A STATE FOCUS

A PICTURE OF CHILD HEALTH IN OKLAHOMA

"Many things can wait. Children cannot. Today their bones are being formed, their blood is being made, their senses are being developed. To them we cannot say 'tomorrow.' Their name is today."

–Gabriela Mistral (1889–1957),
Nobel Laureate, Educator, Poet

A STATE FOCUS: A PICTURE OF CHILD HEALTH IN OKLAHOMA

Good or bad health starts before birth. Health is dynamic for a child. Health status at each stage of development impacts a child's well being at the next stage and further defines their future, and ours. Good health allows a child to learn, to participate, to develop and grow into a healthy, productive adult. The 2005 Oklahoma KIDS COUNT Factbook takes this initial look at the physical and emotional health and development of the state's children.

Historically, good health was thought to be the absence of disease or early death. Today, most health professionals include concepts of disease prevention and health promotion. Threats to a healthy childhood result from complex interactions between biology, environment, behavior, and access to care. Oklahoma health professionals, educators, parents and communities all touch children's lives every day, exercising tremendous influence on their health and development.

Oklahoma is the only state whose health status worsened during the 1990s. For the latest year on record (2003), Oklahoma ranked near the bottom (45th) of all states. Death rates for heart disease, cancer, injuries, strokes and emphysema are higher than the national average. Too many Oklahomans use tobacco and abuse other drugs or alcohol. Teens in Oklahoma have one of the highest rates of birth in the nation. Low immunization rates and lack of health education compound the spread of infectious disease. Disabilities and unnecessary deaths are the unfortunate results of the poor health of Oklahomans.

This 2005 Oklahoma KIDS COUNT Factbook presents the picture of child health in Oklahoma by first taking *A Snapshot of the System*, discussing the difficulties of finding and paying for health care, and how access impacts a child's ability to get health care. Next, the influence of habits, behaviors, the environment and the use of preventive and routine health care on a child's health are discussed in *Developing the Next Generation*. Finally, *A Picture of Health* emerges, detailing the physical and emotional health status of Oklahoma children.

A SNAPSHOT OF THE SYSTEM: Access to Health Care

The door to the doctor's office is closed to too many Oklahoma children. Each year seventeen thousand (17,242; 2.4%) fail to receive all the health care they need. Three of every five (58.5%) Oklahoma children do not have a "medical home," a place with a primary care provider where the child consistently receives all needed care and at least one preventive care visit during the most recent year. One in six (16.5%) have significant problems getting specialty care, services or equipment after it has been recommended or prescribed for them. Among children needing prescription medications, almost ten thousand (9,774; 1.8%) do not receive them. Among children needing mental health care, thirty thousand (30,157; 51.8%) do not receive it. A child's inability to access needed medical care may result from an inability to finance the care or from there being no place to get care.

FINANCING HEALTH CARE

Oklahoma health care expenditures are high and going higher. Garnering an accurate picture of how Oklahoma families pay for health care for their children is a complex prospect. While possessing insurance is commonly equated with an ability to finance or access health care, other factors make it a less than precise measure. Generally speaking, care requiring payment may be covered by private health insurance, public health insurance, paid out-of-pocket or reduced to a bad debt. Unfortunately, many providers refuse to take patients without private health insurance, even if they have public coverage or some ability to pay out-of-pocket. Some care may be available without cost or at reduced cost to some children through publicly-funded health initiatives (Community Health Centers, Community Mental Health Centers, Indian Health Services, county health departments, and others). Where available, these publicly-funded initiatives supplement or replace private care that would otherwise require payment or insurance coverage. Unfortunately, such initiatives often have limited eligibility, services and locations. Children receiving health care through publicly-funded initiatives may or may not have insurance coverage. Those who do not are likely counted among the uninsured even though some of their health care needs may be met.

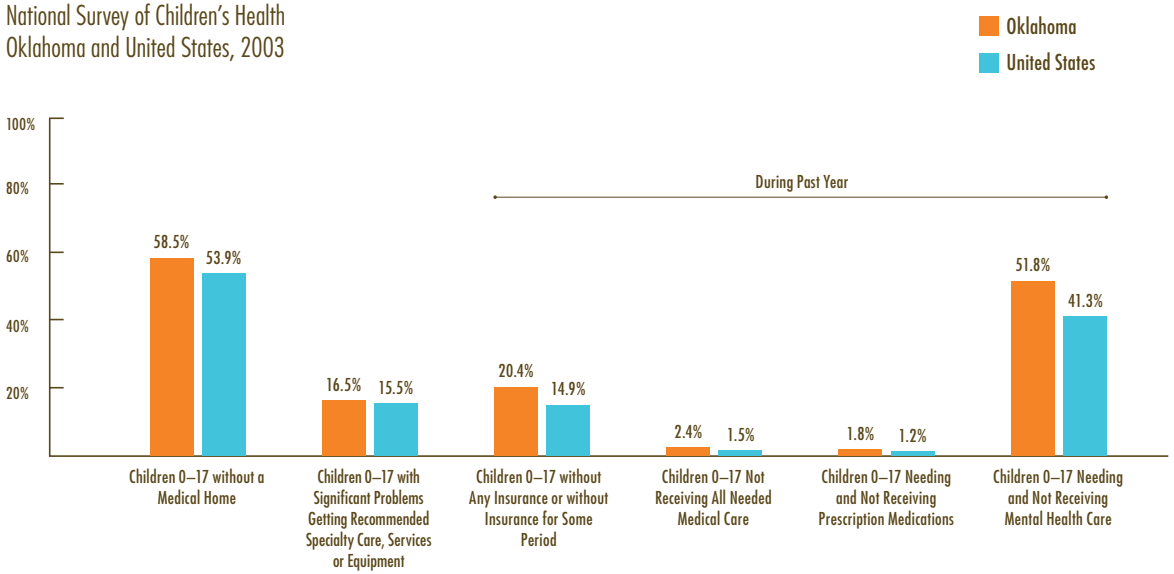
Measuring rates of uninsurance is similarly complex. The most widely quoted numbers, generated by the census bureau, count people as uninsured only if they had no coverage at a specific point in time. New census estimates count people as uninsured only if they had no coverage for the entire year being reported upon. As a result, people may be counted as insured if they have any type of coverage for all or for only some part of the year. Health insurance is generally defined as either private or public coverage. The census measures leave out families and children with inconsistent, irregular coverage who suffer many of the same consequences as those without any insurance. By any measure, health insurance coverage for children has recently improved. The noted decline in employer-sponsored coverage is more than offset by the simultaneous expansion of public coverage under Medicaid and State Children's Health Insurance Program (SCHIP).

