Access to health care is essential for the healthy development of children. Without the ability to easily obtain health care services there is the potential for health problems to go undiagnosed and untreated. Such problems impair a child's capacity to participate in developmentally appropriate activities. This reduces a child's chances to start school ready to learn.

Health Insurance Coverage

Health insurance coverage provides financial access to the range of health care that children need, including physical, mental, and developmental health services. Recent expansions of Medi-Cal and the Healthy Families program have substantially improved young children's financial access to health care.

About 6.8% of young children (or 202,000) in California are uninsured. Reflecting a national trend of eroding employer-sponsored insurance coverage, fewer than two-thirds of insured young children in California (57.1%) are covered by an employer-based plan. Publicly-funded insurance programs have filled some of the gap in employer-based coverage. Nearly one in every three insured young children are covered by a public insurance program. About 28% of young children have Medi-Cal coverage, and 4.1% are enrolled in Healthy Families.

Stability of Coverage: Gaps for Insured Children, and Periods of Coverage for Uninsured Children

Measuring current health insurance coverage does not provide the entire picture because it does not capture the stability of coverage. Continuous insurance coverage is an important determinant of continuity in health care. For some families, maintaining health coverage for a young child is difficult because eligibility fluctuates with changes in parental employment and income.

Among insured young children in California, 4.3% (about 124,000 children) lacked health coverage at some time in the past year. Though these gaps in insurance may ultimately be temporary for most young children, changes in coverage can disrupt ongoing services and cause the child to switch providers.[19] In total, 11% of young children are either uninsured or had a gap in health coverage in the past year. Exhibit 12 shows that five times as many children under 100% FPL (18.5%) as those 300% FPL and above (3.3%) are not covered or had any gap in coverage in the past year. Thus low-income children in California are not only more likely to be uninsured, but when insured they are more likely to have gaps in coverage.

Although increasing the number of children with private or public coverage options is an important goal in California, retaining children is just as important because uninsured children can enroll and then lose coverage. Retention of coverage once a child is signed up assures an ongoing relationship with a provider, which is important for health care continuity, quality of care, patient adherence to medical advice, and parent self-management of children's conditions, such as asthma. Retaining coverage for insured children is just as important as extending coverage to currently uninsured children. Children can lose private insurance coverage when their parents lose a job or change to an employer without benefits. Other children become

19 Kogan MD, Alexander GR, Teitelbaum MA, Jack BW, Kotelchuck M, Pappas G. The effect of gaps in health insurance on continuity of a regular source of care among preschool-aged children in the United States. *JAMA*; 274(18): 1429-35

Eligible for, but Not Enrolled in, Public Coverage

In 2001 there were 202,000 children age 0-5 years who were not insured. Yet most uninsured young children in California should not lack coverage, given that most are eligible for health insurance coverage through either Medi-Cal or the Healthy Families program. In California, children living in the lowest income families (from 0-133% FPL) are eligible for Medi-Cal, while children in families with incomes just above the poverty level (133-250% of FPL) are eligible for Healthy Families. Even though California has recently expanded public coverage, 80% of uninsured children age 0-5 years (158,000) are eligible but not enrolled. This includes children who did enroll but lost eligibility due to premiums or small income fluctuations, which is a "retention" problem.

Lacking health insurance creates several significant consequences for these children, their families and the health care system. Uninsured young children are more likely to receive their care in community clinics and public health centers and are less likely to have a regular health care provider, and therefore less likely to receive age-appropriate health education and guidance, or periodic assessments of development and behavior. National data show that parents of uninsured children are also less likely to receive counseling about psychosocial issues that influence the child's health and development. In addition to receiving poorer-quality health care, uninsured children must be cared for in overburdened public facilities and community health centers. The overall health care system also suffers since California is not receiving the federal matching dollars that are available if public coverage were extended to more uninsured children. In fact, California is sending money back to the federal government due to low enrollment in the Healthy Families program.

Despite a number of new outreach and educational efforts designed to stimulate enrollment, California's outreach efforts are still falling short. Data from CHIS 2001 make it clear that given the large number of children who are eligible but not enrolled in these public insurance programs, there is great need to not only to expand outreach and education efforts, but to consider other innovative ways to improve enrollment. CHIS 2001 shows that most parents of children who are eligible but not enrolled in these programs report not knowing about the program or didn't know that their child would qualify. Outreach efforts should be targeted to certain population groups and geographic locales. CHIS 2001 shows that among all children who are eligible for public insurance programs, there are racial/ethnic disparities in the percentage of children who enroll. This suggests that outreach efforts need to more effectively target Latino and Non-Latino White children in California and need to address their particular barriers to enrolling, through worksite education and other means.

California has recently begun several initiatives to increase enrollment of eligible children in Medi-Cal and Healthy Families. Parents have to jump through multiple hoops to enroll their children in public programs. The concept of "express lane" eligibility is one way of reducing the barriers to enrollment. Families often enroll in one public assistance program that has similar income eligibility as Medi-Cal or Healthy Families. Because so many young children can be found in the Women, Infants and Children (WIC) program and in Head Start, enrolling children in public insurance based on information from these other program applications could go a long way toward reducing the number of young uninsured children. While the "express lane" concept is being piloted in schools, budget cutbacks have scaled down a planned statewide "express lane" program for school-age children to limited pilot projects. For young children, linkages to the WIC program, preschools, and child care centers would create a parallel "express lane" process that could bring thousands of uninsured children into available programs.

Because many county First 5 commissions have identified expansions of health insurance or universal coverage as a programmatic and policy goal, many innovations in outreach, retention, and health care quality are likely to emerge, given the flexibility of First 5 to implement what works. A promising area for First 5 is to embed enhanced outreach, enrollment and retention efforts in other community based programs and community building efforts, such as school readiness centers. Linking enrollment and retention with other community-based services holds great promise for reducing the rate of uninsurance.

EXHIBIT 12 – STABILITY OF INSURANCE COVERAGE BY CHILD POVERTY LEVEL, CHILDREN AGE 0-5 YEARS, CALIFORNIA 2001

	CURRENTLY INSURED		CURRENTLY UNINSURED		
	A. COVERED DURING THE ENTIRE PAST 12 MONTHS	B. NOT COVERED AT ANY POINT DURING PAST 12 MONTHS	C. COVERED AT SOME POINT DURING PAST 12 MONTHS	D. NOT COVERED AT ANY POINT DURING PAST 12 MONTHS	E. TOTAL WITH ANY GAP IN COVERAGE (B+C+D)
TOTAL	**89.0%**	**4.2%**	**2.4%**	**4.3%**	**10.9%**
LESS THAN 100% FPL	81.6%	5.4%	3.7%	9.4%	18.5%
100-199% FPL	83.0%	6.1%	4.0%	6.9%	17.0%
200-299% FPL	90.6%	4.6%	2.7%	2.1%	9.4%
300%FPL AND ABOVE	96.7%	2.2%	0.6%	0.6%*	3.3 %

* This percentage is not reliable due to small sample size
Test of the association of health insurance coverage with income is statistically significant ($p<0.05$) (chi square).

uninsured after losing Medicaid or Healthy Families. This loss of coverage can result from burdensome re-enrollment processes, not paying premiums on time, or from small income fluctuations that cause parents to join the ranks of the "working poor" who do not qualify for public programs.

CHIS 2001 shows that one third (35.8%) of uninsured young children were covered by some form of insurance in the past year but then lost coverage. About 6.6% of young children are uninsured, with 2.4% covered at some point (Exhibit 12). About half of these children had Medi-Cal but lost it. Few of the children who had been insured and lost coverage had been in Healthy Families, although growth in Healthy Families enrollment may increase this rate, over time. Tracking this rate will show how well Healthy Families and other public insurance programs retain eligible children.

