CHILDREN NOW

California Report Card

Focus on Children's Health

2003

CHILDREN NOW

is a research and action organization dedicated to assuring that children grow up in economically secure families, where parents can go to work confident that their children are supported by quality health coverage, a positive media environment, a good early education, and safe, enriching activities to do after school. Recognized for its expertise in media as a tool for change, Children Now designs its strategies to improve children's lives while at the same time helping America build a sustained commitment to putting children first. Children Now is an independent, nonpartisan organization.

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Introduction

CALIFORNIA BOASTS a wealth of health care resources. Yet despite world-renowned hospitals, biotechnology industry innovators and leading research labs, 1.2 million children lack basic health insurance, and even more lack coverage for oral health care. With 88,000 farms, California leads the nation in food production, yet few California schoolchildren eat fresh fruit and vegetables at lunch each day. Moreover, many children go hungry, particularly in some of the state's most agricultural counties. Over one million children in California have been diagnosed with asthma, and nearly one million children ages 2-11 have never been to a dentist. In all areas of health and health care, California children are vulnerable: substantial disparities persist by region, by ethnicity, by immigration status and by income.

1.2 million California children lack basic health insurance.

A child's health derives from a complex mix of individual, family and community factors and the public policy environments in which they interact. In the case of a child with asthma, for instance, current evidence points to several conditions that can lead to development of the disease, including genetic susceptibility, low birthweight, inadequate housing and nutrition, and air pollution. Having access to health care and following prescribed treatments make a difference in an asthmatic child's quality of life. On a larger scale, public policy decisions affect the causes of asthma, the environments in which children must manage their condition, and the quality of care they receive.

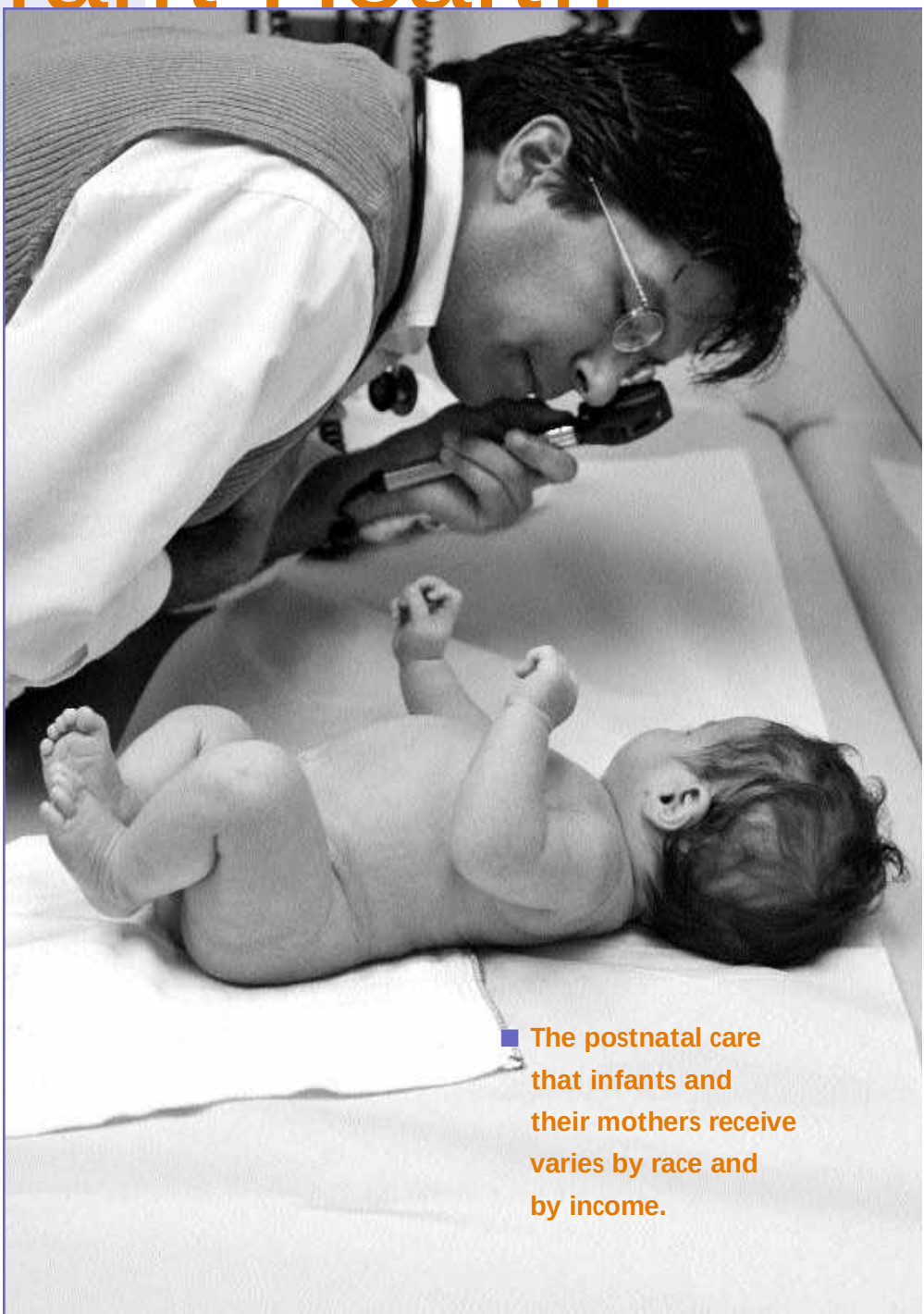
This year's *California Report Card* focuses on some of the central issues in children's health, including infant health, health insurance and access to care, oral health, nutrition and physical fitness, and mental health. The release of data from UCLA's California Health Interview Survey (CHIS), the largest state health survey ever conducted in the U.S. with over 50,000 respondents, gives us a wealth of new information on children's health behaviors and outcomes.

There is bipartisan support for expanding children's access to health care.

This knowledge coincides with an economic crisis that threatens gains the state has made in improving children's health. The size of the state budget deficit is unprecedented; federal tax cuts limit the resources California can draw upon; and public health programs and private hospitals alike are staggering under the combined burdens of cost escalations, increased demand for services and budget cuts. Nevertheless, there are great opportunities for progress in improving children's health.

Historically, political movements to expand children's access to insurance and services have garnered bipartisan agreement. In recent years, the development of the State Children's Health Insurance Program (Healthy Families in California) at the federal and state levels, eligibility expansions in Medi-Cal, the state's Medicaid program, and the development of the Family PACT program and other services, have been the result of hard work by policy-makers from both parties. We know that the public will and political will are there. Even in these difficult times, we must continue to move forward on children's health issues. California's public policies must ensure that all children have access to high-quality medical, oral and mental health care, and create an atmosphere that emphasizes prevention and makes healthy lifestyle choices easy. The stakes—for children, their communities and the state—are simply too high.

Infant Health



- **The postnatal care that infants and their mothers receive varies by race and by income.**

OVER 527,000 BABIES were born in California in 2001. In the last decade, California has expanded programs serving infants and mothers and has seen favorable trends in a number of key measures, including infant mortality, early prenatal care and births to adolescents. Still, troubling differences in access to health care and health outcomes persist across racial and ethnic lines.

Timely prenatal care helps to ensure healthier pregnancies by managing pre-existing and pregnancy-related medical conditions and providing important health advice to expectant mothers. From 1999 to 2001, the percentage of mothers receiving early prenatal care (in the first trimester of pregnancy) improved across California's largest racial and ethnic groups (see Table 1). Pacific Islander and Native American women, however, continue to receive early prenatal care less frequently than other women (69.7% and 73.2% respectively in 2001).

The percentage of mothers receiving early prenatal care has improved across all large racial and ethnic groups.

