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Variation in Access to Care for Low-Income Children with Public Coverage:

Baseline Findings from the 2002/2003 Los Angeles County Health Survey

Children's Health Initiative of Greater Los Angeles

Prepared for:

The California Endowment

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A Baseline Analysis with the 2002/2003 Los Angeles County Health Survey

Executive Summary

Since 2003, the Children's Health Initiative of Greater Los Angeles has sought to reduce uninsurance rates among children in Los Angeles County. Using the 2002/2003 Los Angeles County Health Survey to examine the variation in health care access and use among children with public coverage prior to the Initiative, it appears that certain subgroups are experiencing problems. The Children's Health Initiative of Greater Los Angeles will not have as great an impact on improving children's health unless these barriers are addressed.

Results

This analysis focuses exclusively on low-income children with family incomes under 200 percent of the federal poverty level that have public coverage through Medi-Cal or Healthy Families.

Child's Citizenship Status

- The single biggest differentiating factor affecting access to care.
- Nearly four out of 10 non-citizen children — 38 percent — reported difficulty accessing needed medical care compared to only 17 percent of their citizen counterparts.
- Cost concerns are a factor. For example, 20 percent of non-citizen children could not afford a medical check-up compared to 7 percent of their citizen counterparts.
- Likewise, non-citizen children were less likely to have a usual source of care than their citizen counterparts.

Child's Health Status

- Children in fair or poor health had more difficulty accessing needed medical care than did children in better health.
- Children in fair or poor health were over twice as likely to have unmet prescription drug needs compared to children in better health (20 percent vs. 8 to 10 percent).
- It is possible that some of these unmet needs affect the child's health status.

Child's Age

- Children between the ages of 12 and 17 were more likely to have unmet health care needs and were less likely to have received a well-child exam than their younger counterparts.

Parental Mental Health

- Consistent with other studies, we found that 25 percent of children with depressed parents were reported to have difficulty accessing needed medical care compared to only 14 percent of children whose parents were not depressed.

Income

- Poor children — those with family incomes below the federal poverty line — were more likely to experience transportation and language barriers when trying to obtain needed health care than near-poor children — those with family incomes at or up to twice the federal poverty line.

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Difficulties Accessing Care Among Low-Income Publicly Insured Children Ages 0-17 in L.A. County by Key Characteristics, 2002/2003

	Difficulty accessing needed care for child	Transportation barrier to medical care	Language barrier to medical care[1]
Child's Citizenship Status			
U.S. Citizen^	16.7%	9.8%	10.2%
Non-Citizen	38.4%***	17.6%**	24.3%***
Child's Health Status			
Excellent	13.7%***	8.3%***	4.9%***
Very Good	16.6%***	10.7%	6.2%***
Good	17.8%***	8.6%**	11.9%***
Fair/Poor^	27.3%	14.8%	24.6%
Child's Age			
0-5	16.5%	9.1%**	13.0%
6-11	19.9%	9.4%*	10.5%
12-17^	18.8%	13.5%	10.1%
Parent's Mental Health Status[2]			
Depressed	25.1%***	15.3%***	18.9%***
Not Depressed^	14.2%	7.3%	6.8%
Family Income			
0 to 99% FPL	18.1%	12.5%***	13.4% ***
100% to 199% FPL^	18.7%	7.8%	9.0%
Child's Race-Ethnicity			
Latino	19.0%	9.4%	13.4%***
White^	17.4%	13.6%	2.2%
African-American	11.7%	16.2%	0%
Asian-Pacific Islander	19.8%	11.2%	9.6%
Other	30.3%	21.1%	0%
Functional Limitations			
Yes	32.4%**	19.3%*	10.4%
No^	17.3%	9.6%	11.3%
Parent Citizenship			
U.S. Citizen^	14.9%	13.5%	3.9%
Non-Citizen	20.7%***	8.2%***	16.3%***
Parent Foreign-Born Status			
Foreign Born	19.9%***	8.6%***	14.8%***
U.S. Born^	13.9%	15.6%	0.8%
Marriage Status of Respondent			
Married^	19.3%	8.4%	13.9%
Not Married	17.1%	12.3%**	8.6%***

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	Difficulty accessing needed care for child	Transportation barrier to medical care	Language barrier to medical care
Parent's Education			
Less than High School	19.9%	9.4%	14.3%*
High School	15.1%	11.7%	8.1%
Some College or trade school	18.7%	12.6%	7.8%
College or Postgrad degree^	18.8%	7.8%	8.2%
Work Status of Respondent			
Employed	17.9%	8.9%	10.3%
Unemployed^	18.7%	11.4%	12.2%
Language of Interview			
English	14.0%***	14.7%***	---
Not English^	20.4%	8.3%	16.7%
Number of Children in Household			
2 or fewer	18.3%	9.9%	10.5%
3 or more^	18.5%	11.2%	13.0%
SPA			
Antelope Valley	16.3%	20.9%	8.6%
San Fernando	17.0%	11.1%	13.1%
San Gabriel	15.8%	8.1%	8.9%
Metro	24.9%	10.4%	11.0%
West^	17.9%	12.3%	8.5%
South	18.8%	9.3%	13.6%
East	15.9%	10.1%	12.1%
South Bay	19.1%	10.4%	9.5%

Source: Urban Institute tabulations of the 2002/2003 Los Angeles County Health Survey.

Notes: [1] Only respondents who were interviewed in a non-English language received this question.

[2] The term "depressed" reflects the parent's reported general emotional state and does not necessarily indicate that the parent is clinically depressed.

^ Refers to the reference category

* p <.1, ** p <.05, *** p <.01.

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I. Introduction

Los Angeles County is attempting to make great strides in reducing uninsurance rates for children through its Healthy Kids initiative, which was introduced in July of 2003. The Healthy Kids Program included a coverage expansion to undocumented children and to uninsured children whose incomes were between 250 and 300 percent of the federal poverty level. The initiative included expanded outreach and application assistance with the goal of enrolling more uninsured children who are already eligible for the existing Medi-Cal and Healthy Families programs. Several studies have shown that children with public health insurance in California and nationally have better access to health care than children who are uninsured (Inkelas et al. 2003; Brown et al. 2004; Davidoff and Rubenstein 2006). However, other studies have shown that access disparities exist among children who have public coverage. (Kenney, Rubenstein, et. al. Chap 3 2005; Ku and Matani 2001). For the Healthy Kids initiative to realize significant improvements in children's health, it will require both enrolling uninsured children in public health insurance programs and providing access to needed care for those who enroll.

This brief uses the 2002/2003 L.A. County Health Survey (LACHS) to examine the variation in health care access and use among children with public coverage prior to the rollout of Healthy Kids.[1] We assess the extent to which different sub-groups of children already enrolled in public programs experienced problems obtaining needed care prior the launch of the Healthy Kids Program. Access to care among publicly insured children was assessed based on a child's citizenship status, age, health status, the parent's mental health status, and income among other factors. Multivariate analyses also were conducted to study differences in access to care and unmet health needs among the different subgroups, controlling for other factors. In most cases, the multivariate findings produced results that were similar to the bivarate findings. Therefore, we focus on the bivariate findings, and note the bivariate findings that do not hold up in the multivariate model.

This analysis is part of the Healthy Kids Program Evaluation, a four-year effort directed by The Urban Institute and supported by The California Endowment and First 5 LA. Prior briefs have used the 2002/2003 survey to examine coverage and access to care gaps for children in the baseline period in Los Angeles County (Kenney et. al. 2006 (a and b)), and subsequent briefs will examine the 2005 LACHS data to assess the extent to which the new Healthy Kids Program and renewed outreach efforts appear to be reducing uninsurance among children in Los Angeles County. This evaluation has multiple components, including case studies, focus groups, and a longitudinal survey of enrollees. For more information on the evaluation and these studies, see www.first5la.org/ourprojects/healthykids.php4 or www.urban.org.