Exhibit 13 shows that coverage is least stable for Latino children. Non-citizen children are most likely to be uninsured or have a gap in coverage during the year. Gaps in coverage are more frequent in rural areas, where 20% of young children are uninsured or have a gap, than in suburban areas.

Disparities in Health Insurance Coverage

There are disparities in insurance coverage according to family income, race/ethnicity, and area of residence. Latino children and those in low-income families are less likely to have health insurance. There is a large gradient by income with a ten-fold difference between children in the highest and lowest income households. About one in ten children in families with incomes below the FPL and at 100-199% FPL, and one of every 100 children in higher income families (300% FPL and above) lack insurance.

Latino children are much more likely to be uninsured. About 11.9% of Latino children are uninsured compared to 3.5% of Non-Latino White, and a small percentage of African-American and Asian/Pacific Islander children. Latino and African-American children are more likely than Asian/Pacific Islander and Non-Latino White children to be covered by Medi-Cal (with 45.5%, 45.2%, 18.1%, and 11.6% covered, respectively). Among Non-Latino Whites, 77.1% of children are covered by health insurance obtained through an employer, compared to 69.3% of Asians/Pacific Islanders and only 33.9% of Latinos and 47.3% of African-Americans.

Children in urban and in very rural areas are more likely to be uninsured than children in suburban areas. Differences in average income, eligibility for public programs, and enrollment contribute to these rates.

EXHIBIT 13 – STABILITY OF INSURANCE COVERAGE BY CHILD RACE/ETHNICITY, CITIZENSHIP, AND AREA OF RESIDENCE, CALIFORNIA 2001

	COVERED DURING THE ENTIRE PAST 12 MONTHS	TOTAL WITH ANY GAP IN COVERAGE
RACE/ETHNICITY		
NON-LATINO WHITE	92.7%	7.3%
LATINO	83.0%	17.0%
AFRICAN-AMERICAN	95.3%	4.7%
ASIAN/PACIFIC ISLANDER	93.7%	6.3%
CITIZENSHIP STATUS		
CHILD AND BOTH PARENTS U.S. BORN CITIZENS	93.4%	6.6%
CHILD CITIZEN, PARENT NATURALIZED CITIZEN	91.4%	8.6%
CHILD CITIZEN, PARENT NONCITIZEN WITH GREEN CARD	82.6%	17.4%
CHILD CITIZEN, PARENT NONCITIZEN WITHOUT GREEN CARD	80.0%	20.0%
CHILD IS NONCITIZEN	63.5%	36.5%
AREA OF RESIDENCE		
URBAN	88.4%	11.6%
SECOND CITY	89.2%	10.8%
SUBURBAN	92.8%	7.2%
SMALL TOWN	86.0%	14.0%
RURAL	79.5%	20.5%

Tests of the association of health insurance coverage with race/ethnicity, citizenship, and area of residence, are statistically significant ($p<0.05$) (chi square).

Children Eligible for Medi-Cal and Healthy Families But Not Enrolled

Some low-income working families earn too much for their child to qualify for public insurance but also too little to purchase private coverage if their employer does not offer it. CHIS 2001 shows that most uninsured young children in California are eligible for public coverage. Nearly 80% of uninsured young children (or about 158,000) are eligible to enroll in the Medi-Cal or Healthy Families program. There are several reasons for this. Some parents do not know that their child is eligible for the program. Other parents may want to avoid assistance programs because of the welfare stigma that has been attached to these programs. Some parents of many Latino children fear that participation in these government-supported programs will adversely impact their immigration status or lead to deportation.[20] CHIS 2001 shows that based on reported income, family size, and child citizenship, about 59% of uninsured young children are actually eligible for Medi-Cal coverage, and 19% are eligible for Healthy Families. The remaining 22% are ineligible; 11% are not eligible due to incomes above eligibility thresholds, and 11% are not eligible because they are not citizens.

Parents give many different reasons for why the eligible child was not enrolled. CHIS 2001 shows that the two most common reasons for not enrolling in Medi-Cal are that parents did not know if the child was eligible or thought their income was too high to qualify. For the Healthy Families program, parents most commonly reported they did not know about the program. This speaks clearly to the need for greater parent outreach and education, and to

20 Barreto P, Bourque LB, Halfon N. 2003. Understanding the dynamics of enrollment in Medi-Cal and Healthy Families among low-income children accessing safety net providers. Los Angeles, CA: University of California, Los Angeles.

EXHIBIT 14 – INSURANCE COVERAGE AND TYPE BY FAMILY INCOME, RACE/ETHNICITY, GEOGRAPHY, AND CITIZENSHIP, CHILDREN AGE 0-5 YEARS, CALIFORNIA 2001

	UNINSURED	MEDI-CAL	HEALTHY FAMILIES	EMPLOYMENT -BASED	OTHER
LESS THAN 100% FPL	13.1%	73.5%	0%	11.4%	2.1%*
100-199% FPL	10.9%	32.9%	12.0%	40.1%	3.2%
200-299% FPL	4.8%	10.0%	7.5%	74.4%	3.4%
300% FPL AND ABOVE	1.1%	4.3%	0.4%	88.7%	5.5%
RACE/ETHNICITY					
NON-LATINO WHITE	3.5%	11.6%	1.9%	77.1%	6.0%
LATINO	11.9%	45.5%	5.7%	33.9%	2.9%
AFRICAN-AMERICAN	2.5%*	45.2%	3.4%*	47.3%	1.6%*
ASIAN/PACIFIC ISLANDER	2.6%*	18.1%	7.8%	69.3%	2.3%*
AREA OF RESIDENCE					
URBAN	8.0%	36.2%	5.4%	46.8%	3.6%
SECOND CITY	6.4%	25.2%	2.9%	61.8%	3.7%
SUBURBAN	3.7%	17.7%	2.5%	71.6%	4.6%
SMALL TOWN	8.8%	18.1%	4.5%	61.9%	6.8%
RURAL	10.4%	40.8%	5.6%	40.7%	2.6%*
CITIZENSHIP STATUS					
CHILD AND BOTH PARENTS U.S. BORN CITIZENS	2.9%	17.1%	2.3%	73.1%	4.5%
CHILD CITIZEN, PARENT NATURALIZED CITIZEN	4.9%	26.2%	5.6%	60.2%	3.2%
CHILD CITIZEN, PARENT NONCITIZEN WITH GREEN CARD	12.9%	36.3%	7.1%	39.8%	3.8%
CHILD CITIZEN, PARENT NONCITIZEN WITHOUT GREEN CARD	13.3%	61.9%	5.1%	16.2%	3.5%*
CHILD IS NON-CITIZEN	31.9%	32.9%	3.0%*	23.6%	2.2%*

* This percentage is not reliable due to small sample size
Tests of the association of type of health insurance coverage with income, race/ethnicity, area of residence, and citizenship status are statistically significant ($p<0.05$) (chi square).

consideration of processes, such as linking enrollment with WIC and other public programs that can potentially identify and enroll low-income children without large additional costs. Such "express lane" eligibility programs have already been launched in California schools based on free- and reduced-lunch eligibility.

Exhibit 15 shows that among uninsured young children, the majority under 200% FPL is eligible for Medi-Cal while the majority between 200-299% FPL is eligible for Healthy Families. Because of income-based eligibility criteria, uninsured children in the lowest income families are generally eligible for Medi-Cal while children in higher income families are generally eligible for Healthy Families. Children in families with incomes greater than 300% FPL are not eligible for either program, although Medi-Cal does extend coverage to a small number of children who have costly medical conditions.

