



Women's, Children's, & Family Health



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Child and Adolescent Access to Health Care in Alaska

Access to health care often depends on whether a person has insurance. The uninsured are less likely to have a primary care provider, receive appropriate care, or have had any recent medical visits.¹ Compared to insured children, uninsured children are less likely to have a regular source of health care and are less likely to use prescription medications.²

Seriousness

Healthy People 2010 Targets and National Data

Indicator	Alaska 2002-03†	Nation 2003^	Healthy People 2010
Percent of children less than 18 years of age without health	13.1%	11.8%	0%

- Alaska has not achieved the Healthy People 2010 goal to have all children under age 18 insured.
- Similar to that of the Nation, among Alaskan children less than 18 years of age, approximately 1 in 8 are uninsured.

In addition to the HP2010 goal, a Healthy Alaskan goal is to increase the proportion of children eligible for Denali KidCare or Medicaid who have public health insurance.

Severity

Although the association between insurance status and utilization of health care services among adults is well-documented, less is known about the utilization of services among children. One study found that the uninsured were 4 times as likely to need medical care and not get it. Further exacerbating health problems and increasing the risk of hospitalization, uninsured children are more likely to receive late or no care for health problems.³

Urgency

- From 2001-2003, the proportion of uninsured Alaskan children and teens has remained stable.
- During 2004, the US Census Bureau estimated that 5.7% of children and teens under 19 with an income at or below 200% of the Federal Poverty Limit were uninsured.⁴ The percentage may be inflated, because access to health care through the Native health services system was not counted as insurance. During 2003, 9% of respondents responded on the Alaska Behavior

Risk Factor Surveillance System that the Indian Health Service paid for most of their child's health care and 2.5% of them said their child had no insurance.⁵

- Between 1992 and 2001, the cost of medical care in Alaska increased more than 60%, compared to a 25% increase for the overall Consumer Price Index.⁶ Of cities surveyed by the American Chamber of Commerce Researchers Association (ACCRA), health care costs were higher in Fairbanks, Juneau and Kodiak than in Anchorage, and all four cities are in the top twenty for health care costs among those surveyed across the US.⁶

Available Care

- Alaska's small population and remote location limit the depth and scope of some health care services, even in Anchorage. During April 2004, the All Alaska Pediatric Partnership determined that additional pediatric sub-specialists are needed in Alaska in the following fields: pulmonology, general surgery, urology, endocrinology, neurology and rheumatology.⁷
- Many dentists do not accept new Medicaid clients in their practices and the state has only 14 pediatric dental specialists. Compounding the problem, the Alaska dental labor force is aging: during FY2002 more than 25% of active, licensed dentists were age 55 years and older and 39% were 45-54 years.⁸
- The Division of Behavioral Health Services (DBH) completed a comprehensive assessment of the mental health and substance abuse needs of Alaska's children and youth during 2004. It found that although nearly 6,000 children and youth received services during fiscal year 2002, another 9,300 with significant mental health services needs did not.⁹

Barriers to Care

- About one-third of Alaskans live in rural and remote communities, most of which are not on the road system. Community Health Aide/Practitioners and itinerant providers working in village health clinics provide the majority of routine care to these persons. Distance from secondary and tertiary care facilities,

weather and complex interpersonal relationships between providers and patients may complicate health care delivery in these communities.

- Adolescents use the health care system differently than younger age groups, and many are likely to miss needed care.¹⁰ School-based health clinics are one means of eliminating barriers to care,¹¹ but only one high school in Alaska has a school-based clinic. During Federal Fiscal Year 2003, 36% of Medicaid-enrolled 10–18 year-olds had a regular check-up, while 56% of Medicaid enrolled infants and children < 10 years of age had one.¹²

Disparities

The scope of the Alaska Native health services system means that Alaska's largest minority has as good as or better access to care as other groups regardless of location of residence. Other demographic groups, such as recent immigrants to the United States and non-Natives living in remote communities face the most significant challenges.

Access to oral health care has long been a challenge, especially for low-income families living outside Anchorage.

- Approximately one-third (37%) of the 88,774 children enrolled in Medicaid during Federal Fiscal Year 2003 received any Medicaid-funded dental services.¹³
- This proportion varied dramatically across the State, from 28% of the children living in the North Slope Borough to 53% of those living in the region served by the Eastern Aleutian Tribes.¹³
- An oral health screening of Alaska Native dental clinic users during 1999 indicated Alaska Native children experienced 3 to 4 times the amount of dental decay as their national counterparts. Additionally, severe early childhood caries was found among 60% of 2-4 year old Alaska Native children screened during the project.¹⁴

Economic Loss

During calendar year 2003, Alaska Medicaid paid for travel to receive health care for more than 14,000 individuals, 60% of whom (8,631) were under 18. The average per capita cost of Medicaid-funded travel for these children and youth was nearly \$1,700, of which 44% (\$440) was spent on airfare.