II. Results

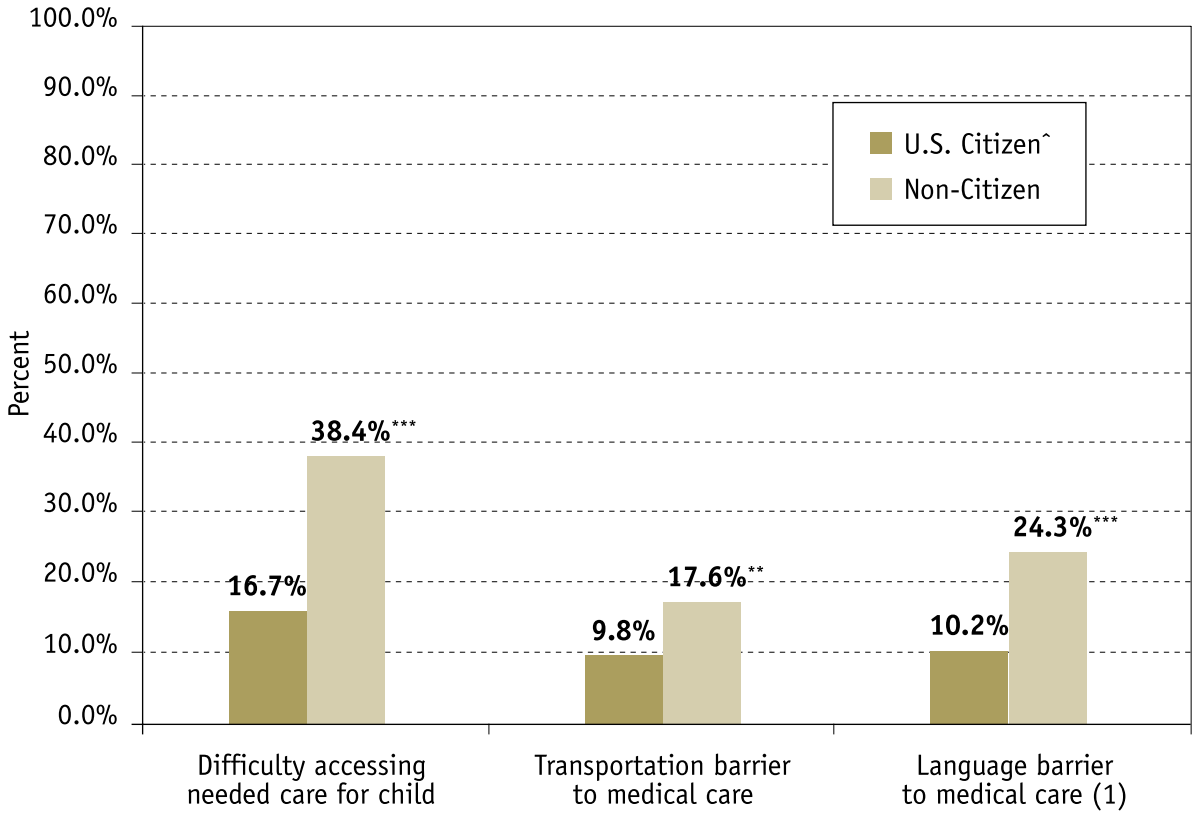
Publicly insured children in Los Angeles County consistently are reported to have better access than uninsured children (Kenney et. al 2006 (b)). Overall, children with public coverage in the baseline period enjoyed high levels of access to care. However, access problems appear to exist for some subgroups of children who had public coverage at the time of the survey.

Tables 1-3 illustrate how various measures of unmet health care needs and access to health care vary according to the characteristics of children and their families. The factors and characteristics that are systematically associated with different access levels are the child's citizenship status, health status, age, the parent's mental health status, and income. This analysis focuses exclusively on low-income children (children with family incomes under 200 percent of the federal poverty level (FPL)) who were reported to have public coverage through Medi-Cal or Healthy Families (i.e. Medicaid or SCHIP). However, regular Medi-Cal was not identified separately from Emergency Medi-Cal on the survey. Thus, some non-citizen children with public coverage may not have full-scope Medi-Cal coverage.

Child's Citizenship Status. Non-citizen children who are not documented immigrants can only receive Emergency Medi-Cal, which may explain some of the access differences between citizen and non-citizen children that are described below. However, we are not able to assess the effects of different types of public coverage on access to care since we cannot distinguish between documented and undocumented non-citizen children.

In 2002/2003, publicly insured low-income children who were non-citizens were more likely to face barriers obtaining needed medical care and to have experienced an unmet health care need than their citizen counterparts. Nearly four of every ten low-income, non-citizen children with public coverage (38 percent) reported they had difficulty accessing needed medical care compared to only 17 percent of their citizen counterparts (Figure 1). In addition, more non-citizen children with public coverage reportedly did not receive a number of different services because of cost concerns. For example among publicly insured children, 20 percent of non-citizen children could not afford to see a physician for a medical check-up, nearly three times higher than the 7 percent share of citizen children who could not afford to see a physician. In addition, 21 percent of low-income publicly insured children were unable to see the doctor for illness and 39 percent did not get dental care because of cost concerns (Figure 2).

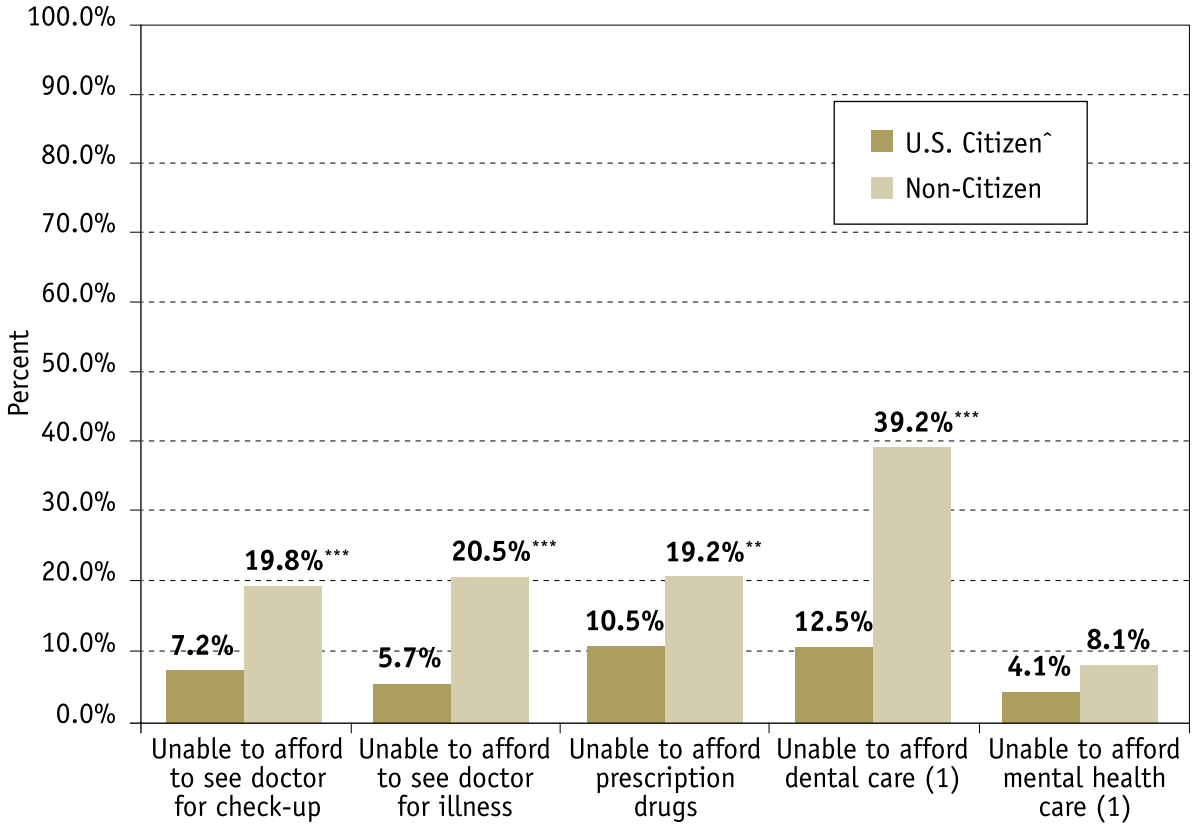
Figure 1. Difficulties Accessing Health Care Among Low-Income Publicly Insured Children Ages 0-17 in L.A. County by Child's Citizenship Status, 2002/2003



Source: Urban Institute tabulations of the 2002/2003 Los Angeles County Health Survey.

