



Child Health

Fighting Poverty and Poor Health

For the first time in our nation's history, the projected life expectancy for children may be less than that of their parents. More than nine million children in the United States remain uninsured and child health programs responsible for so much progress over the past few decades are threatened by budget cuts and policies that undermine our national safety net. States have been cutting back on Medicaid coverage for children, and enrollment in the State Children's Health Insurance Program (SCHIP) decreased in the last quarter of 2003.

Children who are not healthy bear a disproportionate burden of illness. This burden falls most heavily on children from lower-income families and children from ethnic and minority backgrounds. The result: Many of the forward strides in children's health have stalled. In 2002, the infant mortality rate rose for the first time in more than 40 years, from 6.8 deaths per 1,000 births to 7.0 per 1,000 births. The United States now ranks 25th in the world among industrialized nations in preventing infant mortality, and the percent of children born at low birthweight has increased.

Ensuring access to quality health care and reducing health disparities among children are keys to breaking the cycle of poverty and ensuring that all children live healthy and successful lives.



"Housing costs contribute to malnutrition, and malnutrition affects school performance and cognitive capacity... weakens immune systems and makes children susceptible to illness.... If you spend a day in a malnutrition clinic, you will see a dismal parade of babies and toddlers who look much younger than they are. Underweight and developmentally delayed, they cannot perform normally for their ages... doctors describe these conditions as 'failure to thrive'..."

—David K. Shipler, "Children Going Hungry," *The Washington Post*, February 27, 2005

Health is a critical component in the cognitive and social development of children. Children in poor health are more likely to have poor social and economic outcomes and even shorter life expectancies. They cannot fully participate in the learning process, due to greater school absenteeism and behavioral problems resulting from certain health conditions.¹ Children in poor health start out at a disadvantage and, in many cases, maintain that disadvantage throughout their adult lives. However, the life-long impact of poor health in early childhood can be prevented.

During the last half century, public policies have not only enhanced the economic and social environment for a large portion of the U.S. population, they have also increased access to quality health care and achieved tremendous progress in improving children's health. Through such public health programs as Vaccines for Children and public health insurance expansion through Medicaid and the State Children's Health Insurance Program (SCHIP), more children than ever before have access to preventive health care. The infant mortality rate has dropped by more than 70 percent, falling rapidly after the inception of Medicaid in 1965 and again after the Medicaid expansions in the early 1990s. A higher percentage of babies are born to women receiving early prenatal care, and a lower percentage to women receiving late or none. Higher immunization rates have yielded dramatic decreases in the incidence of many childhood diseases, such as disability due to polio or *Haemophilus influenzae* type b (Hib) and deaths due to incidences of diphtheria and tetanus.

Despite the overwhelming evidence demonstrating the importance of these programs in ensuring children's health, there is a growing disconnect between children's health needs and public policy. In fact, the initiatives responsible for most of the improvements in children's health status over the past few decades are being threatened by budget cuts and policies that undermine these safety net programs. States have been cutting back on Medicaid coverage for children and, for the first time since the program's inception, SCHIP enrollment actually decreased in the last quarter of 2003.² In 2002, the infant mortality rate rose for the first time in over 40 years, from 6.8 deaths per 1,000 births to 7.0 per 1,000 births.³ This alarming statistic means the United States now ranks 25th in the world among industrialized nations in preventing infant mortality.⁴ The percentage of children born at low birthweight has increased, and more than nine million children in the United States remain uninsured.⁵

Furthermore, those children who are not healthy bear a disproportionate burden of illness. This burden falls most heavily on children from lower-income families and children from ethnic and minority backgrounds. Differences in health outcomes for poor and minority children continue to persist for most major health problems affecting children, including lack of prenatal care, lead poisoning, inadequate dental care, asthma, obesity, and lack of health coverage. These inequalities in health access and outcomes constitute a major challenge to our nation's ability to thrive because the consequences of many conditions that afflict children continue through adulthood.

Child Health

Recently, new challenges have begun to emerge in children's health, highlighting the need for continued attention to providing all children, especially children living in poverty, with the quality care they need. *A recent study in the New England Journal of Medicine revealed that for the first time in the nation's history, the projected life expectancy for children may drop.* Children today may live as many as two to five years less than their parents as a result of the negative health effects of obesity and obesity-related illnesses.⁶ Reducing health disparities among children is key to breaking the cycle of poverty and ensuring the social and academic success of all children.

This chapter describes the current state of child health across several important indicators. Differences in health outcomes for income and race are examined for each indicator, highlighting the disproportionate number of minority and poor children with poor health outcomes. It goes on to describe the ongoing disconnect between children's health needs and policy. Programs influential in ensuring good health outcomes have been cut or altogether eliminated, even when their cost effectiveness is demonstrated by research. The chapter concludes with suggestions of ways to address and improve children's health outcomes.

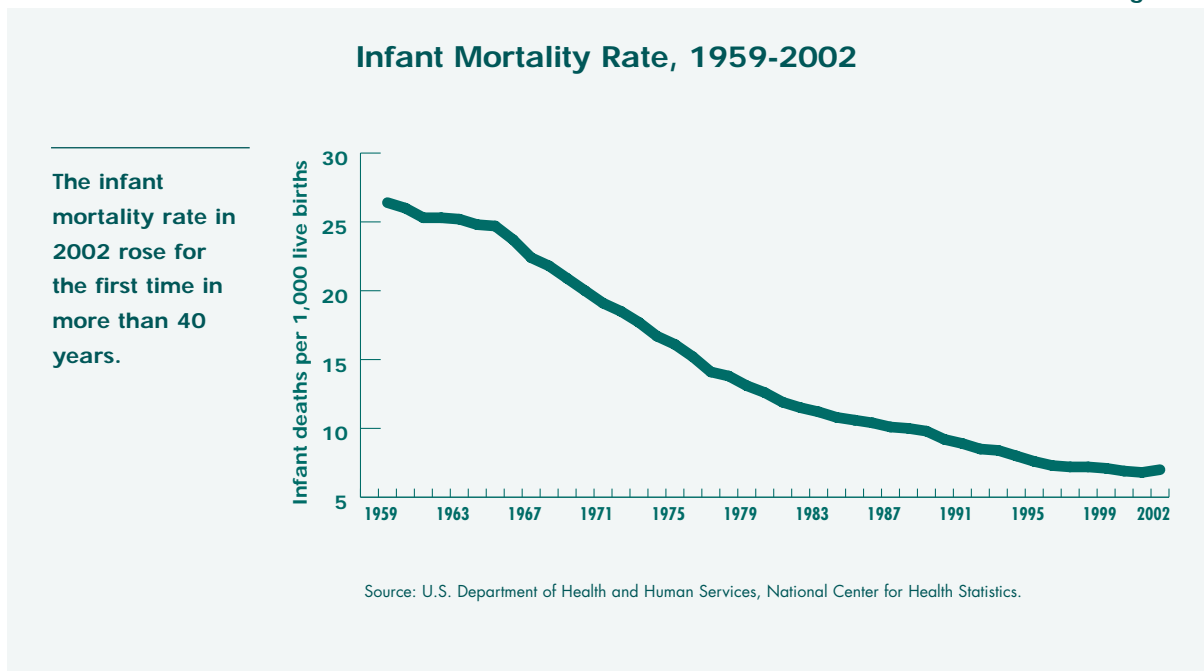
The Poor Health Burden on Low-Income and Minority Children

Most children born today in the United States experience few lasting or significant illnesses. They tend to be in excellent or very good health and suffer no serious abnormalities. Those who are not healthy, however, bear a disproportionate burden of illness, and this burden falls most heavily on children from lower income families and children from ethnic and minority backgrounds. Despite the dramatic progress in children's health, we enter the 21st century no closer to closing the gaps in health outcomes for many children than we were in the last.

