FACT SHEET

Selected Findings on Child and Adolescent Health Care From the 2004 National Healthcare Quality/Disparities Reports

Agency for Healthcare Research and Quality

AHRQ's mission is to improve the quality, safety, efficiency, and effectiveness of health care by:

- Using evidence to improve health care.
- Improving health care outcomes through research.
- Transforming research into practice.

Introduction

Information on health care quality, access, and utilization for the Nation's children and adolescents is available from the 2004 National Healthcare Quality Report (NHQR) and National Healthcare Disparities Report (NHDR). These reports are produced annually, beginning in 2003, by the Agency for Healthcare Research and Quality (AHRQ) on behalf of the U.S. Department of Health and Human Services.

This Fact Sheet uses findings from both reports to:

- Briefly note the importance of focusing on child and adolescent health and health care.
- Highlight key findings from both reports in selected areas of quality of and access to care, including disparities in quality and access.
- List the NHQR and NHDR appendix tables (see box, last page) that provide additional data on the state of quality and access for children and adolescents, including disparities by racial and ethnic minority group and socioeconomic status. These detailed tables, along with the full reports, are available online at: www.qualitytools.ahrq.gov/

Importance of Child and Adolescent Health Care

Children and adolescents ages 0-17 constitute 73 million individuals, or one-fourth of the Nation's population. Health care providers and government agencies and other entities recommend that all children have access to high quality services for health promotion, disease prevention, and acute and chronic care treatment and management. Although children and adolescents are generally healthier than adults, from 13 to 23 percent of this population experience special health care needs or chronic illnesses and disabilities. Among the most prevalent chronic conditions of childhood and adolescence in 2002 were asthma (affecting 12 percent of children ages 0-17), learning disabilities (8 percent of children 3 to17), and attention-deficit hyperactivity disorder (7 percent of

children 3 to 17). Infants (children under 12 months) have a higher death rate than any other age group under age 55.

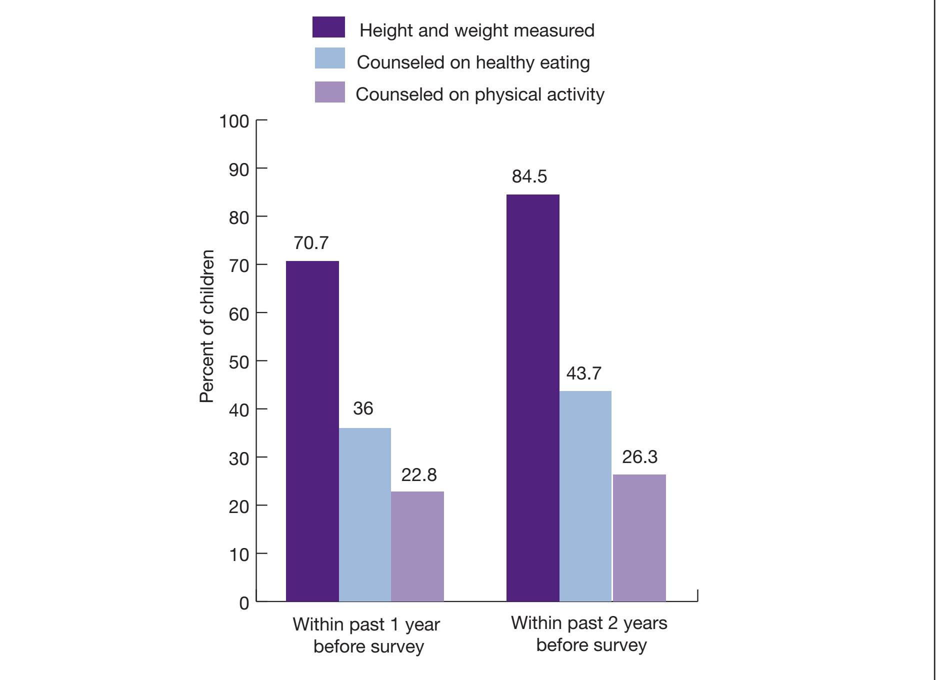
Selected Key Findings

Three aspects of quality of care for children and adolescents are presented below: overweight prevention, antibiotic prescribing for the common cold, and hospitalization for one chronic condition (asthma). One aspect of access to care—insurance coverage—is also discussed.

