



Improving Access to Health Care for Children

An Analysis of Public and Governmental Programs to Improve the Access to Health Care:

A Comparison of Rural and Urban Children within the United States and the State of Ohio

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AUTHOR'S FOREWORD

In surgery, many surgical technologists assist on surgical procedures performed on pediatric patients. From ear tubes to transplant, children of all demographics require procedures to correct a deformity or condition. Unfortunately, many of these children do not have health care insurance, or they depend on state and federally funded Medicaid and State Children's Health Insurance Programs (SCHIP). What does the future hold for these programs, and how does it affect the access to health care for the pediatric population that depends on extensive medical and surgical services? While reading this article, please take time to consider the following questions and access the surgical technology forum area at <http://www.ast.org/forum/> to further discuss these with fellow students and seasoned professionals.

1. Do hospitals have the right to decide who does and doesn't receive surgical care?
2. Are there systems that affect decisions about surgical care?
3. Do geographical and economic demographics influence how and where children will have access to care, and which surgical care will be provided (ie emergency versus elective surgery)?

4. Are surgeons restricted from using expensive instruments or discouraged from opening packs of non-vitally-necessary equipment, if the hospital knows it won't be reimbursed by Medicare?
5. Would a more cost-effective physician assistant, resident, or CFA be called in to assist, instead of having a second surgeon scrubbed in?
6. Is there a difference in the degree or amount of postoperative follow-up care given to a surgical patient who is under- or un-insured?
7. Do hospitals frown on lengthy procedures for under- or un-insured patients, because they're more costly?
8. Are there moral/ethical principles involved? Are any of them being violated?

INTRODUCTION

Currently in the United States, nearly 18 million children live in poverty; half of them are not medically insured.¹⁴ This statistic mirrors the findings in Ohio, where there are 600,000 poor children, and 235,000 are without any health care insurance.¹⁴ Although 43% of uninsured children come from poor or near-poor families, 73% of these children come from low-income families that are considered 200% above the poverty level (\$40,000 for a family of four).¹³ (*The current poverty level for a family of four is \$20,650.*)²³

2007 U.S. Department of Health and Human Services poverty guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$10,210	\$12,770	\$11,750
2	\$13,690	\$17,120	\$15,750
3	\$17,170	\$21,470	\$19,750
4	\$20,650	\$25,820	\$23,750
5	\$24,130	\$30,170	\$27,750
6	\$27,610	\$34,520	\$31,750
7	\$31,090	\$38,870	\$35,750
8	\$34,570	\$43,220	\$39,750
For each additional person, add	\$ 3,480	\$ 4,350	\$ 4,000

Though federal and state governments have developed programs to help children regarding their access to health care through Medicaid and the State Children's Health Insurance Programs (SCHIP), one in five poor children, and 17% of near-poor children, remain uninsured.¹³ Along with children being uninsured medically, they are also uninsured in the areas of dental and mental health care. More than 25 million children lack dental care benefits, though it is a service provided by Medicaid.²⁷

Can the federal and state governments provide health and dental care for the millions of children who are poor or near poor in the country? If so, will there be enough providers to offer the access to care that is needed? In addition, what socioeconomic barriers prevent access to care, even if a public program insures children? This article will examine all the methodologies, regarding access to care and suggests improvements to the current system.

ACCESS TO HEALTH/DENTAL CARE THROUGH THE USE OF PUBLIC INSURANCE PROGRAMS

One of the biggest problems related to access to health care services is insurance. Through the creation of Medicaid and the recently created SCHIP program in 1997, more children are able to receive health insurance benefits than ever before. In Ohio, 65% of poor children and 38% of near-poor children participate in these health care programs.¹⁴ Though Medicaid and the SCHIP programs are available through the state, 12% of the entire child population under the age of 19 and 300% of the poverty level remain uninsured.¹⁴

CAUSES LEADING TO UNINSURED CHILDREN

In a 2003 study, nearly 30% of low-income parents knew what the SCHIP program was, and 40% did not know that their children were even eligible for health coverage.¹⁰ Another study showed that if a parent (or another member of the family) had a negative experience with the process of applying for these programs, then the parent probably would not enroll the children.¹⁰