Table 1

Percentage of Mothers Receiving Early Prenatal Care Improves from 1999 to 2001

	1999	2000	2001
All	83.6%	84.5%	**85.4%**
African American	81.1%	82.1%	**82.5%**
Asian	85.7%	87.7%	**87.7%**
Pacific Islander	N/A	69.0%	**69.7%**
Latino	79.7%	80.8%	**82.4%**
Multiracial	N/A	83.4%	**83.7%**
Native American	72.5%	73.9%	**73.2%**
White	89.1%	85.0%	**90.1%**

Source: Children Now analysis of data from California Department of Health Services, Vital Statistics, Birth Records, 1999-2001.

Despite some progress, low birthweight and infant mortality rates are still much higher for African American infants.

In 2001, nearly one in fifteen California newborns (6.3%) was born at low birthweight, a rate that has changed little since 1995. Infants born at low birthweight (5 pounds, 8 ounces or less) are more likely to experience developmental delays, asthma, and vision and hearing impairments, among other conditions, than larger infants.[1] African American infants remain twice as likely as white infants to be born at low birthweight in California (11.9% compared to 5.9%).[2]

California's infant mortality rate (deaths during the first year of life) has decreased from 6.3 infants per 1,000 births in 1995 to 5.3 infants per 1,000 births in 2001. Although African American infant mortality has declined the most in absolute terms over this time period—from 14.1 per 1,000 births in 1995 to 12.6 per 1,000 births in 2001—African American infants are still more than twice as likely as all California infants to die before their first birthday (12.6 versus 5.3 deaths per 1,000 births in 2001). Multiracial infants are more than one and one-half times as likely to die as all California infants (8.5 deaths versus 5.3 deaths per 1,000 births in 2001).[3]

Nearly all uninsured infants qualify for one of the state's insurance programs.

The postnatal care infants and their mothers receive also varies by race and income, and often falls short of recommended standards. A 1997 California law mandates that insurance companies cover a minimum hospital stay of two days for vaginal births and four days for caesarean section births, but a recent study found that more than 49 percent of mothers and their newborns were discharged earlier than that. Latina women and women covered by Medi-Cal were significantly more likely to be discharged earlier, and two-thirds of infants who were discharged early did not receive recommended follow-up care.[4]

California is missing an opportunity to enroll infants in health insurance programs beginning at birth. In 2001, 49,000 infants in California were uninsured, according to CHIS. Almost all of them (92%) would have qualified for one of the state's insurance programs: Medi-Cal, Healthy Families or Access for Infants and Mothers (AIM).[5] Medi-Cal is the largest potential insurer: more than three-quarters of these uninsured infants qualify for the program due to federal law requiring that infants born to mothers enrolled in Medi-Cal automatically be enrolled in the program at birth.

Births to adolescents have long been a public health concern because of the risks to both mother and child associated with early childbearing. Adolescent mothers are less likely to complete high school or have steady jobs than non-parenting teens. Children of

SPOTLIGHT PROGRAM

Maternal and Child Health Access, Los Angeles

For ten years, Maternal and Child Health Access (MCHA) has helped poor and disadvantaged women in downtown Los Angeles receive vital health care and social services. MCHA serves approximately 3,000 women and their families each year through a variety of activities, including health insurance outreach and enrollment assistance, pregnancy case management, parenting classes, health education and a literacy program. MCHA increases awareness among these women, primarily Latina immigrants, about the importance and availability of health care services. Outreach sites include the Women, Infants and Children Special Supplemental Nutrition Programs (WIC), courts, schools, social service programs, clinics and hospitals.

MCHA also:

- Conducts the Notario Project, which works with community leaders to inform women about available health care services and dispel misperceptions about eligibility for health services;
- Works to improve oral health among pregnant immigrant women by educating them about Medi-Cal coverage for dental care;
- Advocates for implementation of the Medi-Cal "Newborn Enrollment Process" to ensure that infants whose mothers are enrolled in Medi-Cal also receive coverage;
- Monitors coordination among all family health insurance programs, including Los Angeles County's new Healthy Kids for children ages 0-5.

adolescent mothers have lower birthweights and higher infant mortality, as well as poorer school performance.[6] Due to a combination of factors, including state investment in prevention education and accessible health services as well as behavioral changes, births to teens have continued to decrease in California. In 2001, California's childbirth rate for adolescents ages 15-19 was 45 per 1,000, down from a 1991 high of 73 per 1,000, and below the national average for the first time in over a decade.[7] Teen birth rates have declined for all large racial and ethnic groups in California, though they are relatively higher for Latina, African American and Native American teens. Two out of every three babies born to teenagers in California are born to Latinas. White and Asian birth rates are comparatively low, although Laotian and Hmong adolescents ages 15-19 have among the highest birth rates in the state.[8] Regionally, teen birth rates are highest in the San Joaquin Valley and Inland Empire, and lowest in the Sierra counties and San Francisco Bay Area.[9]

In the last decade, teen birth rates have declined across all large racial and ethnic groups.

Health Insurance and Access to Care

- **In California, about 1.3 million children (14.3 percent) lacked health insurance coverage or experienced gaps in coverage over a 12-month period.**

ACCESS TO TIMELY, comprehensive medical care—from preventive care to care for chronic illnesses and disabilities—is critical to children's healthy development. Children who lack health insurance are less likely to receive regular preventive care, compromising the identification of vision and hearing problems, as well as the management of chronic illnesses. They are less likely to see a health care provider when they are ill, increasing the likelihood that they will remain sick longer and miss more days of school.[10] In addition, families without health insurance generally must pay out of pocket for health care costs, leaving them with less money to spend on their children's other needs.[11]

Children's health insurance rates vary significantly by region, ethnicity and income.

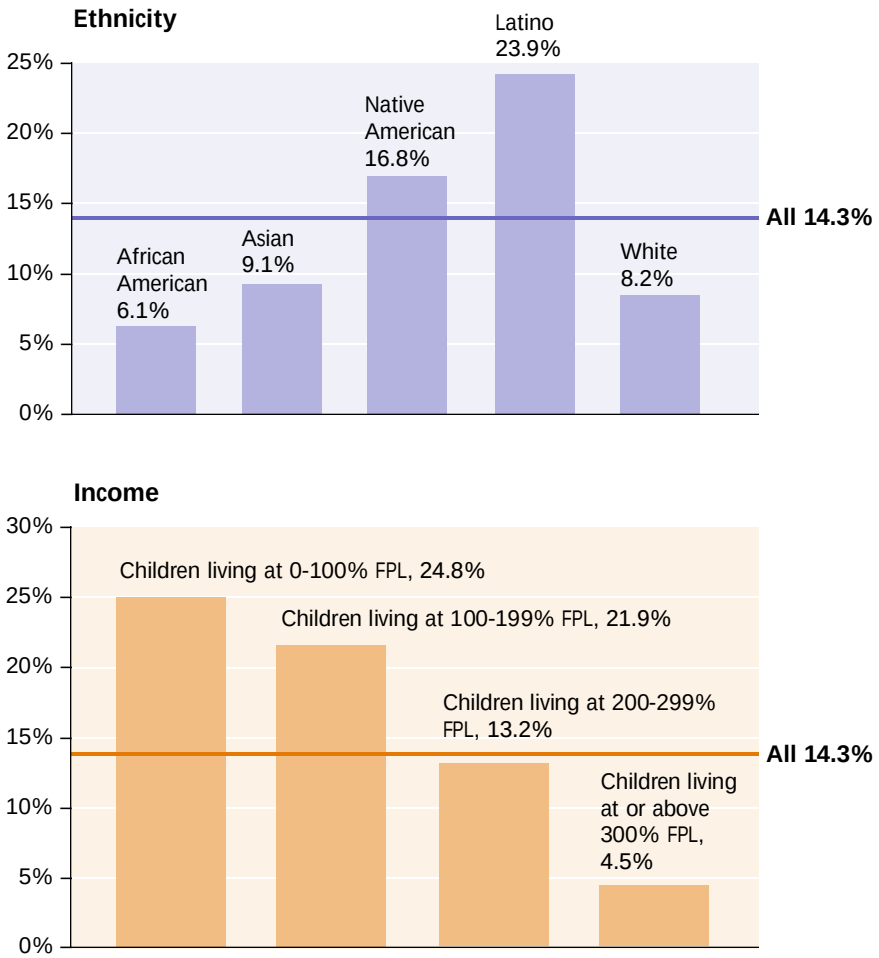
In California, about 1.3 million children (14.3%) lacked health insurance coverage or experienced gaps in coverage over a 12-month period, according to the 2001 CHIS survey.[12] Children's health insurance rates vary significantly by region, ethnicity and income. At the county level, the rates of children lacking health insurance range from 4.3 percent in Solano County to 19 percent in Santa Barbara.[13] In the Central Valley, seven out of eight counties have rates of uninsured children at or above the state average, ranging from 14.3 percent in Fresno to 18.7 percent in Kern (see map on page 13). The nine county San Francisco Bay Area has some of the lowest rates of uninsured children, with an overall uninsured rate of 6.9 percent.[14]