Notes: (1) Only respondents who were interviewed in a non-English language received this question.
^ Refers to the reference category
* p <.1, ** p <.05, *** p <.01.

Figure 2. Unmet Health and Dental Needs for Low-Income Publicly Insured Children Ages 0-17 in L.A. County by Child's Citizenship Status, 2002/2003

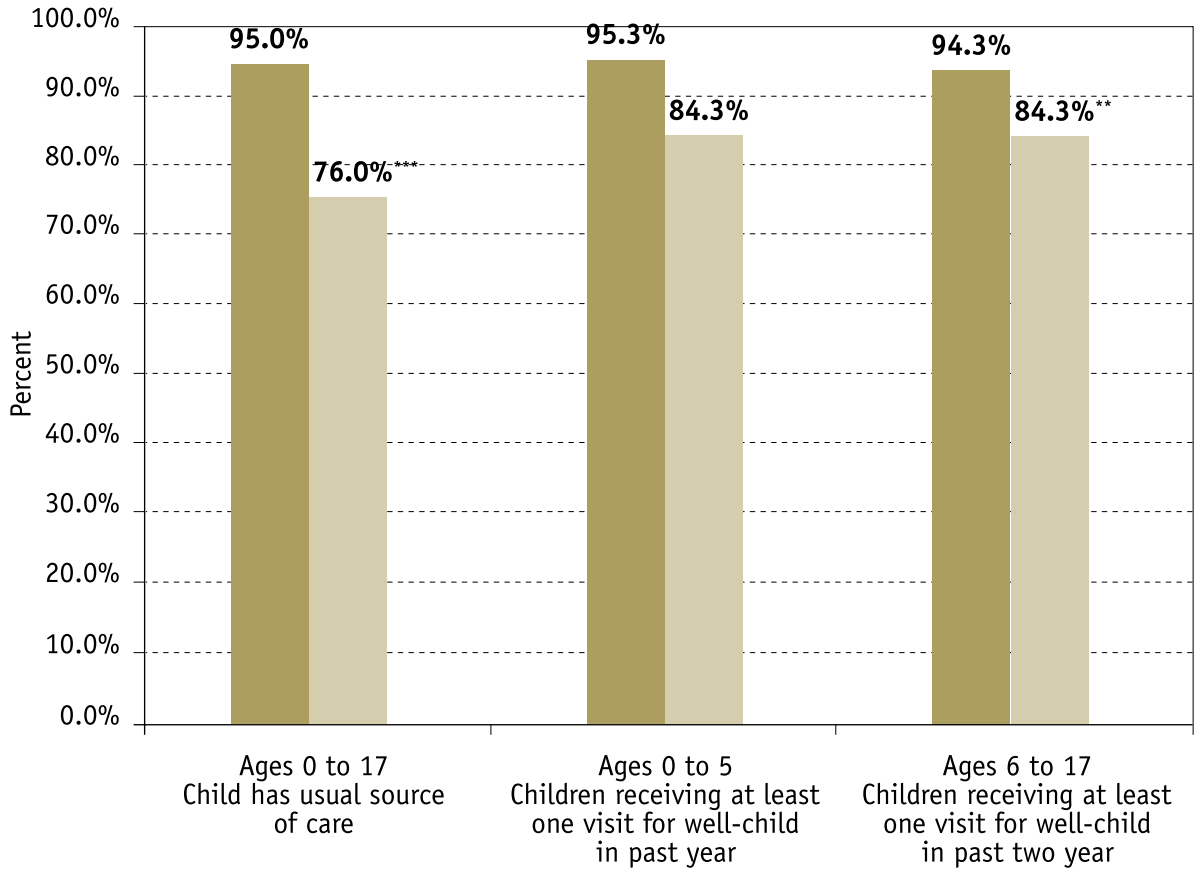


Source: Urban Institute tabulations of the 2002/2003 Los Angeles County Health Survey.

Notes: (1) Only respondents with a child ages 3 to 17 years received these questions.
^ Refers to the reference category
* p <.1, ** p <.05, *** p <.01.

Likewise low-income, non-citizen children with public coverage were less likely to have a usual source of care than their citizen counterparts (76 percent for non-citizen children versus 95 percent for citizen children) and for those non-citizen children ages 6 to 17 less likely to have a well-child exam than their citizen counterparts (84 percent versus 94 percent) (Figure 3). Low-income, non-citizen children ages 0 to 5 also were less likely to have a well-child exam than their citizen counterparts (84 percent versus 95 percent), but this finding was not significant at conventional levels (p=0.20) (Figure 3). The multivariate analyses (data not shown) were similar to the descriptive findings.

Figure 3. Service Use for Low-Income Publicly Insured Children in L.A. County by Child's Citizenship Status, 2002/2003



Source: Urban Institute tabulations of the 2002/2003 Los Angeles County Health Survey.

Notes: ^ Refers to the reference category
* p <.1, ** p <.05, *** p <.01.

Child Health Status. Publicly insured low-income children who were in fair or poor health were more likely than children in excellent, very good, or good health to face barriers accessing needed medical care and to have an unmet health care need. For example, 27 percent of children in fair or poor health had difficulty accessing needed medical care, which is a much larger share than children in excellent (14 percent), very good (17 percent), or good (18 percent) health who had similar difficulties. In addition, nearly 14 percent of children in fair or poor health had parents who said that they could not afford to see a physician for a medical check-up compared to just 6 to 8 percent of children in better health, and children in fair or poor health were more than twice as likely to have unmet prescription drug needs compared to children in better health (20 percent versus 8 to 10 percent) (Table 1, 2). It is possible that some of these unmet needs affect the child's health status. There were only small differences between children in fair or poor health and children in better health for having a usual source of care or receiving a well-child exam.