Overweight prevention. Overweight in children is defined by the Centers for Disease Control and Prevention as body mass index (BMI) for age > 95th percentile.[1] Although not a disease per se, overweight, if unchecked, can lead to diseases such as obesity, diabetes, and heart disease. Overweight among children has increased over time. In 2000, 15.3 percent of children ages 6-11 were overweight, compared to 11 percent in 1988-94.

- In 2001, 70.7 percent of children ages 0-17 had both their height and weight measured within the last year by doctors or other health care professionals, according to parents' reports; 84.5% of children had height and weight measured within the last 2 years (Figure 1).
- In 2001, 36 percent of children ages 2-17 or their parents were counseled on healthy eating within the year before the survey; 43.7 percent had been counseled on healthy eating within the last 2 years.

Figure 1. Percent of children who had preventive care related to overweight prevention: height and weight measurement (ages 0-17), counseling on physical activity (ages 2-17), and counseling on healthy eating (ages 2-17) by doctors or other health care providers within 1 year and within 2 years of survey, 2001



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2001.

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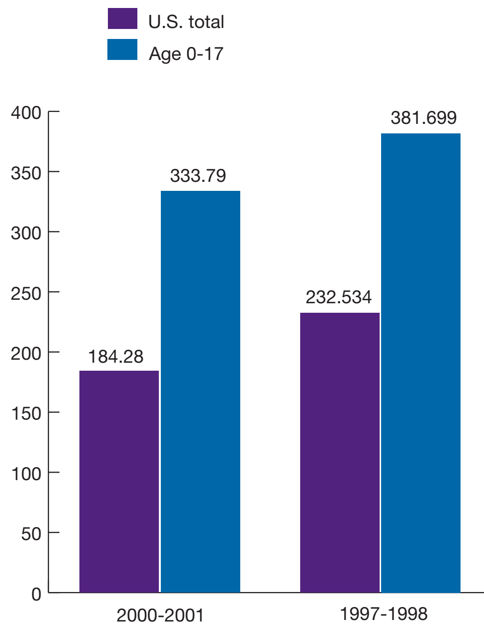
[1] BMI is used differently for children and teens (i.e., BMI-for-age) than for adults. See www.cdc.gov/nccdphp/dnpa/bmi/bmi-for-age.htm for more information.

Figure 2. Number of visits per 10,000 visits for the common cold at which antibiotic was prescribed at visit, U.S. total and ages 0-17



Source: Centers for Disease Control and Prevention, National Ambulatory Medical Care Survey-National Hospital Ambulatory Medical Care Survey, 1997-98 and 2000-01.

- In 2001, 22.8 percent of children ages 2-17 or their parents got counseling about the value of physical activity from doctors or other health professionals within the last year; 26.3 percent got counseling about physical activity within the last 2 years.

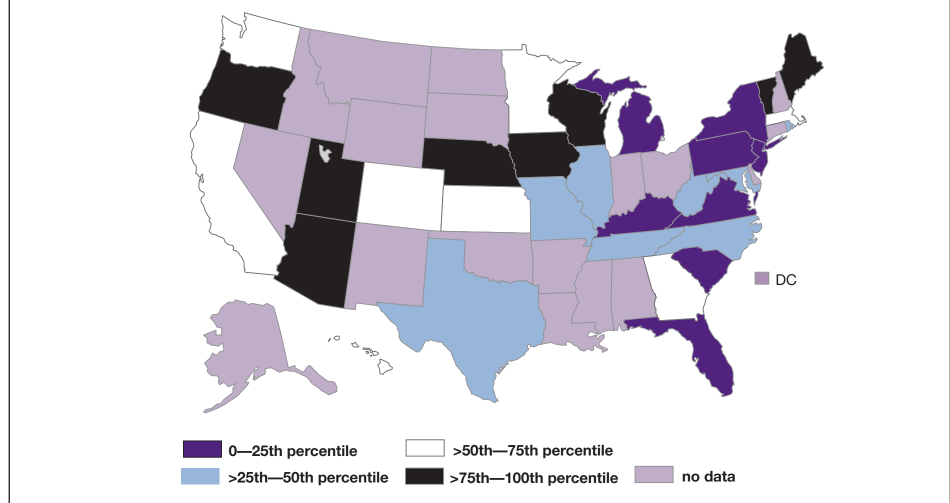
Antibiotic prescribing for the common cold. Antibiotics should not be prescribed for the common cold, which is a viral illness against which antibiotics are ineffective. Antibiotic overuse can lead to antibiotic resistance, an important public health problem.