Racial and ethnic disparities in health coverage persist. Native American children are twice as likely and Latino children are three times as likely as white children to lack health insurance (see Table 2). While 75 percent of white children have health insurance through their parents' employers, only 54 percent of Native American children and 42 percent of Latino children have job-based health insurance. African American children also have lower rates of job-based health insurance than white children (60% among

African American families), but as a result of high participation in Medi-Cal and Healthy Families, they have the lowest uninsured rate (6.1%) of California's largest ethnic groups.[15] Certain subgroups, notably Korean Americans and Central Americans, are insured at particularly low rates (32.8% and 32.6% uninsured, respectively).[16]

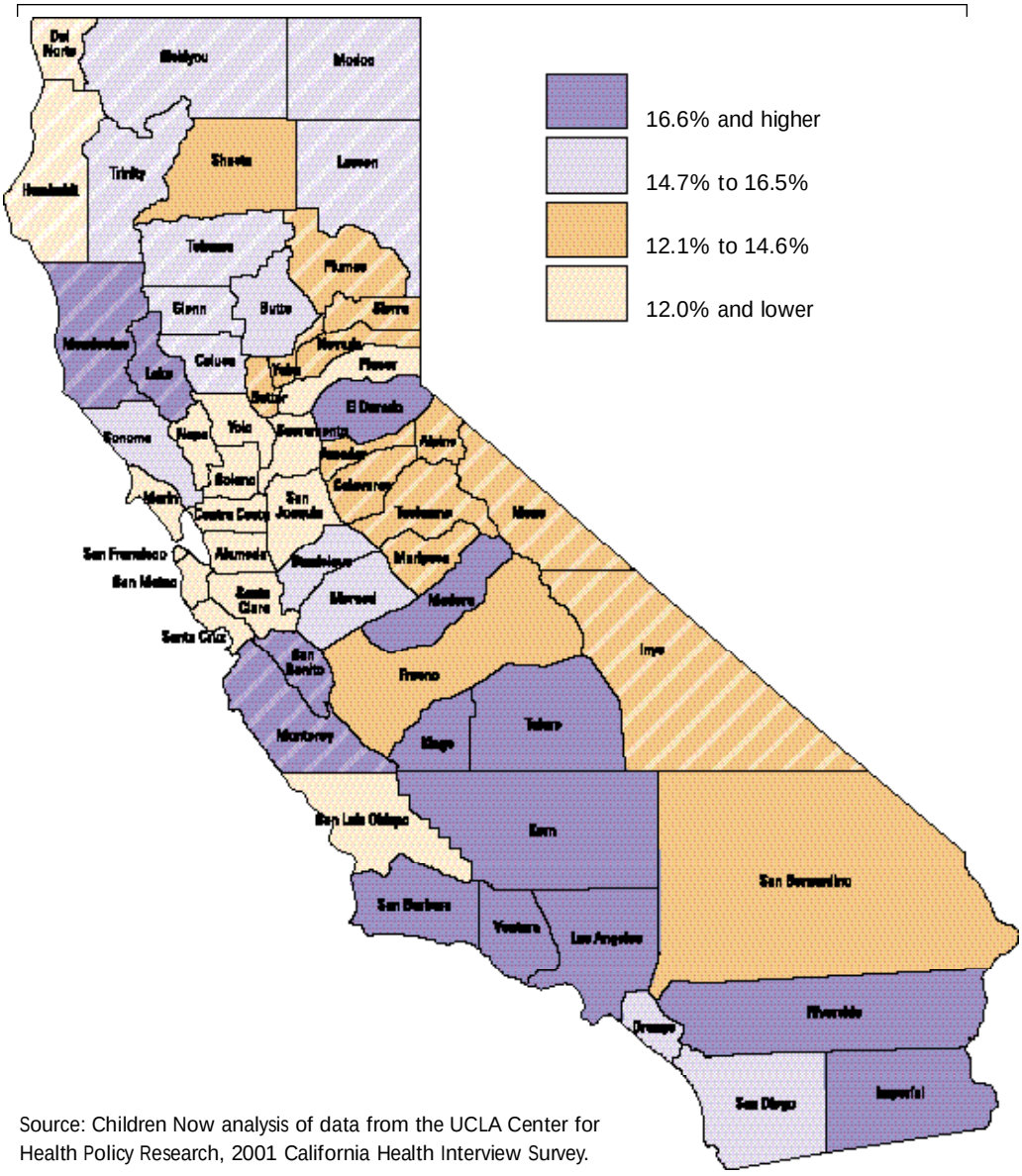
Graph 1

Percentage of Children Ages 0-17 Lacking Continuous Health Insurance, California 2001



Source: Children Now analysis of data from the UCLA Center for Health Policy Research, 2001 California Health Interview Survey. In 2003, 100% of the Federal Poverty Level (FPL) was $15,260 for a family of three.

Children Lacking Continuous Health Insurance, California Counties, 2001

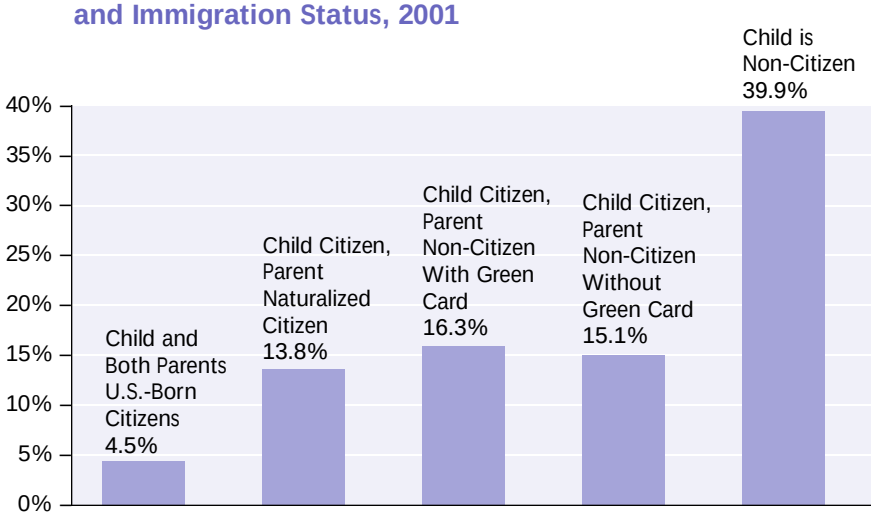


Source: Children Now analysis of data from the UCLA Center for Health Policy Research, 2001 California Health Interview Survey.

