DOCUMENT RESUME

ED 413 108 PS 025 991

AUTHOR	Tinsley, Barbara J.; Wang, Shirley J.; Kwasman, Alan; Green, Delores
TITLE	Between the Cracks: Access to Physical Health Care in Children of the Working Poor.
PUB DATE	1997-04-00
NOTE	10p.; Paper presented at the Biennial Meeting of the Society for Research in Child Development (62nd, Washington, DC, April 3-6, 1997).
PUB TYPE	Reports - Research (143) -- Speeches/Meeting Papers (150)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	Attendance; *Child Health; Demography; *Health Services; *Low Income Groups; Parent Attitudes; Parents; Poverty
IDENTIFIERS	*Access to Health Care; California (South)

ABSTRACT

This study examined the demographic and psychological characteristics of the parents of a group of children with no access to health care, due to their status as "working poor" and thus denied either public or private health insurance whose children were referred for treatment for an acute health problem by a volunteer health care program for children. Participating were 215 children, ranging from 4 to 17 years, referred by Project KIND (Kids in Need of Doctors), located in a large southern California county, to receive health care. Seventy-nine percent were Latino, 15 percent were of European American origin, and 6 percent were of African American or Asian American origin, or were unspecified. Twenty percent of children were from single parent (mother only) families. Findings indicated that 20 percent of fathers and 75 percent of mothers were unemployed. The types of health problems included 39 percent dental, 14 percent skin, and 13 percent each injuries/accidents and eye problems. The average dollar cost for each service was $400, which was positively related to the length of time the child had the problem. About 70 percent of school nurses and parents reported that the health problem was moderately to highly interfering with school functioning. Nurses reported that 37 percent of children would likely miss more than a week of school, and that 40 percent of children would have their lifetime productivity compromised if the health problem were left untreated. Parents moderately agreed that their children's good health came from being lucky, and more strongly agreed that they could do many things to fight illness in their children. Nurses' perceptions of parents' health locus of control generally were highly correlated with parents' perceptions. (KB)

Between the Cracks:

Access to Physical Health Care in Children of the Working Poor

Barbara J. Tinsley, Ph.D.

and

Shirley J. Wang, M.A.

University of California, Riverside

Alan Kwasman, M.D.

Pediatric Group of Riverside, CA

Delores Green, M.B.A., Executive Director

Riverside County Medical Association, Riverside, CA

Paper presented in symposium entitled "Parent Health Beliefs and Childhood Physical Health: Parent Gender, Ethnicity, and Social Class Influences", at the biennial meetings of the Society for Research in Child Development, Washington, D.C. April, 1997

For further information, please contact the first author at the Department of Psychology, University of California, Riverside, CA 92521

Although the general public appears to believe that all working families have health insurance through employment, and that all nonworking families receive medical care through Medicaid or other public insurance programs, neither of these assumptions is true. Many of the working poor, particularly those with young children, are self-employed or work for companies that do not provide health insurance, and many of the nonworking poor are not eligible for Medicaid. Statistics suggest that over 1/3 of children aged 17 and under with low family incomes are without any health insurance, compared to only about 8% of children in families with incomes of $40,000 and above (Bloom, 1990; Klerman, 1991). Furthermore, research strongly demonstrates that poor children suffer lower health status than children from more affluent families.

Thus, while the current U.S. health care system provides care for the children of middle class families through private insurance and managed care, and for children living in impoverished families through federal and state welfare programs, a significant minority of families with young children (e.g., the working poor) have no access to either of these sources of health care, due to a combined inability to afford insurance or qualify for state and federal health benefits.

While studies suggest that poor children's health status is, to a large extent due to their tendency to underutilize health services, research also indicates other demographic and psychological factors that determine poor children's inadequate health status. For example, studies of the effects of demographic variables on child health underscore the influence of maternal education as an important determinant of children's health status. However, it is the distribution of a variety of parent and family health-related beliefs and behaviors within social class, and not social class per se, that is important for understanding utilization of childhood health services, and child health status. Social class, and its proxy variables such as income, is a relevant issue for determining the relations among health attitudes, health behavior, and health status only because health attitudes appear to be differentially distributed across income groups. Also, the identification of social class differences in health care use is a starting point, but more attention needs to be paid to the processes underlying social class and income group differences. Focusing on the variables that underlie class differences, such as belief systems, in contrast to directing attention to social class or income level per se, offers a greater potential for intervention approaches aimed at more modifiable constructs such as parental health beliefs, which have been demonstrated to discriminate between children with varying levels of utilization of health services and actual health status (Tinsley & Holtgrave, 1989).