Table 1. Difficulties Accessing Care Among Low-Income Publicly Insured Children Ages 0-17 in Los Angeles County by Key Characteristics, 2002/2003

	Difficulty accessing needed care for child	Transportation barrier to medical care	Language barrier to medical care[1]
Child's Citizenship Status			
U.S. Citizen^	16.7%	9.8%	10.2%
Non-Citizen	38.4%***	17.6%**	24.3%***
Child's Health Status			
Excellent	13.7%***	8.3%***	4.9%***
Very Good	16.6%***	10.7%	6.2%***
Good	17.8%***	8.6%**	11.9%***
Fair/Poor^	27.3%	14.8%	24.6%
Child's Age			
0-5	16.5%	9.1%**	13.0%
6-11	19.9%	9.4%*	10.5%
12-17^	18.8%	13.5%	10.1%
Parent's Mental Health Status[2]			
Depressed	25.1%***	15.3%***	18.9%***
Not Depressed^	14.2%	7.3%	6.8%
Family Income			
0 to 99% FPL	18.1%	12.5%***	13.4% ***
100% to 199% FPL^	18.7%	7.8%	9.0%
Child's Race-Ethnicity			
Latino	19.0%	9.4%	13.4%***
White^	17.4%	13.6%	2.2%
African-American	11.7%	16.2%	0%
Asian-Pacific Islander	19.8%	11.2%	9.6%
Other	30.3%	21.1%	0%

	Difficulty accessing needed care for child	Transportation barrier to medical care	Language barrier to medical care
Functional Limitations			
Yes	32.4%**	19.3%*	10.4%
No^	17.3%	9.6%	11.3%
Parent Citizenship			
U.S. Citizen^	14.9%	13.5%	3.9%
Non-Citizen	20.7%***	8.2%***	16.3%***
Parent Foreign-Born Status			
Foreign Born	19.9%***	8.6%***	14.8%***
U.S. Born^	13.9%	15.6%	0.8%
Marriage Status of Respondent			
Married^	19.3%	8.4%	13.9%
Not Married	17.1%	12.3%**	8.6%***
Parent's Education			
Less than High School	19.9%	9.4%	14.3%*
High School	15.1%	11.7%	8.1%
Some College or trade school	18.7%	12.6%	7.8%
College or Postgrad degree^	18.8%	7.8%	8.2%
Work Status of Respondent			
Employed	17.9%	8.9%	10.3%
Unemployed^	18.7%	11.4%	12.2%
Language of Interview			
English	14.0%***	14.7%***	---
Not English^	20.4%	8.3%	16.7%
Number of Children in Household			
2 or fewer	18.3%	9.9%	10.5%
3 or more^	18.5%	11.2%	13.0%
SPA			
Antelope Valley	16.3%	20.9%	8.6%
San Fernando	17.0%	11.1%	13.1%
San Gabriel	15.8%	8.1%	8.9%
Metro	24.9%	10.4%	11.0%
West^	17.9%	12.3%	8.5%
South	18.8%	9.3%	13.6%
East	15.9%	10.1%	12.1%
South Bay	19.1%	10.4%	9.5%

Source: Urban Institute tabulations of the 2002/2003 Los Angeles County Health Survey.

Notes: [1] Only respondents who were interviewed in a non-English language received this question.

[2] The term "depressed" reflects the parent's reported general emotional state and does not necessarily indicate that the parent is clinically depressed.

^ Refers to the reference category

* p <.1, ** p <.05, *** p <.01.

Table 2. Unmet Health Care Needs for Low-Income Publicly Insured Children Ages 0-17 in Los Angeles County by Key Characteristics, 2002/2003

	Unable to afford to see doctor for check-up	Unable to afford to see doctor for illness	Unable to afford prescription drugs	Unable to afford dental care[1]	Unable to afford mental health care[1]
Child's Citizenship Status					
U.S. Citizen^	7.2%	5.7%	10.5%	12.5%	4.1%
Non-Citizen	19.8%***	20.5%***	19.2%**	39.2%***	8.1%
Child's Health Status					
Excellent	6.0%***	5.5%***	8.1%***	12.3%***	2.9%***
Very Good	6.3%***	6.4%**	8.7%***	11.9%***	4.0%**
Good	7.6%***	5.0%***	9.9%***	15.5%*	3.2%***
Fair/Poor^	13.8%	12.0%	19.5%	20.8%	8.6%
Child's Age					
0-5	5.7%***	5.0%***	9.6%*	8.8%***	1.4%***
6-11	8.7%	6.6%**	11.1%	13.9%***	3.8%**
12-17^	11.2%	10.4%	13.6%	20.8%	7.7%
Parent's Mental Health Status[2]					
Depressed	11.8%***	12.2%***	17.4%***	21.0%***	8.3%***
Not Depressed^	6.0%	3.8%	7.3%	11.1%	2.0%
Family Income					
0 to 99% FPL	8.7%	7.7%	12.8%**	14.9%	4.6%
100% to 199% FPL^	7.6%	6.2%	9.4%	15.2%	4.4%
Child's Race-Ethnicity					
Latino	9.3%	7.4%	11.2%	15.1%	4.3%
White^	6.4%	4.7%	10.3%	15.0%	10.3%
African-American	0.9%**	2.8%	13.9%	10.0%	3.3%*
Asian-Pacific Islander	6.5%	9.4%	8.5%	20.5%	2.9%*
Other	0%***	0%**	20.0%	11.0%	0%***
Functional Limitations					
Yes	8.4%	6.0%	22.7%**	18.0%	10.4%
No^	8.1%	7.0%	10.2%	14.8%	4.2%
Parent Citizenship					
U.S. Citizen^	5.7%	4.4%	11.5%	14.0%	5.1%
Non-Citizen	9.9%***	8.7%***	11.0%	15.9%	4.2%
Parent Foreign-Born Status					
Foreign Born	9.5%***	7.8%**	10.9%	15.5%	4.5%
U.S. Born^	4.3%	4.5%	12.0%	13.7%	4.6%

	Unable to afford to see doctor for check-up	Unable to afford to see doctor for illness	Unable to afford prescription drugs	Unable to afford dental care[1]	Unable to afford mental health care[1]
Marriage Status of Respondent					
Married^	8.9%	6.6%	9.3%	15.3%	3.7%
Not Married	7.5%	7.4%	13.3%**	14.7%	5.4%
Parent's Education					
Less than High School	9.8%	7.4%	11.0%	15.1%	4.4%
High School	5.7%	5.8%	11.2%	13.6%	4.7%
Some College or trade school	7.0%	8.1%	12.3%	17.4%	5.2%
College or Postgrad degree^	8.1%	5.5%	10.6%	15.1%	3.4%
Work Status of Respondent					
Employed	8.6%	7.1%	11.5%	15.7%	5.0%
Unemployed^	7.9%	6.8%	10.9%	14.5%	4.1%
Language of Interview					
English	5.5%***	4.7%***	12.5%	14.9%	5.1%
Not English^	9.5%	8.0%	10.6%	15.1%	4.2%
Number of Children in Household					
2 or fewer	7.6%	6.6%	10.4%	15.4%	4.7%
3 or more^	9.6%	7.8%	12.7%	14.3%	4.1%
SPA					
Antelope Valley	7.6%	5.0%	14.0%	13.4%	6.6%
San Fernando	9.3%	5.4%	11.2%	16.7%	4.4%
San Gabriel	5.7%	6.0%	5.0%	15.5%	2.3%
Metro	11.7%	7.6%	13.6%	16.6%	4.2%
West^	6.0%	6.6%	12.0%	6.5%	3.3%
South	9.1%	8.9%	12.7%	15.4%	6.5%
East	6.6%	8.1%	14.1%	13.0%	3.5%
South Bay	7.5%	6.1%	9.5%	14.9%	5.6%

Source: Urban Institute tabulations of the 2002/2003 Los Angeles County Health Survey.

Notes: [1] Only respondents with a child age 0 to 17 years received these questions.

[2] The term "depressed" reflects the parent's reported general emotional state and does not necessarily indicate that the parent is clinically depressed.

^ Refers to the reference category

* p <.1, ** p <.05, *** p <.01.

The multivariate analysis supports the findings that publicly insured low-income children in fair or poor health face more difficulty accessing needed medical care (data not shown). The multivariate results were mostly significant for every measure of access and unmet health care needs, including overall difficulty accessing needed medical care ($p=0.02$, $p=0.12$, $p=0.02$ for excellent, very good and good health, respectively), not being able to afford a medical check-up ($p=0.03$, $p=0.08$, $p=0.03$ for excellent, very good and good health, respectively), and not being able to afford prescription drugs ($p<0.01$ for excellent, very good and good health). The child's health status was not associated with differences in the presence of a usual source of care or the receipt of well-child care.