Poverty and Health

Health is strongly correlated with income. Poor people are less healthy than those who are better off, whether the benchmark is mortality, the prevalence of acute or chronic diseases, or mental health. The association of poverty and health could be due to many factors. Families in poverty have higher stress levels as they struggle to meet their basic needs. They live in dangerous neighborhoods

Child Health – Figure 1



The Health Burden on Poor Children

Compared to higher-income children, low-income children are:*

- Almost five times as likely to be in only fair or poor health.
- Three times as likely to have an unmet medical need.
- Almost three times as likely to be uninsured and have no regular place for health care.
- More than twice as likely to not have seen a doctor for two years or delayed medical care due to cost.
- More than one and a half times as likely to miss 10 or more days of school due to illness or injury.



* Low-income is defined as family income below 200 percent of the Federal Poverty Level (FPL).

Sources:

1. National Center for Health Statistics, 2002 National Health Interview Survey. Calculations by Children's Defense Fund, January 2005.
2. National Health and Nutrition Examination Survey, 1999-2000. Calculations by the Children's Defense Fund, October 2004.

where they are exposed to more environmental hazards, and they endure greater hardships in their everyday lives.⁷

A family's well-being is strongly tied to the physical health of its members. When illness strikes one member, the entire family shares the burden. Income dwindles when parents cannot work. Opportunity is lost when children cannot attend school. Yet at the same time, poor people—who lack consistent access to nutritious food, clean water, preventive health measures, or a healthy, sustainable environment—are extremely vulnerable to illness, disability, and even death.⁸

Numerous studies have shown that poverty is associated with higher rates of poor health and chronic health conditions in children. Low-income children have greater exposure to lead, decreased management of asthma, a higher number of dental caries, and higher rates of obesity. Children in poor physical or mental health cannot fully participate in the learning process. All of these factors may contribute to why children who live in poverty experience negative health outcomes.

Race/Ethnicity and Health

Health is also associated with race and ethnicity. Indeed, the gaps in health status between Whites and minorities have persisted and, for some indicators, widened further. For example, while age-adjusted death rates from all causes declined

for both Whites and Blacks, Blacks are still at a 30 percent higher risk of death than Whites, a disparity greater than in 1960.⁹ Major disparities exist in coronary heart disease (CHD) with a disproportionate burden of death and disability among minority and low-income populations. With almost 700,000 deaths a year, CHD is the leading cause of death in the United States, accounting for 29 percent of all deaths. In 2001, premature deaths (occurring in persons under age 64) from CHD were higher among American Indian/Alaskan Native (36 percent), Black (31.5 percent), and Latino (23.5 percent) populations than among Whites (14.7 percent).¹⁰ Similarly, when looking at all cancers combined, Black men are 26 percent and Latino men are 16 percent more likely than White men to die of a malignancy. Black women are 52 percent, and Latino women are 20 percent, more likely than White women to die of cancer.¹¹

Racial disparities in health exist not only for adults; minority children—especially Black and Latino children—continue to lag behind White and affluent children in almost every health indicator. The disproportionate burden of illness and death experienced by low-income and minority children remains a major obstacle to improving children's well-being. Disparities persist in the rates of infant mortality and prenatal care, immunizations, asthma, dental care, lead poisoning, and obesity, to name just a few such indicators. These conditions impact many aspects of children's development and



functioning. Their effects occur before birth, continue through adolescence, and often last a lifetime.

Disparities in Prenatal Care, Infant Health, and Immunizations

The foundation for children's physical, mental, and emotional health begins before birth during the formation of the brain and body, and is linked to maternal health. For example, recent research has studied the far-reaching effects of prenatal brain development on later functioning.¹² These studies suggest that there are certain stages of development, both before birth and after birth, when environmental influences can have a potentially permanent effect on a child.¹³ Early prenatal and infant care and regular health monitoring can help to counterbalance certain negative biological and environmental factors, creating healthier children and most likely healthier adults as well.

Prenatal care, birthweight, and immunizations are all strong contributors to a child's chances (or lack thereof) for healthy physical and mental development, and by extension, success in school and their adult life. For example, a low birthweight child is twice as likely as a normal weight child to have clinically significant behavior problems, such as hyperactivity.^{14, 15} Children born with low birthweight are also about 50 percent more likely to score below average on measures of reading and mathematics.¹⁶ These risks have been measured in young children as well as teens, indicating that the impact of early childhood conditions can affect learning throughout childhood.¹⁷

These risks are also greater if compounded with other physical, ethnic, or socioeconomic factors. For example, one birthweight study found that maternal smoking during pregnancy and Hispanic origin were two predictors of whether low birthweight children would develop behavior problems.¹⁸ Socioeconomic disadvantage is also a risk factor for low birthweight and premature birth.¹⁹

Prenatal Care

Prenatal care for pregnant women, important in reducing the incidence of infant mortality and low birthweight, is consequently a critical compo-

nent in ensuring the healthy development of infants and children. The level and timing of prenatal care is often used as a proxy for access to care and birth outcomes. During the 1990s, the proportion of women starting prenatal care in the first three months of pregnancy improved slowly but steadily. This improvement coincides with a law passed in 1989 that requires Medicaid coverage for pregnant women with incomes below 133 percent of the federal poverty guideline (many states provide coverage to pregnant women at higher-income levels).²⁰

In 2002, 83.7 percent of mothers began prenatal care during the first three months of their pregnancy, a slight increase from the previous year. In that same year, 3.6 percent of all mothers had late or no prenatal care, which is defined as care never initiated or only initiated during the last three months of the pregnancy. However, racial and ethnic differences continue in the timeliness of prenatal care. In 2002, 75.2 percent of non-Latino Black and 76.7 percent of Latino women received prenatal care in the first trimester, compared to 85.4 percent of non-Latino White women.²¹ Further, non-Latino Black and Latino women were more than two times as likely as non-Latino White women to have late or no prenatal care (6.2 percent and 5.5 percent, respectively, vs. 3.1 percent).²²

Infant Mortality and Birthweight

Racial and ethnic differences also exist in the rates of infant mortality and low birthweight. Although the overall infant mortality rate dropped steadily until the increase in 2002, the difference between White and Black infant mortality rates did not. In 2002, there were more than 28,000 infant deaths (children under age one), more than all deaths combined among children ages one through 19. Infants born to Black mothers were more than twice as likely as infants born to White mothers to die before their first birthday (14.4 vs. 5.8 deaths per 1,000 live births). Almost one-third of all infants who died in 2002 were infants born to Black mothers.²³

Infant mortality and birthweight remain critical indicators of children's health and illustrate the

persistence of health disparities among children. While low birthweight is one of the leading causes of infant mortality among all races, it is by far the greatest cause of death for infants born to Black mothers. In 2002, 7.8 percent of infants were born weighing less than 2,500 grams or 5.5 pounds, which is similar to previous years. Non-Latino Black infants were almost twice as likely to be born at low birthweight as non-Latino White infants (13.4 percent vs. 6.9 percent).²⁴

Smoking and Substance Abuse

Prenatal care is also important because it presents opportunities to address behavioral issues during pregnancy, such as smoking or substance abuse, that also have significant impacts on infant and

child health. Women who smoke during pregnancy are at greater risk for having a premature birth, pregnancy complications, low birthweight infants, a stillbirth, as well as a higher rate of infant mortality. Smoking during pregnancy also is associated with Sudden Infant Death Syndrome (SIDS), poor lung development, asthma, and other negative consequences for child health and development.