Currently uninsured Latino and African-American children are more likely than Non-Latino Whites and Asians to be eligible but not enrolled in these public insurance programs. Among uninsured children, 83.3% of Latino and 66.7% of Non-Latino White children are eligible. Much of this difference is attributable to family income differences, but it also shows that Latinos may be less informed about these programs or encounter greater barriers to enrolling.

Given the large number of children who are eligible but not enrolled in these public insurance programs, there is a need to improve outreach and education efforts. Rates of

EXHIBIT 15 – ELIGIBILITY OF UNINSURED CHILDREN FOR MEDI-CAL AND HEALTHY FAMILIES PROGRAMS, CHILDREN AGE 0-5 YEARS, CALIFORNIA 2001

	ELIGIBLE FOR MEDI-CAL	ELIGIBLE FOR HEALTHY FAMILIES	NOT ELIGIBLE	TOTAL
LESS THAN 100% FPL	78.3%	3.8%*	17.9%	100%
100-199% FPL	59.9%	28.1%	12.0%*	100%
200-299% FPL	9.3%*	60.6%	30.1%	100%
300% FPL AND ABOVE	0%	0%	100%	100%
RACE/ETHNICITY				
NON-HISPANIC WHITE	42.3%	24.4%	33.3%	100%
LATINO	65.5%	17.8%	16.7%	100%
AFRICAN-AMERICAN	65.8%	10.4%*	23.8%*	100%
ASIAN/PACIFIC ISLANDER	30.9%*	8.5%*	60.6%	100%
AREA OF RESIDENCE				
URBAN	58.6%	18.3%	23.1%	100%
SECOND CITY	63.9%	13.6%	22.5%	100%
SUBURBAN	47.1%	31.7%	21.2%*	100%
SMALL TOWN	65.8%	17.5%*	16.7%*	100%
RURAL	69.1%	10.8%*	20.1%*	100%
CITIZENSHIP STATUS				
CHILD AND BOTH PARENTS U.S. BORN CITIZENS	49.5%	23.7%	26.8%	100%
CHILD CITIZEN, PARENT NATURALIZED CITIZEN	56.7%	28.4%	14.9%	100%
CHILD CITIZEN, PARENT NONCITIZEN WITH GREEN CARD	73.3%	17.2%	9.5%*	100%
CHILD CITIZEN, PARENT NONCITIZEN WITHOUT GREEN CARD	81.2%	16.9%*	1.8%*	100%
CHILD IS NON-CITIZEN	–	–	97.3%	100%

* This percentage is not reliable due to small sample size
Tests of the association of eligibility for health insurance with income, race/ethnicity, and citizenship are statistically significant ($p<0.05$) (chi square). The association of eligibility and area of residence is not statistically significant.

insurance "uptake" are another way of depicting which children are eligible but not enrolled in public coverage. Rates of "uptake" show that 17% of all Latino and 17% of Non-Latino White children who are eligible for Medi-Cal or Healthy Families are not enrolled, compared to 7% of Asian and 6% of African-American children who are eligible.

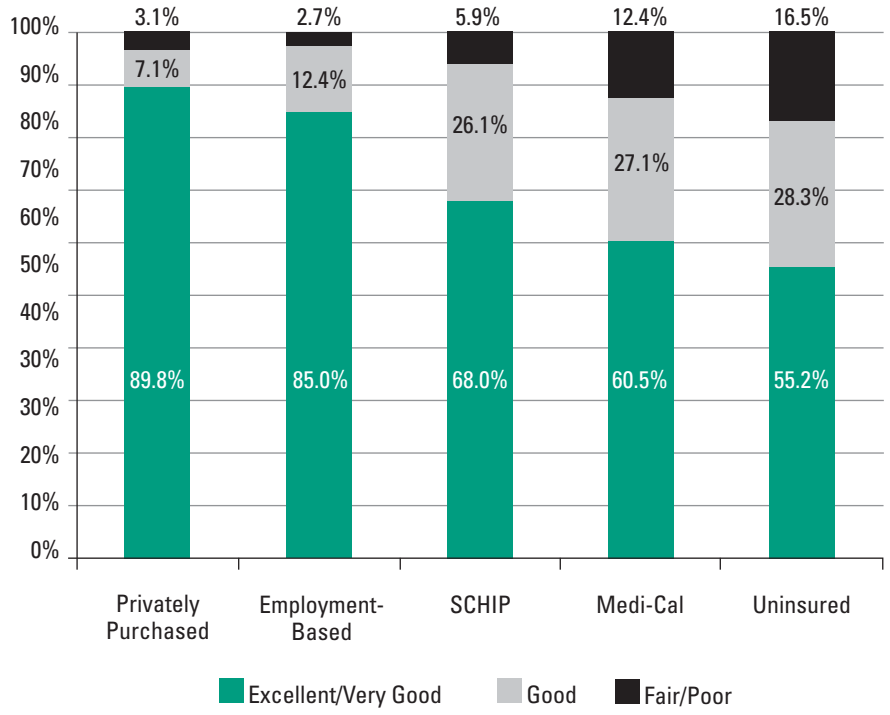
Health Status and Insurance

Exhibit 16 shows that fewer uninsured young children (55.2%) and children in Medi-Cal (60.5%) than children with employer-based insurance (85%) have excellent or very good health. These differences suggest that disparities in health outcomes may be related to disparities in the quality of health care. There is a role that improved access to health care can have in overcoming these disparities. The difference between children in Medi-Cal and children with employer-based insurance also demonstrates the persistent disparities between public and private types of insurance. Enrolling most uninsured but eligible young children into Medi-Cal and Healthy Families may not by itself produce substantial improvements in health status.

Summary

CHIS 2001 provides important new information on insurance coverage, continuity, and retention, which are critical issues for public insurance programs including

EXHIBIT 16 – HEALTH STATUS BY TYPE OF INSURANCE, CHILDREN AGE 0-5 YEARS, CALIFORNIA 2001



Test of the association of health insurance type and health status are statistically significant (p<0.05) (chi square).

uninsured young children in California are eligible for either Medi-Cal or Healthy Families. Outreach to get these children enrolled will not solve the problem, given that even among those children who do enroll, a sizable percentage lose coverage during the year. Retaining eligible children in public insurance programs is an important policy goal in California if the benefits of health coverage—having a usual source of care, reduced financial barriers, better access, and ultimately, improved health and well-being—are to be achieved for young children.

Usual Source of Health Care

Having a usual source of care is an important measure of health care access. It represents continuity in care and is the most fundamental component of the "medical home" concept promoted by the American Academy of Pediatrics (AAP). A continuous relationship with a provider and a place that the parent considers the child's usual source of care are important elements of the medical home. Continuity of care is an important precursor to the quality of care that young children receive.

Most young children in California (97.9%) have a usual source of care. This is nearly the same as the national rate (97%) from the National Health Interview Survey (NHIS) for children age 0-3 years.[21] CHIS 2001 shows that among children without a usual source, the most common reason given by the parents for not having a source of care is that the child is seldom or never sick.

The predominant health care setting of children in California is a physician's office. Among children with a usual source of care, 79.4% of parents report a physician's office or Health Maintence Organization (HMO) as the child's usual source and 20.2% report a community clinic. For young children, the setting of care remains a very important issue. There are unanswered questions about the quality and content of early childhood care in clinics where

21 Newacheck P, Hung YY, Hochstein M, Halfon N. (2000) Access to Health Care for Disadvantaged Young Children. *Journal of Early Intervention*; 25(1):1-11.