This study examined the demographic and psychological characteristics of the parents of a group of children with no access to health care, due to their status as "working poor" and thus denied either public or private health insurance, whose children were referred for treatment for an acute health problem by a volunteer health care delivery program for children. Two important issues are examined. First, after documenting the demographic characteristics of the parents of the children treated in this program, a comparison is made of the estimates of the treated children's parents, referring school nurses, and medical providers concerning the potential disruption to the children's immediate school attendance and functioning, and ultimate societal lifetime productivity should the children's health problems been left untreated. Second, in order to portray the differential perceptions of the children's parents and school nurses concerning the psychological motivations of these children's parents to obtain care for their children's acute health problems, associations among assessments of parental health personal control constructs, and parents' perception of control over their children's health were measured.

Procedure

A group of 215 children referred by Project K.I.N.D. (Kids in Need of Doctors) to receive health care were participants in this study. Project K.I.N.D., located in a large southern California county, uses the volunteer services of a county medical community to provide free health care for those children who have no access to Medical/Medicaid, no health insurance, and whose parents are unable to afford the cost of care for an acute health problem. Primary care pediatricians, pediatric dentists, opthamologists, child and family mental health specialists, pharmacists, ER physicians, general and specialty surgeons, radiologists and other health professionals involved in children's health care volunteer their services and offer supplies such as antibiotics and eyeglasses to provide acute care for elementary school-aged children. These children are referred from county schools by school district personnel such as teachers, secretaries, nurses, and principals. Children are eligible to be referred if their parents state that they have no other resources available to obtain the needed care for their children.

General characteristics of referred families. A subset of 215 children were referred for acute care to the Project K.I.N.D. program within 18 months across 1995-1997. Fifty-seven percent (57%) of the children treated were males, 43% were females, and ranged in age from 4 to 17 years (M=8.7). Seventy-nine percent (79%) of the children were Latino, 15% Euro American, and 6% were African American, Asian American or unspecified immigrants. These demographics are consistent with that of the entire southern California county served by the program. Twenty percent (20%) of the families referred were single-mother-headed families, and the average parent-to-child ratio in participants' households was 2 adults to 5 children.

Twenty percent (20%) of the fathers and 75% of the mothers of the children were unemployed. For both fathers and mothers who were employed, 90% held occupations which ranged from lower level service work (e.g., farm laborers, gardeners), to unskilled work (e.g., construction laborers, food service), to semiskilled work (e.g., machine operators, truck drivers).

The types of acute health problems for which the children were treated in the program during the target period included: 39% dental, 14% skin, 13% injuries or accidents, 13% eye, 8% ear, 6% illnesses, 3% mental, and 4% other problems. Forty percent (40%) of the parents reported attempting to get care for their child before accessing Project K.I.N.D., with almost all parents (97%) reporting inability to afford this care as the primary reason for their earlier failed attempts to find care for their children's acute health problems. Providers (N=141) reported 45% of the children had suffered with the health problem for which they were treated by Project K.I.N.D. volunteers for between 1-10 days, while 55% of the children had endured their health problem for between 2 weeks to over one year.

Potential cost to society for not providing health intervention services. The average estimated dollar cost for each acute care service provided for these children was approximately \$400.00 (SD=904.7), with a range of \$33.00 to \$6403.00. Provider estimates of the cost of service was positively and significantly correlated with provider estimates of the length of time the child had their health problem (r=0.276, $p<0.05$).

Referring school nurses and parents rated the extent to which the child's health problem was compromising school functioning. Sixty-nine percent (69%) of the school nurses and 66%

of the parents reported that the child's acute health problem was moderately to highly interfering with school functioning. Moreover, school nurses reported 62% of the children referred would likely miss school for an additional 1 to 3 days, 40% would likely miss 4 to 5 additional days, and 37% would likely miss more than one week of school, if the current health problem was left untreated. School nurses also reported 43% of the children referred would likely be treated in an emergency room, 14% of the children would probably need to be hospitalized overnight, and 40% of the children would have their lifetime productivity compromised, if the problem was left untreated.

