORK	1,474,713	80.3	35.7
NORTH CAROLINA	478,765	92.6	79.3
NORTH OAKOTA	30,887	89.7	76.4
OHIO	832,484	88.0	64.6
OKLAHOMA	214,412	88.8	72.0
OREGON	185,463	94.6	88.5
PENNSYLVANIA	639,623	87.7	70.1
RHOOE ISLAND*	45,770	90.6	90.0
SOUTH CAROLINA	253,593	93.4	64.3
SOUTH OAKOTA	39,851	96.7	95.4
TENNESSEE	470,657	89.9	71.6
TEXAS	1,429,380	78.7	45.7
UTAH	89,029	94.2	81.1
VERMONT	39,523	100.0	76.4
VIRGINIA	318,892	80.1	54.8
WASHINGTON	334,580	89.5	84.1
WEST VIRGINIA	185,819	97.9	74.3
WISCONSIN	227,019	97.3	62.7
WYOMING	27,933	92.3	95.4

**Number of Medicaid recipients under age 21 is for FY 1989.*

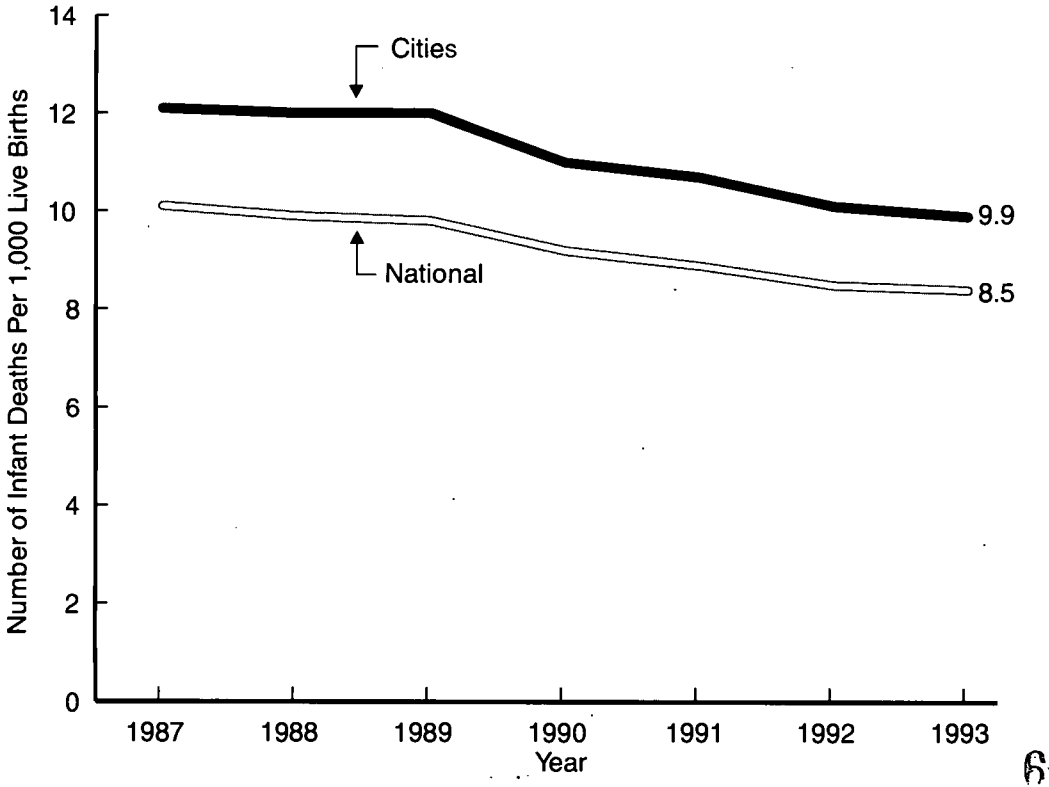
How does the health of infants and children in America's cities compare to that of children nationwide? This section includes data on infant mortality, low birth weight and prenatal care for women and children who reside in the nation's central cities with populations over 100,000.

In 1993, nearly one third of births in the U.S. were to residents of central cities with populations over 100,000. Over 64% of those births were to whites, while approximately 29% were to blacks.

As the following data indicate, the health status of children living in U.S. cities with populations over 100,000 is inferior to that of children in the nation as a whole. Lower rates of access to prenatal care combined with higher rates of low birth weight contribute to the city infant mortality rate of 9.9 deaths per 1,000 live births; the national rate is 8.5. The challenge for health service providers and special initiatives will be to eliminate these disparities by improving the health status of children in the nation's cities.

Infant Mortality Rates in U.S. Cities With Over 100,000 Population: 1987-1993

Source (VI.1): National Center for Health Statistics



INFANT MORTALITY

In 1993, 11,925 infants born to residents of U.S. cities with over 100,000 population died in the first year of life. The city infant mortality rate was 9.9 deaths per 1,000 live births, 17% higher than the rate of 8.5 for the nation as a whole. For 1992, the infant mortality rate was 10.1 per 1,000 live births. The 1993 rate of 9.9 per 1,000 live births represents a decline of 2%.

