The Invisible Children:

Areas for Improvement in the U.S. Child Healthcare System

Zuang Liu

Boston University, School of Education

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Professor Johana Chaparro-Moreno

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“In early June, Jennifer Barrios took her 4-year-old daughter to the dentist for a routine check-up. She was stunned when office staff told her that she would have to pay for the exam herself — her youngest child was no longer covered by Medicaid. That was the first time Barrios learned her family, which lives in Donna, Texas, was among the estimated 6.4 million people disenrolled from Medicaid nationwide since April, including more than 1.2 million children.” (Santhanam, 2023). Try to imagine being one of them who cannot get basic health support.

The presence of insurance is deemed imperative, serving not only as a mechanism providing substantial financial compensation to users under specific circumstances but also as a source of assurance, relieving users from fear and uncertainties in their daily lives. Nevertheless, in contrast to most nations where governments ensure healthcare coverage for all citizens, the United States stands as an exceptional case, being the sole high-income country devoid of any form of universal healthcare insurance (Gunja et al., 2023). Since 1980, healthcare expenditures have demonstrated a global upward trajectory in various countries, with a more pronounced escalation in recent years, particularly due to the impact of the ongoing pandemic. Notably, “In 2021, the U.S. spent 17.8 percent of gross domestic product (GDP) on health care, nearly twice as much as the average OECD country.” (Gunja et al., 2023). The absence of such healthcare insurance has resulted in American citizens having to spend significantly more in healthcare expenses when compared to analogous countries, with nearly two times of healthcare expenditures comparing to Germany and four times comparing to South Korea, which are countries that are most comparable (Gunja et al., 2023).

Ironically, despite the enormous healthcare spending by American citizens, the effectiveness, as measured by the health outcomes of the population, remains far from satisfactory. Whether considering obesity rates, suicide rates, maternal and infant mortality rate, or treatable disease mortality rate, the outcomes are consistently among the least favorable. This underscores a severe inadequacy in the U.S. healthcare system and highlights the urgent need for reform, both in the interest of the nation and its citizens' future well-being.

Each generation of children represents the future backbone of society; therefore, in the pursuit of fostering the physical and mental well-being of future citizens, improving the present child healthcare system stands as the initial pivotal step for change. The purpose of this document is to justify that, to ensure a worth expecting future, children's health care system must not only improve accessibility and affordability, but also reduce disparities in health care, focus on mental health, to improve children's health insurance system.

U.S. Children Healthcare Accessibility and Affordability

Let us first journey back to an earlier era when the establishment of the healthcare insurance system faced substantial obstruction. In 1916, Congress conducted its first hearings concerning government healthcare insurance as part of the deliberations on Social Security programs. Subsequently, in 1939, Senator Robert Wagner convened hearings to propose national health legislation; however, this initiative was delayed due to the outbreak of World War II. It was not until November 1945 that President Harry Truman submitted the first comprehensive federal healthcare insurance proposal to Congress, yet it saw no progress. A turning point came in 1961 when President John F. Kennedy recognized the significance of

healthcare insurance and prioritized its discussion. To this end, he enlisted the services of Clinton Anderson, who later makes significant contributions to the establishment of the healthcare insurance system and who, notably, suffered by chronic illness himself. In 1962, the bill was rejected during its first appearance in Congress. Lyndon Johnson's impressive performance during his 1964 presidential campaign attract support for healthcare insurance in both houses of Congress, providing Anderson with renewed hope. Through close collaboration with House members, the "three-layer cake" insurance coverage proposal, which covers “hospital insurance for the aged, physicians’ insurance for the elderly, and expanded federal assistance to supplement state medical payments for the poor” (United States Senate, 2023) was ultimately ratified on July 28, 1965, marking a historic milestone in the establishment of the healthcare insurance system. In the initial legislation of the Medicaid, the part that relates to children is that, within families receiving welfare benefits, children were eligible to receive healthcare insurance.

Following the enactment of Medicaid, the U.S. Congress, in response to evolving socioeconomic dynamics, implemented a series of refinements to the healthcare system. These refinements included steadily raising income eligibility thresholds for Medicaid, ensuring coverage under Medicaid for all children below the Federal Poverty Level (FPL). The introduction of the State Children's Health Insurance Program (SCHIP) expanded insurance coverage to a subset of low-income children above the FPL. Subsequently, the program was reorganized into the Children's Health Insurance Program (CHIP). Furthermore, the enactment of the Affordable Care Act (ACA) represented a landmark legislative milestone

that brought about a second significant wave of transformative changes to the healthcare landscape.

Undoubtedly, as a result of this series of reforms, there has been a significant decrease in the rate of uninsured children, with a remarkable decline exceeding 67% (Sobel et al., 2016). However, despite these advancements, approximately 4.5% of children remain without coverage within the healthcare system, which translates to roughly 3.3 million children (Sobel et al., 2016). What is even more concerning is that various statistics regarding the uninsured rate for children traditionally categorize a child's insurance status as either "insured" or "uninsured" without accounting for instances of insurance status inconsistency within a given year. This oversight results in a considerably higher number of children who are, in practice, left without insurance compared to the reported figures, a discrepancy of nearly several million (Sobel et al., 2016).