Child Age. Publicly insured, low-income children between the ages of 12 and 17 were more likely to have unmet health care needs and were less likely to have received a well-child exam than their younger counterparts. However, children of different ages experienced difficulty accessing needed medical care at similar rates.

According to the 2002/2003 LACHS, 11 percent of children ages 12 to 17 could not afford to see a physician for a regular medical check-up compared to 6 percent of children ages 0 to 5. Another 21 percent of children ages 12 to 17 were unable to afford dental care compared to 9 percent of children ages 0 to 5 and 14 percent of children ages 6 to 11. Older publicly insured, low-income children were also less likely to receive a well-child exam compared to younger children, although high proportions of both groups did obtain such care. For example, fully 90 percent of children ages 12 to 17 had a well-child exam within the last two years, while 95 percent of children ages 0 to 5 and ages 6 to 11 had received a well-child visit (Table 2, 3).

The multivariate analysis generally supports the descriptive findings for differences based on age for publicly insured low-income children (data not shown). For unmet health care needs, children ages 12 to 17 are more likely than younger children to experience an unmet dental need ($p<0.01$ age 0 to 5, $p=0.06$ age 6 to 11, respectively). The finding on unmet need for a medical check-up shows a weak difference with children 12 to 17 having more unmet need than children ages 0 to 5 ($p=0.09$). For well-child exams among school-age children, there is strong evidence children ages 12 to 17 are less likely to receive an exam compared to children ages 6 to 11 ($p=0.04$), other things equal.

Table 3. Service Use for Low-Income Publicly Insured Children Ages 0-17 in Los Angeles County by Key Characteristics, 2002/2003

	Child has usual source of care	Children receiving at least one well-child visit in past year (0-5)	Children receiving at least one well-child visit in past two years (6-17)
Child's Citizenship Status			
U.S. Citizen^	95.0%	95.3%	94.3%
Non-Citizen	76.0%***	84.3%	84.3%**
Child's Health Status			
Excellent	95.2%**	93.9%	95.8%**
Very Good	94.4%	95.3%	91.9%
Good	92.6%	96.4%	93.6%
Fair/Poor^	91.5%	94.8%	90.4%
Child's Age			
0-5	95.1%**	95.0%	---
6-11	94.0%*	---	95.2%***
12-17^	90.7%	---	90.2%
Parent's Mental Health Status1			
Depressed	92.8%	95.8%	90.7%**
Not Depressed^	93.9%	94.6%	94.8%
Family Income			
0 to 99% FPL	94.4%	94.5%	95.1%**
100% to 199% FPL^	92.6%	95.5%	91.0%
Child's Race-Ethnicity			
Latino	93.0%*	95.6%	94.2%
White^	96.3%	88.3%	92.4%
African-American	99.2%	91.8%	94.3%
Asian-Pacific Islander	90.6%	95.5%	81.4%*
Other	91.2%	83.6%	83.4%
Functional Limitations			
Yes	95.9%	100.0%***	97.6%*
No^	93.6%	94.8%	93.0%
Parent Citizenship			
U.S. Citizen^	95.4%	93.0%	93.1%
Non-Citizen	92.4%**	96.1%	93.1%
Parent Foreign-Born Status			
Foreign Born	92.4%***	96.1%*	93.0%
U.S. Born^	97.1%	91.9%	93.6%
Marriage Status of Respondent			
Married^	93.2%	95.9%	91.5%
Not Married	94.2%	94.2%	95.1%**

	Child has usual source of care	Children receiving at least one well-child visit in past year (0-5)	Children receiving at least one well-child visit in past two years (6-17)
Parent's Education			
Less than High School	92.4%	96.6%	94.1%
High School	95.3%	96.1%	91.7%
Some College or trade school	94.8%	89.6%	93.3%
College or Postgrad degree^	93.1%	91.2%	88.4%
Work Status of Respondent			
Employed	93.5%	95.7%	92.3%
Unemployed^	93.5%	94.7%	94.0%
Language of Interview			
English	97.0%***	92.1%**	93.9%
Not English^	91.9%	96.4%	92.8%
Number of Children in Household			
2 or fewer	93.0%	95.9%*	92.6%
3 or more^	94.8%	91.6%	94.1%
SPA			
Antelope Valley	94.2%	85.2%	85.1%
San Fernando	94.1%	95.4%	92.5%
San Gabriel	92.0%	95.0%	91.2%
Metro	93.6%	91.0%	96.0%
West^	84.7%	80.5%	89.9%
South	94.4%	96.5%	91.4%
East	93.9%	96.8%	95.5%
South Bay	94.2%	97.5%	96.2%

Source: Urban Institute tabulations of the 2002/2003 Los Angeles County Health Survey.

Notes: [1] The term "depressed" reflects the parent's reported general emotional state and does not necessarily indicate that the parent is clinically depressed.

^ Refers to the reference category

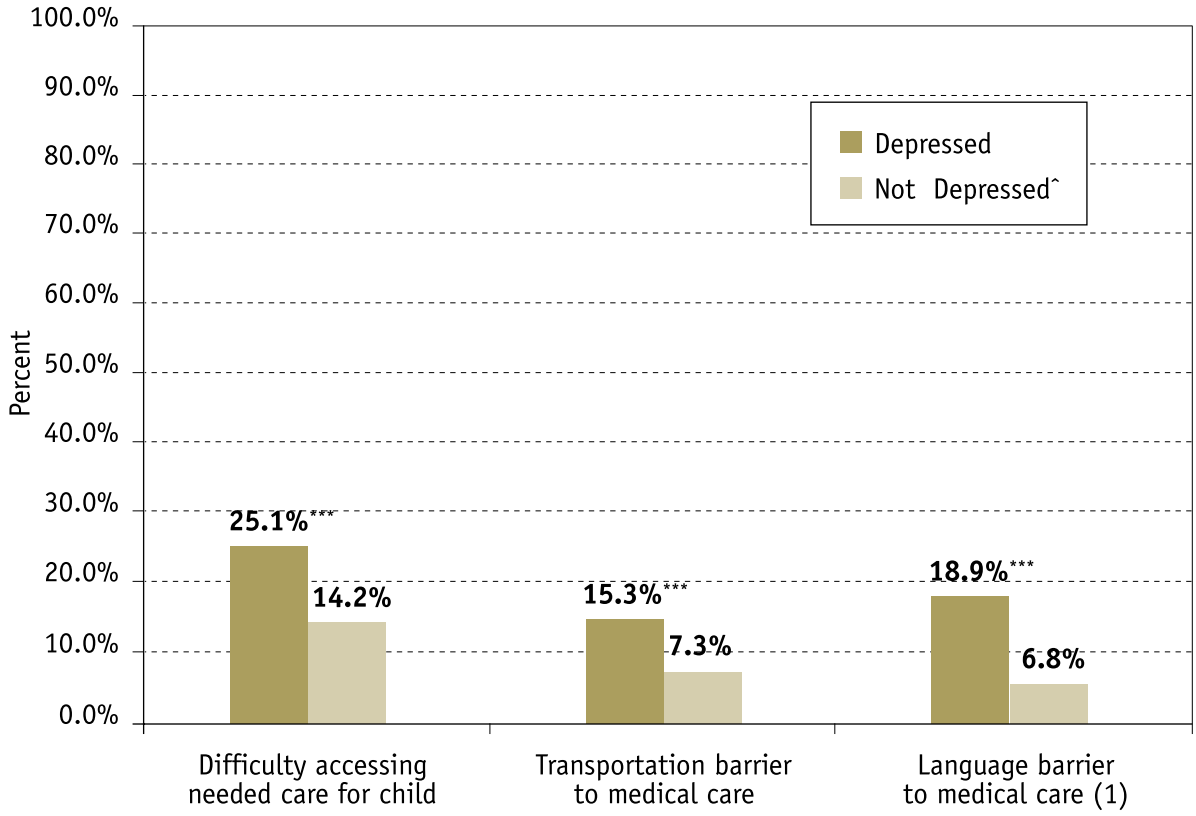
* p <.1, ** p <.05, *** p <.01.

