Family & Health Policy Research Briefs

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FMSC 750 – Family & Health Policy
Department of Family Science
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Introduction

This compilation of policy/research briefs is part of a requirement for a graduate level course in family and health policy that is offered in the Department of Family Science at the University of Maryland. Each of the individuals who prepared a brief is enrolled as a graduate student in the department. The goal of the project was to enable each of these students to learn how to write a policy/research brief and to practice their work. The topics were selected by each student based on his or her interests. We attempted to follow a similar format for each brief. Some of the briefs are based on federal policy areas and other briefs focus more directly on policy in the state of Maryland. It should also be noted that there may be a slight difference between the briefs regarding how the content is presented. For example, some of the briefs focus on a specific piece of legislation and discuss that legislative area and future policy work (see Kondracki, Mountain, Ramsey, Vafai), other briefs identify an emerging area of policy and present future emphasis for the development of policy (see Cassar-Uhl, Fahey, Messman, Quinn, Street, Young), and last some cover a policy area more generally and may refer to several pieces of legislation that relate to the policy topic (see Blick, Pakstis, Schroeder).

The students have attempted to be accurate in the accounting of the data and facts presented and have provided references utilized in the compilation of this information. The suggestions for future policy work have been developed by the individual students, based upon their understanding of the topic. We hope that you enjoy learning more about each of these timely policy areas as much as the students enjoyed preparing the briefs.

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Importance of Child Support
For children who live with only one biological parent, the receipt of child support payments is linked with better physical, social, and academic outcomes. Further, to the child, the receipt of child support symbolically represents the nonresident parent's concern, providing additional psychological benefits beyond the child's economic well-being (Argys et al. 1998).

Importance of Visitation
Interaction between nonresident fathers and their children has been linked with fewer behavioral and emotional problems in the children, as well as improved academic achievement (Stewart, 2003).

What's Wrong with the Current System?
Of the more than 21 million children currently living with only one of their biological parents, less than 50% of receive formal child support payments. Studies indicate that low-income, non-resident fathers often are not financially capable of meeting the formal child support payment requirements. However, these fathers might be making significant contributions to their child's well-being through in-kind payments, such as gifts, clothes, and toys, that aren't recognized by the current child-support policies. These in-kind contributions have also been linked with a higher likelihood of visitation between the father and the child, but the current policies have no measures for encouraging or rewarding the nonresident fathers for these informal contributions.

Child Support Practices Across the United States
Using data from a longitudinal study of individuals and families in the United States, an analysis of child support practices across the U.S. found the following:

• Low-income, non-resident fathers were less likely to make child-support payments than their higher-income counterparts. However, in low-income families, fathers who did not pay formal child support were just as likely to provide in-kind contributions as fathers who did pay child support.

• 96.5% of children who received in-kind support also had visitation with their fathers vs 36.5% of children who did not receive in-kind support.

• The payment of formal child support was only weakly related to the nonresident father's visitation with the child, especially among low-income families. More powerfully related to father's visitation were factors such as the child's age, the child's overall health, and the father's marital status.

• The father was less likely to provide in-kind support or engage in visitation with the child if the child’s mother reported not knowing a characteristic about the child’s father.
Recommendations for Policy-makers

To increase the potential for nonresidential fathers to actively, successfully contribute to the well-being of their children, policy-makers might consider the following:

- Broaden the definition of child support to include in-kind contributions.

- Identify the ways in which circumstances and barriers to paying child support (e.g., travel distance, parent age, parent marital status, child’s health) differentially impact high- and low-income fathers.

- Further study how relational characteristics between the child’s biological father and mother impact the father's contributions to the child's well-being through child support, in-kind support, and visitation.

References/Resources:

Licensure of International Board Certified Lactation Consultants (IBCLCs)

What is an IBCLC?

Breastfeeding, and improving the proportion of babies that are breastfed, is a pressing public health issue in the United States. In its policy statement *Breastfeeding and the Use of Human Milk*, the American Academy of Pediatrics (2012) states, “Given the documented short- and long-term medical and neurodevelopmental advantages of breastfeeding, infant nutrition should be considered a public health issue and not only a lifestyle choice.”

An International Board Certified Lactation Consultant (IBCLC) is a healthcare professional specializing in the clinical management of breastfeeding. An IBCLC is certified by the International Board of Lactation Consultant Examiners®, Inc. under the direction of the U.S. National Commission for Certifying Agencies. She* provides care in hospitals, pediatric offices, public health clinics, and in private practice (International Lactation Consultant Association, 2014).