Still, Oklahoma children are less likely than others around the nation to not have coverage. One in five (20.4%) Oklahoma children have no insurance or were not insured for some period during the last year, compared to one in seven (14.9%) nationally.

Six in ten (62.1%) Oklahoma children covered by insurance have private policies, compared to seven in ten

Access to Care

National Survey of Children's Health
Oklahoma and United States, 2003



(69.6%) nationally. Oklahoma children with insurance are more likely than others around the nation to be covered by Medicaid or SCHIPs, rather than by private coverage.

Counting only children who were not covered by any type of insurance at any time during a year, newly released experimental census estimates place Oklahoma tied for the 46th worst state in the nation with one in seven (15.3%) children uninsured. With only one of every ten (10.4%) children uninsured, Noble County has the best coverage. With as many as one in every four (25.2%) children uninsured, Cimarron County has the worst coverage.

Families without insurance or access to some type of publicly funded health initiative face significant out-of-pocket costs for purchased care. As a result their children are less likely to receive regular care, more likely to have problems getting care, more likely to go without needed care, more likely to rely on emergency rooms for routine care, more likely to be hospitalized for what would have been preventable conditions if early care was received, more likely to experience disabilities and more likely to see their health deteriorate. Without some type of assistance, most cannot pay for the minimal care they do receive, shifting costs to Oklahomans with insurance. Employers, faced with skyrocketing costs to insure their employees, and families, paying double the national average to cover the cost of non-reimbursed care, can be expected to drop coverage, further fueling a vicious cycle in Oklahoma.

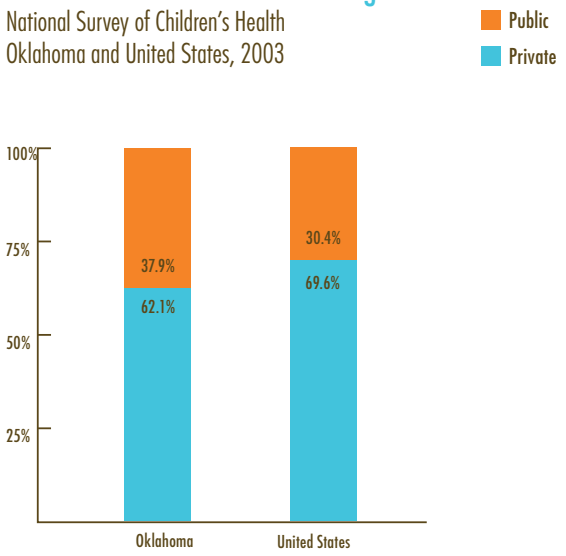
Many insurance policies cover little with large co-payment requirements. Thousands of Oklahomans are spending enormous sums on the out-of-pocket costs associated with health care that is covered by insurance. Many with insurance postpone or skip needed medical care, suffering the resulting medical trauma and disability. Some face financial ruin. About half of all personal bankruptcy cases are the result of unmanageable medical expenses. Three out of every four people bankrupted by medical expenses had medical insurance at the onset of their medical problem.

Racial differences in health coverage are deeper in Oklahoma than in the United States as a whole. In Oklahoma, Hispanic children (42.8%) are far more likely to be uninsured or have inconsistent coverage than white children (17.1%), African American children (23.4%) or multi-racial children (23.5%). Many immigrants with US-born children are afraid to seek health services. Children of immigrants are more likely to have fair or poor health and are more likely to not have any health insurance. Three in 10 (29.3%) children without coverage are under 6 years of age. Almost two-thirds (63.1%) of all uninsured children live in households in which the family head is employed full-time throughout the year.

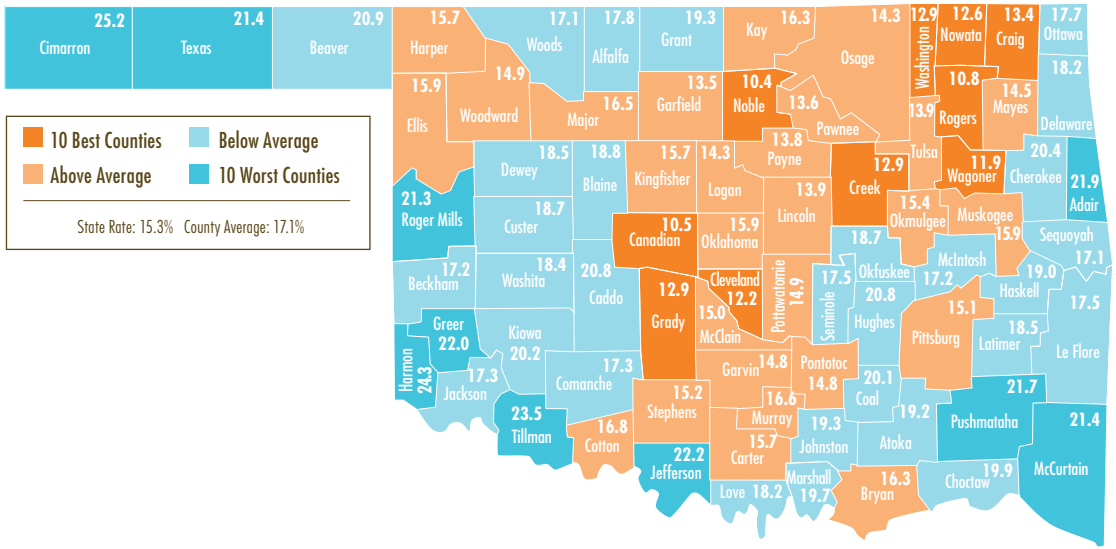
While covering the long term care needs of low income elderly Oklahomans, medical care for poor residents who are blind and disabled and prenatal care and delivery services for low-income pregnant woman in the state, Medicaid also is the largest children's health program in Oklahoma and the nation. Through Medicaid the costs of

Public v. Private Insurance Coverage

National Survey of Children's Health
Oklahoma and United States, 2003



Percent of Children Without Any Health Insurance Coverage for Entire Year (2000)

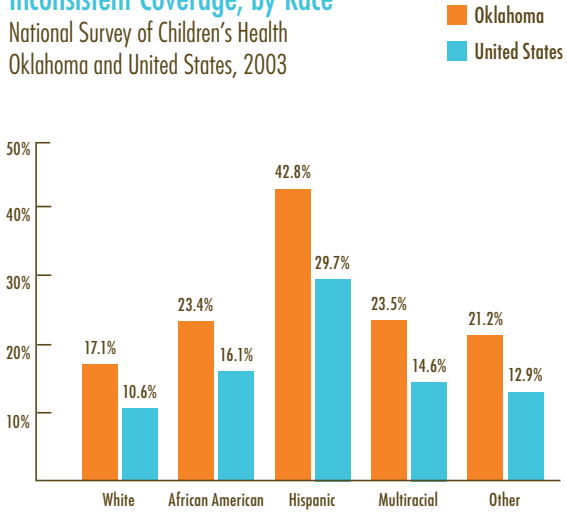


care for covering primary and acute care for low-income children are shared by the federal and state government.