- Children ages 0-17 were prescribed an antibiotic at a visit for a common cold at a rate of 333.79 per 10,000 visits in 2000-01, about twice the rate of such prescriptions for the U.S. population overall (184.28 per 10,000 visits; Figure 2).
- Antibiotic prescribing for the common cold declined for both groups between the 1997-98 and 2000-01 time periods.

Hospital admissions for pediatric asthma. Asthma can be effectively controlled over the long term with recommended medication. Preventing hospital admissions for asthma is one measure of successful management of asthma.

- Child asthma admission rates vary from 98 admissions per 100,000 population for the best performing quartile of States to 261.5 admissions per 100,000 population for the lowest performing quartile of States—a difference of 167 percent (Figure 3).
- While prevalence rates vary by age, admission rates nationally for children are more than twice those

Figure 3. State variation in pediatric hospital admissions for asthma per 100,000 population ages 0-17, 2001



Source: Agency for Healthcare Research and Quality, HCUP State Inpatient Databases, 2001.

Note: Not all States are included. Values for quartiles are: 0-25th percentile=221.4-315.3 admissions/100,000 population; >25th-50th percentile=187.3-220.9; >50th-75th percentile=125.6-176.6; >75th-100th percentile=66.3-120.6.

for adults—26.2 admissions for children per 100,000 population in 2001 vs. 12.5 admissions for adults per 100,000 population (National Hospital Discharge Survey, 2001; see 2004 National Healthcare Quality Report Tables Appendix, Tables 1.93a, 1.94a).

- Black children are roughly three times more likely to be hospitalized for asthma than are white children—55.9 black children versus 16.2 white children per 10,000 children ages 0-17 in 2001 (Figure 4).

Insurance coverage. Insurance coverage is a key determinant of access to care.

- In all 3 years from 1999 to 2001, Hispanic children were less likely than non-Hispanic white children to have heath insurance (Figure 5).

For More Information

For specific references to all detailed tables on child and adolescent health in the 2004 National Healthcare Quality Report and National Healthcare Disparities Report, see: www.ahrq.gov/qual/nhqrdrchapp.htm

Futher information on AHRQ's programs and other activities in child and adolescent health is also available on the AHRQ Web site and from:

