

The Growing Health Care Access Crisis for American Children: One in Four at Risk

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More Than One Child in Four Lacks Regular Access to Health Care

Quantifying the number of children without adequate access to primary health care has been consistently difficult. The way that the number of uninsured children is counted, for example, has a dramatic impact on these estimates. In 2005, there were 9 million children (11.2%) without health insurance, representing a growth of 361,000 from 2004 to 2005. This increase in uninsured children was attributed to loss of employer-provided health insurance and reduced enrollment in public insurance such as Medicaid and SCHIP, each state's child health insurance program.ⁱ

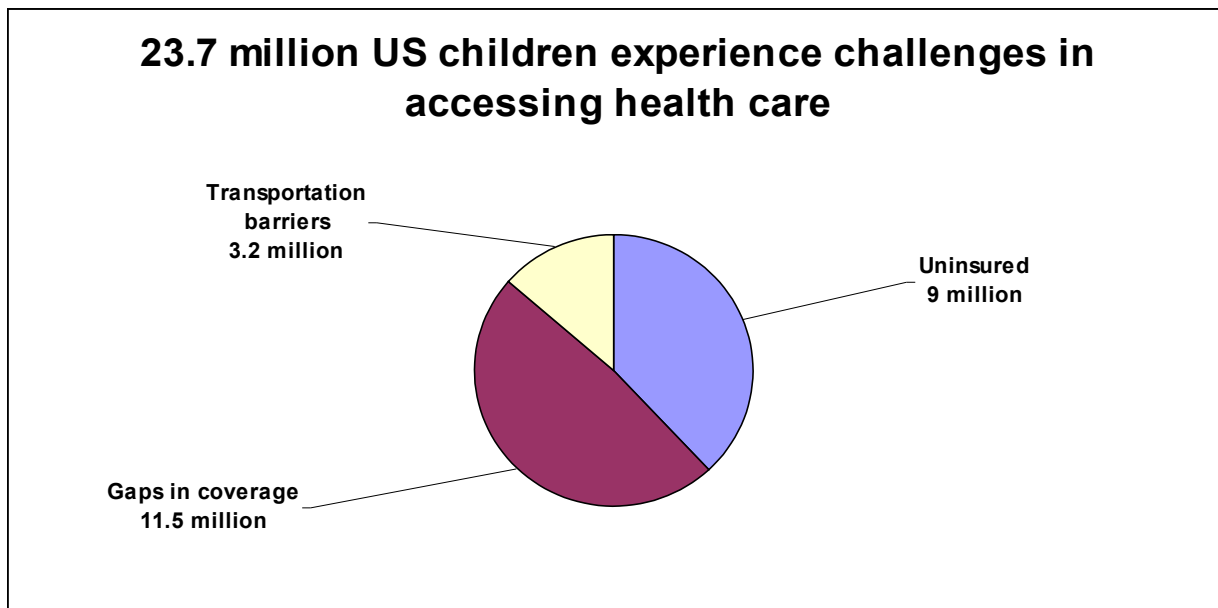
However, these data only reflect children who are without insurance for a full year. Children often experience gaps in their health coverage. Investigators found that an additional 14.4% of children, or 11.5 million based on the 2000 U.S. census, experience gaps in their health coverage during a 1 year period.ⁱⁱ Combined with the 9 million children without any insurance coverage, the total number of children in the United States without full year health insurance coverage is 20.5 million children.

Just having health insurance does not guarantee that our children have access to *health care*. Non-economic factors also interfere with access to health care services. In many poor urban and rural communities there are too few health professionals. These are federally designated as “**health professional shortage areas**”, or **HPSAs**. An inadequate supply of health professionals inevitably results in sparse distribution. Many families, particularly in rural communities, must travel long distances to get to a doctor. In these communities unaffordable, unavailable and/or unreliable transportation can be a powerful, but often overlooked, barrier to health access.ⁱⁱⁱ

In September 2006 The Children's Health Fund (CHF) and The Marist College Institute for Public Opinion completed the first of what will be a series of health surveys intended to describe the extent to which transportation is a barrier to child health access. CHF data show

that, by parent report, 4% of children (3.2 million) either missed a scheduled health care visit, or did not schedule a visit, during the preceding year because of transportation restrictions. Half of the affected families lived in rural areas.¹

Based on these estimates, we conclude that at least **23.7 million children** in the U.S., or more than one child in four under 20 years of age, does not have regular, full year access to needed health care services due to lack of insurance, gaps in insurance coverage, or transportation barriers.