The percentage of women who smoke during pregnancy has declined during the last decade. In 2002, 11.4 percent of women giving birth reported smoking during pregnancy. There were, however, racial differences, with Black women less likely than White women to smoke during pregnancy (8.7 percent vs. 12.3 percent, respectively).²⁵ This difference is unexpected given the higher rates of infant mortality and low birthweight among infants

Child Health – Table 1

Selected Maternal and Infant Health Indicators, by Race and Hispanic Origin of Mother, 2002

Characteristic	All Races	White		Black		Native American	Asian, Pacific Islander	Hispanic*
		Total	Non-Hispanic	Total	Non-Hispanic			
<i>Percent</i>								
Early prenatal care ¹	83.7%	85.4%	88.6%	75.2%	75.2%	69.8%	84.8%	76.7%
Late or no prenatal care ²	3.6	3.1	2.2	6.2	6.2	8.0	3.1	5.5
Low birthweight ³	7.8	6.8	6.9	13.3	13.4	7.2	7.8	6.5
Very low birthweight ⁴	1.5	1.2	1.2	3.1	3.1	1.3	1.1	1.2
Births to teens	10.8	9.8	7.9	18.0	18.1	18.5	3.8	14.9
Births to unmarried	34.0	28.5	23.0	68.2	68.4	59.7	14.9	43.5
Births to mothers who have not completed high school	21.5	21.6	11.7	24.4	24.3	30.8	10.3	48.1
<i>Per 1,000</i>								
Infant mortality rate ⁵	7.0	5.8	5.8	13.8	13.9	8.6	4.8	5.6
<i>Per 100,000</i>								
Maternal mortality rate ⁶	8.9	6.0	5.6	24.9	24.9	na	na	7.1

*Persons of Hispanic origin can be of any race; includes races other than White and Black.

na — data not available

¹Care begun in the first three months of pregnancy.

²Care begun in the last three months of pregnancy, or not at all.

³Less than 2,500 grams (5 lbs., 8 oz.).

⁴Less than 1,500 grams (3 lbs., 4 oz.).

⁵Infant deaths per 1,000 live births. These rates are from the linked birth-death files for 2001, and differ somewhat from other infant mortality rates published by the National Center for Health Statistics.

⁶Maternal deaths per 100,000 live births.

Source: National Center for Health Statistics.



born to Black women, illustrating that a variety of factors can influence outcomes of infant development.

Consistent prenatal monitoring and care are key to the health of both mother and baby, as even small amounts of harmful substances can have devastating effects on infant health. There is no safe threshold for alcohol consumption, demonstrated by findings that negative outcomes have been found in children who were prenatally exposed to the equivalent of just half a drink per day.²⁶ Children born with Fetal Alcohol Syndrome have neurological abnormalities and generally are academically behind their peers. Moderate exposure (measured as 2.2 drinks/day) is associated with learning and psychiatric problems, distractibility, and hyperactivity.²⁷ Even low levels of exposure (measured as .03 oz. of alcohol/day) have been associated with behavior problems in school-aged children.²⁸

Immunization

Prenatal care also allows providers to convey the importance of immunizations and future health visits. Immunization is one of the most effective ways to protect a child from serious, preventable infectious diseases, enabling children to enter school in good health, ready to learn. Vaccination programs in the United States have resulted in the elimination of smallpox and rendered diseases such as rubella, diphtheria, polio, and tetanus exceedingly uncommon. In addition, cases of Hib (*Haemophilus influenzae* type b)—the leading cause of childhood bacterial meningitis and postnatal mental retardation—and cases of measles were reduced significantly as a result of a broad improvement in childhood vaccination levels during the last decade.

Child Health – Table 2

Due in part to increased access to immunizations, more than three-fourths of all poor children are fully immunized, but still lag behind higher-income children.

Immunization of Two-Year-Olds* in 1995 and 2004, by Race/Ethnicity and Poverty Status

	Percent fully immunized 4:3:1:3 series**		Percent fully immunized 4:3:1:3:3 series***	
	1995	2004	1995	2004
<i>All income levels</i>				
All races	73.7%	82.5%	55.1%	80.9%
White non-Hispanic	76.4	85.1	55.6	83.3
Black non-Hispanic	69.8	76.0	53.3	74.5
Hispanic	68.2	81.2	53.0	79.7
<i>Below poverty</i>				
All races	67.3	78.0	51.0	76.8
White non-Hispanic	68.9	77.6	45.6	76.5
Black non-Hispanic	69.6	73.8	53.1	72.0
Hispanic	62.9	79.8	53.4	78.9

*Children 19–35 months of age

**Four or more doses of diphtheria, tetanus, pertussis vaccine (DTP or DTaP or DT); three or more doses of poliovirus vaccine; one or more doses of any measles-containing vaccine (MCV); and three or more doses of *Haemophilus influenzae* type b vaccine (Hib).

***Four or more doses of diphtheria, tetanus, pertussis vaccine (DTP or DTaP or DT); three or more doses of poliovirus vaccine; one or more doses of any measles-containing vaccine (MCV); three or more doses of *Haemophilus influenzae* type b vaccine (Hib); and three or more doses of hepatitis B vaccine (HepB). The hepatitis B vaccine was a relatively new recommendation for children in 1995, so rates of immunization were somewhat low. The percentage of children fully immunized was therefore also lower.

Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1995 and 2004 National Immunization Survey, Table 32, at <<http://www.cdc.gov/nip/coverage/NIS/04/toc-04.htm>>.

This improvement is, in part, attributable to the Vaccines for Children (VFC) program. Established in 1993 as part of the Childhood Immunization Initiative, the VFC program provides free vaccines to doctors for Native American children and children who are uninsured or receiving Medicaid, so they can be immunized in their own private doctor's office. Prior to VFC's implementation in 1993, about two-thirds of two-year-olds had been fully immunized. By 2004, 80.9 percent of two-year-olds were immunized, meeting the *Healthy People 2010* goal. New vaccines that have become available to prevent hepatitis B, chickenpox, and pneumococcal pneumonia are now included in the immunization schedule for children.

While incredible progress has been made in increasing U.S. immunization rates for children, sustained policy, outreach, and educational efforts are necessary to not only maintain current rates, but to improve upon them. The percentage of two-year-olds receiving the full 4:3:1:3:3²⁹ complement of vaccines for diphtheria/tetanus/pertussis, polio, measles, Hib, and hepatitis B reached a high of 80.9 percent in 2004. Yet the immunization rate for children in families below the poverty level was only 76.8 percent.³⁰ According to data from the Centers for Disease Control and Prevention's National Immunization Survey, 74.5 percent of

non-Hispanic Black and 79.7 percent of Latino 2-year-olds received the 4:3:1:3:3 complement, compared with 83.3 percent of non-Hispanic Whites.³¹ These immunization differences indicate a need for renewed immunization outreach and education efforts, particularly to poor and minority children. Disparities such as these leave millions of children at risk for often debilitating and potentially life-threatening infectious diseases.