Although infant mortality in cities has steadily declined, it has routinely been higher in cities than in the nation as a whole. Between 1987 and 1993, infant mortality in cities declined approximately 18%, from 12.1 to 9.9. The decline nationwide in the same period was almost 17%, from 10.1 to 8.4 per 1,000 live births.

LOW AND VERY LOW BIRTH WEIGHT

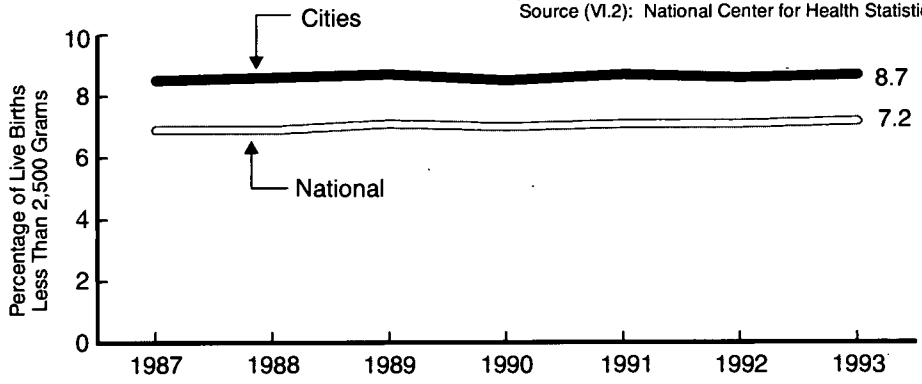
In 1993, 104,714 babies (8.7% of all live births) born to residents of U.S. cities with populations over 100,000 were of low birth weight, weighing less than 2,500 grams, or 5.5 pounds, at birth. The 1993 percentage of city infants with low birth weight was 20% higher than the national percentage of 7.2%.

Infants with birth weights less than 1,500 grams (very low birth weight, approximately 3 lbs. 5 oz.) were at highest risk of poor outcome. The 1993 very low birth weight percentage of 1.7% in cities was approximately 25% higher than the national percentage of 1.3%.

Like the nation as a whole, percentages of city infants with low birth weight and very low birth weight have not declined in recent years. Thus, the gap in low and very low birth weight between cities and the nation overall has not narrowed.

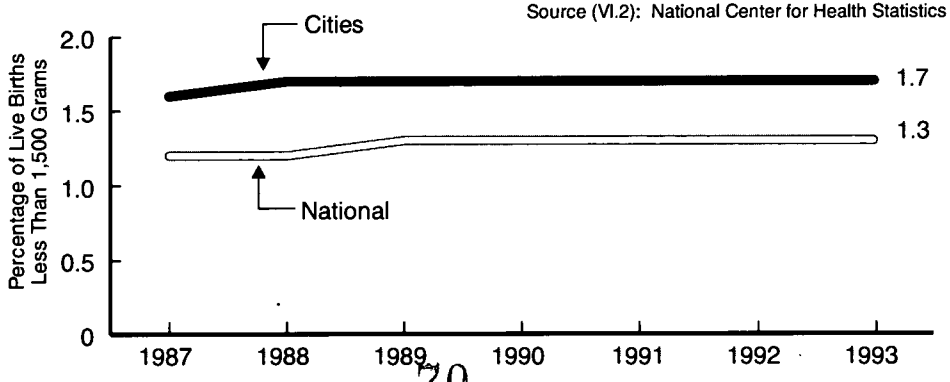
Percentage of Low Birth Weight Infants in U.S. Cities With Over 100,000 Population: 1987-1993

Source (VI.2): National Center for Health Statistics



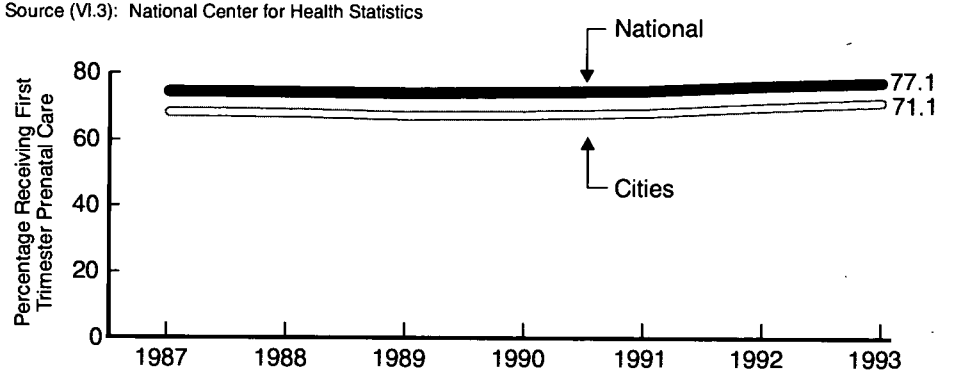
Percentage of Very Low Birth Weight Infants in U.S. Cities With Over 100,000 Population: 1987-1993