EXHIBIT 17 – USUAL SOURCE OF CARE BY POVERTY STATUS, RACE/ETHNICITY, GEOGRAPHIC SETTING AND INSURANCE STATUS, CALIFORNIA 2001

	MD OFFICE	CLINIC	NO USUAL SOURCE	TOTAL
LESS THAN 100% FPL	55.1%	42.0%	2.9%	100%
100-199% FPL	68.9%	27.3%	3.8%	100%
200-299% FPL	86.7%	11.4%	1.9%*	100%
300% FPL AND ABOVE	94.3%	5.1%	0.6%*	100%
RACE/ETHNICITY				
NON-LATINO WHITE	91.1%	7.1%	1.8%	100%
LATINO	60.2%	37.1%	2.7%	100%
AFRICAN-AMERICAN	83.8%	14.8%	1.3%*	100%
ASIAN/PACIFIC ISLANDER	90.2%	8.2%	1.7%*	100%
AREA OF RESIDENCE				
URBAN	74.8%	23.0%	2.2%	100%
SECOND CITY	79.9%	17.8%	2.3%*	100%
SUBURBAN	85.6%	12.7%	1.7%	100%
SMALL TOWN	73.9%	24.0%	2.1%*	100%
RURAL	65.6%	32.5%	1.9%*	100%
INSURANCE STATUS				
UNINSURED	39.7%	45.9%	14.4%	100%
MEDI-CAL	58.2%	39.9%	1.9%	100%
HEALTHY FAMILIES	73.2%	24.3%	2.5%	100%
EMPLOYMENT-BASED INSURANCE	92.7%	6.6%	0.7%	100%
CITIZENSHIP STATUS				
CHILD AND BOTH PARENTS U.S. BORN CITIZENS	89.9%	8.7%	1.4%	100%
CHILD CITIZEN, PARENT NATURALIZED CITIZEN	77.9%	20.7%	1.5%	100%
CHILD CITIZEN, PARENT NONCITIZEN WITH GREEN CARD	67.5%	29.7%	2.9%*	100%
CHILD CITIZEN, PARENT NONCITIZEN WITHOUT GREEN CARD	50.7%	46.5%	2.8%*	100%
CHILD IS NONCITIZEN	40.4%	46.1%	13.5%*	100%

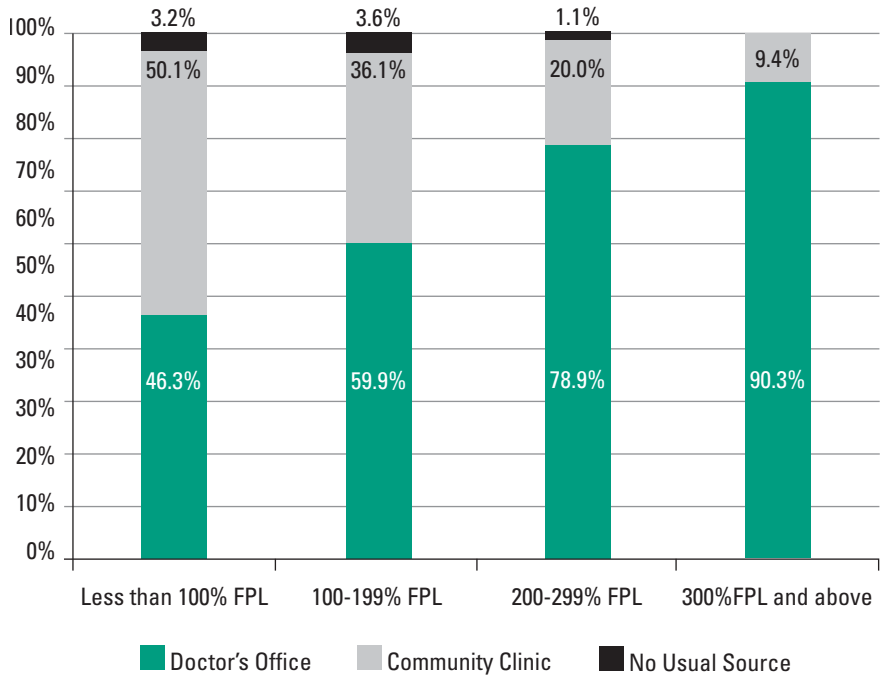
* This percentage is not reliable due to small sample size
Tests of the association of usual source of care with income, race/ethnicity, area of residence, health insurance type, and citizenship are statistically significant ($p<0.05$) (chi square).

quality and content of early childhood care in clinics where a family may be less likely to receive continuous care from a single provider.

Disparities and Gradients in Having a Usual Source of Care

There is an income gradient in the setting of health care. Children in higher income households are more likely than other young children to have a usual source of care (Exhibit 17). These children also generally receive care in private physician offices rather than community or hospital clinics. Children in households with income greater than 300% FPL are almost twice as likely as children in families below the FPL to report a physician's office as the child's regular source of care (94.3% vs. 55.1%, respectively). Differences in health care setting stem from income disparities, disproportionate use of "safety net" clinics by uninsured children, and variation in the availability of private

EXHIBIT 18 – HEALTH CARE SETTING FOR LATINO CHILDREN, BY INCOME, CHILDREN AGE 0-5 YEARS



Test of the association of usual setting of care with income among Latino children is statistically significant (p<0.05) (chi square).

office-based, primary-care providers in different communities. There is a similar gradient in having a usual source of care according to insurance status and type. Children who are uninsured are more likely than privately insured children to lack a usual source of care (14.4% vs. 0.7%). Few children in Medi-Cal (1.9%) and Healthy Families (2.5%) lack a usual source of care. Community clinics are the usual source for many more uninsured children (45.9%) and children in Medi-Cal (39.9%) than children in Healthy Families (24.3%) or private-insured children (6.6%).

Young children in rural areas use community clinics substantially more than suburban children (32.5% vs 12.7%). Children with citizen parents more frequently have a usual source, and use a physician office, than non-citizen children and those with non-citizen parents.

CHIS 2001 shows a clear gradient in the type of health care setting for Latino children by household income (Exhibit 18). Community and hospital clinics are the usual source of care for 50.1% of Latino children in households below 100% FPL and only 9.4% in households at 300% FPL and above. Children in community clinics may not always see the same provider, and may not receive the same level of quality care that children in physician offices receive. The highest-income Latino children use private physician offices as often as Non-Latino White children. Latino children in families living below poverty are five times more likely to use community health centers than Latino children in families with incomes at or above 300% FPL. Given the poorer health status of low-income Latino children and their much greater use of community clinics, ensuring that these settings have adequate health-promotion and disease-management programs could reduce health status disparities.

Use of Health Services

The use of health services is a commonly reported measure of access to care. Preventive care guidelines recommend that children have at least one physician checkup per year while children under age two should have multiple visits. Guidelines such as these are frequently used to measure appropriate access to and quality of preventive care.

Geographic Disparities in Access to Health Care: Barriers for Rural Children

CHIS 2001 shows that across the board, children living in rural areas have poorer access to health care and also suffer from poorer health status. The combined effects of lacking insurance coverage, not having a regular source of care, and having to delay or miss needed services is likely to take a substantial toll on the health and long-term development of rural children.

While many studies have documented geographic disparities in access to health care, CHIS 2001 is one of the first to comprehensively document these disparities in access for young children in California. Children in rural areas are more than twice as likely as children living in suburbs to be uninsured (10% vs. 4%). Children in rural areas also have twice the rate of any other group of children in experiencing gaps in coverage. These gaps threaten continuity of health care, which is important for treatment of chronic illnesses, such as asthma, as well as for health promotion and preventive care. Reflecting income differences in part, children in rural areas are much more likely to be covered by Medi-Cal or by Healthy Families (with nearly 50% covered by public insurance) than children in suburban areas (20%) or towns (22%).

These differences are important given the disproportionate burden of illness in these children. Only two-thirds of rural children have excellent or good health, and they have the highest rate of fair or poor health at 14%. Asthma is also a problem in rural areas. About 8.3% of all rural children in California have asthma symptoms at least monthly, compared to 3.2% of urban children and 2.5% of children in small towns.