Disparities in Childhood Lead Poisoning

The leading source of lead exposure in America's children is deteriorating lead paint in older housing. Lead poisoning continues to be a threat to children's health despite the 1978 nationwide ban on lead paint. Nearly one million children are affected by lead poisoning, exhibiting elevated blood lead levels.³² It is estimated that one out of every 20 children in the United States has some lead poisoning but is not exhibiting visible signs or symptoms.³³

The threat of lead exposure is even greater for low-income and minority children. For example, low-income children (below 200 percent of poverty) are more than five times as likely to have elevated blood lead levels of at least five micrograms per deciliter (mg/dL) than higher-income

STORIES FROM THE STATES

Unsafe Living Conditions and Lead Poisoning

Troccora Nicholson lives in Duncan, Mississippi, with her five children. Their home is a dilapidated trailer that should be condemned. Parts of the wall are falling down; a section of plywood from the wall fell and hit her son in the head. The sky can be seen through a hole in the ceiling. Rain gets into the trailer, which is now filled with mold. In the bathroom, there is a gap in the floor covered with plywood because it is wide enough for snakes to enter. Troccora's unsafe home is the reason one of her younger sons has lead poisoning and RSV (Respiratory Syncytial Virus). She receives Medicaid and other public assistance for her children, but she cannot move out of the trailer because she is currently unemployed and has no way of traveling to a job.



Young Black children are more than twice as likely as White children to have elevated blood lead levels.

	Lead Exposure	
	Percent of children* with lead levels over 5 µg/dL	
	All Children	Ages 1 to 5
All**	3.2%	8.2%
<i>Race/ethnicity</i>		
Non-Hispanic White	2.5	7.0
Non-Hispanic Black	7.0	17.4
Hispanic	2.8	6.3
<i>Family income</i>		
200% of poverty or more	0.9	***
Under 200% poverty	5.2	***
<i>Insurance status</i>		
Insured	2.9	7.7
Uninsured	5.2	11.3
* Children are ages 1 through 18.		
** Includes all children measured, regardless of race, income, or insurance status.		
*** Sample size too small to produce a reliable estimate.		
Source: U.S. Department of Health and Human Services, National Center for Health Statistics, 1999-2000 and 2001-2002 National Health and Nutrition Examination Survey (NHANES).		
Calculations by Children's Defense Fund.		

children.³⁴ These children are more likely to occupy housing and schools that contain lead-based paint. For example, 16 percent of lower-income children living in older housing have lead poisoning, compared with 4 percent of all children.³⁵ Children receiving Medicaid constituted about one-third of the U.S. population of children ages one to five, but represented about 60 percent of children with elevated blood lead levels.³⁶ According to the Alliance to End Childhood Lead Poisoning, Black children are at five times greater risk of exposure than White children.³⁷

Consistent lead screening is essential to the identification of children in need of treatment. As part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit, the Centers for Medicaid and Medicare Services (CMS) requires that Medicaid children be screened for lead poisoning, at a minimum, at ages 12 months and 24 months. Therefore, at least one blood test for lead is supposed to occur by the age

of 2.³⁸ In three states—New Jersey, Massachusetts, and Rhode Island—the law mandates screening of all children younger than age six, regardless of Medicaid status.³⁹

However, a National Conference of State Legislatures survey reported many barriers to consistent application of lead screening, including provider noncompliance, lack of access to laboratories, lack of funding, transient population, and problems with parental follow-through.⁴⁰ Although most states (37) claim that blood lead screenings of children in Medicaid occur regularly as part of EPSDT requirements, a General Accountability Office (GAO) report found that more than 80 percent of Medicaid children have not been screened for blood lead levels despite this requirement.⁴¹ This is particularly disconcerting given that children in the Medicaid program are three times more likely than other children to suffer from lead poisoning.⁴²

All children are potentially vulnerable to lead poisoning because they engage in more hand-to-

mouth activity and, thus, are easily poisoned from chronic ingestion of lead paint chips and house dust or soil that may have lead particles in it.⁴³ In addition, a child's growing body can absorb more lead than adults, and their developing brains and nervous systems are more sensitive to the damaging effects of lead. High levels of lead can cause behavior and learning problems, stunted growth, hearing problems, and headaches.⁴⁴ A variety of studies have tracked the effect of elevated blood lead levels in children, and have found that there is anywhere between a one- and five-point drop in IQ with each increase of 10 µg/dL in blood lead level.^{45,46,47}

Smaller concentrations of blood lead levels also have been associated with decreased IQ scores and cognitive impairment in exposed children. Children with lead levels at half the known danger threshold or lower have demonstrated decreases in IQ and intellectual function.^{48,49,50} This evidence supports what the Centers for Disease Control and Prevention has acknowledged: There is no safe level for lead exposure in children.⁵¹ Children with lead exposure at a variety of levels can suffer from cognitive impairments that hinder their ability to learn.

Disparities in Prevalence and Severity of Childhood Asthma

Asthma is one of the few chronic illnesses that affects children more frequently than adults. While asthma rates have increased among all age groups in the United States, young children have experienced the largest increase in prevalence. Children from birth to age 17 are more likely to suffer from

asthma than adults 18 and older.⁵² From 1980 to 1994, the prevalence of asthma in children under the age of five more than doubled. Older children ages five to 14 also experienced substantial increases, with asthma rates nearly doubling between 1980 and 1994.⁵³ Today asthma affects almost five million children and their families.

Race, poverty, and environmental factors are all contributors to the high number of asthma cases. The problem is most severe for low-income, inner-city youths. Funded by the National Institutes of Health, the National Cooperative Inner-City Asthma Study identified a number of asthma risk factors for Black, Latino, and White children in urban families including: high levels of indoor allergens, especially the cockroach allergen; high levels of tobacco smoking among family members and caretakers; and high indoor levels of nitrogen dioxide, a respiratory irritant produced by inadequately vented stoves and heating appliances.⁵⁴

Although the prevalence of asthma is increasing for all children, low-income and Black children are disproportionately affected. Children from poor families and Black children are not only more likely to have asthma than children from higher income families and White or Latino children, they also are more likely to have suffered asthma attacks.⁵⁵ Children with disabling asthma have almost twice as many restricted activity days and lost school days as children with impairments due to other types of chronic conditions.⁵⁶ Disabling asthma was 66 percent higher among Black children, 46 percent higher among low-income

STORIES FROM THE STATES

Volunteer Medical Care at the Hope Clinic

The Hope Clinic, in Rio Grande Valley, Texas, is a clinic for patients who have no options in health care, no insurance, and do not qualify for government assistance. It is run solely on donations and has an entirely volunteer staff; only the executive director is paid. Jacquelin Bocanegra is an eight-year-old who goes to the Hope Clinic for treatment of her asthma. At the clinic, a volunteer pharmacy student works as a translator to give Jacquelin and her mother instructions on how to use her inhaler.