Before welfare was radically redesigned in 1996 (see 2002 Oklahoma KIDS COUNT Factbook), a child living in a family receiving public assistance was routinely enrolled in Medicaid, thereby receiving coverage for medical assistance. After welfare reform, many eligible children in low-income families went without coverage as both providers and recipients struggled with the new rules. It took time before this unintended reduction in Medicaid participation reversed its downward spiral. Outreach efforts paid off. Families and providers learned that a family did not have to receive public assistance for a child to be eligible. Families leaving public assistance without continuing to receive medical assistance are more likely to return to welfare. Understanding medical coverage for children to be a cost-effective investment, Oklahoma joined other states using a simplified application process. More low-income families enrolled their children in Medicaid.

Children Uninsured or with Inconsistent Coverage, by Race

National Survey of Children's Health
Oklahoma and United States, 2003



Medicaid (Title XIX) eligibility is determined using a complex set of rules about income, assets and family composition. Fortunately for Oklahoma's children, the State Children's Health Insurance Program (SCHIP, Title XXI) is coordinated to wrap around Medicaid and fill any eligibility gaps. As a result, under combined Oklahoma Medicaid and SCHIP eligibility, any child living in any home with an income less than 185% of the federal poverty level ($28,155 for a family of three with two children in 2004) is eligible to be enrolled. During it's brief eight year history, the SCHIP program has dramatically affected uninsurance rates in Oklahoma and around the nation, with a substantial portion of previously uninsured children now eligible for public insurance coverage.

Under these rules, just under half (43.5%) of Oklahoma's children are eligible for public insurance. At the latest point in time for which data is available (May, 2005), about three hundred fifty thousand (347,081) children under age 18 were enrolled in Medicaid/SCHIP, covering 91.2% of the children thought to be eligible under current Oklahoma guidelines. The worst coverage is found in Roger Mills County where only 4 in 10 (40.8%) children thought to be eligible are enrolled. One third (36.4%) of the more than thirty thousand missed children live in the state's two largest metropolitan areas (Oklahoma and Tulsa counties). During May, 2005, one in four (24.7%) Oklahoma counties covered a number of children equal to the number thought to be eligible for Medicaid/SCHIP. Medicaid/SCHIP coverage estimates exclude many foreign-born, low-income children who are not eligible solely because of their undocumented legal status.

Complexities, budget constraints, low reimbursement for providers and difficulties retaining eligible children combine to reduce Medicaid/SCHIP's benefit to Oklahoma's children. State revenue shortfalls have resulted in a cutback of Oklahoma's original commitment to outreach, leaving it to privately-funded efforts to pick up the slack. Oklahoma has not joined the majority of states implementing SCHIP which have set eligibility at 200% or higher as allowed by federal law. More than thirty-two thousand (32,292) additional Oklahoma children could be covered if income eligibility were raised to 200% of the federal poverty level.

The traditionally low reimbursement rates paid by Medicaid/SCHIP resulted in many Oklahoma practitioners limiting the number of children seen in their practices whose health care is financed with public insurance. Locating participating pediatricians and dentists has been particularly challenging. With fewer than half (48%) of the state's pediatricians accepting Medicaid, Oklahoma has the lowest percentage of pediatricians accepting Medicaid in the country. Nationwide, two-thirds (67%) of pediatricians accept Medicaid. Despite annual requests for funding increases, until this year the Oklahoma Legislature resisted. Spurred by a federal lawsuit, recent increases in Oklahoma reimbursement rates for primary care services hold the promise of better provider acceptance.

To continue Medicaid/SCHIP coverage without interruption, parents of an enrolled child must respond to a periodic renewal notice. If the family receives other benefits, such as food stamps or child care assistance, or their circumstances have changed, recertification and review is required to continue their child's Medicaid/SCHIP coverage. In the past this periodic review often required declarations and documentation more onerous than those used to determine initial eligibility. If parents were not able to successfully negotiate the system, coverage was denied for eligible children. Constant review and recent simplification of the state's recertification process are designed to cover Oklahoma children with less interruption. National data indicates that half of all Medicaid/SCHIP cases are closed at renewal.

Federal law allows Medicaid to enhance the benefits of other federal initiatives providing medical care to underserved populations. For example, federal law allows the Indian Health Service (IHS) to bill Medicaid for services it provides to American Indians which in turn

can reimburse IHS for the full cost of care provided to eligible American Indians. Oklahoma can be repaid by the federal Medicaid program without being required to contribute any state funds. Compared to a statewide rate of 91.2% enrolled eligible children, only 85.9% of Oklahoma's eligible American Indian children were enrolled in Medicaid/SCHIP at the latest point in time for which data is available (May, 2005). Many parents do not realize that their American Indian children are eligible for Medicaid/SCHIP or that IHS, tribal and urban clinics can receive support through the state and federal Medicaid/SCHIP system. Many American Indian children need health services beyond what IHS, tribes and the urban clinics can provide, or do not live near enough to access the services.

HEALTH RESOURCES

The availability and quality of community health resources impacts a child's health. Some Oklahoma areas have few services and few providers. Rural areas have particular difficultly supporting local health resources.