While there are few disparities in having a regular source of care, there are large geographic differences in the type of source. Children living in rural areas are almost three times as likely (32%), and children living in small towns are about twice as likely (24%), as children living in suburbs (13%) to use a clinic or health center as the regular source of care. There are some concerns about receiving care from these clinic settings because they may provide less continuity of care with individual clinicians. In addition, many community clinics and health centers are encountering substantial financial difficulties that challenge their ability to maintain high quality care for their patients.

Children in rural areas of California are also more likely to delay or forego needed health care. About 11% of children in rural areas delayed or did not obtain needed care compared to 8% of suburban and 6% of urban children. While these numbers may seem small, each percentage point reflects about 30,000 young children in California. The reasons for delays among rural children may be partially explained by lower insurance coverage, reliance on a network of Medi-Cal and Healthy Families providers, and income disparities among the families living in rural areas. Availability of primary care providers is also generally much lower in rural areas. While families in urban areas also struggle with socioeconomic difficulties, primary care providers and hospitals tend to cluster in urban areas, making it easier to obtain needed services, regardless of ability to pay.

Effort should not only be made to improve financial access to care through aggressive insurance enrollment, but through expansions wherever possible. Assuring an adequate primary care workforce in rural areas is critical to improving access to care for young children.

CHIS 2001 shows that nearly all young children (97.4%) have seen a physician within the last 12 months. Younger children are more likely to have had a physician visit, and a greater number of visits because of the frequency of recommended well-child visits. About 16.4% of young children have one visit, 47.3% have two to four visits, and 32.2% have five or more visits. The CHIS 2001 findings are similar to nationally representative statistics showing that 93.5% of children have had a physician visit in the past year.[22]

Uninsured children are almost twice as likely as insured children to have gone at least 12 months without having a physician visit. About 7.6% of uninsured children have not had a physician visit in the past 12 months compared to 1.9% of children in Medi-Cal, and 2.2% of children with employment-based insurance.

Seeking care from an emergency department (ED) is a commonly used measure of poor access to care. Frequent use of an ED for primary care shows poor access to primary care, while use for conditions such as asthma can indicate poor management of a chronic condition in the primary care setting. Primary care access problems result from lower availability of providers in certain communities, including both readily-available primary care physicians, and non-ED urgent care options. Because of poorer access to primary care, uninsured children nationally are more likely to seek care in EDs for services that are considered inappropriate for the ED such as basic primary care.[23]

CHIS 2001 shows that about 22.4% of children age 0-5 in California have had at least one ED visit in the past year. According to nationally-representative data from the 1996 Medical Expenditure Panel Survey, only 16.8% of children age 0-4 years had an ED visit in the past year. CHIS 2001 shows that 24% of children age 0-4 years in California had an ED visit. These differences underscore the problem of appropriate health care access for young children in California.

Both having insurance and the type of insurance is associated with greater use of EDs. CHIS 2001 shows that a similar proportion of children in Medi-Cal (27.8%) and with employment-based coverage (21.1%) had an ED visit in the past year. Fewer uninsured children (19.1%) than children in Medi-Cal have ED visits. National studies show that uninsured children use fewer ED services than low-income, publicly-insured children due to the costs of ED use for those without insurance.[24] CHIS 2001 findings also point to the problem of ED use among children in Medi-Cal. Greater use of EDs among Medi-Cal covered children may stem from poorer health status, use of emergency departments instead of primary care providers when a convenient appointment cannot be obtained, low availability or knowledge of "nurse advice lines" that some Medi-Cal managed care plans offer, and poor access or use of other urgent care options.

Immunizations

Immunizations for children are the most well-studied indicator of access to care for children. Immunizations are of critical public health importance and the most cost-effective preventive services available. Financial barriers to immunization have declined in recent years because they are becoming universally-covered health benefits, regardless of health insurance type. Children who experience difficulty obtaining immunizations are assumed to be experiencing non-financial barriers to care stemming from shortage of primary care providers, and poor quality and continuity of care. Difficulty obtaining immunizations is an important indicator of potentially larger gaps in the receipt of other preventive services.

CHIS 2001 shows that only 2.8% of parents of young children report difficulty obtaining immunizations for their child. Though CHIS does not collect information on the immunization status of children, recent national estimates for young children (age 19-35 months) suggest that most children (74%) received the series of recommended immunizations and as many as 90% have received the

22 National Center for Health Statistics data, 2000, http://www.cdc.gov/nchs/data/hus/tables/2002/02hus075.pdf

23 McCormick MC, Weinick RM, Elixhauser A, et al. (2001) Annual report on access to and utilization of health care for children and youth in the United States—2000. *Ambulatory Pediatrics*. 1(1): 3-15.

24 Halfon N, Newacheck PW, Wood DL, St. Peter RF. (1996) Routine emergency department use for sick care by children in the United States. *Pediatrics*; 98(1): 28-94.

complete Hepatitis B series.[25] Remaining pockets of under-immunization in California may stem not only from difficulties accessing health services, but also from "missed opportunities" to vaccinate children during well-child or sick visits. The national Vaccines for Children (VFC) program has sought to improve provider vaccine practices, but there still remains much room for improvement in vaccine delivery and in avoiding periodic vaccine shortages.

Parent knowledge of the child's immunization status is important, and CHIS 2001 shows that most (94%) parents have their child's official yellow immunization card at home. Recent statewide and national efforts to improve pediatric provider delivery of immunizations include reminder and recall systems. Such systems remind parents when to obtain immunizations for their child and can prompt providers to offer immunizations during visits. About half of parents of young children in California (57.6%) receive reminders from a physician or medical person about the immunizations that the child needs. Greater use of such reminders could help reduce the pockets of under-immunization among children who have a usual source of care but whose parents do not always adhere to the recommended schedule of visits.

Delayed and Missed Care

Delaying or foregoing needed health care services is a more direct way of measuring access to health care services. It captures the receipt of health care in relation to the parent's perceived need for care, which is the driving force behind most child health care use. Delayed or missed care can affect children's health and well-being. Delays in obtaining asthma medications for young children can potentially lead to a greater duration or course of illness, greater severity of the disease, more urgent care contacts, and greater emergency department utilization.[26]

Approximately 7.3% of all young children in California (218,000) have not received care or received care later than desired by the parent. About 3% (90,000 children) received a delayed prescription or did not have it filled at all. About 1.8% (55,000 children) delayed or missed a test or treatment. About 3.1% (92,000 children) delayed or did not receive needed medical care other than prescriptions or tests and treatment.

For children with chronic health conditions, delayed or foregone prescriptions are frequently related to the management of the chronic illness. Children with asthma have delayed or missed care more frequently than children without asthma. About 2.9% of children with asthma have a delay in receiving a prescription for this disease.

Disparities in Delayed or Missed Care

Having a usual source of care, having insurance coverage, and the child's race/ethnicity are associated with delayed or missed health care (Exhibit 19). A possible disparity of greater delays and missed care in rural areas where 10.8% of young children have delayed or missed care is not statistically significant. Young children without a usual source of care delay or forego care at about the same rate as children with a usual source (10.5% vs. 7.2% respectively). Receiving care in a physician's office rather than a community clinic is not related to having missed or delayed care.

More children with private insurance (7.3%) than with Medi-Cal (6.5%) or Healthy Families (3%) delay or forego care, though the difference between private insurance and Medi-Cal is not significant. Fewer children with Medi-Cal or Healthy Families than children who are eligible for but not enrolled in these programs experience delayed or missed care. About 13% of uninsured children miss or delay care during the year.