IBCLC candidates are eligible to sit for the certifying exam upon receipt of specific college-level instruction in the health sciences; at least 90 hours of lactation-specific education within 5 years before applying to take the exam, and between 300 and 1000 hours (dependent upon the professional background of the candidate) of supervised clinical practice in support of breastfeeding mothers and babies (International Board of Lactation Consultant Examiners, 2014).

Licensure of IBCLCs would not restrict the ability of other community members to provide breastfeeding support; however, currently, anyone can call herself a “lactation consultant,” regardless of her level of education or skill, and consumers have no concrete means for distinguishing which practitioners may provide basic lactation support and which have the education and qualification to provide advanced support in collaboration with the healthcare team.

Why license the IBCLC?

Individual states license certain care providers in the interest of ensuring quality of service and safety of the public that are served by those providers. Licensure is also the basis for reimbursement with public health care funds; private insurers typically model their reimbursement structures to be similar to Medicaid.

Licensure of IBCLCs would demonstrate recognition that those who have met the requirements for certification are able to provide the highest quality of skilled clinical lactation support, and are valued members of the healthcare team.

Why is the IBCLC a necessary member of the healthcare team?

Many of the obstacles mothers experience to successful breastfeeding are cultural/social, rather than of a clinical nature. Some reasons mothers cite for prematurely weaning their babies include a belief that breastfeeding is inconvenient, a desire to leave the baby with another caregiver, concerns about milk supply, and worries about breastfeeding in public (Li, Fein, Chen, & Grummer-Strawn, 2008).

While an IBCLC can provide support under these circumstances, especially with helping a mother distinguish between perceived milk insufficiency and a true low milk supply, these reasons can also be addressed, perhaps more effectively, by knowledgeable family, friends, or peers. However, other reasons mothers cite for stopping breastfeeding earlier than they had intended are of a clinical nature, pertaining directly to breastfeeding mechanics and lactation physiology.

An IBCLC is the specialized healthcare professional who can recognize physiological barriers to successful breastfeeding and, when necessary, refer to the appropriate partners on the healthcare team for management or resolution. When this specialized care is not readily available to a mother, she may be less likely to continue breastfeeding.

* Of over 26,500 IBCLCs worldwide, fewer than 1% are male.
Improving access to lactation care

One major aim of licensure of IBCLCs is to improve access to the care they provide, especially among low-income families. While Medicaid, which funds healthcare for low-income families in all U.S. states, allows authorized providers to bill and be reimbursed for one-on-one lactation evaluation and consultation for new mothers (Centers for Medicare and Medicaid Services, 2012), in no state is the “standalone” IBCLC, without another credential that permits her to provide healthcare services under a state license (such as physicians, midwives, or nurse practitioners) able to bill Medicaid for her services. There are select private insurance plans that will reimburse IBCLCs, but because Medicaid does not, most insurers also do not.

Some argue against licensure of IBCLCs and purport that a credential obtained by successful completion of a week-long course in basic lactation management (including an exam administered during the counted “instructional hours”), represents equivalent or superior qualification to provide specialized lactation care. Other, similar certifying programs do not assert that their credentials are adequate for independent practice; rather, they offer substantial stepping stones toward the required lactation-specific education for IBCLC candidacy, or foundational knowledge bases in breastfeeding for other perinatal healthcare personnel, such as doulas or public health nurses.

Policy Recommendations

1. Research demonstrating the necessity of the IBCLC over other providers of lactation care, in a variety of settings.
2. Research demonstrating a positive correlation between receipt of lactation care from an IBCLC and improved breastfeeding outcomes.
3. Comparative studies that illustrate the benefit of licensure to the public in similar allied health professions.
4. Specific definition of the necessary qualifications for licensure.

References:


A Need to Innovate in Approach to Prenatal Care Services

Despite efforts that have succeeded in increasing access to prenatal care, rates of low birth weight and preterm labor have not decreased significantly. In certain segments of our population, the rates of these complications has actually increased. Additionally, there continues to be a wide racial gap in birth outcomes in Maryland. Black mothers have nearly twice the risk of having a preterm birth than do White mothers. The March of Dimes recently gave Maryland a grade of "C" on its premature birth report card.

Limitations to Traditional Prenatal Care

Quality of prenatal care has been measured by number of visits rather than the content of care, so there has been little critical examination of what is happening during prenatal visits and its impact on outcomes.

Economic pressures related to decreased reimbursements and increased costs of practice has led providers to see more clients during each clinical session which means shorter visits. This limits opportunities for the educational component of prenatal care.

A Call for Change

The Public Health Service (PHS) Expert Panel on the Content of Prenatal Care recommends that prenatal care should address not only traditional medical concerns, but that there should be a new emphasis on the psychosocial dimensions of care.