During an analysis of Medicaid/SCHIP eligible children in Ohio, lower household income, parental unemployment, parental health insurance coverage, and lower child age were associated with greater child participation in Medicaid and SCHIP.¹⁸ What causes the decrease in enrollment? Parents participating in a 13-city focus group study reported frustration over answering numerous questions on the application; enduring long waiting periods in county offices; long, complicated and degrading applications, and finally, “rude” and “disorganized” social service workers.¹⁰ Many parents reject the challenges associated with enrolling children, especially in a single-parent situation. Another frustration is an application form published in English and the absence of an interpreter for non-English speaking clients. Consequently, many communication problems occur, and the time for children to gain coverage may be prolonged.

THE BUREAUCRACY OF GOVERNMENT RUN INSURANCE PROGRAMS AND THE COST SAVINGS OF PRIVATE HMOS

Child health care issues, such as the reauthorization of the SCHIP program, have recently become lost among other questions. The SCHIP program was originally created to offer assistance to children from working families that made too much money to be covered under Medicaid, but earned less than twice the federal poverty level. It is a genuine concern that the amount of money appropriated for the SCHIP program may remain the same as its creation in 1997 (\$40 billion) or even decrease.¹ How will this affect a child’s access to health care? With the decrease in funds, fewer children will be able to apply to the program, or coverage for mental health services, speech and physical therapy, or dental care may become more limited.¹ For example, if SCHIP is eliminated, children who need therapy services that cost \$25,000 will not receive it.³² In some states such as Georgia, SCHIP had to close out enrollment due to a lack of money at the state level.³²

Some members of Congress are using SCHIP as a tool to try to achieve universal health care coverage for all children, or to include other individuals besides children. Seven states (Hawaii, Illinois, Maine, Massachusetts, Pennsylvania, Vermont, and Washington) have enacted universal coverage.¹³ The majority of these states have used the SCHIP program as a tool to accomplish this goal. In Ohio, House Bill 119 was passed in the 2008-2009 state budget.¹¹ It included an



expansion of SCHIP eligibility for children with family incomes up to 300% of the federal poverty level and represented a 100% increase from the current level. In dollar amounts, a family that now earns approximately \$60,000 annually will qualify for state SCHIP benefits, which include a Medicaid Expansion Package (Individuals will receive all of the benefits as Medicaid recipients.).

Unfortunately, SCHIP will not guarantee universal coverage for children, or at least a *free* universal health care structure. SCHIP does not grant an entitlement to care as reflected in Georgia. With the number of children applying for this program and Medicaid, a sliding scale based on

income is under discussion. Therefore, a family earning \$60,000 annually will be charged higher co-payments and deductibles than a family earning \$40,000 a year.¹

The growing problem with SCHIP is that it was developed for uninsured children from low-income families. Over its 10-year lifespan, SCHIP has included children from middle-income families earning more than 300% above the federal poverty level, the child's family, or even single adults without children.¹⁵ Consequently, individuals who may be able to purchase private health insurance will enroll under SCHIP and squeeze out those that cannot afford private insurance. As more beneficiaries are added, needier children may lose coverage.

In order to control the costs of SCHIP, state governments have looked for alternative ways of managing their Medicaid programs as well. In Georgia, SCHIP had to limit enrollment due to a lack of money at the state level.³² At the same time, the state turned over responsibility for the Medicaid system to private health maintenance organizations (HMOs). In addition to Georgia, 32 other states turned their Medicaid systems into HMOs in "hopes of cutting through red tape, providing better care to needy patients and saving taxpayers money."³³ The result of this shift has been a decrease in needed covered therapy and specialty care, longer wait times to see physicians, and the elimination of some services.³³ In a "Good Morning America" report, the major HMO corporations that have assumed responsibility for state-run Medicaid programs have experienced billion dollar profits and higher stock prices.³³

WHAT'S IN YOUR WALLET?