Disparities in access are evident for children of different race/ethnicity. Although Latino children are more likely than Non-Latino White children to be uninsured, about 9.6% of Non-Latino White parents report delayed or missed care compared to 5.5% of Latino children. The fact that delayed or missed care is no more frequent for higher income than for lower income children suggests that while uninsured children are at greater risk for missed care and delays, delays are not always due to coverage issues or financial problems. Inconvenient provider hours and waits for appointments can occur for children in all insurance types and income groups.

25 Centers for Disease Control and Prevention. National Center for Health Statistics and National Immunization Program, 2000 (Table 73); U.S. National Immunization Survey. 1999.

26 National Heart, Lung, and Blood Institute. Guidelines for the Diagnosis and Management of Asthma. NIH Publication No. 97-4051. July, 1997.

EXHIBIT 19 – DELAYED OR FOREGONE CARE ACCORDING TO POVERTY LEVEL, RACE/ETHNICITY, GEOGRAPHIC SETTING, HEALTH INSURANCE COVERAGE, AND CITIZENSHIP, CHILDREN AGE 0-5 YEARS, CALIFORNIA 2001

	ANY DELAYED OR FOREGONE CARE
LESS THAN 100% FPL	7.5%
100-199% FPL	6.5%
200-299% FPL	9.1%
300% FPL AND ABOVE	6.9%
RACE/ETHNICITY	
NON-LATINO WHITE	9.6%
LATINO	5.5%
AFRICAN-AMERICAN	7.8%
ASIAN/PACIFIC ISLANDER	4.3%
AREA OF RESIDENCE	
URBAN	5.9%
SECOND CITY	8.6%
SUBURBAN	7.5%
SMALL TOWN	8.3%
RURAL	10.8%
HEALTH CARE SETTING	
HAVE USUAL SOURCE	7.2%
NO USUAL SOURCE	10.5%
INSURANCE STATUS	
UNINSURED	13.0%
ELIGIBLE FOR MEDI-CAL OR HEALTHY FAMILIES	12.4%
NOT ELIGIBLE	15.2%
MEDI-CAL	6.5%
HEALTHY FAMILIES	3.0%
EMPLOYMENT-BASED	7.3%
CITIZENSHIP STATUS	
CHILD AND BOTH PARENTS U.S. BORN CITIZENS	9.0%
CHILD CITIZEN, PARENT NATURALIZED CITIZEN	5.5%
CHILD CITIZEN, PARENT NONCITIZEN WITH GREEN CARD	4.3%
CHILD CITIZEN, PARENT NONCITIZEN WITHOUT GREEN CARD	7.1%
CHILD IS NONCITIZEN	10.3%

Tests of the association of delayed or missed care with race/ethnicity, health insurance type, and citizenship status are statistically significant ($p<0.05$) (chi square). Tests of the association of delayed or missed care with income, area of residence, and having a usual source of care are not statistically significant.

EXHIBIT 20 – INITIATION AND PERIODICITY OF DENTAL CARE BY AGE OF CHILD, CHILDREN AGE 2-5 YEARS, CALIFORNIA 2001

	EVER VISITED DENTIST	VISIT IN PAST 6 MONTHS	VISIT IN PAST 12 MONTHS
2 YEARS	21.3%	14.2%	20.6%
3-4 YEARS	60.1%	39.6%	55.6%
5 YEARS	85.7%	58.2%	81.0%

Tests of the association of child age with ever visiting a dentist, having a visit in the past 6 months, and having a visit in the past 12 months are statistically significant ($p<0.05$) (chi square).

DENTAL HEALTH

Dental disease is common, preventable, and can have significant impact on children's physical growth and development. In young children, tooth loss caused by dental decay can impair speech development. Nutritional problems can develop when tooth decay impairs a child's ability to eat nutritious foods. Premature loss of primary teeth can prevent permanent teeth from entering normally. Premature loss of teeth can also cause psychological problems when children feel self-conscious about their unusual appearance. The tooth decay that often begins in early childhood is a major cause of missed school days among school-age children. Missing school interferes significantly with learning.

Access to dental care in early childhood can prevent these problems by instilling good dental health behaviors and protecting young children's teeth from dental decay. Dental providers can identify problems before they impair a child's physical or emotional growth. Early treatment of dental decay in young children can prevent a worsening condition.[27] Pediatric dentists now recommend a visit at 12 months of age to assess dental risk and begin preventive home behaviors. The AAP also recommends an initial visit aa early as age 12 months.[28]

The 1993-1994 California Oral Health Needs Assessment (OHNA) showed substantial unmet need for dental treatment among young children enrolled in preschool programs.[29] About 27% of California's preschool children were found to have untreated tooth decay while 9% needed urgent dental care. CHIS 2001 provides the first population-based data on dental care initiation and use for young children in California.

Dental Visits

CHIS 2001 shows that many young children in California are not receiving preventive dental services or treatment. Exhibit 20 shows that children age two are least likely to have seen a dentist with only 21.3% ever having a visit. Initiating dental care is not only a problem for the youngest children. Fewer than two-thirds of preschool age children (3 and 4 years) have ever seen a dentist, and a small but important number of children age five years (14.3%) have never had a dental visit.

Standards for dental care have changed in recent years as new preventive care and treatments became available for young children. Bright Futures guidelines recommend visits every six months in early childhood once children have grown out of infancy. CHIS 2001 shows not only that parents of most of California's young children are not initiating dental care at the recommended age but also that the majority of young children are not receiving visits at the recommended periodicity. Few children age two years (14.2%) have had a recent visit in the past six months. A larger percentage of children age 3-4 years (39.6%) have had a recent visit. This suggests little progress since the 1993-94 OHNA estimated that 44% of children in preschools had been to a dentist.[30] Only half of children age five years, the age group that is preparing to enter school, have had a visit in the past six months. Nationally 36.4% of children age 2-4 years have had a dental visit in the past year, compared to 54.6% age 2-4 in California.[31]

27 Platt LJ and Cabezas MC, *Early Childhood Dental Caries*. In Halfon N, Shulman E, Shannon M and Hochstein M, eds., Building Community Systems for Young Children. UCLA Center for Healthier Children, Families and Communities, 2000.

28 American Academy of Pediatric Dentistry. *Handbook of Pediatric Dentistry*. Chicago, IL: the Academy, 1999.

29 The California Oral Health Needs Assessment of Children, 1993-94, The Dental Health Foundation, San Rafael 1997.

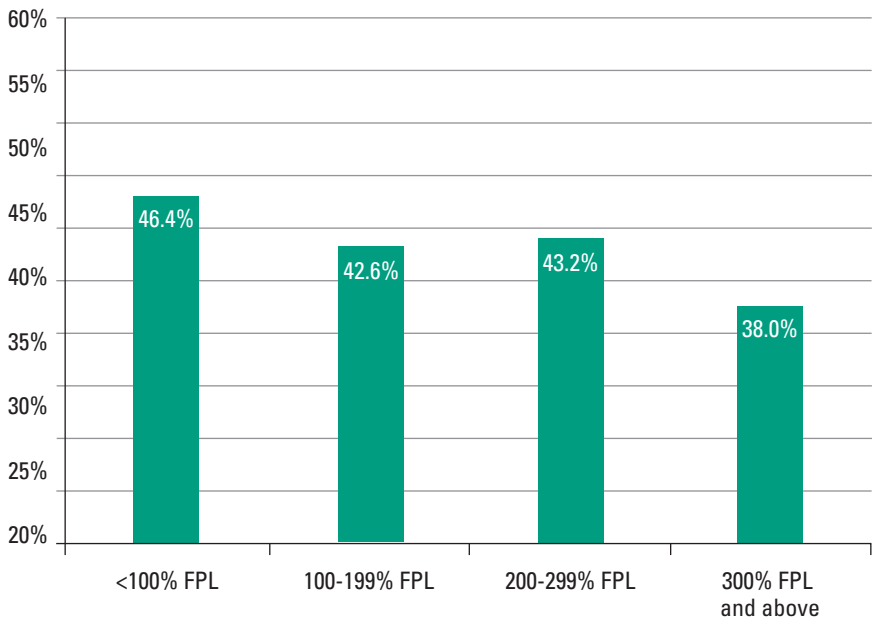
30 The California Oral Health Needs Assessment of Children, 1993-94, The Dental Health Foundation, San Rafael 1997.