children, and 37 percent higher among children in single-parent families.⁵⁷

Poorly controlled asthma can result in costly emergency care and hospitalization. Each incidence of emergency room treatment can easily translate into many missed days of school. Children under 18 years of age made up 36 percent of all asthma-related outpatient visits and 38 percent of emergency department visits in 2002.⁵⁸ In one study of acute emergency room asthma treatment, 45 percent of the children studied missed more than two days of school, and 24 percent missed more than five days of school as a result of their acute asthma episode.⁵⁹

Racial differences also exist in the number of hospital visits, emergency room visits, and deaths attributed to asthma. Black children under the age of five are almost three times as likely to be hospitalized for asthma as young White children. In addition, hospital emergency department visits are four times higher for Black children under the age of five than for White children. Although the overall death rate in children with asthma is low, Black children five to 14 years of age are five times as likely to die from asthma as are White children of the same age.⁶⁰ The rate of hospitalization for Black children increased by 25 percent from 1980-1999 compared with the 11 percent increase seen in White children.⁶¹ In fact, Black and Latino caregivers were more likely than White caregivers to report that the emergency department was their primary

source for asthma treatment and medications for their children.⁶²

The lack of health insurance is a powerful barrier to proper asthma management, which is particularly important for severe cases of asthma. Compared to similar children with health insurance, uninsured children with disabilities or chronic illness are seven times as likely to lack a regular source of health care and almost five times as likely to lack needed medical care.⁶³ Access to comprehensive health care will give children the preventive treatment they need to control their asthma.⁶⁴ Other barriers to care also need to be addressed because Black and Latino children are less likely to see a specialist for a follow-up visit, even when they are enrolled in their state's Medicaid program.⁶⁵

Disparities in Access to Dental Care

Tooth decay (dental cavities and caries) is one of the most common chronic diseases affecting children in the United States. This preventable health problem begins early and progressively worsens with age. Seventeen percent of children ages two to four years have decay. By age eight, approximately 52 percent of children have experienced decay. By age 17, dental decay affects 78 percent of the youth population.⁶⁶

Eighty percent of all dental caries occur in only 25 percent of children.⁶⁷ The burden of untreated

Community Success Stories: Community-Based Childhood Asthma Management Project

Waianae, Hawaii, has among the highest prevalence of asthma in the state, especially in its Native Hawaiian pediatric population. By providing a community-based asthma management program, the program's staff sought to reduce inappropriate medical utilization and improve the quality of life for their pediatric asthma population. They also aimed to decrease the Waianae Coast Comprehensive Health Center's (WCCHC) emergency department pediatric asthma utilization rates.

Program staff implemented a comprehensive asthma management system that included an automated asthma tracking system and a standard system of care adapted for cultural sensitivity and based on the National Asthma Education and Prevention Program Asthma Guidelines. This coordinated team care approach is responsible for the significant decrease in both per capita expenditures (from \$735 to \$181), asthma-related emergency department visits (from 60 to 10), and overall asthma-related visits (from 1.5 to 0.25) in individuals served by the program over a three-year period.



Black, Hispanic, low-income, and uninsured children have greater dental problems and less access to care than other children.

Children's Dental Health and Access to Dental Care

	Percent of children who had:		
	Two or more years since last dental contact*	Unmet dental need*	Mouth and teeth in fair or poor condition**
<i>Race/ethnicity</i>			
White, non-Hispanic	14.9%	5.5%	10.6%
Black, non-Hispanic	20.0	6.4	21.3
Hispanic	25.9	7.3	22.0
<i>Family income</i>			
200% of poverty or more	14.3	4.0	9.9
Under 200% of poverty	24.1	10.2	19.5
<i>Insurance status</i>			
Insured	15.8	4.8	13.7
Uninsured	35.9	15.2	22.8

* Children ages 2 through 17

** Children ages 2 through 18

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, 2002 National Health Interview Survey; and U.S. Department of Health and Human Services, National Center for Health Statistics, 1999–2000 National Health and Nutrition Examination Survey (NHANES). Calculations by Children's Defense Fund.

dental caries is concentrated among low-income and minority children. The level of untreated dental caries among Black children (36 percent) and Latino children (43 percent) ages six to eight years is greater than for White children (26 percent) of the same age.⁶⁸ Children in low-income families are more than twice as likely as children in higher-income families to have untreated dental cavities and 20 percent more likely not to have had a dental visit in the past year.⁶⁹ They also are twice as likely to have mouths and teeth in fair or poor condition.⁷⁰

A nationally drawn sample of children's well child and dental visit prevalence revealed that being low-income, uninsured, Black, or Latino is associated with a lack of recommended dental care.⁷¹ Black and Latino children are significantly less likely than White children to have the recommended amount of dental visits as set forth by the American

Academy of Pediatric Dentistry.⁷² This is consistent with other data on Medicaid-enrolled patients and their limited amount of dental care. Past reports show that less than 20 percent of Medicaid-enrolled children receive any preventive dental visits.⁷³ Also, when the U.S. General Accounting Office asked states for the percentage of their dentists that saw 100 or more Medicaid patients (adults and children combined) in a year, not a single state reported a number that exceeded 50 percent.⁷⁴

A major factor contributing to infrequent use of dental services among low-income children with Medicaid coverage is the shortage of dentists who will treat them. In some cases, particularly in rural areas of the country, there are a limited number of dental providers. In other areas, few dentists are willing to treat Medicaid beneficiaries due to low provider payment rates and burdensome paperwork.⁷⁵ Nationally, only about 10 percent of all



STORIES FROM THE STATES

Lack of Medicaid Dentists and Delayed Care

Beth Lovett lives in Jackson, Ohio, and has two daughters, ages five and nine, who are covered under Healthy Start/Healthy Families (Ohio's Medicaid/SCHIP programs). Beth's younger daughter, Makayla, needs fillings for her teeth. A summer preschool dental exam revealed the problem, but she will have to wait more than six months to get her daughter in to see a dentist in her area that takes Medicaid. Beth would like to be able to take her daughter in sooner for a dental visit, but she said it could cost \$150 just for a simple cleaning if you are uninsured.

dentists accept Medicaid patients.⁷⁶ Less than one in five Medicaid-covered children visited a dentist during a year-long survey by the U.S. Inspector General.⁷⁷

Other barriers to receiving dental care include obtaining reliable transportation to dental clinics, and overcoming scheduling difficulties and a perceived bias against Medicaid patients.⁷⁸ The result is often a missed school day for a child and a long wait at the dentist's office. Caregivers faced with these and other barriers to care will sometimes postpone their children's dental care, which can lead to more acute symptoms and additional dental caries.⁷⁹

Untreated caries can progress into infections and abscesses, leading to facial swelling, pain, and discomfort. Children with serious dental problems can get to the point where their mouths hurt too much for them to eat, leading to malnourishment and stunted growth. School absenteeism due to both decay and other dental problems is estimated at 52 million hours each year.⁸⁰

Childhood tooth decay is preventable when a combination of policies, including national, professional, community, and individual measures, are put into practice. In addition to water fluoridation and dental sealant programs, community programs also must address issues at the root of disparities in oral health care: health illiteracy and lack of awareness, apathy about preventive services, infant feeding practices, diet, language and cultural differences with providers, and lack of access and transportation to dental care.⁸¹