Note: The 2001 California Health Interview Survey produced county-level results for 33 counties and area-level results for contiguous groupings of counties with smaller populations. These county groups, indicated by striped lines, include: Tuolumne, Calaveras, Amador, Inyo, Mariposa, Mono and Alpine; Siskiyou, Lassen, Trinity and Modoc; Humboldt and Del Norte; Tehama, Glenn and Colusa; Nevada, Plumas and Sierra; Mendocino and Lake; Sutter and Yuba; and Monterey and San Benito.

Graph 2

Percentage of Uninsured Children by Family Citizenship and Immigration Status, 2001



Source: E.R. Brown et al., The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey (Los Angeles, CA: UCLA Center for Health Policy Research, 2002).

Insurance rates also vary by age. In 2001, 16.7 percent of adolescents ages 12-17 reported that they lacked health insurance for at least part of the previous year, compared to a parent-reported figure of 13.1 percent of children ages 0-11. The rate of insurance among older adolescents is even lower: 31 percent of all youth ages 18-19, including 45 percent of Latino youth, 24.6 percent of African American youth and 20.4 percent of white youth, lacked continuous health coverage over a 12-month period.[17]

SPOTLIGHT PROGRAM

San Mateo County Health Initiative

The San Mateo County Children's Health Initiative (CHI) is one of nine county initiatives recently developed in California to provide health insurance to children who do not qualify for state or federal programs and whose families do not have job-based insurance. The agency, which established the county's Healthy Kids insurance program, seeks to enroll children ages 0-18 whose family income is less than 400 percent of the Federal Poverty Level and who are ineligible for Medi-Cal or Healthy Families. Targeting its outreach to families through businesses, faith-based organizations, child care centers, schools and labor unions, the program enrolled an estimated 5,350 children in its first six months. CHI contracts with the Health Plan of San Mateo to provide comprehensive health services to eligible children in San Mateo County, with oral health services provided by Delta Dental and mental health services provided by the county's own Division of Mental Health Managed Care Network. The program is financed through county First 5 funds, county general funds, hospital and health care districts and community foundations.

The number of uninsured children in California could be reduced by two-thirds if all children eligible for public insurance programs were enrolled. Children living in families with incomes up to 250 percent of the Federal Poverty Level ($38,150 for a family of three in 2003) may be eligible for either Medi-Cal or Healthy Families. Medi-Cal provides comprehensive health care coverage (medical, dental and mental health) to over three million children in California, while over 600,000 children are enrolled in Healthy Families. Yet, of the nearly one million children who were uninsured at the time of the 2001 CHIS survey, two-thirds (656,000) were eligible for, but not enrolled in, Medi-Cal or Healthy Families.[18] Children in immigrant

The number of uninsured children in California could be reduced by two-thirds if all children eligible for public insurance programs were enrolled.

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SPOTLIGHT PROGRAM

SacAdvantage, Sacramento County

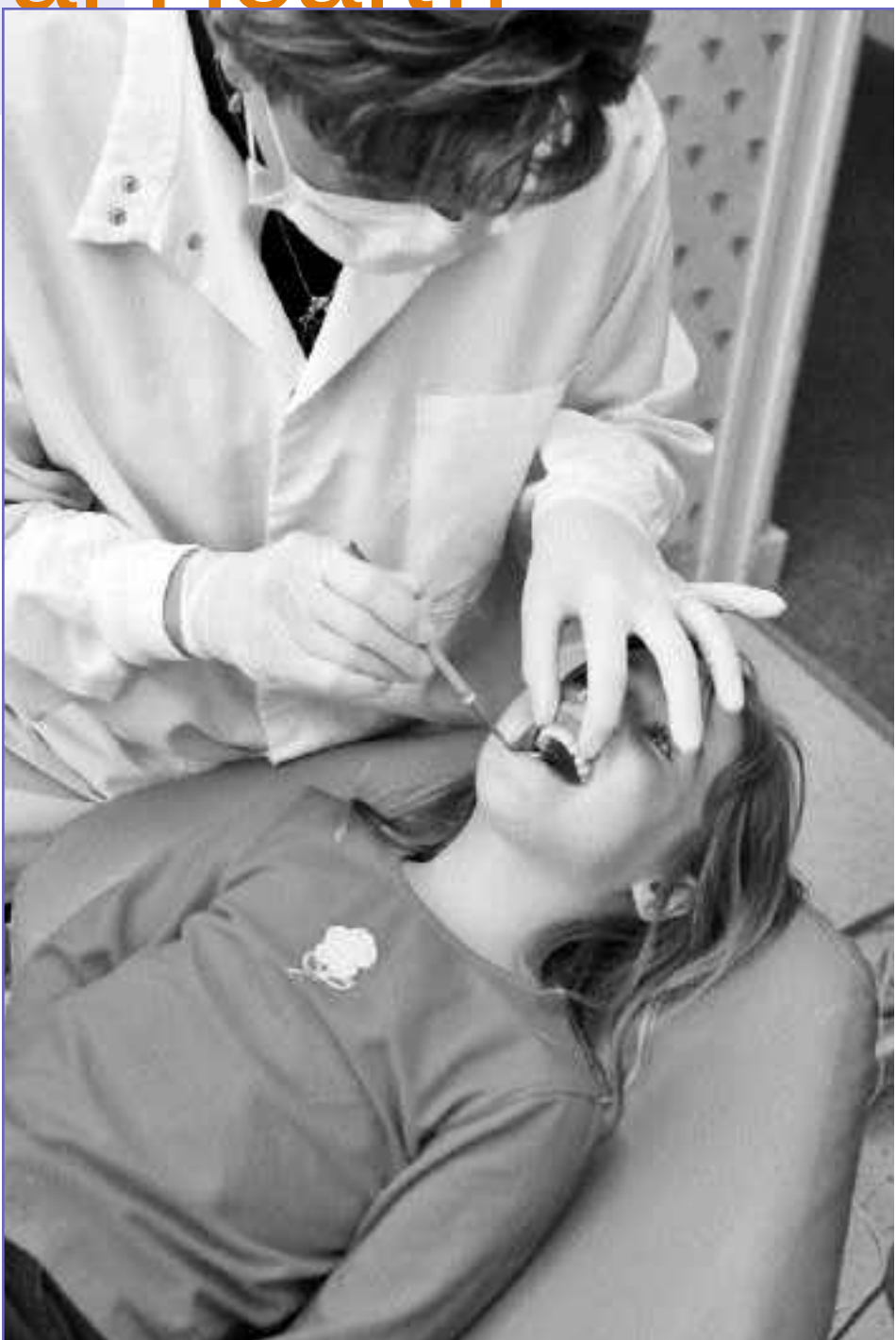
SacAdvantage is an innovative effort to insure the uninsured through a public-private partnership. Working with county businesses with fewer than 50 employees, SacAdvantage provides low-cost health insurance to low-income employees and their dependents not eligible for either Medi-Cal or Healthy Families. The county, small businesses and employees each pay a portion of the insurance premiums. The employees and their dependents receive health care services through PacAdvantage. Since its inception in January 2003, SacAdvantage has added 20 participating employers and covered 100 employees and their dependents as of June 2003. SacAdvantage offers an important resource to small businesses and to employees who otherwise would lack health insurance.

families, frequently assumed to be ineligible for public insurance, make up a significant percentage of this group. One-quarter (24%) of California children born in the U.S. to at least one undocumented parent were uninsured at some point in 2001, although two-thirds of these children were eligible for Medi-Cal and one-quarter were eligible for Healthy Families.[19]

Uninsured children are more than five times as likely to lack a usual source of care.