¹ Our data suggest that these 3.2 million children are comprised primarily of children with health insurance; however, some are uninsured or under-insured. While this may seem to “double count” some children, this is more than counter-balanced by the additional groups with health access barriers not included in our estimate. An undetermined percentage of children in transient living conditions experience significant health access barriers. Homelessness and foster care are both associated with insurance gaps as well as loss of continuity from primary care providers if one had previously been available. In addition, an undetermined number of children have so-called “catastrophic” health insurance that covers hospitalization but not routine care such as immunization.

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Barrier to health access	Percent of children	Number of children
Uninsured, all year	11.2%	9 million
Gaps in coverage, uninsured part of year	14.4%	11.5 million
No transportation to health care services	4.0%	3.2 million
Total children with barriers to health access	29.6%	23.7 million

The Medical Home

The American Academy of Pediatrics defines a “medical home” as a source of health care that is continuous, comprehensive, coordinated, and family-centered.^{iv} The medical home is more than just a usual source of care; it is the gold standard of a health care provider for optimal care of children. In the absence of a medical home, rates of up-to-date immunizations, health screening services, and quality of care for chronic conditions are all in jeopardy.

An integral part of the medical home is the delivery of preventive health care at well child visits. At well child visits children are assessed for their medical, developmental, and social-emotional needs. Parents receive anticipatory guidance to help them optimally care for their child. Preventive health care services are delivered, including mandatory immunizations; height, weight, and body mass index tracking to prevent overweight and obesity; hearing and

vision screening for early identification of problems that may affect development and school success; and dental screening and referral.^v

Economic Barriers to Care: Income and Insurance

Family income is a major determinant of access to health care. Nearly one-fourth, 23%, of children and adolescents in families with annual income under \$35,000 goes more than one year – some more than five years – without any medical visits at all. One way to bridge economic barriers to health care is to make sure that all of our children have health insurance. Twelve percent of uninsured children have unmet medical needs. For nearly one in five, 17%, the reason is the cost of care. By contrast, only 2% of children with public health insurance have unmet health care needs and only 3% cite cost as a reason.^{vi}

Health insurance is essential to health care access. More than one-third, 34%, of children with no usual source of care lack health insurance, compared to 12% of children with public health insurance (Medicaid or SCHIP). In 2005, 11% of children under six years of age, 2.5 million preschoolers, were uninsured all year.^{vii} Children without health insurance are significantly less likely than children on Medicaid to receive well-child visits and other preventive health care services. One-third of preschool age children do not receive preventive health care services. Immigrant children, whether or not they are citizens, are significantly less likely to get well child care. One out of five children (20%) living in families below the federal poverty level do not get even one well child visit during the year.^{viii} One serious consequence of denying children access to preventive care is delayed immunizations. Partial or delayed immunization status places their health, and the health of the other children with whom they come into contact, at risk.

Health insurance is a family matter. Using Medical Expenditure Panel Survey (MEPS) data, investigators found that only half of children receive a well child visit during a calendar year. However, children with Medicaid are more likely than uninsured children to have this important preventive care, 41% to 28%. And children whose parents also have Medicaid coverage are most likely to have a well child visit, 62% compared to 41% for children with uninsured parents.^{ix}

Lack of access to preventive health care is associated with more costly medical conditions later in life, such as cardiovascular disease and cancer. It is also associated with more immediate, and preventable, costs to the health care system. In a large study of pediatric emergency room use, the majority of children were brought in for treatment of acute conditions that could have been treated in a primary care setting. The average emergency room user was 6 years old. The most common diagnoses were fever, infections, viral syndromes, and asthma. Most of these children, 9 out of 10, were discharged after treatment and only 11% were admitted to the hospital. Asthma, a manageable chronic illness, was one of the principle causes of hospitalization.^x

Asthma responds positively to primary care treatment. Appropriate asthma management can improve a child's quality of life by reducing severity and frequency of attacks. Proper management also reduces the child's need for hospital services.^{xi} Reviewing the impact of our comprehensive asthma treatment program in primary care for The Children's Health Fund's homeless patients in New York City shelters, we found that the reduction in emergency room use and in-patient hospitalization for patients with asthma was associated with a savings to the health care system of \$2,578 per patient with asthma. That is an approximate savings of \$3.3 million per year just for the patient population utilizing CHF's New York Children's Health Project.