However, medical professional volunteers treating these same children (e.g., doctors) reported less dire consequences should the children's problems been left untreated, suggesting that 41% of the children referred would likely miss school for 1 to 3 days, 29% would likely miss 4 to 5 days, and 23% would likely miss more than one week of school, if the problem was left untreated. These medical providers also reported 45% of the children referred would likely be treated in an emergency room, 20% of the children would probably need to be hospitalized overnight, and 33% of the children would have their lifetime productivity compromised, if the problem was left untreated.

Psychological profile of the parent. Both school nurses (N=141) and parents (N=133) completed 6-point rating scales (6=strongly agree) which assessed parental locus of control with regard to their child's health. On average, parents of referred children moderately agreed that their children's good health came from being lucky (M=3.0), while they more strongly agreed that they felt they could do many things to fight illness in their children, (M=5.0), and moderately agreed that maintaining their children's health was a function of doing what others told them to do (M=3.0). Overall, school nurses' perceptions of parents' health locus of control on behalf of their children were highly correlated with parents' perceptions (luck: $r=0.562$, $p<0.01$; powerful others: $r=0.365$, $p<0.01$), except for ratings of how much control parents felt they had over their children's health ($r=-0.044$, ns). Parents rated themselves significantly higher on the control they perceived they had over their children's health than school nurses' ratings of the parents' perceived control ($t=5.043$, $p<0.01$).

These findings suggest several theoretical and applied conclusions. First, this study underscores the importance of early attention to acute childhood health conditions. Not only does the immediate monetary cost of treating these children's health problems rise substantially when treatment is delayed, but the children's ultimate contributions to society can be further compromised due to the detrimental effects these health problems have on school functioning. Rapid, effective attention to children's acute health problems is critical for individual children's short- and long-term functioning, and from a public health standpoint, critical for the health of the U.S. population, no matter what children's families health insurance status.

Overall, based on the ratings of parents' perception of control over their children's health, it is apparent that these parents without the resources to obtain treatment for their children's acute health problems have belief systems concerning the control influences on their children's health consistent with those of parents who can control their children's access to care, as has been demonstrated in previous work on parental health locus of control (Reisch & Tinsley, 1994; Tinsley & Holtgrave, 1989). In other words, these parents who cannot provide medical care for their children when they have acute health care needs still believe that parents can control their children's health, and have been active in trying to access care for their children prior to utilizing Project K.I.N.D. medical services. Stereotypes of parents with children who do not have regular access to care which suggest that these parents are content to leave the health care of their children in the hands of fate appear inaccurate, at least for this sample of "working poor" parents. The pattern of similarities and differences among the parental and school nurse ratings of parents' perception of control over their children's health suggests that these beliefs are able to be assessed by professionals involved in young children's health and developmental care. However, it is apparent that school nurses' judgments of the control "working poor" parents perceive with respect to their children's health is less than that of the parents' themselves, and may be susceptible to the class stereotypes just mentioned. Education of professionals concerning the important difference between uninsured parents' ability to access health care for their children's acute care needs and the strength of their efforts to find affordable health care for their children is warranted.

It is encouraging to see that children's health is the focus of legislation proposed in Congress this year, and in initiatives announced last month by the Clinton administration (*The Nation's Health*, March, 1997). Grants to states to cover families' health insurance premiums for up to six months when a principal wage earner is temporarily unemployed, state partnership grants to help working families who earn too much to qualify for Medicaid, but too little to pay for private insurance, and stepped-up efforts to cover more children who are eligible for Medicaid but not enrolled, are suggestions under current consideration.

Too many children are falling through the cracks of our health care system. Accurate assessment of the demographic and psychosocial characteristics of those children and their families are among the first steps needed to improve our health care system.

References

Bloom, B. (1990). Health insurance and medical care. Health of our nation's children, United States, 1988. Advance data from vital and health statistics. No.188. Hyattsville, MD: National Center for Health Statistics.

Klerman, L. V. (1991). The health of poor children: Problems and programs. In A. C. Huston (Ed.), Children in poverty. Child development and public policy (pp. 136-157). Cambridge: Cambridge University Press.

Reisch, L.M., & Tinsley, B.J. (1994). Ethnically diverse low-income women's maternal health locus of control and propensity to utilize prenatal health services. Journal of Reproductive and Infant Psychology, 12, 223-232.

The Nation's Health, March, 1997.

Tinsley, B.J., & Holtgrave, D.R. (1989). Parental health beliefs, utilization of childhood preventive health services and infant health. Journal of Developmental and Behavioral Pediatrics, 10, 236-241.

