RAND HEALTH

RESEARCH HIGHLIGHTS

Triple Jeopardy for Vulnerable Children

Greater Health Needs, Less Access, Poorer Primary Care

Children need primary care. Good primary care improves health, reduces racial and ethnic health disparities, and lowers overall health care costs. Children's primary care is a major focus of both state and national health expenditures and health policy.

Nonetheless, for many children, primary care is inadequate. The most obvious problem is lack of insurance. Many children—even those eligible for public insurance—are not insured. However, RAND researchers have found that insurance is only part of the answer. Just as important as insurance (which provides financial access to health care) is potential access (the child has a regular health care provider) and realized access (the child actually receives care when it is needed).

Access problems are compounded by vulnerability. *Vulnerable children* are those who face multiple risks for both poor health and poor primary care. These children are in triple

Key findings:

- **Eligible children are more likely to be insured in states in which the State Children's Health Insurance Program is an expansion of Medicaid.**
- **Many parents do not understand SCHIP, and non-English speakers are less likely to enroll their children.**
- **Insurance is necessary, but not sufficient. For insurance to have a beneficial effect, children must also have a regular provider and receive care when they need it.**
- **Language barriers contribute significantly to racial and ethnic disparities.**
- **Children with the greatest health care needs have the greatest difficulty in obtaining primary care.**

This Highlight summarizes RAND Health research reported in the following publications:

Seid M, Stevens GD, and Varni JW, "Parents' Perceptions of Pediatric Primary Care Quality: Effects of Race/Ethnicity, Language, and Access," *Health Services Research*, Vol. 38, No. 4, August 2003, pp. 1009–1031.

Seid M and Stevens GD, "Access to Care and Children's Primary Care Experiences: Results from a Prospective Cohort Study," *Health Services Research*, Vol. 40, No. 6, Part I, December 2005, pp. 1758–1780.

Yu H and Seid M, "Uninsurance Among Children Eligible for the State Children's Health Insurance Program: Results from a National Survey," *Managed Care Interface*, Vol. 19, No. 5, May 2006, pp. 31–39.

Stevens GD, Seid M, Mistry R, and Halfon N, "Disparities in Primary Care for Vulnerable Children: The Influence of Multiple Risk Factors," *Health Services Research*, Vol. 41, No. 2, April 2006, pp. 507–531.

Stevens GD, Seid M, and Halfon N, "Enrolling Vulnerable, Uninsured but Eligible Children in Public Health Insurance: Association with Health Status and Primary Care Access," *Pediatrics*, Vol. 117, No. 4, April 2006, pp. e751–e759.

This product is part of the RAND Corporation research brief series. RAND research briefs present policy-oriented summaries of individual published, peer-reviewed documents or of a body of published work.

Corporate Headquarters
1776 Main Street
P.O. Box 2138
Santa Monica, California
90407-2138
TEL 310.393.0411
FAX 310.393.4818

jeopardy. They have greater needs, less access, and poorer primary care.

Many Eligible Children Are Not Insured

Legislators are keenly aware of the insurance needs of vulnerable children. Several public programs target this group. Children in low-income families are eligible for Medicaid. Children whose families earn too much to qualify for Medicaid and too little to afford private insurance are eligible for SCHIP (the State Children's Health Insurance Program), which became law in 1997. Nationwide, over 4 million children (just over 6 percent of the total child population) were eligible for SCHIP in 2000.

However, there is a big difference between being eligible and being enrolled. About 35 percent—well over one-third—of SCHIP-eligible children are not enrolled in SCHIP or any other insurance program.

Why are eligible children not enrolled? To answer this question, RAND researchers analyzed data from a nationwide survey conducted in 2000 and 2001 by the National Center for Health Statistics. Three key findings emerged.

First, administration matters. Each state sets up its own procedures for administering SCHIP. Sixteen states and the District of Columbia integrate SCHIP with Medicaid (in other words, they administer SCHIP as an expansion of the Medicaid program). The other 34 states have set up their SCHIP as a freestanding program. SCHIP *eligibility*, as a percentage of the population, varies only a little from state to state. But SCHIP *enrollment* varies dramatically. In those states in which SCHIP is an expansion of Medicaid, children were much more likely to be enrolled. The difference is nearly fourfold—children in Medicaid-expansion states were nearly four times more likely to be enrolled than were children in states with freestanding SCHIPs. It seems likely that, in the Medicaid-expansion states, SCHIP was easier to understand and the application process was simpler.

