INFORMATIONAL HEARING

The State of our Children's Health

February 22, 2005
1:30 p.m.
State Capitol, Room 437

This hearing will examine critical areas of children's health, including asthma, dental disease, mental health, diabetes, and rates of health insurance coverage.

Background

The health of children in the United States has improved in many ways over the past several years, including lower births rates for adolescents and higher immunization rates. However, increases in obesity, infant mortality, and low birth weight present major challenges. According to the Federal Interagency Forum on Child and Family Statistics (FIFCFS), between 1976 and 1980, 6% of children were overweight. By 1988-1994, this proportion rose to 11%, and to 15% in 1999-2000. Black, non-Latino girls and Mexican-American boys are at an even higher risk of being overweight. In 1999-2000, 24% of Black, non-Latino girls and 29% of Mexican-American boys were overweight. A California Center for Public Health Advocacy (CCPHA) study found that approximately 27% of California children are overweight and 40% are unfit.

Infant mortality has increased for the first time in decades, from a rate of 6.8 infant deaths per 1,000 live births in 2001 to seven per 1,000 live births in 2002. The Centers for Disease Control and Prevention (CDC) attributes the increase to deaths among neonates (infants less than 28 days old), particularly infants who died within the first week of life. One of the most significant risk factors for infant mortality is low birth weight (babies weighing 5.5 pounds or less). Low birth weight rates rose from 7% in 1990 to 7.8% in 2002. The rate of low birth weight babies among Black, non-Latino infants (13.4%) exceeds the rate for any other racial or ethnic group. Growth in multiple births (largely due to increasing use of fertility treatments) partially explains the low birth weight increase, even though there have been increases among singleton infants.

California has come a long way in improving the health status of its children. However, despite great steps towards increasing access to health care, disparities among racial/ethnic lines, socioeconomic status, language, and geographic regions persist. Along with increases in the numbers of overweight children, asthma and type 2 diabetes rates are on the rise. There is great opportunity for improvement in all areas of pediatric health. This hearing will examine opportunities in five major areas.

Asthma

Asthma is one of the most common chronic conditions for all age groups. According to the 2001 California Health Interview Survey (CHIS), 3.9 million Californians have asthma (equaling 11.9% of the population; the national prevalence is 10.1%). Those living in rural areas experience the highest rates of frequent asthma symptoms (up to 15%), while urban counties' prevalence rates reach up to 9%. Asthma disproportionately affects children and young adults. Approximately 600,000 California children are afflicted with asthma, an increase of 160% since 1980. Asthma prevalence is highest among children ages six to 11 (13.7%) and adolescents ages 12 to 17 (16.3%). Children of low-income families and children of color are more likely to have had an asthma attack in the past 12 months. Finally, childhood asthma is considered to be a leading cause of school absenteeism. According to CHIS, of the approximately 667,000 school-aged children who experienced asthma symptoms, 20% missed one or more days of school and 24% were limited in their ability to participate in physical activities.

Asthma is a chronic disease that cannot be cured, but its symptoms can be controlled. People with asthma are symptomatic when exposed to certain environmental triggers (such as tobacco smoke, air pollutants, chemicals, mold, cockroaches, dust mites, pollen, and animal dander). Effective control of asthma requires timely access to comprehensive health care and educational services. Independent analyses by the RAND Corporation, the federal Health and Human Services Office of Disease Prevention and Health Promotion, and CHIS all call for comprehensive asthma education services for those afflicted with asthma and their family members. RAND also recommends the development of a model benefits package for people with asthma needs. Specifically, their 2001 report "Improving Childhood Asthma Outcomes in the United States: A Blueprint for Policy Action" calls for a set of basic benefits for all children with asthma to ensure that all private and public health insurance plans cover all services essential for the proper management of the disease.

Dental Disease

According to the CDC, the oral health of children has improved significantly over the past few decades. However, tooth decay remains one of the most common diseases of childhood: five times as common as asthma and seven times as common as hay fever. More than half of children age five to nine have had at least one cavity or filling and 78% of 17-year-olds have experienced tooth decay. By age 17, more than 7% of children have lost at least one permanent tooth to decay.

The most advanced dental disease is found among children living in poverty. This risk group is enormous as one quarter of American children are born into families that live below the federal poverty line (annual income of $17,000 or less for a family of four). Children living in poverty experience twice as much tooth decay as other children, and their disease is more likely to go

untreated. Advanced disease is also frequently found among some racial/ethnic minority populations, disabled children, and children with HIV-AIDS.

According to the CDC, children without health insurance are less than half as likely as insured children to receive dental care, and children without dental insurance are three times more likely than insured children to have unmet dental needs. Children with untreated oral disease often are in persistent pain, unable to eat comfortably or chew well, embarrassed over discolored and damaged teeth, and distracted from play and learning. More than 51 million school hours are lost each year because of dental-related illness.

Mental Health

According to the National Institute of Mental Health (NIMH), one in ten children in the United States suffers from a mental disorder severe enough to cause some level of impairment. Common mental disorders affecting children and adolescents include attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, bipolar disorder, borderline personality disorder, depression, eating disorders, and childhood-onset Schizophrenia.