Insurance is Not Enough: Transportation Barriers

Where a family lives also affects access to routine pediatric care. Children in rural counties are most vulnerable. Nearly half, 47%, living in households below the middle income level compared to 28% in urban counties. Similarly, lack of health insurance is higher in rural and near-rural counties compared to urban centers. Children in rural communities are also less likely to have a usual source of care.^{xii}

Data show that the shorter the distance from home to a safety net health care provider, the more likely the child is to receive routine care. In rural communities, with their shortage of health professionals and restricted public transport systems, access to transportation becomes a significant barrier to receiving routine care, treatment for acute conditions, and management of chronic health conditions including asthma and diabetes.^{xiii}

The Children's Health Fund/Marist Institute for Public Opinion data indicate that 4% of children nationwide miss at least one health care appointment because of transportation restrictions. The figure rises to 7% for children in families with an annual income under \$50,000. The problems are greatest among African-Americans and families living in rural communities. Almost half, 48%, of the missed appointments were for well-child visits, 11% for acute care, and 23% were for management of a chronic illness. Nearly one-third, 31%, of parents reported that they had to take their child to a hospital emergency room to get care for the problem associated with that missed appointment.

We applied these data to current population estimates^{xiv} and found that nearly 3 million children in the U.S. miss at least one health care appointment a year because of transportation barriers. These missed appointments resulted in about a million potentially avoidable emergency

room visits. Using 2003 MEPS data, we estimate the cost of these ER visits to be about \$750 million – that’s three quarters of a billion dollars that could be saved in the health care system just by improving access to care through better transportation to non-emergency health visits.

Oral Health Care

When it comes to oral health needs, the data are staggering. Nearly half, 49%, of preschool age children have never been to a dentist. In families with an annual income under \$35,000, 64% go more than one year without a dental visit. For nearly half of these children, more than five years went by without seeing a dentist.^{xv} Insurance is a key issue, with 22% of U.S. children lacking dental insurance. Children without dental insurance – which includes a disproportionate representation of poor, minority and rural children – were least likely to get preventive dental care and most likely to have unmet needs for oral health services.^{xvi}

Data describing the reasons for dental emergency visits show that 40% were for infections or other acute problems rather than accidental injuries. Nearly one-third of the children (30%) with dental emergencies were uninsured. Medicaid patients were twice as likely to be seen for an infection rather than an accident, as were minority children compared of white children.^{xvii}

The shortage of pediatric dentists, especially the lack of pediatric dentists willing to accept Medicaid reimbursement, can have devastating consequences. This was tragically illustrated in February 2007 when a 12-year-old homeless child in Prince George’s County, Maryland, a suburb of the nation’s capital, died of complications from a preventable and treatable tooth abscess. The family’s Medicaid coverage had lapsed, and the boy was temporarily uninsured. However, even with Medicaid, the family was unable to find a dentist and the child went without regular dental care. While his mother attempted to locate a dentist and arrange a

visit, his tooth infection spread to his brain. He died after six weeks in the hospital and two operations to save his life.^{xviii}

Only 900 of the 5,500 dentists in the state of Maryland accept Medicaid. Less than one-third of Maryland children on Medicaid saw a dentist during 2005. The percentage of children on Medicaid receiving oral health care was even lower in the surrounding areas, Virginia and the District of Columbia. Currently, there is pending legislation (the Children's Dental Health Improvement Act of 2007 sponsored by Senators Bingaman and Cardin), which would provide funding to help safety net providers – community health centers and health departments – make oral health care more available to poor children.^{xix}