There are a number of means that communities can employ to address systemic issues associated with a lack of dentists, their poor geographic distribution, and the limited number of minority dental professionals. Partnerships with dental schools can help introduce volunteer providers into the community, mobile clinics can service rural areas without access, and scholarship programs and loan forgiveness initiatives can help increase the minority presence in the dental profession. Communities also have overcome barriers to access by integrating dental services into primary medical care or other child health and education programs, including Head Start and the Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Disparities in Obesity

Obesity has not only reached epidemic proportions for adults in the United States, but has also become a health crisis facing children. The number of overweight children has more than tripled since 1980. It is estimated that 15.3 percent of children and 15.5 percent of children and teens ages six to 19—almost nine million young people—are overweight.⁸² Another 15 percent are considered at risk of becoming overweight.⁸³ Even among preschool children between ages two and five, more than 10 percent are overweight.⁸⁴

While the prevalence of excessive weight and obesity has increased for both genders and across

all racial, ethnic, and age groups, the increases have not been even. Children in lower income families generally experience a greater prevalence than do those from higher-income families.⁸⁵ There has been a significant increase in the prevalence of very young (birth to five years) low-income children who are overweight. Between 1983 and 1995, there was an overall 16 percent increase for overweight and obese low-income children. The greatest increase in age groups was seen by four- to five-year-olds, with a 23.3 percent increase from 1983-1995.⁸⁶

From 1988 to 2000, the percentages of Black and Latino children who were overweight more than doubled while the number of overweight White children climbed by 50 percent.⁸⁷ From 1999-2000, non-Latino Black and Mexican-American adolescents ages 12 to 19 were more likely to be overweight (24 percent) than non-Latino White adolescents (13 percent).⁸⁸ Mexican-American children ages six to 11 were more likely to be overweight (24 percent) than non-Latino Black children (20 percent) and non-Latino White children (12 percent).⁸⁹ Non-Latino Black girls and Mexican-American boys are at particularly high risk of being overweight.

On an individual basis, the main causes of overweight and obese children are the same as those for adults—eating too much of the wrong foods and moving around too little. According to

the Centers for Disease Control and Prevention, only one-fifth (22 percent) of all U.S. children in grades nine to 12 eat the recommended five or more servings of fruits and vegetables per day.⁹⁰ Children at younger and younger ages are being exposed to foods high in calories, fats, and sugars and low in nutritional value, setting the stage for possible poor health and the negative outcomes that come with it. In one survey of infant and toddler diets, 23 percent of 19- to 24-month-olds had consumed soda or another sweetened beverage on the day of the interview.⁹¹

Compounding the problem of generally poor diets is the decline in physical activity among children and teens. Exercise can reduce the rates of excessive weight and obesity by offsetting the amount of calories consumed. However, less than half of all high school students are vigorously active on a regular basis, and 11.5 percent report no recent physical activity at all.⁹² Activity levels for students are lower among minorities, with Black students in grades nine through 12 less likely (54.8 percent) to participate in vigorous physical activity than Latino (59.3 percent) or White students (65.2 percent).⁹³ This is illustrated by a recent study that followed Black and White girls from ages nine to 19 years of age. The drop in their activity levels continued through adolescence, and by the age of 16 or 17, 56 percent of the Black girls and 31 percent

STORIES FROM THE STATES

The Battle Between Nutrition and Making Ends Meet

Martha Estella Luevanos is a single mother with seven children, ranging from ages three to 13. She receives a disability check because her eight-year-old daughter, Elvira, was injured in a car accident. Her other income is through food stamps, Social Security, and Medicaid. Martha used to be the woman other neighborhood mothers would send their children to while they worked nights at the local bars. The children would show up skinny and sickly, and Martha would give them healthy foods like soup and beans. The other mothers would wonder how she was able to get their children looking so well. She would say it was food and love. But Martha's husband recently left and she is no longer able to take in the neighborhood children. In order to make a living, she has begun selling candy bars to the same children she used to provide with healthy foods.



Three out of ten children of all ages are overweight or at risk of becoming overweight.

Overweight Children*

	Percent of					
	All children ages 2 to 18			Children ages 6 to 18		
	At risk	Overweight	At risk or overweight	At risk	Overweight	At risk or overweight
All**	14.6%	14.7%	29.3%	15.4%	15.9%	31.3%
<i>Race/ethnicity</i>						
White, Non-Hispanic	13.8	12.3	26.1	14.5	13.3	27.8
Black, Non-Hispanic	14.8	18.2	33.0	14.9	20.7	35.6
Hispanic	16.9	19.5	36.4	17.7	20.6	38.3
<i>Family income</i>						
200% of poverty or more	13.4	13.3	26.7	13.9	14.7	28.6
Under 200% of poverty	15.5	16.4	31.9	16.4	17.5	33.9
<i>Insurance status</i>						
Insured	14.2	14.6	28.8	14.8	15.8	30.6
Uninsured	17.3	15.3	32.6	18.6	16.1	34.7

* "At risk" of overweight are those children with a body mass for age (BMI) from the 85th percentile to less than the 95th percentile. "Overweight" designates those children with a BMI for age at the 95th percentile and above.

** Includes all children measured, regardless of race, income, or insurance status.

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, 1999-2000 and 2001-2002 National Health and Nutrition Examination Survey. Calculations by Children's Defense Fund.

of the White girls did not engage in any consistent leisure time activity. Higher body mass index (BMI) levels also were associated with declines in leisure activity.⁹⁴

While eating habits and physical activity are the two direct actions that yield the positive energy balance that leads to weight gain, there are an infinite number of social, economic, cultural, psychological, biological, and political factors that shape and affect those two simple activities. The differences in obesity rates are partially due to variations in access to physical education classes, school sports, and safe recreation areas in neighborhoods and school districts—factors that are often impossible to change on the individual level. For example, while it may be appropriate to encourage children to increase their activity levels by walking to school, this is problematic for children living in unsafe neighborhoods.

A report by the Secretary of Health and Human Services and the Secretary of Education highlights the many aspects of American culture that discourage physical activity, including an emphasis on cars rather than walking; unsafe community areas and playgrounds; and the appeal of television and video and computer games.⁹⁵ The report recommends that more school-based and after-school programs, community programs, and health education programs be implemented. These can help to improve children's health status, self-esteem, and social skills and contribute to the reduction in the number of children who suffer from obesity.

To date, very few programs have been successful in alleviating and treating obesity. This means that efforts must be concentrated on primary prevention. Moreover, because obesity is a condition attributed to learned behaviors, it is essential that children become the focus of interventions. By assessing all

Community Success Stories: SPARK

SPARK's (Sports, Play, and Active Recreation for Kids) mission is to "Create, Implement and Evaluate," with a goal of teaching physical education from a public health approach instead of a sports-oriented approach. Making physical activity a lifetime activity alongside behavior change is an important core component of the program.

SPARK has been implemented in Head Start programs, supplemental nutrition programs for Women, Infants and Children (WIC), preschool, elementary, middle and high schools, as well as after-school programs, nationwide. SPARK trainers travel to schools and community organizations to instruct teachers and educators on how to set up the program. Their comprehensive approach includes an assessment, age-appropriate curricula, staff development, equipment, and a follow-up consultation. Components of the program involve training on how to instruct effectively, how to incorporate physical activity into their lesson plans, and how to "disguise" physical activity as fun.