The treatment of mental health disorders in children can be complicated. There have been numerous reports of public concern over young children being prescribed psychotropic medications. According to the NIMH, studies are needed to determine the best treatments for children with emotional and behavioral disturbances because children are in a state of rapid change and growth during their developmental years. Mental health professionals must take this into consideration during diagnosis and treatment of mental disorders. While it had been previously believed that disorders such as anxiety, depression, and bipolar disease began only after childhood, it is now known that they commonly begin at an early age. While some problems are short-lived and do not require treatment, others are persistent and very serious, and require professional intervention. Of the children that have mental disorders, fewer than one in five receive treatment. Even the childhood-onset mental disorder that has been studied, diagnosed, and treated most frequently (ADHD) has a significant amount of further research necessary in very young children.

Diabetes

Type 1 diabetes mellitus (DM1) results when the pancreas produces insufficient amounts of insulin to meet the body's needs. Type 2 diabetes (DM2) results when the pancreas produces insulin, but the cells are unable to use it efficiently, also known as insulin resistance. DM2, which used to be commonly referred to as "adult-onset diabetes," is far more common than DM1, making up approximately 90% of all diabetes cases. To manage the disease, diabetics must keep their blood sugar as close to normal as possible to reduce the risk of long-term complications. If not treated properly, both types of diabetes can lead to kidney failure, blindness, cardiovascular disease, stroke, and renal failure.

According to CCPHA, diabetes affects as many as 18.2 million people in the U.S., including an estimated 5.2 million people that have not been diagnosed. DM2 affects a growing number of children, and accounts for almost 50% of new diabetes cases in some communities. If current trends continue, approximately 33% of boys and 39% of girls born in 2000 will develop diabetes

sometime in their lives. Ninety-four percent of the nation's children and adolescents with DM2 are from communities of color and it is estimated that close to half of African American and Latino children born in the year 2000 will develop diabetes sometime in their lives. More than 12,000 adolescents in California were diagnosed with the disease in 2001. Diabetes prevalence in California is greater among certain racial/ethnic groups, with 10.3% of African Americans having been diagnosed with diabetes, 9.3% of American Indians and Alaska Natives, and 6.0% of Latinos, compared to 5.6% of Whites and 4.7% of Asians and Pacific Islanders.

Genetics play a large role in DM2, and family history is a risk factor. Environmental factors such as a low activity level and poor diet can also increase the risk for DM2. The American Diabetes Association (ADA) recommends screening for children starting at age ten if they are over-weight and have two other risk factors, such as a parent with DM2, signs of insulin resistance, or if they are American Indian, Latino, or African American. Yet, outside of large clinical obesity programs, screening for diabetes in children is rare, despite the fact that DM2 diagnoses have reached alarming rates in children.

Rates of Insurance

According to the California Health Interview Survey (CHIS), more than 1.1 million California children under age 19 (more than the populations of nine states) were uninsured for all or part of the year in 2003. This is a decline from the 1.5 million children who were uninsured for all or part of 2001. This decline resulted from increased enrollments in Medi-Cal, Healthy Families, and county health initiatives. These public programs enrolled 600,000 more children over the two-year period, and more than overcame the drop in employment-based coverage of children.

The disappointing trend in the coverage of California children is the decline of employment based coverage. Two hundred thousand fewer children were covered in 2003 through their parents' employment than were covered in 2001. This drop in employment-based coverage reflects a weak labor market (which may be cyclical) and rapidly rising health insurance costs, including a 79% increase in employee share of premiums for family coverage (which are likely not reversible). The following chart summarizes the health insurance status of California children in 2003:

INSURANCE STATUS	2003	PERCENTAGE POINT CHANGE FROM 2001
Uninsured All Year	5.1% (508,000)	-2.4%
Uninsured Part Year	6.2% (626,000)	-1.1%
Employment-based Insurance All Year	50.8% (5,102,000)	-4.3%
Medi-Cal or Healthy Families All Year	29.3% (2,942,000)	+5.2%
Other Insurance All Year	8.7% (873,000)	+2.7%
Population in 2003	100% (10,050,000)	---

Source: CHIS, UCLA Center for Health Policy Research, December 2004

Based on insurance status at the time of the CHIS interview, 55% of all uninsured children were eligible for enrollment in either Medi-Cal or Healthy Families (227,000 for Medi-Cal; 224,000 for Healthy Families). Another 6% (44,000) children were eligible for insurance through county-based insurance programs. Although children eligible for county-based programs had grown to over 100,000 by December 2004, limited funding resulted in enrollment caps in many county programs. Thirty-nine percent of uninsured children were not eligible for public programs because of family income level (159,000 children) or immigration status (148,000 children).

Conclusion

The state of health of California children impacts children's lives in many ways, including their school performance, their family relationships and their future wellbeing. In addition, unhealthy children mean higher overall health care costs for all Californians. In 2002, the Select Committee on California Children's School Readiness and Health held a series of hearings and reported that healthy children attend school more regularly and students' absenteeism rates have a direct correlation with their academic performance. Children must start school healthy and be ready to learn. Children who have insurance have better access to care, including prevention and treatment. Many children begin their lives with preventable health risks, but do not have access to preventive care services. These same students are expected to perform at grade level by age nine and ultimately pass an exit exam to graduate from high school. Without proper intervention and attention to health needs, many students needlessly face extreme challenges in meeting academic standards and moving on to successful adult lives.