Parental Mental Health. Publicly insured low-income children with parents or caregivers who reported feeling down, depressed, or hopeless, or who reported being bothered by little interest and pleasure in doing things in the past month at the time of the survey were much more likely to experience difficulties accessing medical care and more likely to experience unmet health care needs than children whose parents were in better mental health. For example, 25 percent of children with depressed parents were reported to have difficulty accessing needed medical care compared to only 14 percent of children whose parents were not depressed (Figure 4). While this analysis is exploratory, as the mental health data for parents has not been fully validated for the 2002/2003 LACHS, the findings are consistent with other studies that have shown that parental depression may have negative effects on various aspects of children's health (Kenney, McFeeters, Yee 2005; Fairbrother et al. 2005; Olfson et al. 2003). This issue will be revisited with the 2005 LACHS, which included more comprehensive information on mental health status. In addition, the term "depressed" as used in this analysis reflects the parent's reported general emotional state and does not necessarily indicate that a parent is clinically depressed.

For each category of unmet health care need analyzed, children of depressed parents were more likely to have experienced greater rates of unmet needs as reported by their parents. Nearly 12 percent of publicly insured, low-income children with depressed parents were not able to afford to see a physician for a regular check-up compared to only 4 percent of children whose parents were not depressed (Figure 5). Low-income, school-age children with depressed parents also were less likely to receive a well-child exam than their counterparts whose parents were in better mental health, (91 percent versus 95 percent) (Figure 6) but both groups were reported to receive well-child care at high rates. These findings for difficulty of access, unmet health care needs, and the receipt (by school-age children) of well-child care remained strong in multivariate analyses where parental mental health was one of the factors analyzed (data not shown). Interestingly, the parent's mental health status was not associated with differences in the presence of a usual source of care.

Income. Publicly insured poor children (children with family incomes between 0 and 99 percent of the FPL) were more likely than publicly insured near-poor children (children with family incomes between 100 and 199 percent of the FPL) to experience transportation and language barriers when trying to obtain needed health care. For example, fully 12 percent of poor children faced transportation barriers to receiving medical care compared to 8 percent of near-poor children. Finally for language barriers, 13 percent of poor children whose parents were interviewed either in English or a non-English language faced language barriers when trying to obtain medical care compared to 9 percent of near poor children. Multivariate analysis supported these descriptive findings (data not shown).

Figure 4. Difficulties Accessing Health Care Among Low-Income Publicly Insured Children (Ages 0-17) in Los Angeles County by Parent's Mental Health Status, 2002/2003



Source: Urban Institute tabulations of the 2002/2003 Los Angeles County Health Survey.

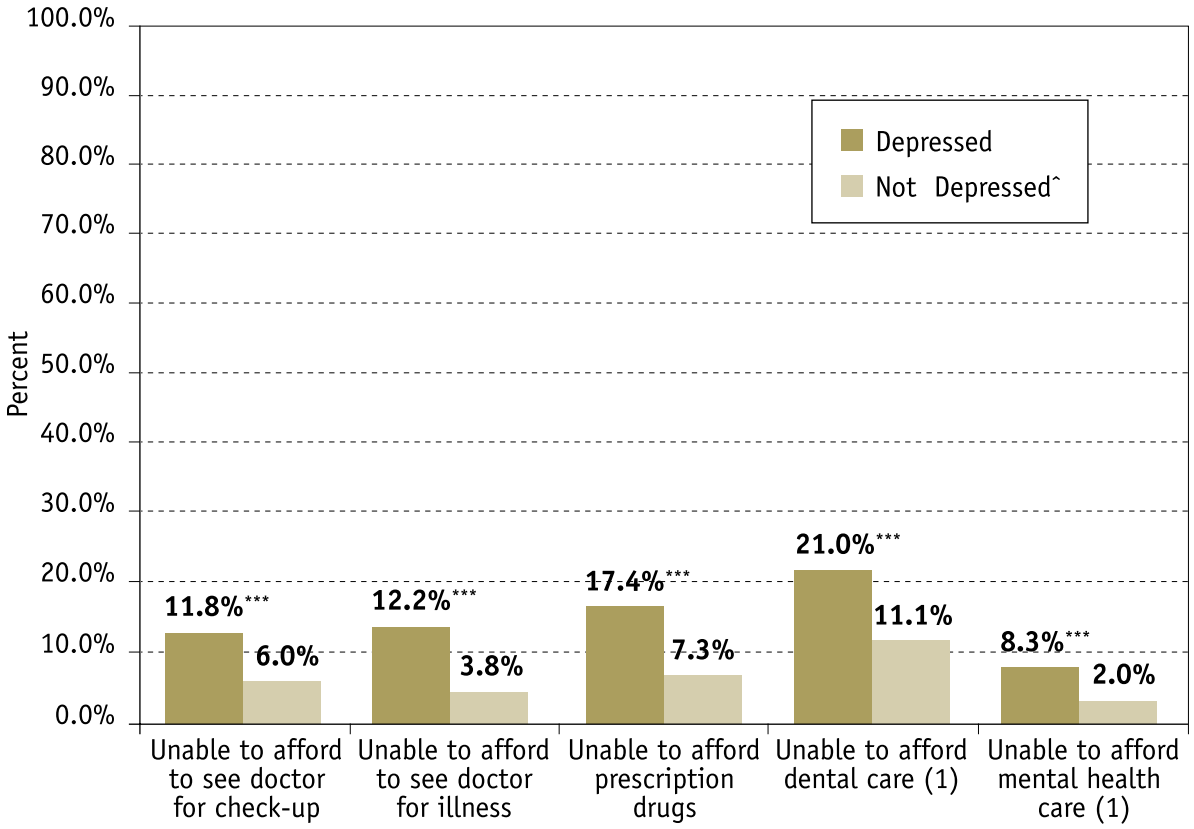
Notes: The term "depressed" reflects the parent's reported general emotional state and does not necessarily indicate that the parent is clinically depressed.

(1) Only respondents who were interviewed in a non-English language received this question.

^ Refers to the reference category

* p <.1, ** p <.05, *** p <.01.

Figure 5. Unmet Health and Dental Needs for Low-Income Publicly Insured Children (Ages 0-17) in Los Angeles County by Parent's Mental Health Status, 2002/2003



Source: Urban Institute tabulations of the 2002/2003 Los Angeles County Health Survey.

Notes: The term "depressed" reflects the parent's reported general emotional state and does not necessarily indicate that the parent is clinically depressed.

(1) Only respondents with a child ages 3 to 17 years received these questions.

^ Refers to the reference category

* p <.1, ** p <.05, *** p <.01.