Not having insurance makes access to care very difficult. The CHIS survey reported that uninsured children were more than five times as likely to lack a usual source of care as children who had been continuously insured over the previous 12 months.[20] One-quarter of uninsured children (25.5%) had no doctor visits in the previous year, compared to 10 percent of all children.[21] Having insurance does not guarantee access to care, however. Even insured children face barriers to care, including limitations on coverage, low numbers of participating providers, language barriers and lengthy travel times to appointments. These problems are more likely, and more difficult to overcome, when children live in low-income households.[22]

Oral Health



■ **In 2001, nearly one-quarter of California children ages 2-11 did not have dental insurance.**

ORAL HEALTH PROBLEMS are rampant among California children, from infancy through adolescence. Tooth decay can develop as soon as baby teeth come in, and, if left untreated, can lead to nutrition problems and severe pain. Collectively, older children miss thousands of school days each year due to problems with their teeth and mouths,[23] and low-income children miss nearly twelve times as many school days because of dental problems as higher income children.[24] Racial disparities are also evident in access to oral health care. According to a 2000 report, about 40 percent of Asian, African American and Latino preschoolers do not receive the dental care they need, compared to only 16 percent of white preschoolers.[25] The needs are even greater among school-age children: approximately 65 percent of Latino, African American, and Asian elementary school children have unmet oral health care needs, as do half of all African American high school students and three-quarters of Latino high school students.[26]

Low-income children miss nearly twelve times as many school days because of dental problems as do higher income children.

Part of the reason for these unmet needs is lack of dental insurance. In 2001, 23.3 percent of California children ages 2-11 did not have dental insurance.[27] Because dental insurance rates for children ages 12-17 are not available, a direct comparison with medical insurance rates for children of all ages is not possible. It is clear, however, that many more children lack dental insurance than health insurance.[28] Although both Medi-Cal and Healthy Families cover oral health services, many employer-sponsored insurance plans do not, or include it only at significant additional cost.[29] Latino children are more likely than the average California child to lack dental insurance, with 30.7 percent uninsured. Children of Central American origin, in particular, are likely to lack dental insurance; 43 percent of these children do not have insurance, one of the highest rates for any subpopulation. While Asian children overall are insured at a rate slightly higher than the average, over 40 percent of Korean American children lack dental insurance.[30]

Table 2

Children Lacking Dental Insurance (ages 2-11)

By Race/Ethnicity	Number	Percentage
All	**1,216,000**	**23.3%**
African American	48,000	13.5%
Asian	86,000	17.4%
Cambodian	1,000	16.5%
Chinese	13,000	9.8%
Filipino	19,000	17.6%
Korean	22,000	41.5%
Vietnamese	7,000	14.2%
Latino	601,000	30.7%
Central American	67,000	43.0%
Mexican	489,000	30.9%
Puerto Rican	3,000	21.2%
South American	10,000	39.3%
Multiracial	26,000	20.1%
Native American	4,000	18.7%
White	451,000	19.9%

By Income	Number	Percentage
Family Income under 100% FPL	401,000	33.4%
100-199% FPL	314,000	26.7%
200-299% FPL	167,000	21.2%
300% FPL and above	334,000	16.2%

Source: Children Now analysis of data from the UCLA Center for Health Policy Research, 2001 California Health Interview Survey.

Even children who have dental insurance frequently lack access to appropriate care. In 2000, 56 percent of continuously-enrolled Healthy Families beneficiaries ages 4-19 saw a dentist.[31] Utilization among children insured through Medi-Cal also is low. In 2002, only 39.2 percent of continuously-enrolled 4- to 19-year-olds had an oral health visit.[32] Finding a dentist who will accept Denti-Cal, the oral health component of Medi-Cal, can be a challenge in many areas of the state. According to a 2000 report, nearly one-quarter (22%) of all California communities had no available Denti-Cal dentist.[33] A 2002 study found that even when a child insured by Denti-Cal sees a dentist and receives an examination, medically necessary services often are denied, in part because the state's process for evaluating children's treatment requests is not followed consistently.[34]

Finding a dentist who will accept Denti-Cal, the oral health component of Medi-Cal, can be a challenge in many areas of the state.

SPOTLIGHT PROGRAM

Friends of Children Health Center, La Habra, Orange County

Located on the campus of Las Lomas Elementary School in La Habra, Friends of Children Health Center provides oral health services to over 3,000 low-income, under-insured and uninsured children annually. The Center's dental clinic (it also operates a primary health care clinic) is staffed by a team of part-time dentists, hygienists and dental assistants, and provides services Monday through Saturday and on two evenings each week. The staff also provides dental screenings at all schools in the La Habra School District and refers children in need of services to the clinic for routine preventive services. Cavities and more complex treatment needs are referred to a panel of community dentists.

All family members present for appointments receive oral health education, including a video presentation and written materials, and children get toothbrushes and floss to take home. The center accepts Denti-Cal and charges uninsured families a nominal co-pay, but relies on its parent organization, the non-profit Institute for Healthcare Advancement, to cover the majority of the costs of the care it provides.

Nutrition and Physical Fitness

California children are not getting the nutrition and physical activity they need to maintain good health.

CALIFORNIA IS FAILING its children in the critical areas of nutrition and physical fitness. Obesity is an epidemic in California, and so are the chronic diseases that stem from it. Too many California children go hungry—inexcusable in a state that produces more fruits and vegetables than any other in the nation. The food that is easily available at low cost often is of poor nutritional value. On Saturday morning television, children see one food commercial every five minutes.[35] Public policies and other external factors influence the choice of foods available to children, the quantities they eat and their opportunities for exercise.

On Saturday morning television, children see one food commercial every five minutes.

SPOTLIGHT PROGRAM

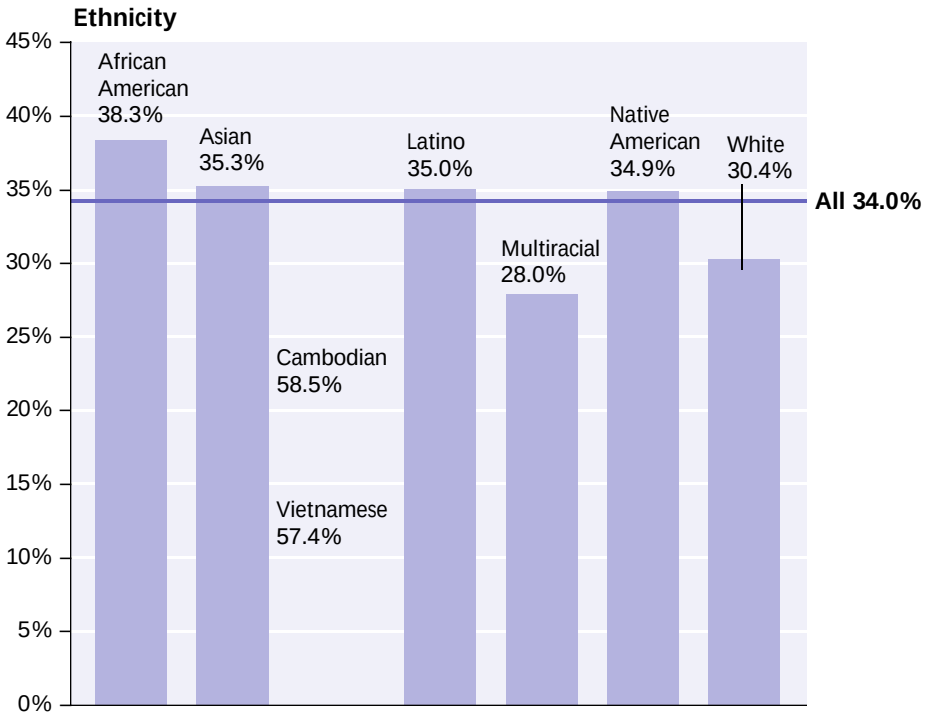
Del Norte School District School Food Programs, Del Norte County

Four years ago, the Del Norte County Unified School District (DNCUSD) began utilizing a provision in the federal School Lunch Act that permits districts with a high percentage of children in low-income households to serve free school meals to all students, regardless of individual need. This has allowed Del Norte County to be more successful than any other county in serving school breakfast to eligible children. (Research shows that serving school breakfast to children in need improves school performance and reduces absences.) By serving no-cost meals to all children, schools have saved time and money on program administration, allowing them to focus on creative ways of encouraging children to eat healthy food. Innovations include creating a breakfast study hall for children who come to school early and providing a "sharing table" where children exchange wrapped food to minimize waste. DNCUSD also held a "Nutrition Olympics," sponsored by the California Nutrition Network, where high school students created fun activities to help educate younger students about physical activity and nutrition.