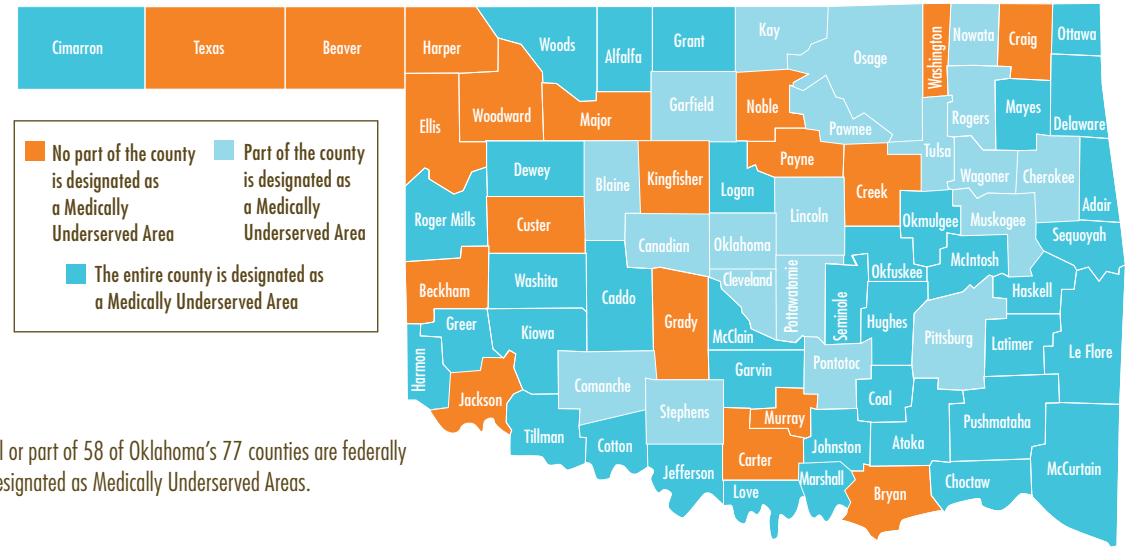
More than 32,000 additional Oklahoma children could be covered if SCHIP eligibility were raised to 200% of the federal poverty level.

Four Oklahoma counties have no hospital providing general medical inpatient care. Eight have no public health department. Only eleven Oklahoma counties have federally-funded Community Health Centers. Indian Health Service (IHS), tribal or urban clinics serve native populations in less than half (36) of Oklahoma's counties. Even though the entire state is divided into community mental health service areas, some type of facility or program is physically located in only 59 Oklahoma counties. Many of those serve only adults. For every one thousand Oklahomans, there are fewer than two (1.9) physicians, just over twelve (12.4) nurses and less than one (0.5) dentist. To improve health services in Oklahoma, community-based initiatives have emerged throughout the state. Focusing on public health, Oklahoma Turning Point partnerships are active or forming in most (54 of 77) Oklahoma counties. Oklahoma Systems of Care partnerships, working to improve mental health and substance abuse treatment for youth with severe emotional disturbances, are active or forming in about one-third (24 of 77) of Oklahoma counties. See the Data Tables and County Benchmarks of the 2005 Oklahoma KIDS COUNT Factbook on-line at www.oica.org for additional information on these health resources.

A federal designation as a Medically Underserved Area (MUA) results from a score based on the ratio of primary care physicians per population, infant mortality rate, percentage of the population with incomes below the poverty level, and the percentage of the population age 65 and over. Most of Oklahoma is medically underserved. All of thirty-eight Oklahoma counties and parts of twenty Oklahoma counties are designated as federal Medically Underserved Areas. Since an MUA designation documents a community's severe lack of health resources, it is required to receive some related federal programs, such as a grant for planning, developing or operating a Community Health Center, receiving preferred reimbursement under Medicaid, or being the preferred location for public health service training programs.

Access worsens for non-white children. Documented racial and ethnic disparities in child health suggest that minority children often fail to receive necessary health care, and when care is received it is inferior or incomplete.

Medically Underserved Areas



All or part of 58 of Oklahoma's 77 counties are federally designated as Medically Underserved Areas.

DEVELOPING THE NEXT GENERATION: Factors Influencing Child Health

Personal habits and behaviors, environment and use of preventive and routine health care provide the foundation for a child's health and well-being, or lack thereof. Tobacco, alcohol and other drugs are part of a dangerous routine for many youth who are encouraged to drink at high school parties and who return home to parents unwilling to quit smoking. Serious illness can result from a child's failure to be immunized against childhood diseases or their exposure to a parent's lead-laden work clothes. Obesity is the norm for too many young Oklahomans addicted to television and video games. Everyday decisions and activities impact the health of Oklahoma children and determine their future.

NUTRITION AND EXERCISE

One in five (20.5%) Oklahoma children ages 10 through 17 fall below or above the weight they should be for their age. The consequences of being underweight and poorly nourished are dangerous to a child.

Some Oklahoma children simply don't get enough to eat. Oklahoma's rate of food insecurity (defined primarily as uncertain availability of nutritionally adequate and safe food) or hunger (defined as recurrent and involuntary lack of access to food) is among the worst in the nation (14.1% of households, 6th worst in 2003). Underfed, hungry children get sick. Inadequate nutrition decreases a child's immune function and impairs their ability to get well.

The serious health consequences of a child's food insecurity and hunger last for a lifetime. Malnourished, thin infants are more likely to grow into adults with diabetes, hypertension, heart disease and strokes. Poverty increases the likelihood a child will be poorly nourished.

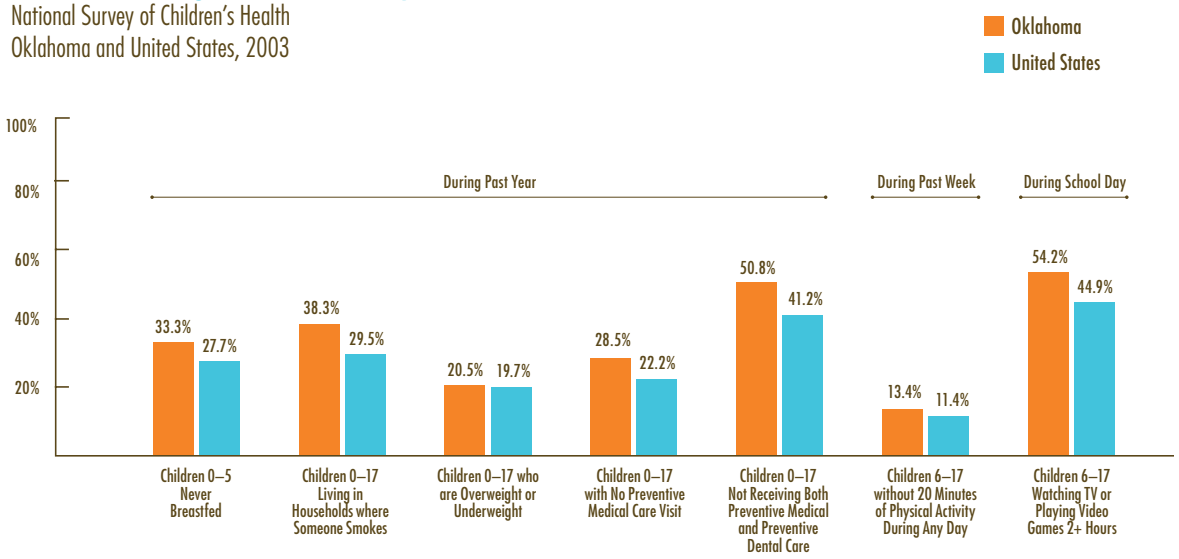
Unhealthy foods are cheap and widely available to low-income families struggling to stretch their limited resources. Whether by choice or as a result of food not being available, fewer and fewer children eat breakfast, a meal documented to improve a child's weight, health and functioning.

