CONNECTICUT VOICES FOR CHILDREN

Child Health and Health Care Disparities in HUSKY A in 2003

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This report is the third annual summary of health and health care disparities in HUSKY A (Medicaid managed care), issued by the Children's Health Council in 2002 and 2003 and by Connecticut Voices for Children in 2005.[1]

Methods

Using HUSKY A enrollment and encounter data for calendar year 2003, health status (diagnosed asthma) and utilization rates for selected types of health care were determined for continuously enrolled White, Black/African American, and Hispanic/Latino children. The odds of having asthma or having had selected types of care by race/ethnicity were determined for African American children and Hispanic children, compared with White children, after adjusting for other sociodemographic and enrollment factors that may have affected access to care and utilization (age, gender, residence, primary language, and health plan).

Results

Utilization rates that were previously reported are shown in Table 1.[2] After adjusting for other sociodemographic and enrollment factors that may have affected access to care or utilization, health and health care disparities were evident (Table 2):

- **Preventive care**: African American children were significantly less likely than White children to have had well-child care, other ambulatory care and preventive dental care. Hispanic children were significantly more likely than White children to have had preventive dental care.

- **Emergency care and hospitalization**: Hispanic children were significantly more likely than White children to have had any emergency care or to have been hospitalized in 2003.

- **Asthma and asthma care**: African American and Hispanic children were significantly more likely than White children to have had care with an asthma diagnosis. They were also more likely to have had emergency care, but no more likely to have been hospitalized for treatment of asthma.

Table 1. Health and Health Care Utilization: 2003

	African American	Hispanic	White
Had well-child care	49%	52%	52%
No ambulatory care	20%	15%	14%
Had preventive dental care	38%	43%	39%
Had any emergency care	30%	40%	30%
Was ever hospitalized	4%	5%	3%
Had asthma	9%	11%	8%
ER visit for asthma	26%	26%	19%
Hospitalized for asthma	5%	4%	4%

Conclusion

Race and ethnicity affect access to health care, utilization of health services, and health outcomes for children in the United States.[3] In the general population, disparities are attributable at least in part to differences in income and insurance coverage.

These finding show that health and health care disparities are also evident and persistent among the low income children who have coverage in Connecticut's HUSKY A program. Use of

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emergency care for asthma suggests disproportionate problems with access to primary and specialty care. Although some of the differences are relatively small, the disparities build upon earlier evidence that African American children generally fare worse in HUSKY A, while results for Hispanic children are mixed. For all children, and especially African American children, utilization of preventive services falls short of federal goals and professional recommendations for children's health care.

Table 2. Health and Health Care Disparities in HUSKY A: 2003

	Black/African American Children		Hispanic/Latino Children	
Type of Care or Condition	**Odds ratio[a] (95% CI)**	**Compared with White children…**	**Odds ratio[a] (95% CI)**	**Compared with White children…**
Well-child care	0.92 (0.89, 0.95)***	***WORSE***	1.05 (1.02, 1.08)	**SAME**
No ambulatory care	1.59 (1.53, 1.65)***	***WORSE***	1.04 (1.00, 1.09)	**SAME**
Preventive dental care	0.93 (0.90, 0.95)***	***WORSE***	1.12 (1.09, 1.15)***	**BETTER**
Had any emergency care	1.01 (0.98, 1.04)	**SAME**	1.47 (1.43, 1.51)***	***WORSE***
Was ever hospitalized	0.97 (0.91, 1.05)	**SAME**	1.25 (1.17, 1.33)***	***WORSE***
Had asthma	1.12 (1.07, 1.18)***	***WORSE***	1.52 (1.45, 1.59)***	***WORSE***
Had ER care for asthma	1.36 (1.21, 1.52)***	***WORSE***	1.31 (1.18, 1.45)***	***WORSE***
Hospitalized for asthma	1.19 (0.95, 1.49)	**SAME**	0.93 (0.74, 1.15)	**SAME**

[a] Odds or likelihood of having had a condition or care (with 95% confidence interval), adjusted for age, gender, urban residence, primary language and health plan. If the odds of Hispanic child having had asthma equals 1.52, that means that after taking into account age and other factors, Hispanic children are 1½ times, or about 50% more likely, to have had asthma than White children. If the confidence interval includes 1.00, then the likelihood is no greater or less compared with White children. Differences that are statistically significant at p<.001 are indicated (***) and characterized as "better" or "worse."

[1] Connecticut Voices for Children is a non-profit organization that conducts research and policy analysis on children's issues. This report on disparities in HUSKY A was prepared under a contract between the Connecticut Department of Social Services and the Hartford Foundation for Public Giving, with a grant to Connecticut Voices from the Hartford Foundation. Performance monitoring in HUSKY A builds on work begun by the Children's Health Council which was created by the Connecticut General Assembly in 1995 and charged with evaluating the impact of Medicaid managed care on children's health services. Connecticut Voices for Children contracts with MAXIMUS, Inc. for data management and data analysis. This report was prepared by Mary Alice Lee, Ph.D., Senior Policy Fellow. This report is also available at www.ctkidslink.org.

[2] Reports showing methods and unadjusted racial/ethnic-specific rates for ambulatory care, dental care, emergency care, hospitalization, and asthma in 2003 are available at www.ctkidslink.org.

[3] Dey AN, Schiller JS, Tai DA. Summary health statistics for US children: National Health Interview Survey, 2002. Vital and Health Statistics, 2004; 10(221): 1-78. Simpson L et al. Health care for children and youth in the United States: Annual report on patterns of coverage, utilization, quality, and expenditures by income. Ambulatory Pediatrics, 2005; 5(1): 6-44.