In California, one-third (34%) of low-income parents experienced food insecurity in 2001.[36] (People are considered food insecure if they report being uncertain of having enough food or are unable to get enough food to meet the basic needs of their families.) While parents try to protect their children from the impacts of food insecurity by limiting their own food intake first, approximately 100,000 California children live in households where one or more children went hungry over a 12-month period.[37] Children who lack proper nutrition or experience hunger have worse health than other children, suffering more colds, ear infections, headaches and oral health problems. Hunger impedes children's motor skill development and makes them less likely to perform well in school.[38]

Graph 3

Percentage of Low-Income Parents Experiencing Food Insecurity, California, 2001



Source: Children Now analysis of data from the UCLA Center for Health Policy Research, 2001 California Health Interview Survey.

School food programs can improve children's nutrition and school performance. In 2001, the National School Lunch Program served nearly two million students in California, or seven out of ten (71.1%) eligible students.[39] School breakfast participation in California has increased in recent years. Three-quarters of schools that offer school lunch now also offer breakfast,[40] and one-quarter (27.4%) of eligible students in California—770,000 children—ate school breakfasts in 2001.[41]

In 2001, the National School Lunch Program served nearly two million students in California.

Despite these programs, eating well at school is not easy for California's children. High-calorie, low-nutrition foods are available right at school and compete with nutritious school meals. A national survey conducted in 2000 found that 43 percent of elementary schools, 74 percent of middle/junior high schools, and 98 percent of senior high schools have either a vending machine or a school store where students can purchase food or beverages, the most common offerings high in fat and/or sugar.[42] While district and state policies toward these types of foods are changing, too many California children still confront unhealthy options during the school day.

In California, only 21 percent of children ages 9-11 and 30 percent of adolescents ages 12-17 eat the recommended minimum five servings of fruits and vegetables per day.[43] Furthermore, about one in three teens eats at least one fast food meal per day.[44] California parents report that their children do not eat fruits and vegetables due to high cost, low availability, inconvenience of preparation and their children's dislike for them.[45] Accessing healthy foods can be even more difficult for low-income families. Many low-income neighborhoods lack supermarkets, and those markets that do exist frequently charge higher prices than similar stores in more affluent areas.[46]

Poor nutrition can lead to being overweight or obese; obesity can lead to health problems including increased risk of heart disease, hypertension and Type 2 diabetes.[47] In California in 2002, over one-quarter (26.5%) of 5th, 7th and 9th grade students were overweight, according to the Fitnessgram test.[48] An estimated 176,000 California

■ **In California in 2002, over one-quarter of 5th, 7th and 9th grade students were overweight.**

teenagers not already diagnosed with diabetes (6.0%) are at risk for adult obesity, the primary contributor to Type 2 diabetes, because they are overweight or at risk of becoming overweight, and they do not participate in regular physical activity.[49]

Like good nutrition, exercise improves school performance and helps prevent children from becoming overweight or obese. Only about one-quarter of students evaluated met minimum standards for all six categories in the Fitnessgram physical fitness test. The California Daily Food Guide recommends at least one hour of vigorous physical activity per day for children and adolescents, but many children fail to meet that recommendation. Some are almost completely sedentary. One-quarter of teens ages 12-17 (23.4%) reported in CHIS that they had done less than thirty minutes of moderate exercise in the previous week.[50] A more rigorous state standard could help, particularly for older teens: California requires only one year of physical education in grades 10 through 12. Television and video games also contribute to sedentary lifestyles. Nearly one in three (31.5%) California children spends three hours or more each weekday watching television.[51]

Like good nutrition, exercise improves school performance and helps prevent children from becoming overweight or obese.

A lack of resources contributes to some California children's inactivity. Schools in poorer areas often cannot afford proper equipment, facilities and personnel for in-school and after school programs. A lack of safe outdoor facilities in some communities makes it difficult for children to exercise and play outside.[52] Lacking health insurance can also make children less active: 20 percent of parents of uninsured children report that they do not allow their children to play sports out of concern that they could not pay for needed care if their child were injured.[53]

Asthma

- **Asthma is a chronic lung disease that can be controlled with proper treatment and management, including environmental changes.**

FOR CHILDREN in the United States, asthma is the foremost cause of hospitalization and the number one reason for school absences.[54] More than one out of eight (13.6%), or 1.2 million California children, have been diagnosed with asthma.[55] In 2000, the United States Department of Health and Human Services found that California had the highest prevalence of asthma of any state.[56]

Asthma is a chronic lung disease that can be controlled with proper treatment and management, including environmental changes. There is no single known cause, but certain risk factors, including low birthweight, genetic characteristics and certain infectious diseases, have been associated with the development of the disease.[57] Environmental factors, including indoor and outdoor pollutants, are known to trigger the onset of asthma.[58]

More than one out of eight California children have been diagnosed with asthma.

Asthma diagnoses for California children vary by region, race and ethnicity. Rates range from one in ten children (9.5%) in the Siskiyou, Lassen, Trinity and Modoc county area to more than one out of five children in Fresno (21.0%) and Solano (21.3%) counties (see Graph 4).[59] African American and Native American children are diagnosed with asthma at rates far above the state average (22.1% and 26.8% respectively, compared to a state average of 13.6%) (see Graph 5).

Many California children with asthma do not receive adequate advice or medication, often because they lack access to regular medical care. One in five (18.2%) California children who report daily or weekly asthma symptoms do not take any medication to control their disease.[60] In addition, CHIS found that one-quarter (25%) of adolescent respondents with daily or weekly asthma symptoms said they had not received information from their health care provider about how to manage their asthma.[61]

SPOTLIGHT PROGRAM

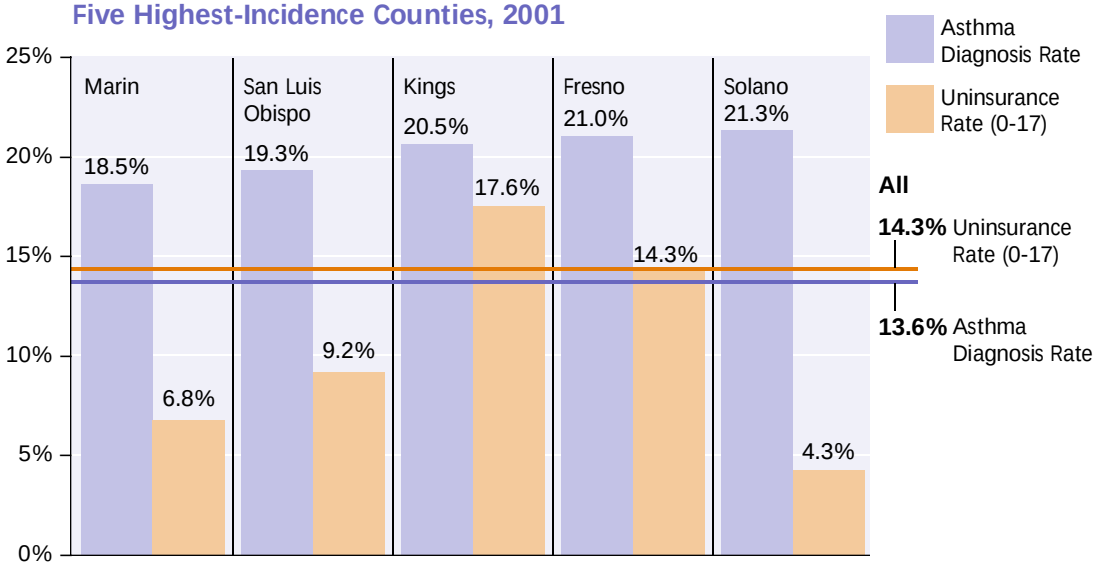
Darin M. Camarena Health Centers, Inc. Asthma Program, Madera County

Since August 2001, the Madera Community Asthma Initiative has provided asthma education services to over 1,000 asthmatic children and youth, with dramatic results. The Initiative's asthma educators work closely with children and their families over many months to develop individualized asthma management plans, and provide training about what asthma is, how to use medication and medical devices and recognizing and reducing environmental triggers, among other topics. Asthma disproportionately affects minority children, and the program's materials are culturally appropriate; asthma management materials are illustrated to overcome language and literacy barriers. The Initiative uses a problem-solving empowerment approach to teach families how to collaborate with physicians and schools and how to develop strategies for care that promote adherence to children's treatment programs.