The consequences of being overweight are equally staggering. Obese children in the United States miss four times as much school as healthy-weight children. Pharmacy, medical and hospital costs related to obesity soar. For Oklahomans, obesity has become the second most preventable cause of death. Since 1980, obesity has doubled among children and tripled among adolescents. Childhood obesity has resulted in increased rates of Type 2 diabetes, formerly called "adult onset" diabetes. Extremely uncommon in children just ten years ago, Type 2 diabetes is now considered an epidemic in younger age groups. Complications from diabetes can lead to amputations, kidney failure, blindness and heart disease. Obesity particularly impacts Hispanic and African American children. Adolescents in poor families are twice as likely to be overweight than those in non-poor families.

Poor nutrition and inadequate physical activity are major contributors to childhood obesity. Children consume record amounts of sugar-added products and processed foods, "super-sized" by a fast food industry that encourages overeating. Experts recommend that children should get an hour of exercise over the course of each day. Almost half of all children do not participate in any regular physical activity, instead opting for sedentary activities. TV and video games have become a risk factor predicting poor health. Oklahoma children are less active and spend more time watching television or playing video games than their national counterparts. Too many (13.4%) Oklahoma children go without sufficient exercise every day during the week and more than half (54.2%) watch television or play video games two or more hours of every school day.

Factors Influencing Health and Development

National Survey of Children's Health
Oklahoma and United States, 2003



ALCOHOL AND DRUGS

Beginning in teenage years, and frequently lasting a lifetime, drug and alcohol use and abuse accounts for significant disability. One measure of substance abuse among youth is the number of arrests for alcohol- and drug-related criminal offences. Each year, there are almost a thousand (960.6) arrests for drug and alcohol-related offenses for every 100,000 Oklahoma juveniles ages 10 through 17. Currently, the highest and worst arrest rate is in Okfuskee County, where during an average year, youth ages 10 through 17 are arrested for drug- and alcohol-related offenses at a rate of 3,220.0 per 100,000 youth. The lowest and best rate (0.0 per 100,000) is found in three Oklahoma counties (Cimarron, Ellis and Roger Mills).

Since the body of a young person goes through important developmental phases, the consequences of alcohol and drug use and abuse are more negative on a youth's health than they would be for an adult. Drugs and alcohol can interfere with a young person's education and development by causing memory problems, learning problems, reasoning difficulties and impairing brain function. Judgment and social functioning diminish substantially, frequently resulting in serious behavior and emotional problems. Coordination and motor functioning become impaired, increasing the risk of serious injury or death. Extensive alcohol and drug use increases the risk a young person will develop serious medical complications or die young.

UNHEALTHY ADOLESCENT BEHAVIOR

Oklahoma high school students too often engage in behaviors that contribute to poor health, disability or death. Two-thirds (64.1%) have tried cigarettes. One in four (26.5%) still smoke. Almost half (47.8%) currently drink alcohol. Two in five (42.5%) have tried marijuana. One in five (22.0%) currently smoke marijuana. Half (50.0%) have engaged in sexual intercourse. More than a third (37.2%) are currently sexually active. See the 2004 Oklahoma KIDS COUNT Factbook for related data and analysis.

AIR QUALITY STANDARDS

A child's health is impacted by where they live, go to school and play. Children need a safe, clean place in which to grow. Since a child eats, drinks and breaths more per body weight than an adult, they face an increased potential of exposure to environmental contaminants. The U.S. Environmental Protection Agency sets national air quality standards for principal pollutants, including carbon monoxide, lead, nitrogen dioxide, ozone particulate matter and sulfur dioxide. In 2001, 1 in 5 children (19%) around the nation lived in areas that did not meet one or more of these standards. None of these unfortunate children reside in Oklahoma. No part of Oklahoma fails this basic measure of air quality.

LEAD EXPOSURE

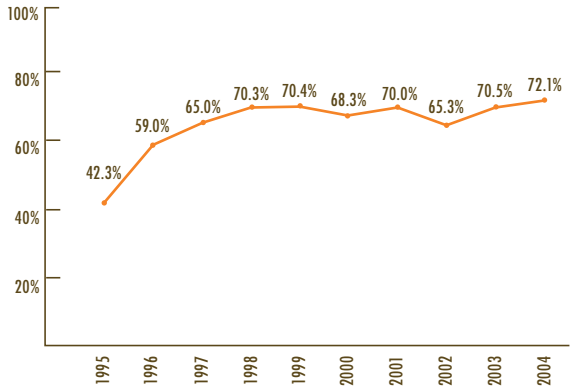
Notwithstanding the lack of concentrated lead contaminants in Oklahoma's air, lead remains the number one environmental hazard for children in Oklahoma. Lead, a highly toxic metal, is especially harmful to a small child's body, which absorbs a greater proportion of any lead ingested than does an adult's body. A poorly nourished child is at grave risk. Exposure at a very young age harms developing brains, kidneys and nervous systems. Left untreated, lead poisoning results in developmental problems, behavior problems, a lower I.Q. and damaged organs. The negative consequences are permanent and life-threatening. Because of the extreme danger, the federal government banned the use of lead-based paint in homes and in gasoline. Unfortunately, older homes with lead-based paint still pose a danger of lead exposure, along with some work-place contaminants, lead pipes, lead-fired pottery and even lead lettering on some candy wrappers imported from Mexico.

Five of every ten thousand (5.1/10,000) Oklahoma infants and toddlers (ages 6 to 72 months) have elevated levels of lead in their blood. Currently, the highest and worst rate (66.3/10,000) is found in Greer County. Almost half (35 of 77) of Oklahoma counties share the lowest and best rate (0.0/10,000), with no elevated lead levels found among the infants and toddlers who were tested.

High levels of lead are documented in children who lived near Ottawa County's Tar Creek, an area located in far northeastern Oklahoma infamous for debris from old mines. Tar Creek, the state's most notorious Superfund Site, threatens the health of approximately 30,000 Oklahomans living in parts of five communities (Picher, Cardin, Quapaw, North Miami and Commerce). The mining process resulted in miles of underground tunnels, open mine shafts and piles of an unmarketable waste product (chat), which contains elevated levels of lead and other heavy metals. Chat was used for fill and foundations for local homes, driveways and businesses. In 1983, the Environmental Protection Agency (EPA) listed the Tar Creek site on its national priorities list, subjecting it to a process to fund and accomplish its clean-up. After the Indian Health Service found dangerous elevated lead concentrations in the blood of about one-third of the Indian children living in the Tar Creek area, the EPA accelerated efforts to clean-up homes, day care centers, schools, parks and business properties. Oklahoma's recent creation of a Relocation Assistance Trust assists families with young children in the most hazardous part of the site to move entirely out of the area.