Source (VI.2): National Center for Health Statistics



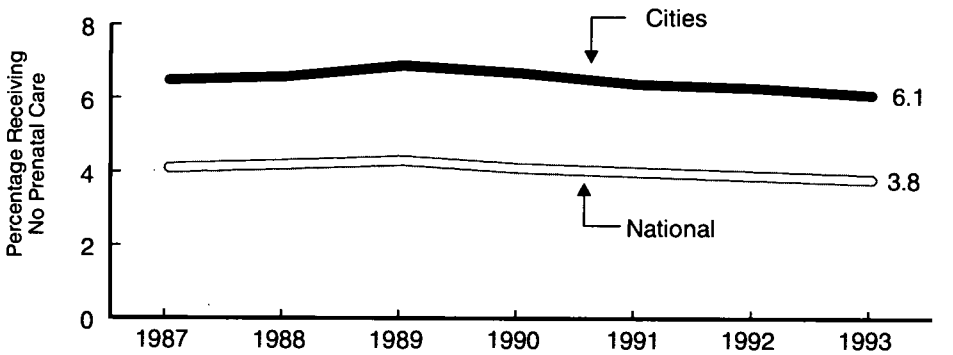
Percentage of Pregnant Women Receiving First Trimester Prenatal Care in U.S. Cities With Over 100,000 Population: 1987-1993

Source (VI.3): National Center for Health Statistics



Percentage of Pregnant Women Receiving No Prenatal Care in U.S. Cities With Over 100,000 Population: 1987-1993

Source (VI.3): National Center for Health Statistics

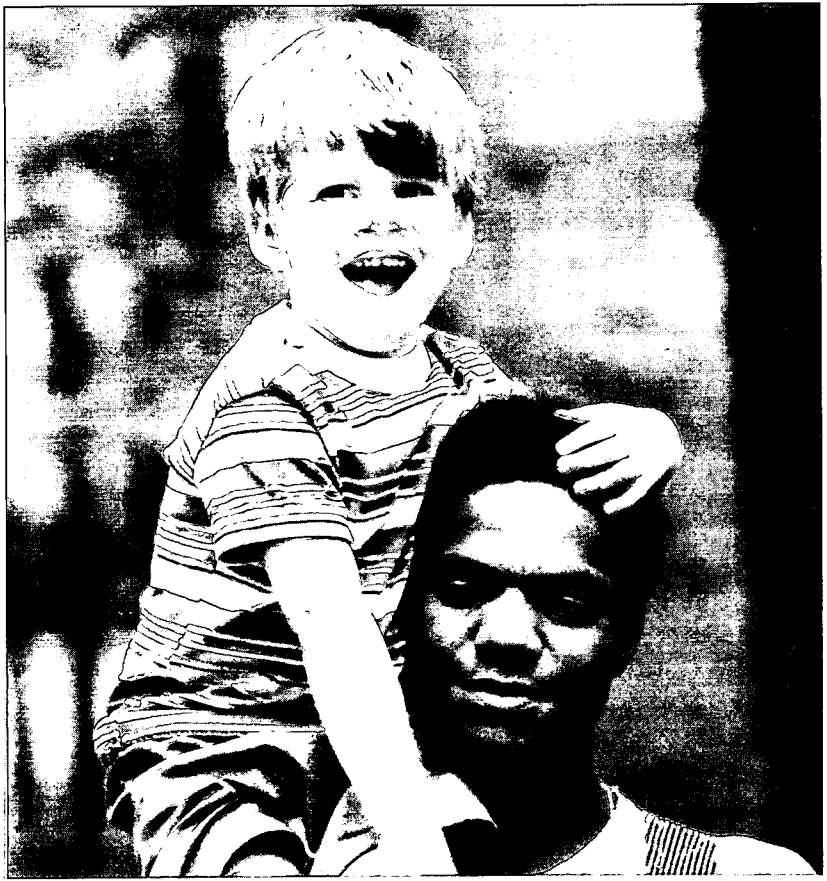


PRENATAL CARE

Women in U.S. cities are less likely to begin prenatal care in the first three months of pregnancy than are women nationwide. Since 1987, the gap in prenatal care between cities and the nation has not narrowed.

In 1993, 71.1% of pregnant women living in U.S. cities received prenatal care in the first trimester of pregnancy, compared to 77.1% of pregnant women nationwide.

The percentage of pregnant women living in U.S. cities receiving no prenatal care decreased slightly, from 6.3% to 6.1% between 1992 to 1993. The percentage of women receiving no prenatal care is over 60% higher among women living in cities than among the overall U.S. population.



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