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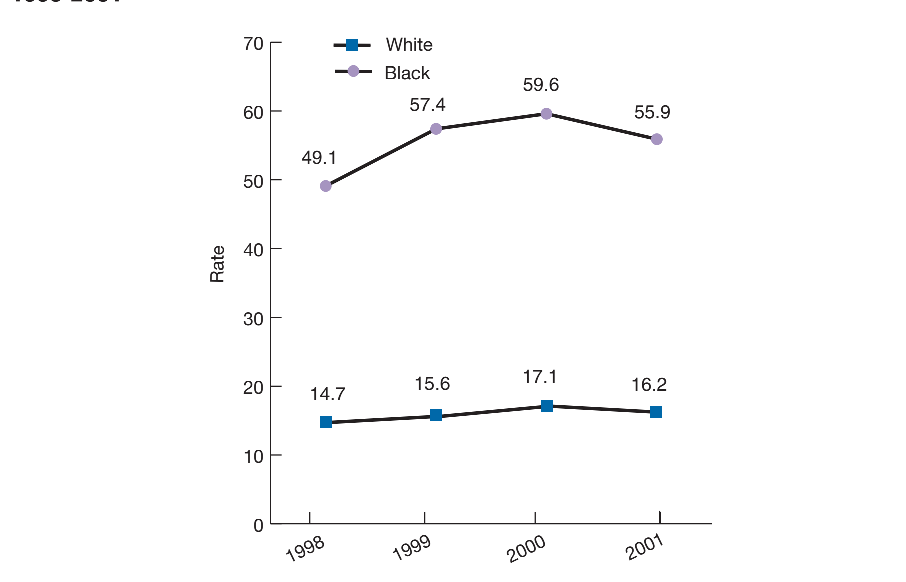
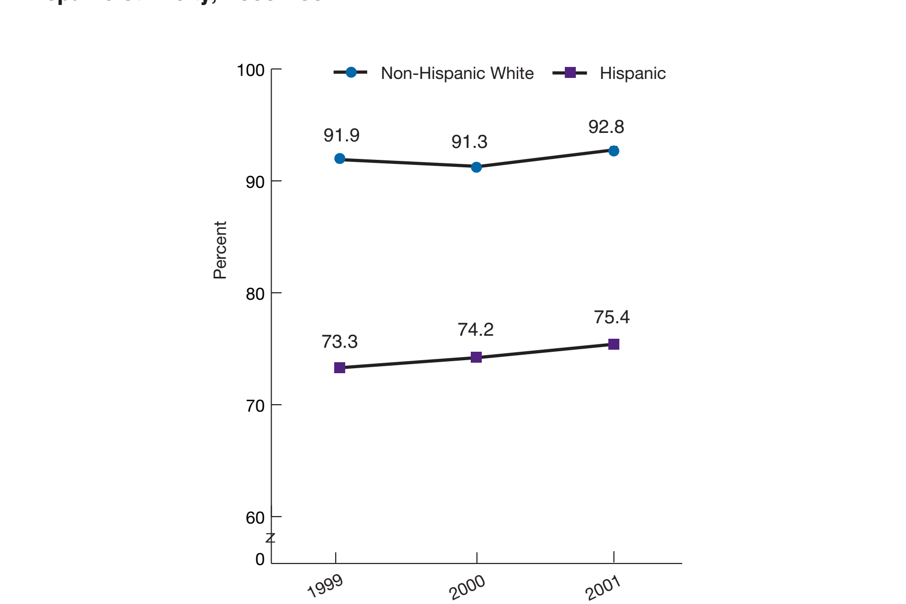
Figure 4. Hospital admissions for asthma per 10,000 children ages 0-17, by race, 1998-2001



Source: Centers for Disease Control and Prevention, National Hospital Discharge Survey, 1998-2001.

Figure 5. Percent of children ages 0-17 with any health insurance coverage, by Hispanic ethnicity, 1999-2001



Source: Centers for Disease Control and Prevention, National Health Interview Survey, 1999-2001.

2004 National Healthcare Quality and Disparities Reports: Detailed Appendix Tables* With Data on Child and Adolescent Health Care Quality and Access

Measure category	NHQR tables	NHDR tables
Quality of Care		
Effectiveness:		
Cancer	1.8	5
End stage renal disease	1.27–1.28	22–23
Heart disease	1.48	33
HIV and AIDS	1.54–1.55	34–35
Maternal and child health:		
Maternity care	1.57–1.59	36–43
Immunizations	1.60–1.64	44–54
Overweight prevention	1.67–1.69	56–58
Dental health	1.65	65
Vision health	1.70	59
Passive smoking	1.71	60
Gastroenteritis management	1.66	55
Mental health	1.77	66
Respiratory diseases	1.91, 1.93	75–76, 78, 220
Patient Safety:		
Birth-related trauma	2.1, 2.22	114–116
Potentially avoidable deaths	2.2–2.3	118–119
Transfusion reactions	2.4	
Nosocomial infections	2.7, 2.11, 2.17, 2.25	101
Complications of care	2.5, 2.8–2.9	108, 113
Injuries or adverse events due to technical errors	2.10, 2.13–2.16, 2.18–2.19	103–106, 110–112
Timeliness:		
Getting an appointment when wanted	3.4, 3.6	225A/B/C–226A/B/C
Emergency department waits	3.7–3.8	—
Patient Centeredness	4.2, 4.8	228A/B/C–231A/B/C, 237
Overall Measures	5.2	232A/B/C
Access to Care		
Getting Into the Health Care System:		
Health insurance coverage	—	120–124, 238–239
Usual source of care	3.1	127–129, 131–132, 223, 240
Getting Care Within the Health Care System	—	141–143, 145–149, 241–242
Patient Perceptions of Care	—	150, 155
Health Care Utilization:		
General medical care	—	171–178
Avoidable admissions	—	190–191
Mental health care and substance abuse treatment	—	197–201
Ambulatory care	—	207–218

*For a detailed list of specific tables, by individual measure, see: www.ahrq.gov/qual/nhqrdrchapp.htm

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