In the United States, 20 million children use Medicaid as their primary insurance; 700,000 of them live in Ohio.¹⁴ Of the two public programs, Medicaid continues to be the primary public insurance resource for the poor and near poor of individuals living at 150% above the federal poverty level. Parents who spend time to apply for these benefits feel that their children have coverage for any medical, specialty, mental health or dental care issue. Unfortunately this is not the case. While children have the

necessary insurance, there is a lack of qualified providers to furnish services to clients with Medicaid as their primary insurance. In numerous reports it has been stated, "Children who lack health insurance have worse access to care than those with either public or private health insurance."⁴

Poor kids need more protection against unforeseen health effects. Early and periodic screening, diagnosis, and treatment, while perhaps unnecessary in middle-class contexts, address the real moral-hazard problem of capitated insurers' incentive to "not discover" all present and latent conditions.²¹

MEDICAID AND HOW IT RELATES TO MORE PROTECTION AGAINST UNFORESEEN EFFECTS

According to the Center for Medicare and Medicaid Services (CMS), dental care for children with Medicaid insurance is covered. A poignant example is the case of 12-year old Deamonte Driver who was covered for dental care as part of his Medicaid benefits.²⁷ One day, Deamonte complained of a toothache, and his mother Alyce phoned local dental clinics and dentists for an appointment. While she struggled to find a dentist who accepted Medicaid insurance, Deamonte's toothache developed into an abscess. The infection from the tooth spread into his brain requiring two major surgeries. Unfortunately, the surgeons were too late, and Deamonte died.

A study published by the American Academy of Pediatrics reports this example represents a problem within the Medicaid system. This survey found that physician participation in public programs was approximately 89%. Unfortunately only two-thirds of these providers accepted all Medicaid/SCHIP patients.⁴ In Ohio, SCHIP is based on the Medicaid expansion and therefore has the same fees for reimbursement as Medicaid. Other forms of SCHIP lead to a lower reimbursement than Medicaid.

ACCESS TO HEALTH CARE VERSUS QUALITY OF HEALTH CARE

The Medicaid and SCHIP programs have reduced the number of uninsured, low-income children by one-third.⁴ The problem with these programs along with private insurance companies is the failure to provide reports that show how the differences between public and private insurance affect overall quality of care for the pediatric patient. In addition, how is the quality of care affected by the access to care? In the Medicaid and SCHIP populations, it is often difficult to perform long-term studies on access versus quality of care. The main cause for this is the lack of a primary care provider (either by families opting to use a multi-practice clinic or the emergency department). Children without any form of insurance have adverse effects on medical care



use and health,⁹ and children living in poverty have more health problems and poorer utilization of preventative health.²⁶ This is due to a lack of a "medical home," and the fact that many parents do not believe that their children are eligible for medical benefits.

With the current reduction of private providers accepting Medicaid payments, many individuals with Medicaid or SCHIP insurance are forced to

utilize the emergency department (ED) as their resource for primary care. ED care is meant to be expedient in order to assist individuals undergoing genuine medical emergencies. A more common sight in today's ED is the "Fast Track," a section that cares for patients needing treatment for non-emergency medical conditions. This gives the opportunity for uninsured individuals or those who have Medicaid to receive medications and treatments



usually performed by a primary care provider. The result is a decreased ED work force and the inability of physicians to see patients with medical emergencies. A study by Hadley regarding health care changes among uninsured individuals concluded that, "An uninsured person who experiences an unintentional injury or a new chronic condition has greater difficulty obtaining recommended medical care and takes longer to return to full health, if at all."⁹ Hadley also states that uninsured individuals receive significantly less care and have poorer health outcomes than those with insurance; in addition, they depend more on EDs for their care, which will eventually become "episodic and lack continuity."⁹ This lack of continuity in care can also be applied to those with Medicaid insurance. As previously noted in Georgia, if the physician or dentist does not accept Medicaid insurance, then the access to care is no longer available.

Not only do the participants in these plans suffer. Those communities that have a network of

primary care physicians that do accept Medicaid payments become frustrated with the inability of their patients to access specialty services and medications along with the lack of continuing patient relationships.³ This is especially important for those children who are medically fragile.