III. Policy Implications

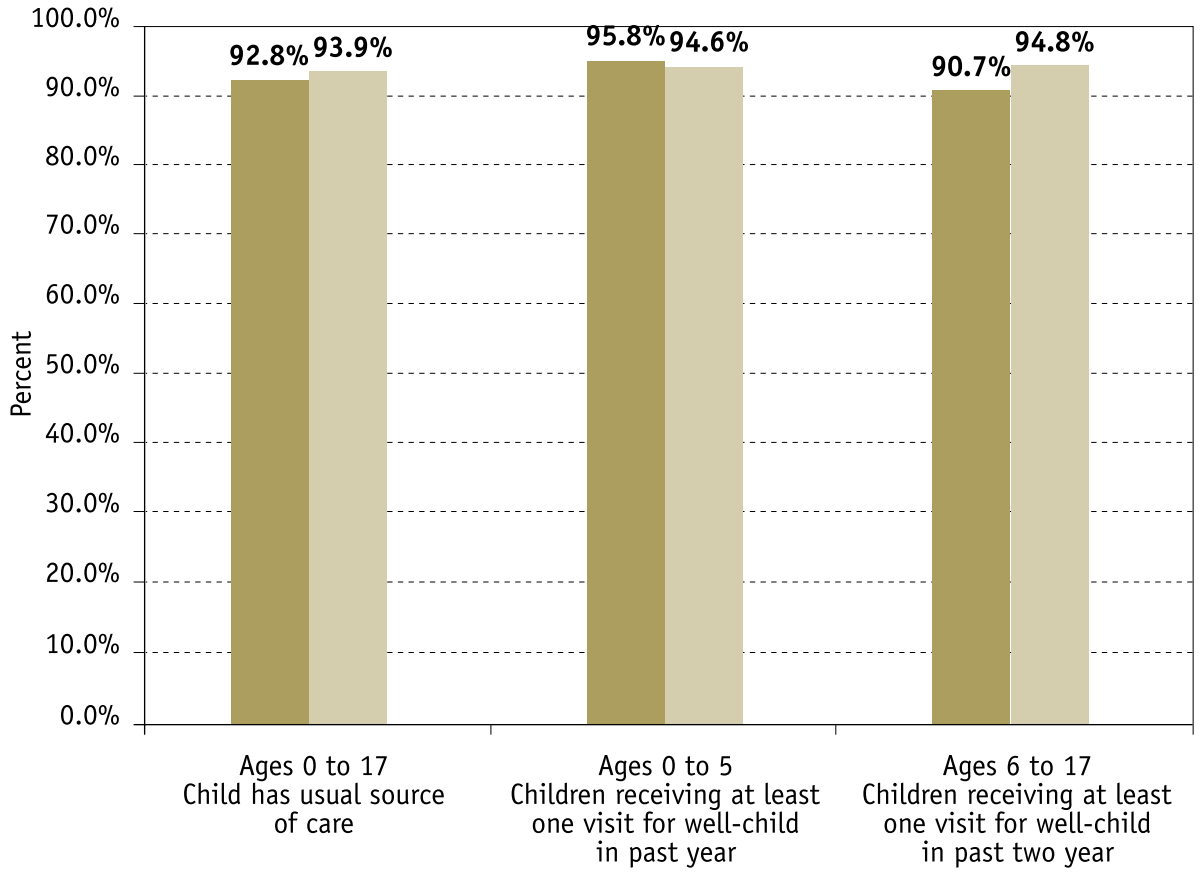
Based on the information provided in the 2002/2003 LACHS, it appears that certain subgroups of children served by public programs are experiencing more access problems. Unless these barriers are addressed, the Healthy Kids program will not have as great an impact on improving children's health care as hoped. Having coverage is only the first step to improving the health of children; their families must also be able to obtain the health and dental services that their children need.

The LACHS shows that among those with public coverage prior to the launch of the Healthy Kids program, non-citizen children, children in fair or poor health, children with parents in poor mental health, and children ages 6 to 18 were more likely to have problems accessing health care and to experience unmet health care needs. Among these factors, the characteristic that seems to be the single biggest differentiating factor affecting access to care is the child's citizenship status. Not only do non-citizen children with public coverage experience more access problems and greater unmet health care needs, they are also much less likely to have a usual source of care and to receive well-child care.

These data do not indicate why non-citizen children with public coverage have lower access to care compared to citizen children. Some of the access issues reported for non-citizen children may arise because some of the non-citizen children only have emergency Medi-Cal services. In addition, non-citizen children are different from citizen children in terms of their race/ethnicity, their parents' immigration and citizenship status, and whether English is spoken at home. These factors may affect where these children live, which may affect their proximity to providers. It is possible that their families may be less knowledgeable about how to access care on behalf of their children, or it is possible that language barriers limit their ability to navigate effectively the health care delivery system. It will be important to understand the root causes of these access differences related to citizenship in order to address them.

The Healthy Kids program has great potential to reduce disparities by providing comprehensive insurance coverage to children who would not have had coverage or at best would have only had emergency Medi-Cal. However, the program may need to provide additional support to families in order for children to fully benefit from program enrollment. If access problems facing non-citizen children with public coverage could be reduced or eliminated, the potential of the Healthy Kids initiative to improve health outcomes could be greatly expanded. Additional access gains could be obtained by providing more assistance to parents facing depression, by aiding families whose children are not in good health and by targeting services at adolescents. While these issues are found nationally and are not unique to Los Angeles County, Gaskin et al. 2005; Ku and Matani 2001; Weinick et al. 1998) to obtain the greatest improvement in child health outcomes the Healthy Kids program may need to develop strategies to address the disparities that exist within public health insurance.

Figure 6. Service Use for Low-Income Publicly Insured Children in Los Angeles County by Parent's Mental Health Status, 2002/2003



Source: Urban Institute tabulations of the 2002/2003 Los Angeles County Health Survey.

Notes: The term "depressed" reflects the parent's reported general emotional state and does not necessarily indicate that the parent is clinically depressed.

^ Refers to the reference category

* p <.1, ** p <.05, *** p <.01.

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Appendix: Data and Methods

The data source for this analysis is the 2002/2003 Los Angeles County Health Survey (LACHS). The LACHS is a random digit-dial survey of Los Angeles County, California. The survey has two components. One component is the Adult Survey where one randomly selected adult from a household is interviewed for the survey via telephone using an unrestricted random digit dialing methodology. The 2002/2003 Adult Survey had a total sample of 8,167 respondents. The response rate was 31.1 percent and the cooperation rate was 56.7 percent.

The second component is the Child Survey where a random telephone sample of parents of children under 18 was interviewed about their children. The survey was administered only to the mother of a selected child unless the child's mother did not reside in the household. If the mother did not reside in the household, then the father or other primary caregiver for the child was interviewed. There were two phases to the survey. The first phase involved interviewing 2,460 mothers or primary caregivers who had previously been interviewed for the Adult Survey and were identified as having at least one child under age 18 in their household. The second phase involved interviewing an additional sample of 3,535 mothers or primary caregivers from households with a child under age 18. In total, there were 5,995 respondents to the survey, a response rate of 33.9 percent, and a cooperation rate of 77.5 percent. For the Child Survey, the parent provided answers to the survey for only one randomly selected child even if the household contains more than one child.

The LACHS was designed to addresses potential biases caused by language barriers and by the exclusion of non-telephone households. To improve coverage of households where languages other than English and Spanish are spoken, the LACHS was conducted in other languages including Cantonese, Mandarin, Korean and Vietnamese. Thus, this should minimize the bias associated with language barriers since U.S. Census data show that 98 percent of adults in Los Angeles County speaks one of the six languages used by the survey (Field Research 2003). The LACHS excludes households who lack telephone landlines. However, the weights developed by the survey attempt to address this issue by collecting information on interruptions in telephone service. Data provided by respondents with intermittent telephone service are given more weight to compensate for households without telephones.

This brief examines variations in the access to health care for low-income children enrolled in public programs. To determine health insurance status, the survey asks about the health insurance coverage of a child at the time of the survey. There are three main categories of insurance coverage used in our analysis.[2] The categories are: 1) public coverage — a child is covered by Healthy Families (SCHIP) and Medi-Cal (Medicaid); 2) private insurance — a child is covered under an insurance plan, such as those provided by an employer, that is not publicly sponsored;[3] 3) no insurance — a child does not have health insurance coverage.