31 The Third National Health and Nutrition Examination Survey (NHANES III) 1988-1994, National Center for Health Statistics, Centers for Disease Control.

Ever having a dental visit is associated with household income and with race/ethnicity. Dental care initiation is earlier among higher income children (Exhibit 21). About 46.4% of children in households below the FPL and 38% of children in households above 300% FPL have never had a dental visit. California has slightly better dental access for low-income children than the U.S. overall, although figures are not directly comparable. About 14.2% of children age 0-5 years in the U.S. below 100% FPL have had a preventive visit, while 58.2% of an older group in California (2-5 years) have had any dental visits. Exhibit 22 shows that about half of young Asian/Pacific Islander children (42.6%) and American Indian/Alaska Native children (45.9%) have never had a visit, compared to 39.9% of White and 33.6% of African-American children.

Bright Futures and AAP guidelines also suggest a role for pediatric health care providers, recommending that pediatric providers assess dental risk in young children starting as early as one year of age, and refer children to dental care. This is an important strategy in California since young children receive periodic well-child care from a regular provider. Most young children in California who have never seen a dentist do have a usual source of health care. Only 2.1% are lacking a usual source of care. This outreach should happen in all primary care settings for children, since a similar proportion in the predominant health care settings—about 40% of young children in physician offices and 46.9% in community clinics—have never had a dental visit. This suggests that outreach to parents about starting dental care early is important in private physician offices as well as in community health centers.

EXHIBIT 21 – NEVER HAVING A DENTAL VISIT BY HOUSEHOLD INCOME, CHILDREN AGE 2-5 YEARS, CALIFORNIA 2001



Test of the association of ever visiting a dentist with household income is statistically significant ($p<0.05$) (chi square).

Access to Dental Care: Gaps in Care and Coverage

Oral health in early childhood is essential to overall growth and development. Early child development depends upon good oral health because the infection or pain associated with dental caries and disease can lead to failure to thrive, impaired speech development, absence from preschool (limiting social development), inability to concentrate, and ultimately, reduced self-esteem and other psychosocial problems. Early childhood caries can result in severe oral decay in young children. By conservative estimates, this problem affects more than one out of seven preschoolers and over half of California's elementary school children. The 1993-1994 California Oral Health Needs Assessment found that one-third of children in preschool had at least one dental filling or untreated decay. Children in Head Start had substantially higher rates of dental need than other preschoolers.

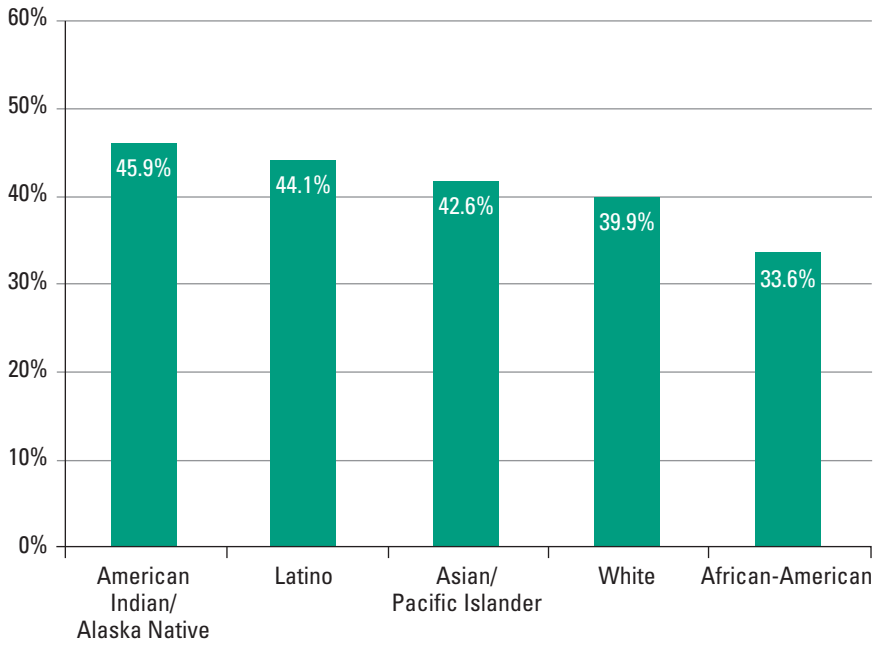
Good oral health in early childhood includes prevention such as parenting routines with no night-time bottles with milk or juice. Environmental factors are also important. Although fluoridated water has been shown to be an effective, population-based strategy to improve oral health, only about one-third of Californians receive fluoridated water. Nutrition in early childhood is also important. Soda intake among young children is a potential culprit in exacerbating risk for dental problems. Soda provides no nutritional value and places children at greater risk for dental decay. CHIS 2001 shows that about one-quarter of young children drink soda daily, and there is a large income disparity in soda consumption. Among children living in households with income below the federal poverty level, about 25% of children age two consume soda, and this rate increases to 33% of children 3-4 years of age and to 46% of children age five. These rates are double the rates of children above 300% FPL.

Access to high quality dental care is a necessary component of overall health care to prevent and treat tooth decay, and maintain good oral health. Yet CHIS 2001 shows that just over half (58%) of all children 2-5 years of age have ever received dental care. Initiation of dental care varies greatly by age even though current recommendations call for an initial visit even for young toddlers. The youngest children (age 2 years) are least likely to have a dental visit in the past six months (the recommended interval), but rates are not much better among preschoolers age 3 to 4 years (40%) or even among children age five years (58%). It is of great concern that 40% of children age 3-4 years and 14% of children age five have never seen a dentist.

As with medical care, the likelihood of having a dental visit varies with family income, race/ethnicity, and insurance coverage. While most young children in California (93%) have health insurance coverage, only 76% have dental insurance. Even Medi-Cal coverage does not guarantee that a child will have dental coverage, with only 80% of young children with Medi-Cal having dental insurance. Yet, the problem of initiating dental care occurs for privately-insured as well as publicly-insured children with only about half in each group initiating dental care before age five years.

A number of strategies will need to be used to improve access to dental care for young children. The shortage of pediatric dentists will need to be addressed statewide. Payment for dental services also is a problem in California. Some dental packages provide very limited benefits, and low payment rates for dental providers has worsened the problem of dental provider availability. Encouraging pediatricians and family physicians to refer children to dental providers could improve parent awareness and initiation of care. Finally, it is important to integrate dental services with existing general health and social welfare services. Since oral health is often the last domain of health to be addressed, coordinating these services with many other early childhood programs, such as public health nursing, WIC, and child care, may be an important mechanism for assuring that dental needs are addressed. In fact, Head Start has a federally-mandated dental component and could serve as a model for strategies attempting to link dental care with other early childhood services.