Medically fragile children present lifelong illnesses or conditions that leave them "technology-dependent." Causative factors commonly include the increase in extremely preterm or very low birth weight infants.¹⁹ In 1990, the US Supreme Court ruled in the case of Sullivan versus Zebley that, "Childhood disability should be determined by individualized functional assessments of children ineligible for Supplemental Security Income (SSI) on the basis of medical standards alone."¹⁹ The court's decision allowed medically fragile children to receive SSI benefits, and subsequently receive coverage under the state Medicaid system. The rationale for enabling medically fragile children to enter the Medicaid system was attributed to the children's increased chances of having "extensive, chronic health care needs," and that "these children would need frequent use of long-term and acute care facilities."¹⁹ This rationale adds additional support to the argument for a consistent relationship with a primary care physician and access to the appropriate specialists who will work together in the child's long-term care.

Families with these children have major concerns, when publicly administered programs convert to privately operated agencies. First, the child's primary care may be turned over to a general practitioner who lacks experience with the child's condition and medical history. Second, many managed care plans limit the amount and type of pediatric specialists, which also may reduce specialty care in the form of family support groups, and counseling.

OTHER AREAS THAT AFFECT ACCESS TO CARE

Public insurance and the medical community are not the only culprits responsible for the lack of access to care. Two other barriers that hinder access to care include the location of the service provider and a means of transportation.

In the urban sector, missing appointments due to a lack of transportation commonly occur.²⁵ Low-income parents and single parents often cannot afford a reliable automobile or other mode of transportation, as well as the costs of maintenance, fuel and parking.

Children in rural areas are limited to the primary providers in their community, and therefore are geographically disadvantaged. When these children are hospitalized, they are admitted to non-rural hospitals due to the lack of local specialty or subspecialty resources in their community (ie mental health and high-risk newborn care).⁵ Governmental policy has focused on ways to bring health care providers to rural patients by providing physicians with complete tuition reimbursement in exchange for serving three to four years in a rural area. This philosophy is now changing, because specialty care in rural areas may affect quality and safety of care due to the relatively small number of cases performed in the rural setting.

The trend is for mobile health clinics or other forms of outreach, including telemedicine. The Cleveland Clinic has launched a new initiative for expanding health care access to rural areas. Understanding that individuals throughout Northeast Ohio need access to the best quality care, the Cleveland Clinic created 15 Family Health Centers; six of them are located in rural areas. These Family Health Centers offer primary care services in family medicine, pediatrics, and internal medicine, while also providing experts in specialty care, radiology and lab services; and some centers also have an attached surgery center. Now individuals living miles away from Cleveland Clinic's main campus can receive the same level of care. Through the clinic's E-Chart system, if an individual is referred to the main campus, the physician on the other end has total access to the patient's chart, X-rays, lab results and other information required to maintain continuity of care.

ANALYSIS OF THE INVEST IN CHILDREN PROGRAM

How does a community change an ailing system in order to increase access to health care? One community has successfully reached out through collaboration. The *Invest in Children* program was created in 1999 to:

Mobilize resources and energy to ensure the well-being of all young children in Cuyahoga County, provide supportive services to parents and caregivers, and build awareness, momentum, and advocacy in the community around children and family issues.



The vision of this organization is to see that all children in Cuyahoga County (the county that includes Cleveland, Ohio, currently ranked as the fourth poorest city in America)³⁴ reach their full potential and are supported by a community committed to their success. This program is led by a partnership committee with representation from local and state government, philanthropic organizations, religious agencies, business owners, corporations and the three major health systems in Cleveland. This program combines agencies within Cuyahoga County, (Cuyahoga County Employment and Family Services, Cleveland Department of Public Health, Cuyahoga County Board of Health, Cuyahoga County Community Mental Health Board, Help Me Grow, and Start-



ing Point) in a creative collaboration to provide quality services to all children within the county.

Through the contributions of the members of this collaborative, the *Invest in Children* program has made substantial impact on families and children within Cuyahoga County. Achievements include:

- Approximately 86% of all parents up to age 25 and first time parents of any age receive a

newborn home visit from an RN. One percent of infants being served had contact with at least one *Invest in Children* service before six months of age.