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
Educational Resources Information Center (ERIC)

ERIC®

REPRODUCTION RELEASE

(Specific Document)

I. DOCUMENT IDENTIFICATION:

Title: "Between the Cracks: Access to Physical Health Care in Children of the Working Poor"

Author(s): Tinsley, B.J., Wang, S.J., Kwasman, A., Green, D.

Corporate Source: Society for Research in Child Development

Publication Date: SRCD 1997 (April)

II. REPRODUCTION RELEASE:

In order to disseminate as widely as possible timely and significant materials of interest to the educational community, documents announced in the monthly abstract journal of the ERIC system, *Resources in Education* (RIE), are usually made available to users in microfiche, reproduced paper copy, and electronic/optical media, and sold through the ERIC Document Reproduction Service (EDRS) or other ERIC vendors. Credit is given to the source of each document, and, if reproduction release is granted, one of the following notices is affixed to the document.

If permission is granted to reproduce and disseminate the identified document, please CHECK ONE of the following two options and sign at the bottom of the page.

☒

Check here
For Level 1 Release:
Permitting reproduction in microfiche (4" x 6" film) or other ERIC archival media (e.g., electronic or optical) ***and*** paper copy.

The sample sticker shown below will be affixed to all **Level 1** documents

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

Sample

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

Level 1

The sample sticker shown below will be affixed to all **Level 2** documents

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN OTHER THAN PAPER COPY HAS BEEN GRANTED BY

Sample

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

Level 2

☐

Check here
For Level 2 Release:
Permitting reproduction in microfiche (4" x 6" film) or other ERIC archival media (e.g., electronic or optical), but ***not*** in paper copy.

Documents will be processed as indicated provided reproduction quality permits. If permission to reproduce is granted, but neither box is checked, documents will be processed at **Level 1**.

"I hereby grant to the Educational Resources Information Center (ERIC) nonexclusive permission to reproduce and disseminate this document as indicated above. Reproduction from the ERIC microfiche or electronic/optical media by persons other than ERIC employees and its system contractors requires permission from the copyright holder. Exception is made for non-profit reproduction by libraries and other service agencies to satisfy information needs of educators in response to discrete inquiries."

Sign here→ please

Signature: Barbara J. Tinsley

Printed Name/Position/Title: Barbara Tinsley / Professor

Organization/Address:
Department of Psychology
University of California - 042
Riverside, CA 92521

Telephone: 909 787 3889

FAX: 909 787-4517

E-Mail Address: Tinsley @ UCRAC1. UCR. EDU

Date: 10/28/97

PS025691

62nd Biennial Mtg. of the Society for Research in Child Development (Wash., D.C., Apr. 3-6, 1997)

University of Illinois
at Urbana-Champaign

ERIC

Clearinghouse on Elementary and Early Childhood Education
National Parent Information Network

Children's Research Center
51 Gerty Drive
Champaign, IL 61820-7469

217 333-1386 800 583-4135 *toll free*
217 333-3767 *fax* ericeece@uiuc.edu *e-mail*

August 22, 1997

Dear Colleague:

After doing a blanket solicitation for papers at the **62nd Biennial Meeting of the Society for Research in Child Development** held in Washington, D.C., April 3-6, 1997, I am now contacting individual presenters, particularly in our scope of early childhood through early adolescence, to consider sending two copies of your presentations for possible inclusion in the **ERIC** database. As you may know, **ERIC (the Educational Resources Information Center)** is a federally-sponsored information system for the field of education. Its main product is the ERIC database, the world's largest source of education information. **The Clearinghouse on Elementary and Early Childhood Education** is one of sixteen subject-specialized clearinghouses making up the ERIC system. We collect and disseminate information relating to all aspects of children's development, care, and education.

Ideally, your paper should be at least eight pages long and not have been published elsewhere at the time of submission. **Announcement in ERIC does not prevent you from publishing your paper elsewhere** because you still retain complete copyright. Your paper will be reviewed and we will let you know within six weeks if it has been accepted.

Please complete and sign the reproduction release on the back of this letter and return it with two copies of your presentation to **ERIC/EECE**. If you have any questions, please call me at (800) 583-4135 or by (e-mail at ksmith5@uiuc.edu). I look forward to hearing from you soon.

Sincerely,

Karen E. Smith

Karen E. Smith
Acquisitions Coordinator

Enclosures