Late Preterm Birth by Race

Alternative Models of Care

Midwifery-led care and group prenatal care are two alternative models of care that emphasize on the psychosocial dimension of pregnancy and have demonstrated the potential to improve birth outcomes.

Group Prenatal Care

"The group model of prenatal care is the most ambitious and revolutionary approach to prenatal care in the last century." In the Centering Pregnancy model of group prenatal care, women are seen by their provider in groups of 8-12 pregnant women who are due at about the same time.

Instead of a 15-20 minute visit, the women spend two hours with their provider getting not only their medical needs addressed, but also addressing their educational and social support needs.

The Centering model of group prenatal care has demonstrated a 33% decrease in rate of preterm birth - a leading cause of infant mortality and illness.

Additional Advantages of Group Model:

* Increased time with healthcare provider
* Increased focus on educational components
* Opportunity to learn from other pregnant women and build a network of support
Midwifery-Led Care

Midwifery-led prenatal care of low risk women is associated with:

* Equal or improved outcomes for women and their infants both in hospitals and birth centers when compared to physician-led care of women of equal risk.

* Lower costs to the healthcare system due to decreased rates of unnecessary medical interventions and increased rates of breastfeeding.

* High rates of patient satisfaction with care.

"Midwives offer evidence-based healthcare services. In today's world of high technology, midwifery services provide the individualized care women need." - Doug Luabe, MD, Former President, American College of Obstetricians and Gynecologists.

Increased Access to Maternity and Primary Care Services

The National Institutes of Medicine (IOM), has recommended that access to nurse-midwives be increased so that they can take on larger responsibility for primary care services for women.

Policy Recommendations

Improve Access

- Ensure equitable reimbursement for prenatal care provided in midwifery-led and group models of care.

- Institute legislation that allows certified nurse-midwives (CNMs) to be admitting providers of record for their patients in all Maryland hospitals.

- Require that insurance companies cover midwifery services in all settings at the same rates as for the same services provided by obstetricians.

Broaden Provider Network

- Support legislation and funding for the opening or expansion of accredited midwifery educational programs.

- Provide scholarships or tuition breaks for students choosing midwifery -especially underrepresented minorities.

- Promote collaborative practices that include physicians and midwives working together.

Consumer Education

- Increase patient awareness of the availability of midwifery-led prenatal care and group prenatal care through their insurance companies.

- Support a public awareness campaign that presents the evidence that midwifery-led and group models of care produce improved health outcomes.

References/Resources:


State of Maryland Diabetes Epidemic:

Implications for Policy and Prevention Programs in Local Communities

Diabetes as a health problem:

Regardless, whether a person has been diagnosed with type 1 and type 2, gestational diabetes, prediabetes or just has a borderline high blood sugar, it is serious health problem. Diabetes affects people of all ages, races and ethnic backgrounds, and may appear early in overweight children and adolescents. (1) Diabetes rates, especially in minority populations, have reached epidemic proportions nationally and globally. (2)

29 million people in the US age 20 or older have diabetes, 86 million have prediabetes, and 8.1 million people (27.8%) are not yet diagnosed. (2)

If these tendencies continue, 1 of 3 American adults could have diabetes in 2050, and one in every three children will develop diabetes during a lifetime. (2)

Barriers to diabetes prevention and control in Maryland:

- Lack of general awareness of seriousness of diabetes and its complications
- Limited health literacy and poor understanding of concept of prevention, self-care and chronic-disease management (3)
- Growing young minority population with high risk for developing diabetes (4)
- Inadequate surveillance, screening for risk factor detection, lifestyle and self-management support among health professionals and public health clinics (5)

Prevalence of diabetes in Maryland:

- Prevalence of diabetes in adults (8.7% in 2008) is above the national level
- 21.2 per 100,000 persons with diabetes died from heart disease, and 3.3 per 100,000 had a stroke
- In 2010, there were 10,620 emergency department visits for diagnosis related to diabetes
- Among white Marylanders prevalence was 7.5% and 12.3% among black Marylanders. (4)

Many risk factors for developing diabetes are modifiable. In Maryland:

- 36.0% of population is overweight, and 25.2% are obese
- 11% high school students are obese (≥95th percentile for BMI)
- 71.8% of people have low consumption of fruits and vegetables
- 35.1% have high cholesterol
- 27.9% have high blood pressure
- 22.9% are physically inactive
- 19.4% are current smokers (56.8% are former smokers). (4)
Maryland economic burden projections for 2015:

**Total annual cost (2010 dollars)** $7.5 Billion

- Seniors $2.2 Billion
- African-Americans $2.8 Billion
- Hispanics $581 Million
- Asian-Americans $349 Million
- Native Americans $28 Million

**Total Medical costs** $5.3 Billion

- Seniors $1.5 Billion
- African-Americans $1.9 Billion
- Hispanics $408 Million
- Asian-Americans $247 Million
- Native Americans $19 Million

Source: Institute for alternative futures and MD BRFSS

**Policy recommendations for community-based strategies:**

1. **Continue to raise awareness** in schools and workplaces, disseminate information on local media about available community services
2. **Enhance diabetes surveillance** in the county and local diabetes training programs to identify people at risk
3. **Increase efforts** targeting higher risk **minority populations** (Blacks, Hispanics, American Indians, Alaskan Natives, Asians and Pacific Islanders), improving health literacy, through culturally sensitive education and support
4. **Build community partnerships** linking health providers, local health departments and schools to educate children and adolescents

**References/Resources:**


This policy brief created by: Anthony J. Kondracki, MCH doctoral student, Department of Family Science, University of Maryland, School of Public Health

Reviewed by: Elaine Anderson, PhD, Instructor for FMSC 750 Family and Health Policy
The State of Transgender Health Care: Implications for Policy

Overview of Transgender Health Care
A transgender person is one who identifies with or expresses a gender identity that differs from the person's sex assigned at birth. Current estimates have suggested that 0.3% of US adults, or 1 million people, identify as transgender. Health care for this population has been and continues to be overlooked by academic, governmental, and health care establishments. Transgender people have a unique set of mental and physical health needs with limited access to routine, preventative, and life-saving surgical procedures.

Barriers in Health Care for Transgender People
- Lack of insurance
- Exclusionary language in health insurance policies, specifically limiting or barring transgender-related medical procedures
- Denial of, and limited access to, welcoming and competent medical care
- Lack of research regarding transgender specific health care needs and issues
- Absence of transgender health issues from most medical school criteria
- Lack of enforcement of non-discrimination clauses

Health Disparities Among Transgender People
- Lifetime suicide risk 41%; compared to 1.6% in general population
- Increased use of drugs, alcohol, and smoking in order to cope with life and social stigma stressors
- Increased rates of homelessness, some due to refusal of home or eviction directly related to gender identity/expression

In a survey of 6,456 transgender adults in the US...
- 24% denied equal treatment in a doctor’s office or hospital

  "Denial of health care by doctors is the most pressing problem for me. I have been denied care by doctors and major hospitals so much that I now use only urgent care physician assistants, and I never reveal my gender history."

- 16% denied equal treatment in an emergency room

  “I have been refused emergency room treatment even when delivered to the hospital by ambulance with numerous broken bones and wounds.”

- 28% postponed or avoided medical treatment when they were sick or injured and 33% delayed or did not try to get preventive health care, due to discrimination and disrespect

  “I have been living with excruciating pain in my ovaries because I can’t find a doctor who will examine my reproductive organs.” (from a transgender man)

  “I was forced to have a pelvic exam by a doctor when I went in for a sore throat. The doctor invited others to look at me while he examined me and talked to them about my genitals.”

- Study participants were less likely than the general population to have health insurance, more likely to be covered by public programs such as Medicare or Medicaid (which specifically exclude transgender-related services), and less likely to be insured by an employer.

  "My choices for health coverage at my employer all exclude any treatment for transgender issues, even though they cover things like hormones for other people."

  “I cannot afford gender reassignment surgery which is crucial to my mental well-being and thoughts of suicide are always present.”
Fears and Concerns about Accessing Health Care

Percent of Adults Avoiding or Delaying Medical Care

- Heterosexual Adults: 17%
- LGB Adults: 29%
- Transgender Adults: 48%

Anticipated vs. Actual Experiences in Health Care

- I will be refused medical care because I am...:
  - Heterosexual: 9.1%
  - LGB: 20.0%
  - Transgender: 51.9%
- Medical personnel will treat me differently because I am...:
  - Heterosexual: 28.5%
  - LGB: 35.5%
  - Transgender: 73.0%
- Not enough health professionals adequately trained to care for people who are...:
  - Heterosexual: 49.0%
  - LGB: 48.0%
  - Transgender: 89.4%
- Not enough support groups for people who are...:
  - Heterosexual: 24.3%
  - LGB: 31.0%
  - Transgender: 50.5%
- Not enough substance abuse treatment for people who are...:
  - Heterosexual: 28.8%
  - LGB: 31.1%
  - Transgender: 58.8%
- Community fear/dislike of people who are... a problem:
  - Heterosexual: 52.4%
  - LGB: 66.1%
  - Transgender: 85.7%