Immunization Rates for Two-Year Old Children

National Immunization Survey, Center for Disease Control and Prevention
Oklahoma, 1995–2004



SECONDHAND SMOKE

Compared to the rest of the nation, more Oklahomans smoke (26.6%, 42nd worst in the nation), and these smokers consume more cigarettes per person. Tobacco use is the leading preventable cause of death in Oklahoma. The smoking habits of Oklahomans expose children to harm. Two in five (38.3%) children live in households where someone smokes. Children who are exposed to tobacco smoke in their homes have an increased risk of infections, bronchitis, pneumonia and sudden infant death syndrome. Secondhand smoke contributes to the development and exacerbation of asthma, fast becoming an epidemic in the United States.

PREVENTATIVE AND ROUTINE HEALTH CARE

By intervening early, parents and health professionals can influence a child's health and development. Preventive and routine care can decrease the risk of a child suffering poor health during childhood and developing many adult illnesses, such as heart disease, obstetric problems and stokes. Oklahoma children are less likely to receive preventive and routine care than other children around the nation. During the past year, one in four (28.5%) Oklahoma children received no preventive medical care. The rates double to one in two (50.8%) Oklahoma children when the absence of both preventive medical care and preventive dental care is measured.

IMMUNIZATIONS

Childhood vaccines prevent serious illnesses, including diphtheria, measles, mumps, rubella, hepatitis, polio and

chickenpox. Vaccines, considered by health professionals to be one of the most effective ways to protect children, are required to attend a childcare facility or school. Without immunizations, a child is at risk for serious illness or death. Without immunizations, communicable diseases can spread to other children.

The percentage of two-year-olds receiving a completed course of shots measures whether immunizations are received when they should be. Over one-third (34.8%) of Oklahoma children have not received the recommended course of vaccinations by the age of two. Currently, the lowest and worst rate (27.3%) is found in Cimarron County; the highest and best (86.7%) is in Roger Mills County.

Oklahoma has made impressive gains in immunization coverage over the last decade, improving from 42.3% in 1995 to 72.1% in the most recent national comparisons

available (2004). Notwithstanding the improvement, Oklahoma remains near the bottom (48th worst) of all states, falling well below the national average for children receiving the recommended course of immunizations by age two.

PERINATAL CARE

A baby's health during pregnancy, birth and early infancy impacts a child's health for their entire life. Experts agree that outcomes improve when the expectant mother is old enough to be ready to parent, receives high quality prenatal care and breastfeeds her child.

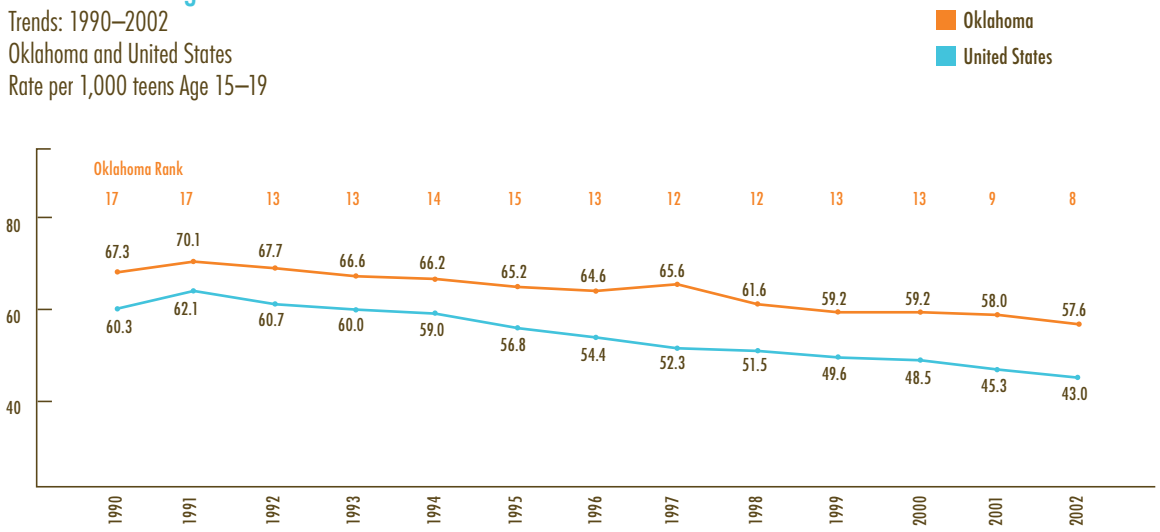
About seventy-four hundred (7,352 average annual, 2001-2003) babies are born annually to Oklahoma women under the age of twenty. Although the rate of birth (57.2 per 1,000) to teens ages 15 through 19 is decreasing, Oklahoma is not keeping pace with the rest of the nation in the reduction of teens births. As a result Oklahoma's rank relative to other states is near the bottom and the worst in a decade. Young mothers and their babies are more likely to face bleak futures of poverty, deprivation and poor health than those who delay birth until age twenty or later. See this Oklahoma KIDS COUNT Factbook Benchmark Topics, County Benchmarks and Data Tables for additional information.

Adequate prenatal care during pregnancy, as measured by public health professionals, requires an expectant mother to begin prenatal care during her first trimester of pregnancy and receive at least ten visits before giving birth. Prenatal care, by managing pre-existing and pregnancy-related medical conditions and by providing health behavior advice, helps improve outcomes for both the mother and the child. Women who receive regular high quality care during pregnancy are more likely to have healthier babies and less likely to deliver prematurely or have serious pregnancy-related problems. In Oklahoma, two of every five (39.2%) expectant mothers fail to receive the prenatal care that is recommended to be adequate. Currently, the lowest and worst rate of expectant mothers receiving adequate prenatal care (31.0%) is found in Texas County; the highest and best rate (81.5%) is in Kingfisher County.