The Division of Behavioral Health Children and Youth Needs Assessment found that the type of mental health services available dominates the choice of care provided for a child, rather than the child's treatment needs. Consequently, children or youth with acute needs may be placed in day treatment or an emergency shelter because no higher-level resources are available, or they may remain in an acute setting longer than needed because of limited access to community-based care.¹⁵

Interventions & Recommendations

Health Insurance Coverage

During 2003, the Alaska Legislature voted to lower the eligibility ceiling for Medicaid from 200% of the Federal Poverty Level (FPL) to levels equal to 175% of the 2002 FPL as a cost-savings measure. Since then, Medicaid enrollment for children in families with incomes above 133% FPL has remained steady, although it has increased substantially among families in the lower income group. Families that had qualified for Medicaid before the eligibility change have limited disposable income and are at high risk of being underinsured or deferring care, especially if a child has unusual health care needs.

Access to Oral Health Care

Head Start Oral Health project – during the early 1990's, the Head Start program in Norton Sound worked with the agency providing technical assistance to Head Start programs in Alaska to create a comprehensive oral health care program.

Pediatric dentist travel – The Medicaid Early Periodic Screening Diagnosis and Treatment program paid for travel by pediatric dentists from Anchorage to villages served by the South East Regional Health Consortium (SEARHC) and to Soldotna during fiscal year 2001-03.

Neighborhood health centers – The number of communities served by a neighborhood health center has increased since 2000 and many have integrated a dental facility.

Dental Health Aides - The Native health services system is developing a new type of Community Health Aide/Practitioner (CHA/P), called Dental Health Aides (DHA). As with the CHA/P program, DHAs are trained through certified programs and return to their communities to provide services.

Access to Mental Health Care

The Children and Youth Needs Assessment (CAYNA) recommends enhancing the Alaska mental health services system by adding: targeted case management and home-based services; therapeutic foster care; 120 residential care beds; a specialized evaluation and assessment center for young Alaskans who have been identified as being at high risk, difficult to serve, and needing specialized care; a secure/semi-secure long-term residential psychiatric treatment center; and an acute adolescent psychiatric unit.

There is an inadequate number of mental health care providers at all levels, and the CAYNA suggests creating a loan repayment, scholarship and grant program to support professionals in training and creating and facilitating internships and fieldwork in the area of children's services.¹⁵ Training for community-based paraprofessionals is available through the Rural Human Services Worker certificate sponsored by the University of Alaska Fairbanks.

Intervention Effectiveness

Analysis of data from the National Health Interview Survey showed that Medicaid expansions that increased the proportion of a State's eligible population lead to increases in enrollment, enhanced utilization of medical services, and lower child death rates.¹⁶

The Head Start Oral Health project had a strong positive impact, but was not implemented statewide. Although there has been attrition among the volunteer dentists, some continue to travel to the region to provide care and have anecdotally reported diminished numbers of children with severe oral health problems. The Pediatric dentist travel project was successful and is now self-sustaining as SEARHC pays for the travel from receipts from the clinics. The Cottonwood Neighborhood Health Center in Soldotna has an active dental clinic.

There were 149 village-based mental health workers who were attending or had completed the Rural Human Services Training program during FY 2004¹⁷, compared with 136 during FY 2000.¹⁸

Capacity

Propriety

The Women's, Children's, and Family Health Section (WCFH) should take the lead among State agencies for activities for oral health and pediatric sub-specialty access issues and should collaborate on access to mental health issues. The Divisions of Health Care Services and Public Assistance will be responsible for activities associated with raising the Denali KidCare eligibility ceiling. Although limited access to mental health services is extremely important, the Division of Behavioral Health has plans in place for addressing some of these issues. WCFH should participate in discussions and help identify concerns, but need not have a leading role.

Economic Feasibility

The economics of health care access are complex. Future cost savings from anticipated improved care must be weighed against the availability to raise public funds today and against foregone opportunities to invest in other interventions that might have larger future health impacts (e.g., economic development, safe water, primary prevention programs, and others). Moreover, many newer health interventions are of increasingly limited marginal benefit yet are often considerably more expensive than traditional interventions (for example, leukotriene modifiers versus inhaled steroids in the treatment of asthma); in this scenario, increasing the number of people with access may mean limiting the number of services accessible to each individual.

Acceptability

Access to care is a universally recognized benefit. Controversy exists over how to pay for it and what implementations will work.

Resources

- WCFH Oral Health Program and their collaborative work with Indian Health Services in developing the dental health aid program and pediatric dental residency.
- Collaborative partners such as the American Academy of Pediatrics-Alaska Chapter and the All Alaska Pediatric Partnership.
- The Specialty Clinics program, funded by Title V, is an excellent vehicle for responding to access to care issues for children with specific, rare, health care needs.
- Collaborative activities with grantees such as the University of Anchorage, the LEND program, Stone Soup Group, faith based non-profits organizations such as Catholic Social Services, medical centers, Federally qualified health centers, and care coordination organizations such as HOPE, ARC and others.
- Collaboration with services organizations such as the Lions club, Kiwanis, Shriners and others.
- Collaboration with the Medicaid program in the ongoing support and improvements to the SCHIP/Denali KidCare health program, CCMC & MRDD waiver programs through the Division of Senior Services and Developmental Disabilities, Qualis case management, Aetna and Blue Cross.

Legality

There is no specific state statute or regulation corresponding to these activities. Changing eligibility for Denali KidCare will only happen if the Legislature passes a new law.

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