These interventions are working. The California Department of Health Services evaluated the 254 children ages 0-5 who participated in and completed the program, and found that while nearly half had suffered continuous daytime and nighttime asthma symptoms at baseline, after working with asthma educators less than five percent reported these symptoms. The number of children making emergency room and urgent care visits for their asthma decreased dramatically, from 85 percent to seven percent, and children missed many fewer days in child care.

Graph 4

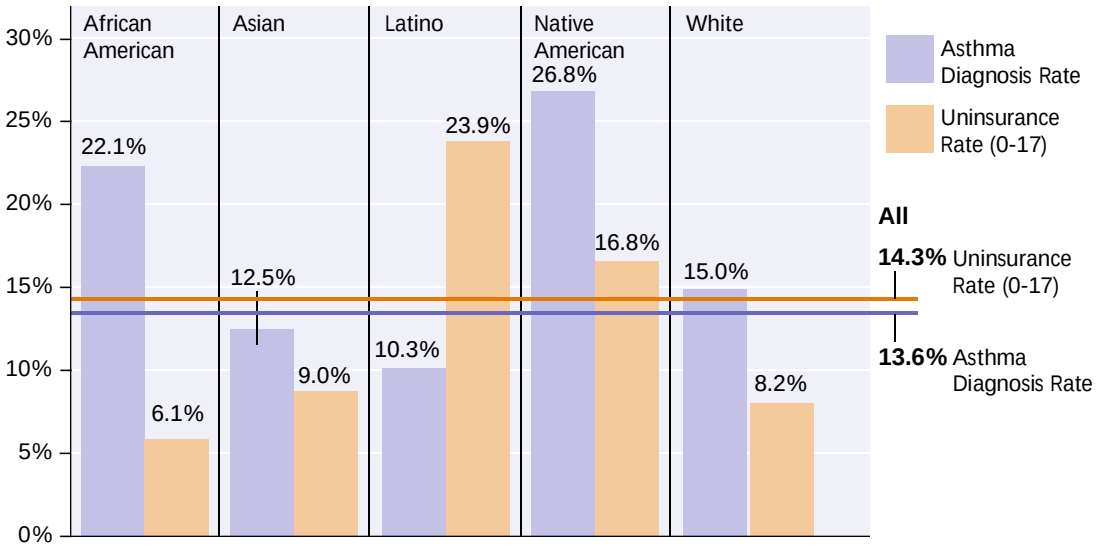
One in Five Children Is Diagnosed with Asthma in Five Highest-Incidence Counties, 2001



Source: Children Now analysis of data from the UCLA Center for Health Policy Research, 2001 California Health Interview Survey.

Graph 5

Asthma Diagnoses by Ethnicity, 2001



Source: Children Now analysis of data from the UCLA Center for Health Policy Research, 2001 California Health Interview Survey.

Mental Health

- **Many mental health problems develop during the teenage years, and suicide is the third leading cause of death for adolescents.**

AWARENESS OF CHILDHOOD mental health problems is increasing in California. Unfortunately, reliable information about the extent of these problems is difficult to obtain. In 2000, California county mental health programs served 137,045 children ages 0-17, a rate of 14.8 per 1,000 children, well below the estimated need.[62] Although many children receive care outside these county programs, many others in need do not receive mental health services at all, particularly preventive services.

SPOTLIGHT PROGRAM

Infant-Parent Program, San Francisco

Since 1979, the Infant-Parent Program (IPP) of the University of California, San Francisco has worked to help families in distress by focusing on infant mental health. IPP targets children under three who are at risk for socio-emotional or developmental problems that stem from difficulties in the relationship with their parents. Referrals come from the city's Department of Human Services, medical providers and community programs. Many parents referred to the program suffer from chronic mental health problems or substance abuse, often compounded by poverty, inadequate housing and legal problems.

IPP's therapeutic approach, which follows a pioneering model developed by Selma Fraiberg at the University of Michigan, is tailored individually to the family's clinical needs. The length of intervention ranges from three months to two years, with cases averaging eight months. Pre- and post-intervention assessments typically show decreased parental stress and positive changes in the parent-child relationship that benefit the child. Although many families initially are reluctant to participate, nearly all parents involved with IPP report a positive experience, and further interventions are rare for families that have completed the program.

Adolescent mental health has long been recognized as an area of particular concern, as many mental health problems develop during the teenage years, and suicide is the third leading cause of death for adolescents.[63] In 2000, 146 teens ages 13-19 committed suicide in California, a rate of 4.3 per 100,000. Although these figures are troubling, significant improvements in suicide prevention occurred during the last decade, as the suicide rate among California teens ages 15-19 fell from a rate of 9.2 suicides per 100,000 in 1992-93 to 5.3 in 2000-01, a decrease of nearly 50 percent.[64] At the same time, adolescent hospitalization rates for self-inflicted injuries, including suicide attempts, indicate that many California teens continue to struggle with serious psychological issues. Hospitalization rates for self-inflicted injuries are much higher for female adolescents than for males, with a rate of 141 per 100,000 females ages 13-19, compared to a rate of 45 per 100,000 males ages 13-19.[65]

A lack of resources for mental health care means services that do exist often must focus on crises, such as suicide, at the expense of preventive care.

A lack of resources for mental health care means services that do exist often must focus on crises, such as suicide, at the expense of preventive care.[66] The Surgeon General estimates that nearly 21 percent of children and adolescents ages 9-17 in the U.S. have a diagnosable psychological or addictive disorder.[67] An estimated 50 percent of these young people receive no mental health services to help them cope with their illnesses.[68] In California, teens who find themselves confronting mental health problems such as depression similarly go without services. Of the 4.2 percent of adolescent CHIS respondents who reported feeling depressed all or most of the time, over three-quarters (77.4%) had not received any psychological or emotional counseling in the past 12 months.[69]

Children in the foster care system suffer disproportionately from psychological and emotional health problems, among other conditions.[70] While federal and state laws guarantee foster children's access to a broad range of health care services through Medi-Cal, many children do not receive the services they need. Access to health care services for foster children may be compromised by

multiple placements, placements across county lines and other bureaucratic hurdles. In 2003, the Little Hoover Commission reported that half of foster children in California had not received appropriate mental health services.[71] (The same percentage lacked dental care, and one-quarter had not received timely medical services.) Nearly one-quarter of foster children who entered the system in 1998 remained in the system for more than three years.[72] As a result, lack of access to mental health care may have serious, long-term effects on children's well-being. It also may jeopardize the stability of children's placements. Children with untreated mental health problems are more difficult for foster parents to care for and are more likely to experience multiple placements, which, in turn, may aggravate their mental health problems.[73]

In 2003, the Little Hoover Commission reported that half of foster children in California had not received appropriate mental health services.