Second, children are more likely to lack insurance if they live in a household in which English is not the first language.

Third, many parents do not understand how SCHIP works. When asked why their children were not enrolled, nearly 50 percent of parents said SCHIP "costs too much." Another 16 percent said that they "cannot get SCHIP through my employer." Both statements are factually incorrect: SCHIP is offered free or at very low cost in most states; and it is offered not by employers but by the government. The widespread level of misunderstanding highlights the need for additional communication and outreach.

Children who lack insurance receive less care. A RAND study focusing on children in California found that children who were eligible for (but not enrolled in) public health insurance were less likely than enrolled children to have visited a doctor or a dentist in the past year, and less likely to have a regular health care provider. For uninsured children with multiple risk factors, the disparities were even greater.

Insurance Is Important, But Quality Primary Care Requires More Than Insurance

Medicaid, SCHIP, and other public programs are designed to remove financial barriers to primary care. However, insurance is only one factor in the receipt of high-quality primary care. The RAND team analyzed and compared three key components of children's primary care: financial access (whether the child is covered by public or private insurance), potential access (whether the child has a regular provider of medical care), and realized access (whether the child actually receives care when it is needed).

The study focused on parents of elementary-school children in a large urban school district in California. Participants represented a diversity of ethnic, racial, and socioeconomic backgrounds, and they included native speakers of English, Spanish, Vietnamese, and Tagalog (a language spoken in the Philippines). The study was designed to measure parents' experiences with their children's primary care, including how well the doctors understood the child's needs, communicated with parents, provided comprehensive care, and coordinated care with other providers when necessary.

The study found that all three components—financial access, potential access, and realized access—were vital to receiving high-quality primary care. However, lack of potential access and lack of realized care had greater negative effects on primary care quality than did the absence of insurance. Having insurance is necessary, but not sufficient, for good-quality primary care. For insurance to have a beneficial effect, children must also have a regular provider and receive care when they need it.

The study also found that equalizing access to all three components could largely eliminate differences relating to race and ethnicity. Looking at race and ethnicity alone, RAND found that Asian and Latino parents reported lower scores than African-Americans and whites. However, when additional factors were included in the same analysis, another finding emerged: Race and ethnic differences largely disappeared when comparing children who all have health insurance, a regular source of care, and parents who speak English. In other words, disparities in primary care quality could largely be eliminated if public policies were in place to ensure that all children have good access to primary care in a language they and their parents understand.

Finally, the study found that the results for children with chronic health problems, such as asthma, were no different from the results for other children. This finding suggests that good primary care is equally important for all children.

Vulnerable Children Face Multiple Risks

Risk factors are usually studied one at a time (for instance, many studies document the effects of lack of insurance). But in the real world, risks often appear in clusters. For example, if the child's parents did not graduate from high school (one risk factor), they are more likely to have low-paying jobs (a second risk factor) and to lack health insurance (a third risk factor). These risks could be compounded by race and ethnic issues and by language difficulties.

To analyze the effects of multiple risks on vulnerable children, the research team studied primary care experiences in relation to five common risk factors: the child's race/ethnicity, the household poverty status, parents' education, whether or not the child is insured, and the child's primary language. The study used data on children and adolescents (up to age 19) from the 2001 California Health Interview Survey.

Figures 1 and 2 show key findings. Figure 1 shows that children with multiple risk factors have poorer health (e.g., parents are more likely to report that the child's health is "fair" or "poor" versus "excellent" or "very good"). Figure 2 shows that children with multiple risk factors are less likely to have a regular provider. As noted above, having a regular provider is an important factor in receiving good primary care. Taken together, the findings show that children with the greatest health care needs also have the greatest difficulty in obtaining primary care.

Strategies for Improving Primary Care

What can be done? The first step is to enroll SCHIP-eligible children who are currently not enrolled. Remedies could be relatively easy. States should review their application processes and simplify those that are cumbersome. In addition, integrating SCHIP with Medicaid (as 16 states have done) dramatically increases the level of enrollment. Outreach, especially to minority communities, should be improved. SCHIP information and enrollment materials should be more aggressively disseminated in a variety of commonly spoken languages, such as Spanish.