Even though more than two decades of research documents that the best nutrition for an infant is breast milk, Oklahoma children are less likely to be breastfed than children around the nation. Valuable colostrum, containing antibodies protecting against disease, is transferred to an infant who is breastfed quickly after their birth. Human milk contains just the right amount of fatty acids, lactose, water and amino acids for human digestion, brain development and growth. Breastfed babies have fewer ear infections, allergies, rashes and bouts of diarrhea. Bottlefed babies have more hospital admissions and other medical problems. Their risk of health problems increases significantly. Health experts point out that increased breastfeeding rates increases mother-baby bonding, improves health, and saves lives and money. Less is spent on infant formulas, supplements and health care. However, only one-third (33.3%) of Oklahoma infants, toddlers and preschool children have never been breastfed. Except for a very few medical reasons (such as the mother being HIV-positive), there are no medical reasons why a mother should not breastfeed.

Births to Teens Ages 15–19

Trends: 1990–2002
Oklahoma and United States
Rate per 1,000 teens Age 15–19



A PICTURE OF HEALTH: The Physical and Emotional Status of Oklahoma's Children

The starkest and most unmistakable result of disease is the death of a child. The death of one child is too great a loss. Oklahoma loses a citizen, a young person loses a friend, parents lose their child. That one child might have become a doctor curing illness, a soldier defending our freedom, a teacher educating others, a fireman saving lives, a scientist creating a better future, a policeman protecting our homes, a good neighbor in an Oklahoma community. The death of one hundred and forty-four Oklahoma children from disease each year becomes unimaginable, though brutally real.

PHYSICAL HEALTH

Over eighty-three thousand (83,649; 9.6%) Oklahoma children have a moderate or severe health problem. Seventy-six thousand (76,610; 8.8%) are adversely affected by asthma during the year. Thirty-one thousand (31,188; 10.8%) infants, toddlers and preschool children (ages 0-5 years) have injuries during the year that require medical attention. In addition to the pain and expense associated with being sick or injured, the interruption to a child's education and social development is immeasurable. Compared to the nation as a whole, Oklahoma children miss more school due to illness and injury. With about one child in every classroom (6.6% of all Oklahoma school-age children) missing eleven or more days of school a year due to illness or injury. Some may never catch up.

MENTAL HEALTH, EMOTIONAL AND BEHAVIORAL HEALTH

One in ten children (9.1%, ages 3-17) are impaired by a serious mental health problem. Mental disability is the most common childhood disability in Oklahoma. Fewer than one in five receive treatment. Without treatment children suffer greatly. Children in despair cannot learn or form healthy relationships.

Young people with mental distress may become antisocial or depressed, often abusing drugs or alcohol, committing crimes or attempting suicide. More than half of young people who commit suicide abuse substances. Thirty-five young Oklahomans (under the age of 20) commit suicide each year (average annual, 2001-2003). Thirteen were under the age of 15. It is estimated that as many as twenty-five suicide attempts are made for every suicide completion.

Healthy social and emotional development is essential to a good childhood. Poor children are more commonly victims of mental illness than non-poor children.

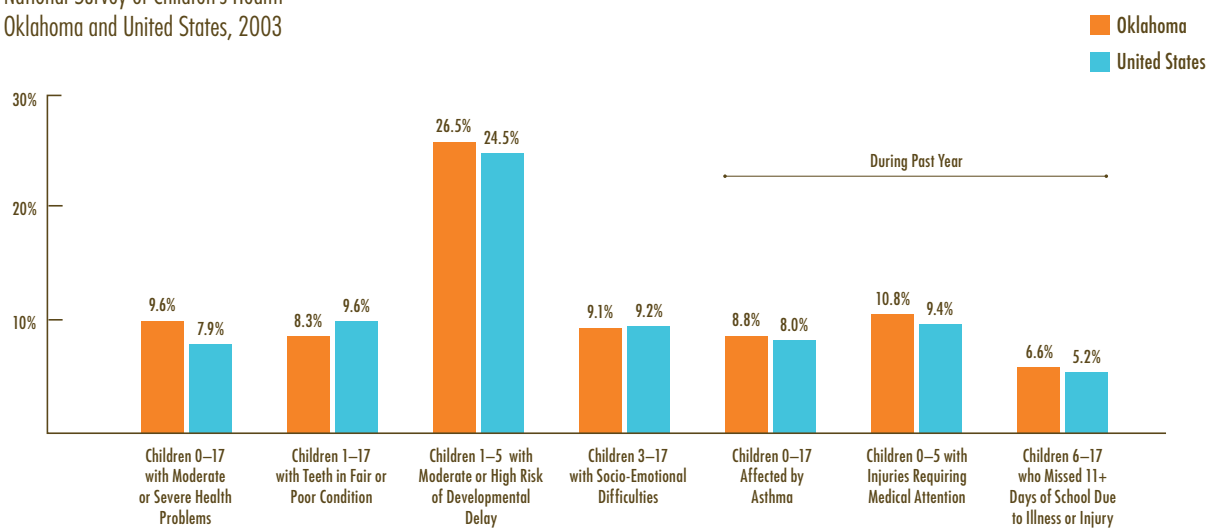
DENTAL HEALTH

Tooth decay (dental caries) is the most common childhood disease. Oklahoma children have particularly poor oral health. The teeth of sixty-seven thousand (67,511; 8.3%) children ages 1 through 17 are in only fair or poor condition. Oklahoma ranked second worst among the states monitored on two key child oral health issues. Among Oklahoma third grade students, seventy percent (69.4%, 2002-2003) have had tooth decay, with forty percent (40.2%) of third grade students having untreated tooth decay. Twice as many parents report their children have unmet dental needs as report unmet medical needs. A higher percentage of children have unrepaired cavities today than did ten years ago.

Without treatment, tooth decay grows progressively worse, impacting a child's overall health, growth and ability to learn. Untreated tooth decay requires increasingly costly care. Pain can limit a child's ability to eat and speak. Effects are lifelong. Poor dental health

Physical and Emotional Health

National Survey of Children's Health
Oklahoma and United States, 2003



On average, one child in every Oklahoma classroom misses eleven or more days of school each year due to illness or injury.

prevents toddlers from growing properly, compromises childhood nutrition and causes heart and obstetric problems when they grow into adults.

Non-white children, ethnic minorities and low-income children are less likely to use dental services and more likely to have tooth decay than white children and higher income children. Oklahoma's largest child minority group, American Indians, are noted for poor oral health. The Indian Health Service reports that one in three American Indian school children misses school because of dental pain, one in four avoids laughing or smiling due to poor oral health, one in five avoids meeting people because of the way their teeth look.