Mental Health and Child Development

Comprehensive health care for children includes screening and referral for services to address mental health problems and to detect developmental delays in early childhood. Using National Health Interview Survey (NHIS) data for 2000, investigators estimated that about 6% of children and adolescents, approximately 4.8 million children, have disability-related activity restrictions. Significantly more developmental disabilities affect African-American children compared to white children. Prevalence among African American children is 6.71% compared to 5.97% among white children. Careful examination of the data, however, reveals that the difference in prevalence is attributable to risk factors associated with poverty, not race-ethnicity.^{xx}

Estimates of the prevalence of emotional disturbance among children vary widely. The 2001 national “call to action” on children’s mental health issued by then Surgeon General David Satcher found that 10% of American children and adolescents have impaired functioning due to

mental illness – and only one in five children and adolescents in need of mental health services gets help.^{xxi}

This extraordinary lack of appropriately available child mental health services is, in part, attributable to the continuing shortage of child and adolescent psychiatrists. Rural communities and communities with many poor and low-income families are the least likely to have access to appropriate mental health services.^{xxii} This affects not only children but their parents as well. A 2004 study of mental health need among parents of children in an urban Head Start center found that 56% were identified with psychosocial problems that warranted intervention. Only 14% received any mental health services during the preceding 12 months. Parents who needed mental health services and did not receive any were most likely to report behavior problems in their children.^{xxiii}

The availability, or lack, of mental health services is especially influenced by state policy. In fact, state by state variation in access to mental health care was found to be more closely related to state-level policy and health care market place factors than level of need or population characteristics, including race-ethnicity and poverty. The three states with the highest level of unmet mental health need were Florida, Texas and California.^{xxiv}

One essential policy action that states should take to enhance access is to establish financial parity of mental health services with the “physical” elements of comprehensive medical care. The recent passage of Timothy’s Law in New York State, which requires that health insurers provide mental health coverage with a minimum of 20 outpatient days and 30 inpatient days, and co-payments and deductibles comparable to those for physical illness, is an example of state legislation influencing health care financing to facilitate access to mental health services.

For young children at high risk of developmental delay, including children who are homeless or in foster care, integrating developmental screening in the well-child visit is an essential feature of the medical home and necessary to ensure school readiness and prevent or limit costly special education services. The federal Medicaid law has traditionally required that all providers reimbursed by Medicaid deliver “Early Periodic Screening, Diagnostic and Treatment (EPSDT)” services, which include screening “to detect physical and mental conditions.” Included among the requirements under EPSDT are an “unclothed” physical examination, dental, vision, and hearing screening and services, health education, and enabling services such as transportation.

We now find that, with so-called Medicaid reform, states may be offered the option of tailoring the Medicaid benefit to their short-term fiscal needs. This can include making EPSDT services optional. It is a measure of how much has been lost with respect to policies affecting child health access that in 1997, when SCHIP was being operationalized, advocates took the position that Medicaid requirements including EPSDT should also be mandated under SCHIP. Not all states did so. Now the SCHIP model giving states flexibility to exclude essential child health services may become a feature of Medicaid.

Recommendations

- While bolstering health insurance programs for underserved children is essential, the ultimate goal is to assure access to a medical home and comprehensive health care for *every child* in the United States.
- The pending reauthorization of the State Children’s Health Insurance Program (SCHIP) needs to be fully funded under legislation in this Congressional session. The reauthorization legislation should include provisions that (1) support states’ efforts to expand and improve coverage and (2) do no harm to other vital health programs such as Medicaid.
- EPSDT should be retained as a standard for child health benefits within Medicaid and be extended as the standard of care into all SCHIP programs.
- Dental and mental health care coverage should be mandated under all federally or state supported insurance programs for children.
- While non-emergency medical transportation is mandated as a benefit within EPSDT, it should also be required coverage within all SCHIP programs.
- Congress should consider legislation that would create a Health Professional Shortage Area (HPSA) type designation for communities that are transportation disadvantaged and are not able to adequately support transportation access to necessary health care services. Communities so designated would be eligible for health care and transportation subsidies to build transportation capacity.

- CHF supports efforts to restore and enhance funding of the National Health Service Corps to bring critically needed health professionals to severely underserved communities.

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