- Approximately 89% of eligible children under age six living in poor and low-income families receive free insurance from Healthy Start, and 96% of all children in the county have some form of health insurance. The estimated percent of uninsured children under age six fell from 10.5% to 4.4 %.
- 2,924 prenatal home visits were conducted in 2006.
- 7,317 newborn home visits were conducted in 2006, for a total of 34,279 visits during the duration of the program.
- 6,525 ongoing home visits and service coordination were conducted, for a total of 19,799 visits during the duration of the program.
- 344 early childhood mental health visits were made.
- The percentage of women with adequate prenatal care rose to approximately 80%.
- 131,342 children have accessed *Invest in Children* services (107,965 from Medicaid recipients).

According to Shannon Phillips, MD, who sits on the Partnership Committee, *Invest in Children* has increased child health and early developmental services, but as with any complex initiative, there is still room for improvement. Phillips comments that dental and mental health services are inadequate largely due to the lack of qualified providers that offer services. Although 80% of women in Cuyahoga County receive adequate prenatal care, the low birth weight rate (9.0%) continues to increase. Current initiatives are focused on getting information about the program out to the community. Recently, a mass media campaign was launched in the county market. Commercials, billboards, and radio ads informed the public about the services *Invest in Children* provides the children of Cuyahoga County. This program is one of the most comprehensive of its kind in the United States, seeking to link access and education to optimal health and developmental outcomes.

HOW DO WE INCREASE THE ACCESS TO CARE?

From government-administered Medicaid and SCHIP programs to community-based programs described in the *Invest in Children* program, great steps have been made by programs across the country to increase the access to care for children. Is universal health care the answer? According to a CNN/Opinion Research Corporation Poll, 73% of Americans feel that there should be a national health insurance program for all children under the age of 18, even if this would require higher taxes.

Although Medicaid and SCHIP programs are operating effectively on behalf of poor and low-income children, the methods of provider reimbursement for services need to be re-examined so children will have continuity and quality of care.

Outpatient clinics (based on the Cleveland Clinic Family Health Center model) staffed by primary care providers could be established in other states. Operating hours could be extended to accommodate working parents and facilitate families with limited transportation options. Once established, these clinics would be available to provide a continuity of care while potentially reducing the number of non-emergency ED visits, thereby allowing the EDs to return to focusing on urgent medical care.

Ideally, these clinics would be networked within an affiliated health system in order to provide continuity of care for children with long-term medical needs, including access to highly trained specialists. To address the question of transportation, community hospitals could be enlisted to provide resources for appointments and by limiting the distance between rural children and major medical centers.

In Ohio and Cuyahoga County, there are excellent hospitals to provide medical care to children. Unfortunately, in the shadows of these great medical centers, over 26,000 children remain uninsured within Cuyahoga County, and over 212,000 are uninsured in the state.

With the rising population of uninsured children and the decreasing number of children having access to care, the community, medical

centers, and health care providers have an opportunity to increase public awareness of programs and how to enroll in these programs, while also providing public health services, including education and screening.

The Cleveland Clinic Men's Minority Health Center and the Health Equity Initiative have



proven that public health programs and community involvement lead to positive outcomes in health care disparities. The Men's Minority Health Center, chaired by Charles Modlin, MD, FACS, is the first in the country to address the challenges of health care disparities among minority men. Utilizing a multidisciplinary approach to clinical care research and screening, minority men who do not have access to these services are treated, utilizing a world-class care approach to medicine. During the yearly health fair, minority men are able to participate in free screenings, such as prostate cancer, blood pressure, diabetes and cholesterol. The event represents an opportunity to provide information about diseases and other public health issues, including smoking cessation and nutritional health.

With the expansion of the Men's Minority Health Center with the Health Equity Initiative, children in Cleveland will receive the same opportunities. The initiative hopes to create a

children's health fair that will provide screenings for children, and also offer information to parents, including tips on keeping their children healthy, resources and assistance available for parents and children of need, and parenting information.



In Phillips's opinion, "Health care is a right, not a privilege." While an important part of the issue, insurance alone does not provide a direct access to health care. Society must join together in order to encourage individuals to apply for eligible benefits, while giving assistance to families unable to obtain necessary treatment, so all children can become the leaders of tomorrow.

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