Among SPARK's many successes is the academic achievement experienced by its participants. Despite spending between 200 and 300 percent more time out of the classroom, SPARK students performed either as well or better than other students on standardized tests.

of the factors that affect obesity, including culture and the built environment, successful interdisciplinary programs, policies, and cultural adaptations may help curb this growing problem.

Disparities in Health Insurance Coverage

Health insurance coverage is fundamental to ensuring children's access to necessary and appropriate health services, including primary and preventive care. Health coverage makes a positive impact on children's overall health and quality of care. Uninsured children are more likely to lack a usual source of care, go without needed care, and experience worse health outcomes than children with health coverage. For example, uninsured children are almost nine times more likely than insured children to have no regular source of care and over five times more likely to have not had contact with a health professional for two or more years.⁹⁶ Uninsured children are also more than one and a half times more likely than insured children to have mouth and teeth in fair or poor condition.⁹⁷

Over the past decade, public health coverage expansions through Medicaid and the creation of the State Children's Health Insurance Program (SCHIP) have provided critical health care for the nation's poorest children, many of whom could not

afford coverage otherwise. Children with health insurance have more regular sources for their medical care, report fewer unmet medical needs, and see a reduction in preventable hospitalizations.^{98,99} Compared to uninsured children, publicly-insured children are more likely to obtain preventive and primary medical care, more likely to receive dental care, and less likely to miss out on necessary medical or dental care because of their families' inability to afford the care.¹⁰⁰

Because of the availability of public health programs, children's health coverage improved slightly in the last couple of years despite the recent weak economy and the erosion of private health insurance coverage. However, progress in children's coverage has drastically slowed and is currently being threatened by continued state budget shortfalls that have led to increasing cuts in public health insurance programs, such as Medicaid and SCHIP.

Trends in Children's Coverage

In the midst of an anemic economy and escalating health insurance premiums, employer-based coverage has declined by 3.8 million people. This decline contributed to the addition of 5.2 million uninsured adults to a record 45 million people, an increase of 1.4 percent for the period from 2000 to 2003.¹⁰¹

Uninsured children are more than five times as likely as insured children to lack access to medical care.

Children’s* Health Status and Access to Care, 2002

	Percent of children who:				
	Were in only fair or poor health	Had no usual place of care	Had two or more years since contact with health provider	Had delayed medical care due to cost	Had unmet medical need
<i>Race/ethnicity</i>					
White, non-Hispanic	1.5%	3.2%	2.5%	3.1%	1.8%
Black, non-Hispanic	3.5	5.8	3.6	3.9	2.9
Hispanic	3.1	11.6	9.3	4.4	2.8
<i>Family income</i>					
200% of poverty or more	0.8	3.0	2.5	2.3	1.3
Under 200% of poverty	3.9	8.4	5.9	5.6	4.0
<i>Insurance status</i>					
Insured	2.0	3.0	2.7	2.3	1.3
Uninsured	2.3	26.4	14.4	13.4	9.4

* Ages 0 through 17

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, 2002 National Health Interview Survey. Calculations by Children’s Defense Fund.

STORIES FROM THE STATES

Medicaid/SCHIP as Acute Care Providers

Misty Smith, a Jackson, Ohio, Head Start worker, has two sons, ages four and six. She works 28 hours a week for \$6.50 an hour, bringing home less than \$500 a month. She receives Healthy Start/Healthy Families health care coverage for her children, as well as food stamps and child care assistance. She is a very committed mother and attributes her ability to provide for her children to the assistance she receives, especially Healthy Start/Healthy Families. “If I never had assistance, I would not make it. My youngest had [a serious food allergic reaction]. He ended up being hospitalized for a week because of it. My oldest had his tonsils removed and was hospitalized for two days because of a stomach virus.” Healthy Start/Healthy Families paid for all of this care so that Misty did not have to worry about the medical bills.



In contrast to adults, children's coverage has remained stable due to coverage expansions under Medicaid and SCHIP. From the years 2000 to 2003, the number of uninsured children declined from 9.4 million to 9.1 million.¹⁰² According to the Urban Institute, coverage under Medicaid, SCHIP, and other state programs increased by 4.8 percent between 2000 and 2003.¹⁰³

However, 11.8 percent, or 9.1 million, of the nation's children ages from birth through 18 still have inadequate access to health care because they lack health insurance coverage.¹⁰⁴ About six million of these uninsured children are eligible for Medicaid or SCHIP under current law.¹⁰⁵ Enrolling these eligible children is key not only to shrinking the number of uninsured children, but also to decreasing the entire uninsured population, since children make up a significant portion of the uninsured.

Demographics of Uninsured Children

The progress in increasing the number of insured children has not been successful in closing the gap in access to health coverage for some children. Disparities in health coverage continue to persist among minority, poor, immigrant, and older children.

The establishment of SCHIP has led to significant progress in reducing the number of uninsured near-poor children. However, similar progress has not been achieved concerning the poorest children. Poor children (under 100 percent of poverty) are nearly four times more likely than their most affluent counterparts (above 300 percent of poverty) to be uninsured. About one in five children living in families under 200 percent of poverty are uninsured, compared to one in nine children in families between 200-300 percent of poverty. Children in families with incomes exceeding 300 percent of poverty had a one in 19 chance of being uninsured.¹⁰⁶

In addition to poor children, children of color are also less likely to be insured. Although non-Latino White children make up the largest single group (38.7 percent) of uninsured children ages zero to 18, Black and Latino children combined represent over 50 percent of all uninsured children.¹⁰⁷

Also, when comparing all children regardless of insurance status, 14.9 percent of Black children and 21.9 percent of Latino children are uninsured compared to 7.7 percent of White children.¹⁰⁸ That means that Black children are almost twice as likely and Latino children almost three times more likely to be uninsured than non-Latino White children.

Efforts to decrease the number of uninsured children also must focus on children in older age groups. Adolescents constitute a somewhat larger share of the uninsured than other children.¹⁰⁹ About 13.6 percent of children ages 12 to 18 are uninsured, compared to 11 percent of children ages six to 11 and 10.3 percent of children under age six. Adolescents make up more than 44 percent

Child Health – Table 7

Almost two-thirds of all uninsured children have at least one parent who works full-time throughout the year.

Who Are the Uninsured Children?*

Race and Ethnicity

- 38.7% are White
- 34.8% are Latino
- 18.9% are Black
- 4.2% are Asian or Pacific Islander
- 2.3% are of more than one race
- 1.1% are American Indian or Alaskan Native

Family

- 52.2% live in a two-parent household
- 85.5% have at least one working parent
- 65.1% have a least one parent who works full-time throughout the year
- 69.1% live in families with incomes above poverty
- 86.6% are citizens of the United States

*Ages 0 through 18

Source: U.S. Department of Commerce, Bureau of the Census, 2004 Annual Social and Economic Supplement to the Current Population Survey. Calculations by Children's Defense Fund.



of all uninsured children.¹¹⁰ Rates of employer-sponsored coverage are higher for older children, but coverage under public programs is significantly lower, partially due to age-based eligibility criteria.¹¹¹

Connecting the Dots: Children’s Health Needs and Public Policy

Despite overwhelming evidence that public health policies have greatly improved children’s health through programs that have increased children’s access to quality health care, there is a disconnect between children’s health needs and current public policy. Programs that spurred most of the improvements in children’s health outcomes over the past half century are not expanding in line with needs. Recent efforts to freeze, cut, and even eliminate certain health programs critical to children’s health are undermining the framework of safety net programs of public insurance, despite their cost-effectiveness in ensuring that children grow up healthy. Underlying issues that impact health disparities, such as children’s poverty, are not being adequately addressed.