U.S. Children Health Care Disparities

In the early years of human life, children progressively undergo the development of cognitive abilities, motor skills, and social competence, which constitute fundamental survival skills with future significance. The acquisition of these skills is contingent upon the experiential impact of childhood on the evolving brain. Unfortunately, not all children have the opportunity for healthy development, and the determinants of these disparities may encompass factors such as family income, community environment, physical health, and parental attitudes, race, among others.

When considering the underlying factors contributing to healthcare disparities, it is imperative to engage in a comprehensive analysis across various dimensions, as these disparities are rooted in societal inequities. Consequently, a disconcerting reality emerges: the propensity to experience healthcare disparities is, to a considerable extent, preordained. For instance, let us posit the scenario of two expectant mothers, one hailing from a high-income family in a clean and secure community, and the other from a low-income family in a deprived and hazardous neighborhood. When these mothers give birth, the child born to the latter is significantly more likely to experience a higher risk of mortality in comparison to the former. Yet, this contrast merely scratches the surface, as it neglects to account for the myriad determinants that underlie the conditions of the respective communities, as well as the differential psychological and physical impacts these circumstances impose on these mothers. From this hypothetical illustration, we discern that, in the scrutiny of healthcare disparities, a holistic perspective is imperative, necessitating a multifaceted approach to recognize and rectify these issues. However, a number of pivotal factors include, but are not limited to, the following:

Racial disparities represent a significant determinant in the genesis of healthcare differentials. Research has demonstrated that, when assessing factors such as obesity rates, overall health status, and rates of insurance coverage, children from non-English-speaking households are more predisposed to experience socioeconomic disadvantage when compared to their counterparts hailing from English-speaking households (Flores & Tomany-Korman, 2008) Another crucial factor to consider is geographical location. Research has indicated that there are significant disparities in the fulfillment of healthcare needs among different states,

with variations far exceeding the national average. This is particularly pronounced in the realm of mental healthcare, with disparities even reaching twofold (5% in California and Texas, compared to 10% in Colorado and Massachusetts). The geographical disparities often surpass those resulting from racial differences, underscoring their substantial impact on healthcare access and outcomes (Sturm et al., 2003).

U.S. Children Mental Health

Mental health constitutes a vital component of a child's overall well-being, exerting a profound influence not only on a child's cognition, emotions, and behaviors but also in assisting them to cope with the cumulative stresses of life, such as social and academic pressures. It is essential to note that childhood mental disorders are not isolated events (Ghandour et al., 2019); they can co-occur, necessitating heightened parental awareness of their children's mental states. The prevalence of children who have experienced some degree of mental disorders in reality may be more extensive than commonly perceived. Among the 3–17-year-old children and adolescents in the United States, the most common mental health conditions include anxiety, attention-deficit/hyperactivity disorder (ADHD), each affecting approximately 10% of children. In the adolescent population aged 12-17, one-fifth has experienced severe depressive episodes, while over one-third have seriously contemplated suicide. Nevertheless, a mere 7% of children and adolescents aged 3-17 have received psychological therapy, a notably less optimistic statistic (Bitsko et al., 2022).

A multitude of factors contribute to children's mental health issues. Firstly, it is observed that children from low-income households are more likely to be diagnosed with Mental,

Behavioral, or Developmental Disorders (MBDD) compared to those from higher-income families. Children living below 200% of the Federal Poverty Level (FPL) have a nearly one-in-five chance of having an MBDD (Cree et al., 2018). Furthermore, adverse childhood experiences significantly impact children's mental health. It is imperative to recognize the risk factors in children's environments, categorizing them as personal and familial risks as well as community-level risks. Personal and familial risk factors may encompass low family income, low parental education levels, limited or no social activities, the use of corporal punishment, and frequent domestic violence, among others. Community risk factors may include high crime rates, elevated poverty levels, high unemployment rates, easy access to drugs or alcohol, and a high rate of neighbor turnover. Hence, an emphasis should be placed on identifying and nurturing protective factors. Personal and familial protective factors may include strong school performance, conflict resolution skills, close family relationships, and a healthy social network. Community protective factors may comprise economic assistance, mutual support among neighbors, and a commitment to child development. In addition, geographical location can serve as an impediment to children accessing mental health care. Living in rural areas often entails economic challenges, manifesting in difficulties in meeting basic needs such as food and housing (Robinson et al., 2017). Additionally, rural communities typically lack public amenities like parks, recreational centers, and libraries, resulting in adverse childhood environments.

According to the HealthCare.gov website, all insurance plans available in the market are mandated to include coverage for mental and behavioral health services, encompassing services such as psychological counseling, inpatient care, medication therapy, and more.

Nevertheless, despite this regulatory requirement, one in five children in need of psychological counseling services, approximately 20%, does not receive them (DeRigne et al., 2008). Furthermore, children utilizing public health insurance are more likely to go without psychological counseling compared to their peers with private insurance (DeRigne et al., 2008). This suggests that the scope of coverage for children's mental health insurance needs to be further expanded to assist families caught in a cycle of long-term poverty.

Conclusion:

In this document, we have examined areas where improvements can be made in the context of child healthcare system in the United States, focusing on three main dimensions: accessibility/affordability, healthcare disparities, and mental health. Irrespective of the dimension under analysis, it is evident that there is significant room for improvement in the realm of child healthcare system in the United States. Both the government and the general public bear a moral and societal responsibility to actively work towards a healthier future for children. It is worth noting that the three dimensions discussed herein represent only a fraction of the broader spectrum of issues that await exploration and reform.

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