Language barriers, in addition to impeding children's enrollment in public programs, also result in lower-quality care and contribute to racial and ethnic disparities. Providing linguistically appropriate health care services (such as helping parents find providers who speak their native language and increasing the number of trained, professional medical translators) would both improve the quality of primary care and help to reduce disparities.

While financial access is a necessary component of good primary care, policymakers should place an increased emphasis on programs to enhance both potential and realized access. Potential access (having a regular provider) could be improved if health plans routinely allowed open panels (so new enrollees would not have to change existing providers) and set up programs to link providers and enrollees. Realized access (receiving care when needed) could be improved through nurse helplines and extended hours for office and urgent care.

Figure 1
As the Number of Risks Goes Up, Health Status Goes Down

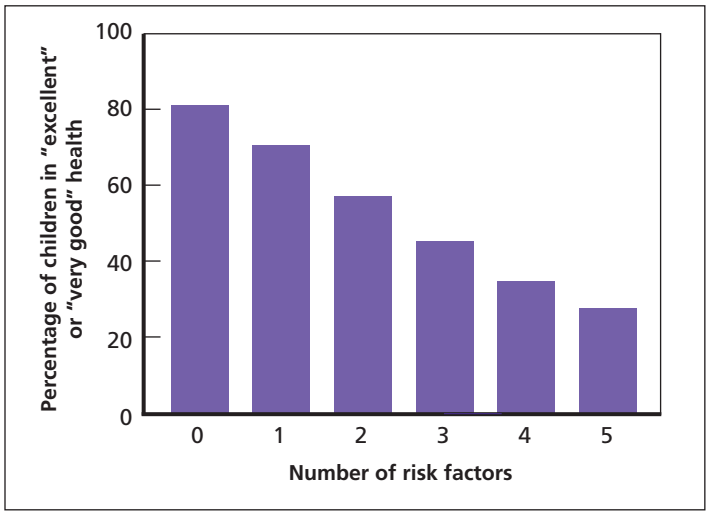
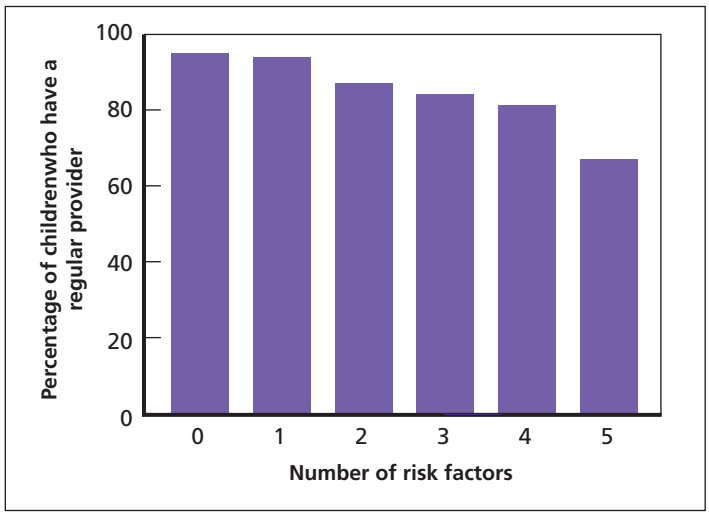


Figure 2
High-Risk Children Are Less Likely to Have a Regular Provider

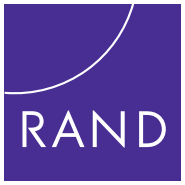


Implications for Policymakers

The research results point to a number of policy implications.

First, a greater number of eligible children could be enrolled in SCHIP if application processes were simplified and educational outreach efforts were increased. Second, primary care quality could be improved and race and ethnic disparities substantially reduced if policies were in place to ensure that all children have access to a regular provider when they need care, and that they can communicate with the provider in a language they and their parents understand. Finally, policies to improve access to health care, in addition to insurance needs, must address the multiple risk factors faced by vulnerable children. ■

RB-9215-1 (2006)



HEALTH