EXHIBIT 22– NEVER HAVING A DENTAL VISIT BY RACE/ETHNICITY, CHILDREN AGE 2-5 YEARS, CALIFORNIA 2001



Test of the association of ever visiting a dentist with race/ethnicity is statistically significant

Use of Pediatric Dental Care

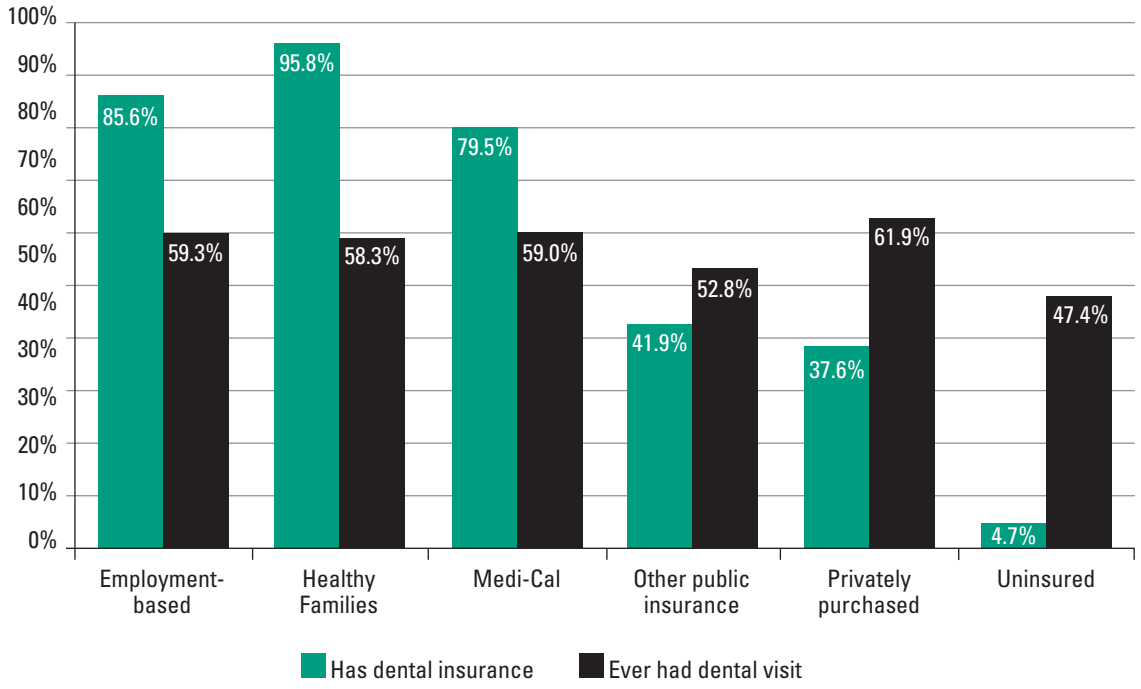
Ideally most young children using dental care would be receiving preventive care rather than treatment for a problem. About half of children (48.2%) receiving dental care received only routine preventive care in their last dental visit. Younger children receiving dental care are more likely to be receiving care for a problem than for prevention. About 16.5% of children age 2, 49.8% of children age 3-4, and 71.9% of children age 5 received early preventive care at their last visit.

Dental Insurance

Having dental insurance should reduce the cost barrier to dental care for children. Earlier estimates for children in preschool suggest that only three quarters have dental insurance. CHIS 2001 confirms that fewer young children in California have dental insurance than health insurance. While 93.2% of young children have health insurance, only 76.4% of children age 2-5 years have some type of dental insurance. In total, 478,000 young children age 2-5 in California have no dental coverage. Clearly lack of dental coverage is not only a problem for medically uninsured children. Little progress has been made since the early 1990s.

The likelihood that a child has dental insurance varies with the type of health insurance they have (Exhibit 23). Most parents of children insured by Healthy Families report that the child has dental coverage (95.8%). Rates of dental insurance are also high, although not universal (85.6%), for children with employment-based insurance. Relatively few children with privately-purchased insurance that is not job-based have dental coverage (37.6%). There is also a gap for children in Medi-Cal. About 79.5% of children with Medi-Cal are reported to have dental insurance. Only 41.9% of children with other public insurance (such as California-Kids or other public programs) are reported to have coverage. Expanding dental coverage to more young children through their health insurance would close some of the financial gap.

EXHIBIT 23 – DENTAL INSURANCE AND DENTAL VISIT INITIATION BY HEALTH INSURANCE TYPE, CHILDREN AGE 1-5 YEARS, CALIFORNIA 2001



Test of the association of health insurance type with having dental insurance is not statistically significant. Test of the association of health insurance type with ever visiting a dentist is statistically significant ($p<0.05$) (chi square).

CHIS 2001 also shows that not all parents may be aware that their child has dental coverage. For example, although all children in Healthy Families have dental coverage as a basic benefit, about 5% of their parents report no dental insurance for the child. This shows that it is important for parents to know what dental services their child is entitled to. Assuring that parents know what dental care costs are covered could reduce the financial barrier to access.

Exhibit 23 shows that initiating dental care is a concern for children, irrespective of their health insurance type. The percentage of children who have initiated dental care varies slightly at 41% of children in Medi-Cal, 41.7% in Healthy Families, 40.7% with employment-based insurance, and 53.6% of uninsured children. This reflects the U.S. pattern where use of preventive dental services for children below 100% FPL is equally low among privately- and publicly-insured children. Parent knowledge about the importance of dental care or willingness to take the child to the dentist—common access problems across insurance types that stem from pediatric dentist shortages, or inadequate benefit packages, or payments to dentists—are creating a problem across many California communities.

Improving access to dental care for medically uninsured children is a bigger problem. Virtually no uninsured children (about 4.7%) have dental insurance. CHIS 2001 shows that free dental programs are not filling the gap for these children. Among the 23.6% of children who do not have dental insurance, very few (8.5%) have used a free community or public dental program. Greater use of the Child Health and Disability Prevention (CHDP) program might improve access for many of these children.

Dental Health Behaviors in the Home

Positive dental health behaviors in the home can prevent dental disease in early childhood and into adulthood. Infants and toddlers are at increased risk if their teeth are

exposed to sugary substances (such as milk, formula, or fruit juice) for long periods of time. Dental problems in very young children are often caused by sleeping with a bottle that has milk or a sugary substance. Up to 14% of Children assessed in preschool had symptoms of "baby bottle tooth decay" in the 1993-94 assessment. Sleeping with a bottle with water is also not recommended due to increased risk of ear infections.

Of the 6.2% of young children who sleep with a bottle, most have milk or a sugary drink in the bottle (91.7%) and very few have water (8.3%). CHIS 2001 shows that about six percent of all young children age 0-5 years are exposed to the inappropriate practice of sleeping with a bottle of milk or a sugary drink such as fruit juice. The percentage of children ever affected by this practice as infants and toddlers may be higher. These young children are at risk for serious dental problems due to inappropriate patterns of sleeping with a bottle. Sleeping with a bottle should be discouraged as part of parent education and anticipatory guidance in pediatric health care visits.

Summary

CHIS 2001 provides the first population-based information for California on use of dental services in early childhood. We now know that many young children have never seen a dentist and are not receiving frequent dental exams. About half (58.2%) of children age 2-5 years have never seen a dentist or other dental provider, and most children age 2-4 years have never seen a dentist, despite prevailing professional guidelines that call for early initiation of dental care. While there are income disparities and a particular gap for uninsured children, initiating dental care and periodicity fall far below professional recommendations and Healthy People 2010 objectives for young children. Given the known prevalence of dental problems, utilization of dental services is much lower than what is needed to promote good dental health.

Improving the dental health of California's young children will require a broad range of interventions, including better home health and preventive measures, greater availability of affordable dental insurance, more information and education about how to receive dental coverage, and how to access available services. Because most young children have a usual source of medical care, and see a doctor regularly, greater outreach to parents by pediatric providers—including community health centers and clinics—might improve the use of dental care significantly. Improving access to dental care for children will also require that policy makers confront the shortage of pediatric dental providers who are able and willing to take on low income patients. Low payment rates for dental care and the financial incentives of managed dental health plans also likely impair young children's access to dental care.