CHILDHOOD DISABILITIES

Depending on its severity, a childhood disability can cause a minor struggle or a major upheaval for the child, their family and their community. The common reality is that a child with a disability may not receive an early or accurate diagnosis, is often denied health insurance coverage, may not be able to attend school regularly, may regress between school years, is rarely placed in appropriate child care or may be kept isolated from children without disabilities. Good parenting, quality medical care, early intervention, individualized therapies and reasonable accommodations combine to maximize the potential for a child with a disability. Poor children are at higher risk for developmental delay than non-poor children. One in 4 (26.5%) Oklahoma children between the ages of 1 and 5 is at moderate or high risk for developmental delay. More than thirty-five thousand (35,033) Oklahoma children from the aged of 5 through 15 have a disability. Ranking thirty-eighth (38th) with 6.4 % of 5 through 15 year old children having at least one disability, Oklahoma is in the worse half of all states. Mental disability is the most common disability among Oklahoma children. See Oklahoma KIDS COUNT Factbook 2003 for comparable county data.

DISEASE DEATHS OF CHILDREN AND YOUTH

Deaths from disease are frequently referred to as "non-preventable" death, reflecting a fatalism that discounts the contribution capable of being made by preventive health care and advances in medical treatment. Death rates are the most basic indicator of health status. Child death from disease is the final statistic measuring the effectiveness of Oklahoma's child heath system. Every year an average of one hundred and forty-four (144) Oklahoma children and youth ages 1 through 19 die from disease, a rate of 15.3 for every 100,000 children and youth that age. Currently, the highest and worst death rate is in Harmon County, where during the average year youth ages 1 through 19 die from disease at a rate of 85.5 per 100,000. The lowest and best rate (0.0 per 100,000) is found in eleven Oklahoma counties (Alfalfa, Beaver, Cimarron, Coal, Craig, Grant, Jefferson, Kiowa, Noble, Roger Mills and Washita).

RACE, ETHNICITY AND CHILD HEALTH

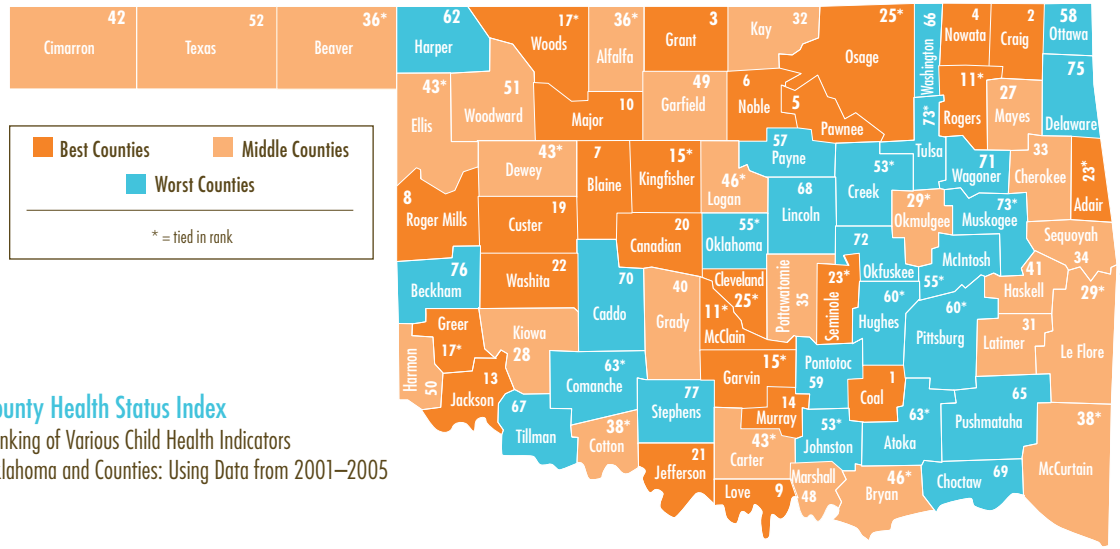
While most Oklahoma children are very healthy (86.3%), significant and disturbing differences occur by race and ethnicity. Rates of excellent or very good health plummet for Hispanic (63.3%) and African American (78.5%) Oklahoma children. Compelling evidence indicates that race and ethnicity correlate with persistent, and often increasing, health disparities among Oklahoman children (see Benchmark Topics in this and earlier Oklahoma KIDS COUNT Factbooks). Oklahoma babies born too small are most common in the African American community. Similarly, African American infants are more likely than other Oklahoma babies to die before their first birthday. In Oklahoma, teen birth rates are the highest among African American, American Indian and Hispanic girls and young women. African American children and youth are more likely to die from disease than other Oklahoma children. Unless these trends are reversed, the health of Oklahoma will decline further as racial and ethnic minorities comprise an increasingly larger portion of the Oklahoma population in coming years.

STATE & COUNTY HEALTH INDICATORS

HEALTH STATUS OF OKLAHOMA'S CHILDREN

61.8%	Birth mothers received adequate prenatal care
5.1/10,000	Infants/Toddlers exposed to lead
65.2%	Two-year olds immunized
91.2%	Eligible children covered by Medicaid/SCHIP
960.6/100,000	Juvenile arrests for drug- & alcohol-related offenses
15.3/100,000	Children & teen deaths from disease

Key health status indicators, reported here for the State of Oklahoma and by county in the benchmark section of this 2005 Oklahoma KIDS COUNT Factbook, can be grouped together and compared, allowing each Oklahoma county to be ranked based on the quality of child health in that county. Four indicators measuring key factors which influence health and development (prenatal care, lead exposure, immunizations, drug and alcohol arrests of youth), one measuring the health of children in the county (death from disease) and one measuring a child's access to health care coverage (Medicaid or SCHIP coverage) combine to provide a picture of the health of Oklahoma's children. The worse the county rank, the more work is needed to improve the health of local children. Based on these indicators, Coal County is best, Stephens County is worst.



County Health Status Index

Ranking of Various Child Health Indicators
Oklahoma and Counties: Using Data from 2001–2005

CONCLUSION: An Unfinished Picture

For some, this 2005 Oklahoma KIDS COUNT Factbook begins the discussion of child health. For others, it continues the discourse. Either way, it is unfinished. Policy makers, advocates, parents and Oklahoma children themselves will complete the picture.

In the coming years we will learn whether children can get the health care they need. In the coming years we will see if we have what it takes to keep young people safe and healthy in their homes and communities. In the coming years we will discover if we know how to keep children healthy enough to stay in school. In the coming years we will see if we can ease the mental distress of young people that leads to depression and suicide. In the coming years we will learn whether the health of a child is important enough to commit the resources necessary to make improvements. In the coming years we will learn how many more children have to die.

Oklahomans will decide whether the health of Oklahoma's children gets better or worse. The next picture is almost ready to take.