The Positive Role of Government in Improving Children’s Health

Government can play a positive role in promoting policies that improve children’s health. During the last half-century, we have witnessed tremendous progress brought about by public policies that have improved the health of the U.S. population. Access to public health programs, such as

Lower-income children are more likely to be uninsured than higher-income children.

Uninsured Children*, by Income, 2003

Total number of uninsured children	9.1 million
Percent of children who are uninsured	11.8%

Percent uninsured in families with incomes of:

under 100% of poverty	20.1
100-199% of poverty	18.4
200-299% of poverty	10.6
300% of poverty or more	5.4

*Ages 0 through 18

Source: U.S. Department of Commerce, Bureau of the Census, 2004 Annual Social and Economic Supplement to the Current Population Survey. Calculations by Children’s Defense Fund.

Vaccines for Children and public insurance through Medicaid and SCHIP, has increased the primary and preventive health care that children receive, dramatically improving children’s health. The many achievements of public policies include the eradication of devastating diseases such as smallpox, the virtual elimination of disabilities from diseases such as polio, the drastic decline in infant mortality, and the extension of life expectancy by more than a decade.

Government can continue the progress in children’s health care by further investing in these pro-

STORIES FROM THE STATES

Insured and Uninsured in the Same Family

Rachel Blevins is married with four children and lives in Jackson, Ohio. Rachel and her husband, who owns and drives a semi truck, make above the income limits for Healthy Start/Healthy Families, Ohio’s Medicaid/SCHIP programs, but they qualify for Head Start for their four-year-old daughter, Paige. Paige also has medical coverage because she was a premature infant, born at 34 weeks and weighing only three pounds. However, the Blevins must pay out-of-pocket for medical care for their 12-year-old son.

STORIES FROM THE STATES

Preventive Health Education in the Rio Grande Valley

Lourdes Flores is a “promotora” with Migrant Health Promotion in Texas. Promotoras are usually members of a community who take the initiative to educate themselves and their community members about the importance of healthy lifestyles. In the Rio Grande Valley community, diabetes is particularly prevalent due to genetic predisposition and an unhealthy diet. Lourdes holds a health class, oftentimes in the poorest areas of the Valley, to educate residents (usually women) on basic health care for themselves and their children. The promotoras develop the curriculum, prepare the classes, and recruit people from the neighborhood to attend. Lourdes and other promotoras play a vital role in education and preventive health in the Rio Grande Valley community.



grams to improve health care access and reduce health disparities. This investment is not only a moral commitment that must exist for our children, it is imperative for the economic well-being of our nation.

Investing in Child Health

Studies have shown that preventive health care, such as newborn hearing screenings and immunizations, not only save lives and improve health, but also save money. The Universal Newborn Hearing Screening Program (UNHS) is able to diagnose hearing loss in infants as young as six months of age, compared with 12 to 18 months of age when other selective processes are used. There is a large potential cost savings in early diagnosis, since early therapy and treatment can prevent both the loss of language development as well as more expensive reactive treatments for a hearing-impaired child. One model in particular has predicted a potential cost savings of \$44,000 per child when diagnosed early for hearing loss. Even though this was a model and not a formal study of infants, a cost savings of that amount warrants further research and the continuation of the UNHS program.¹¹²

Diseases like measles and hepatitis B have not been eradicated, and vaccination is the only method we have of preventing children from suffering the permanent and sometimes debilitating effects of these diseases. For every \$1 spent vacci-

nating children against measles, mumps, and rubella, \$16 is saved in medical costs to treat those illnesses.¹¹³ Influenza vaccination of school-age children has been shown to yield a net savings from a societal perspective and have health benefits within the community.¹¹⁴ The risks involved in not vaccinating youth have been seen as recently as the 1970s, when both the United Kingdom and Japan saw epidemics of pertussis due to a drop in immunization rates.^{115,116}

Regarding obesity, overweight kids tend to become overweight adults, continuing to put them at greater risk for heart disease, high blood pressure, and stroke. The probability of childhood obesity persisting into adulthood is estimated to increase from about 20 percent at four years of age to roughly 80 percent by adolescence.¹¹⁷ Approximately 112,000 U.S. deaths each year are associated with obesity.¹¹⁸ The total direct and indirect costs attributed to excessive weight and obesity amounted to \$117 billion in the year 2000.¹¹⁹

Cost-Effectiveness of Health Coverage

Whether or not a person has health coverage often governs how soon that person will be able to get health care and whether it is the best available. Conversely, individuals who are uninsured or underinsured are less likely to receive appropriate and timely health care, if they receive any care at all.

STORIES FROM THE STATES

The Cost of Being Uninsured

Toni Callis is a single mother with three daughters living in Plattsburgh, New York. She works as a waitress and does not receive health benefits. She is studying to become an RN, building on her experience in a hospital unit in the Army. In July, Toni applied for Medicaid for herself and her daughters, but all were denied. It wasn't until September that she learned about Child Health Plus and Family Health Plus (New York's SCHIP and Parental Medicaid expansion programs) and then only through word of mouth. Before getting public health insurance, she couldn't afford to purchase glasses for one of her daughters, and Toni herself could not get preventive treatment for an infection. Her subsequent visit to an emergency room resulted in a \$400 medical bill.



Every parent knows that children do not stop getting sick simply because they lack health coverage. As children's medical needs remain untreated, the costs to treat the more serious conditions that develop often are passed onto communities through uncompensated hospital stays and clinic visits, contributing to higher premiums for the insured. Access to health coverage is also a strong determinant of health outcomes and has been cited often as a key issue in reducing disparities. These conditions especially affect racial and ethnic minorities, with Blacks almost twice as likely and Latinos almost

three times as likely as Whites to be uninsured.

For decades Medicaid has provided critical health care, including primary and preventive care, for the poorest children in America. Providing preventive care for children is cost-effective, especially in comparison to older populations. This care includes immunizations and newborn hearing screenings. Per-capita costs for children (\$1,850) are the lowest of all groups eligible for Medicaid, compared to \$10,700 per elderly enrollee in fiscal year (FY) 2002. At a cost of about \$47 billion, children account for less than a quarter of total program spending.¹²⁰

STORIES FROM THE STATES

Medicaid as a Safety Net for Children in Need

Maria Morales lives with her husband and two daughters, Saida and Maricela, in Mercedes, Texas. Their neighborhood (colonia La Mesa) has no sewer, only septic tanks that cause a sewage hazard when it rains. Maria's daughter Maricela suffers from Attention Deficit Hyperactivity Disorder (ADHD) and depression. Recently, the family protested the loss of their Children's Health Insurance Program funding at the Hispanic Chamber of Commerce. At present, Maria and her husband's combined income is low enough to qualify for Children's Medicaid, which has been a blessing for them because Medicaid covers mental health and dental care, which were cut from the SCHIP program. This means that Maricela can still receive treatment for her ADHD and depression.