SPOTLIGHT PROGRAM

Developmental Screening and Enhancement Program, San Diego County

Children in foster care are more likely to have developmental delays than other children. Developmental Screening and Enhancement Program (DSEP) of San Diego is one of only a few in the country that screens young children entering the foster care system for developmental and behavioral delays. The program has served nearly 2,500 children ages 0-6 since it was founded in 1997. Each child receives a developmental screening within 48 hours of entering the county's main foster care center or within two weeks of being placed directly in a foster home. A psychologist evaluates children identified with developmental delays. Based on the results of these evaluations, DSEP recommends follow-up treatment and connects children with intervention agencies. When children return home or are placed in foster or kinship care, DSEP maintains close contact with public health nurses or other caseworkers. DSEP also provides resource information to foster parents, caregivers, social workers and physicians working with each child. DSEP receives both public and private support.

Recommendations

THE RECOMMENDATIONS that follow recognize the current budget constraints in California and include a number of effective, short-term and lower-cost approaches. They also include more ambitious ideas, with the understanding that forgoing more critical investments in children's health today would have enormous consequences for children and society in the future.

Infant Health

VISION **All pregnant women in California receive early and continuous prenatal care, and all newborns have access to comprehensive health care services to monitor growth and development.**

- California should develop electronic systems that automatically enroll Medi-Cal-eligible infants when they are born. An estimated 39,000 infants born in California are eligible for Medi-Cal at birth because they are born to women enrolled in the program. An automatic enrollment process based in maternity wards could ensure almost all newborns leave the hospital with ongoing access to health care.
- Insurers and local public health agencies should provide prenatal care outreach to traditionally underserved communities. Public and private funders should continue to support linguistically and culturally appropriate services directed to women who are less likely to access early prenatal care, such as Pacific Islander and Native American women.
- Providers should refer low-income pregnant women to Early Head Start and other programs that offer them resources to promote positive child development.[74]

Health Insurance and Access to Care

VISION **All California children have comprehensive, continuous and affordable health insurance, and access to timely and appropriate health services.**

- California should reinvest in community-based outreach and enrollment by restoring funding for Certified Application Assisters (CAAs) and community- and school-based organizations that are crucial to successful enrollment in Medi-Cal and Healthy Families.
- California should simplify enrollment requirements for Medi-Cal and Healthy Families.
  - Eliminate the requirement for families to provide income documentation at enrollment; instead, verify income eligibility using existing state database systems and annual audits.
  - Remove the requirement for families to provide detailed paperwork about their assets. This "assets test" rarely affects eligibility for the program, but does create bureaucratic complications and may deter application.
- California should invest in the development and implementation of a family-friendly electronic enrollment system.
  - Support implementation of "Express Lane Eligibility" strategies to connect families to health insurance through food stamps and school lunch programs, and support further development of the Child Health and Disability Prevention (CHDP) "Gateway" that links eligible children to health insurance.
  - Support the development and implementation of the "One e-App" that will create one electronic door to enroll in public insurance and other programs.

- California should make sure that children, once enrolled, keep their health insurance coverage.
  - Eliminate income documentation at renewal.
  - Provide pre-printed renewal forms for families and require them to return the forms only if information has changed.
  - Allow families with children in both Medi-Cal and Healthy Families to renew enrollment at the same time.
- California should support counties that are undertaking initiatives to provide universal health insurance for children by enabling regional collaboration and facilitating federal waivers.

Oral Health Insurance and Access to Care

VISION **All California children have access to oral health insurance, education and services, and to environments that prevent oral disease.**

- California should prioritize the oral health needs of young children. Tooth decay can begin within months of a child's first tooth. Health care providers and outreach workers serving infants and pregnant women should educate new parents about tooth decay, and direct education efforts to parents should be promoted. To increase access, dentists should be trained to work with young children, and the CHDP program should mandate referral to a dentist by age one instead of the current standard of age three.
- California should support pilot efforts to provide uninsured and other underserved children with oral health care services by non-oral health care providers and in non-traditional settings. Other states have piloted successful models of oral health care delivery in schools and primary care settings. Dentists, hygienists, pediatricians and other providers must work with the state to expand the number and types of providers and venues where children can receive care.

- Local governments and water wholesalers should take steps to expand access to community water fluoridation. In 1999, the Centers for Disease Control and Prevention (CDC) profiled the widespread practice of fluoridating community drinking water to prevent dental decay as one of 10 great public health achievements of the 20th Century.[75] Less than 30 percent of Californians drink fluoridated water, one of the lowest rates in the country.[76]

Nutrition and Physical Fitness

VISION **All California children eat a nutritious, balanced diet and engage in the physical activity they need for healthy development.**

- California and the federal government should improve public nutrition programs for low-income children and their families.
  - School districts should implement "Breakfast in the Classroom," which can raise National School Breakfast Program (NSBP) participation close to 100 percent. Many districts across the nation, including six in California, have already implemented such programs.
  - California should build on federal efforts begun in the 1990s to maximize the benefits of the National School Lunch Program (NSLP) and NSBP by reducing fat levels and increasing the availability of fresh fruits and vegetables in meals. State and local governments should take steps to make sure that unhealthy foods no longer undermine NSLP and NSBP.
  - California should take action to improve the food stamp program through reforms to the eligibility and application processes. Currently, only 12 percent of California's poorest adults receive food stamps, and almost half of non-recipients live in households with children.[77]

- California and local communities should make sure children and adolescents have daily opportunities for physical activity.
  - After school programs should prioritize physical activity and should be expanded to serve more middle and high school students. After school programs, public and private, also should participate in the After School Snack Program through the NSLP or the Child Care Food Program.
  - Physical fitness should be required each year through the 12th grade, with a diversity of exercise options—not team sports alone—promoted through the curriculum.

Asthma

VISION **California enacts environmental and health policy changes to reduce the incidence of asthma, and all California children diagnosed with asthma have access to comprehensive health education, health care and suitable living environments to manage their illness.**

- Community-based organizations should work with state and local health agencies to manage asthma and to educate others about asthma prevention. At the community level, health plans, public health departments, First 5 County Commissions and health care providers should coordinate efforts to educate parents, schools, child care centers, caregivers and others about asthma triggers and prevention. Education efforts should be linguistically and culturally accessible.
- State, local and federal governments, as well as schools and families, should work to minimize outdoor and indoor pollutants. Schools and families can reduce children's exposure to indoor pollutants such as pesticides, scented cleaning solutions, tobacco smoke and cockroach residues. Schools can receive assistance through programs such as the EPA Indoor Air Quality/Tools for Schools and the Asthma Friendly Schools Initiative. Public policies to improve air quality, by reducing ozone and particulate matter emissions, should be considered and advanced.

Mental Health

VISION **All California children have access to high-quality, preventive mental health services. Children experiencing psychological or behavioral problems secure timely diagnoses and appropriate care.**

- State, county and local governments should improve the quality and availability of mental health screenings and supports for infants and their families. Parents should be given information about young children's mental health and development and referred to needed services through early care and education programs and other agencies already involved in families' lives.
- Mental health services should be available in school and after school. Local governments should forge partnerships between local mental health programs and after school providers. Schools and school districts should develop school-based peer counseling programs for older students to address a spectrum of mental health issues, de-stigmatizing counseling and offering preventive care to students who are experiencing difficulties.

- All children who are removed from their home and placed in the state's care should receive an immediate, multi-faceted screening from a team of medical, mental health and educational experts. The screening must be sensitive to the fact that the child has experienced a crisis and should be developmentally appropriate and culturally competent. Follow-up mental health treatment should involve both the child's birth family and out-of-home caregivers. Caseworkers must ensure that when a child's placement changes, any mental health treatment is continued in the new location.

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2003 County Data Are Available Online at
www.childrennow.org
Including County Profiles and County Ranking Charts

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