Parents were asked if their children had health insurance coverage at the time of the survey. If the parents said their children had current health insurance, the parents were asked about different types of health insurance policies to determine their children's type of insurance coverage. If the parents said their children did not have health insurance, the parents also were then asked about different types of health insurance policies to determine if their children may be covered by an insurance policy that the parents had not previously considered to be health insurance.[4] Children were determined to be uninsured if the parents initially said the children did not have insurance coverage or did not know if the children were insured, and did not indicate in subsequent questioning that the children had insurance coverage.

The child health insurance coverage variable was created based on the responses from the survey and a selection method to deal with parents who indicated that their children had more than one type of health insurance coverage.[5] The selection method used by the LACHS takes into account the types of insurance coverage mentioned by the parent, family income, and the age of the children being studied to determine the appropriate coverage category. When parents indicated that their children have private coverage and either Healthy Families or Medi-Cal, and the age and family income of the children and show that the children are eligible for public insurance, the children were assigned to either Healthy Families or Medi-Cal. Otherwise, the children who were reported to have both public and private coverage were assigned to private coverage.[6]

The survey also obtains information on family income. If a child's family income is below 200 percent of the federal poverty level (FPL), a child is considered to be low-income. Parents were asked about their annual pretax income. The survey then used income thresholds based on the household size of the family to determine if a family's income was 1) 0 to 99 percent of the FPL, 2) 100 to 199 percent of the FPL, 3) 200 to 299 percent of the FPL or 4) 300 percent or more of the FPL.

For this analysis, parents were asked a series of questions about their children's use of health care. Parents were asked if they had difficulty getting medical care for their child. Parents were also asked that if in the past year their child had unmet health needs because the family could not afford to pay for some health care services including: 1) medical exams when their children were sick or had a health problem; 2) prescription medicines; 3) dental care including dental check-ups; and 4) mental health care. The survey asked parents if they had one health care provider or a preferred health care provider to obtain care for their children, a usual source of care. Last, the parents indicated how recently their children had a medical check-up. There were different time options for children ages 0 to 5 (within last six months, six to 12 months ago, one to two years ago, more than two years ago, never) than for children ages 6 to 17 (within the last two years, two or more years, never).

We examine how access to health care services, the level of unmet health needs, access to a usual source of care and frequency of a medical check-up were different for publicly insured children for

a number of characteristics of the children and their family. Family characteristics included the responding parent's gender, martial status (married or not married), educational attainment (defined as: less than high school; high school; some college or trade school; college or post-graduate degree), employment status (working/non-working; part-time vs. full-time) citizenship status (citizen vs. non-citizen) and birthplace (United States or other country), the language in which the interview was conducted (English vs. non-English), number of children in the household (two or fewer or three or more), and geographic location (defined according to the Service Planning Area (SPA) in which the child lived — Antelope Valley, San Fernando, San Gabriel, Metro, West, South, East and South Bay). We also examined the mental health status of the parent (the parent is considered to be depressed if the parent said they often felt down, depressed, or hopeless or had little interest or pleasure in doing things), but this analysis is considered exploratory because the parent mental health questions for the 2002/2003 survey have not been validated. Child characteristics included: age (0 to 5, 6 to 11, 12 to 17), gender, race/ethnicity (Latino, White, African-American, Asian-Pacific Islander, Other), citizenship status (citizen vs. non-citizen), health status (categories are excellent; very good; good; fair; poor), and presence of functional limitation or other special health need (defined as: having a chronic medical, health or behavioral condition requiring prescription medication; a chronic medical, health or behavioral condition requiring either a high level of care or specialized therapy for treatment; or an emotional, developmental or behavioral problem for which the child receives counseling).

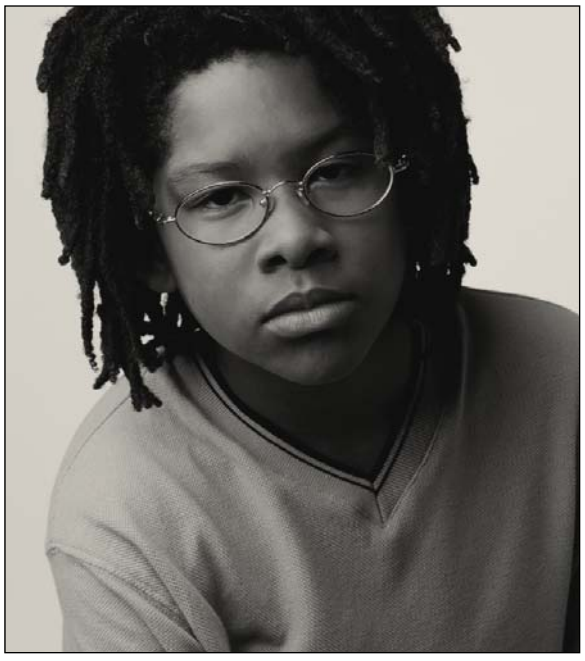
In all analyses, we used survey weights in an attempt to make the survey data representative of all of Los Angeles County. We calculated standard errors that took into account the complex nature of the survey design related to the unequal probabilities of selection and other factors used in the creation of survey weights. We conducted bivariate and multivariate analyses on the measures of access to health services, unmet health care needs, usual source of care, and receipt of well-child care for low-income, publicly insured children, with the family and child-specific characteristics described above.

Study Limitations

All of the data are self-reported, and it is possible that some survey respondents may not have understood that they or their children have valid public health insurance coverage, or may believe they or their children have valid public health insurance coverage when they do not. In addition, there may be a potential disconnect between the health insurance measures and the access measures included on the survey. The insurance coverage questions reflect the children's status at the time of the survey, whereas many of the access measures pertain to the experiences the children had over the 12-month period prior to the survey. For access to health care services, unmet health needs, and having a usual source of care it is possible that parents underreported the problems they have with obtaining health care for their children to not appear negligent. Likewise, parents may have claimed that their children received more frequent medical check-ups than the children actually received to avoid appearing negligent.

In addition, the reliance on a single question to define household income likely introduces downward bias into our estimates of income. Indeed the share of children under 200 percent FPL in the LACHS is higher than the U.S. Census and the California Health Interview Survey. Another limitation is that we do not have information that allows us to identify which children in the sample are undocumented. Our analysis therefore focuses on non-citizen children, which include both documented and undocumented children.

There is also a concern that the access and use differences found among publicly insured children are due to unobserved differences among the different types of children that are not accounted for by the control variables included in the regression analyses. Finally, the low survey response rates could lead to estimates of difficulty with accessing health services, unmet health care needs, having a usual source of care, and the frequency of a medical check-up to be different than the actual population of Los Angeles County. It is possible that the portion of the sample that did not respond may be different from those who did respond in ways that are not accounted for by the weights.



Notes

1 Refer to the appendix for information on the 2002/2003 L.A. County Health Survey, including information on the access to care measures, health insurance measures, and characteristics of the child and their family included in this study. Results from multivariate regressions are available upon request from the authors.

2 There also are options if parents did not know if their children had health insurance or if parents refused to provide information.

3 Valid coverage for this category includes employer-sponsored insurance or union or trade association policies, military insurance programs, California Kaiser Kids or similar programs, or any non-group insurance policy.

4 The types of insurance policies mentioned included employer-sponsored insurance and other related insurance provided through a union or trade association, Medi-Cal and Healthy Families which are public insurance programs, military insurance, and California Kaiser Kids and other similar programs. If the parents did not indicate coverage for their children under any of these types of policies, they were asked if the children were covered under a non-group insurance policy.

5 Survey data indicated that 5 percent of children surveyed had more than one type of health insurance.

6 An exception is made if the children have military coverage or coverage through California Kaiser Kids or similar programs. Then the children are assigned to private insurance without regard to their age or family income.

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