Policy Recommendations:

Education & Training

- Transgender health basics addressed in medical, physician assistant, and nursing schools on a national scale
- Transgender-specific care incorporated into medical, nursing, and paramedical curricula
- Strengthen and create dedicated centers for research and dissemination of best practices
- Clear guidelines for all federally funded health centers adopted by medical societies – related to appropriate language, adoption of gender-neutral bathrooms, and other safe environment measures
- Federal grants offered for programs teaching postgraduate-level care of transgender patients, including sexual confirmation surgery

Inclusive Health Care Policy

- All government funded programs include coverage of transition care to ensure safe, appropriate and sensitive care
- Continued monitoring and enforcement of the inclusion of gender identity in the ACA nondiscrimination clause
- Incorporate questions regarding gender identity into health surveys

References


1When Health Care Isn’t Caring: Lambda Legal’s Survey of Discrimination Against LGBT People and People with HIV (New York: Lambda Legal, 2010).


This policy brief created by: Jenna Beckwith Messman, Doctoral Student in Family Science
Reviewed by: Elaine Anderson, PhD, Instructor for FMSC 750 - Family and Health Policy
Importance of Leave

Each country differs when we look at Employee Leave policies. The United States is ranked one of the lowest compared to other countries when we examine parental leave laws. The US does not provide paid leave for employees. However, federal employees, and employees in California, Rhode Island, and New Jersey have their own laws providing pay, as well as longer leave periods compared to the rest of the United States.

Employees are given time, assuming they meet the requirements, to take care of a family member or have a child, but using leave can still be a source of stress. Unpaid leave can be a financial burden, thus causing new mothers to return to work sooner than recommended, fathers to be out of the home more often, and other parties being paid to care for family members. Lack of accommodations in the Family Medical Leave Act (1993) has led to new legislation. (1)

Parental Leave Policies across the World

An international topic of interest is the difference in parental leave, particularly when comparing length and pay of parental leave. According to Ray, Gornick, and Schmitt (2008), most countries provide between three months and one year of full-time equivalent paid leave. Denmark guarantees about 20 weeks FTE paid leave; Sweden and Germany provide the most FTE paid leave at 47 weeks; Norway, Greece, Finland, Canada, Spain, and Japan offer at least six months of FTE paid leave; Italy, France, Ireland, Denmark, Spain, Belgium, and Portugal have between four and six months of FTE paid leave; Austria and the Netherlands offer approximately 16 weeks, New Zealand has 14 weeks, the United Kingdom has 13 weeks, and Switzerland has 11 weeks FTE paid leave. Australia and the United Stated grant no paid leave; however, there are “baby bonuses” given to families in Australia. (2) A "baby bonus" is a lump sum payment of $4, 258 AUD per child, or $3,085USD allowing parents to be better able to take leave.

Recent Employment Leave Legislation

Federal Employees

The Federal Employees Paid Parental Leave Act of 2013 allows federal employees to substitute any available paid leave for any leave without pay available for either the: (1) birth of a child, or (2) placement of a child with the employee for either adoption or foster care. For 12 weeks of leave an employee is entitled to: (1) four administrative weeks of paid parental leave in connection with the birth or placement involved, and (2) any annual or sick leave. The Act amends the Congressional Accountability Act of 1995 and the Family and Medical Leave Act of 1993 to allow the same substitution for covered congressional employees, Government Accountability Office (GAO) employees, and Library of Congress employees. The Federal Employees Paid Parental Leave Act of 2013 counts certain service by an active duty employee of the executive branch, Congress, GAO, or the Library of Congress as a member of the National Guard or Reserves. Such status determines an employee's eligibility to take or substitute leave as provided under this Act. (3)
State Coverage and Provisions

State of Maryland

The state of Maryland follows the FMLA federal law requiring certain employers to grant job-protected leave to employees who meet FMLA eligibility requirements. Leave is unpaid and allows an employee to take leave for (a) the birth and care of the newborn child, (b) the placement of a child for adoption or foster care, (c) necessary care for the employee's spouse, child, or parent with a serious health condition, or an adult child who cannot care for himself or herself, (d) a serious health condition that makes an employee unable to perform the functions of the employee's job or (e) any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on (or has been notified of an impending call to) “covered active duty” in the Armed Forces. (1)

In May 2013, MD H 804, which required an employer to provide reasonable accommodation of a disability caused or related to pregnancy, including temporary transfer of an employee to a less strenuous or hazardous position, was approved. MD S 12 also passed in 2013 authorizing employees to take leave from work on the day an immediate family member leaves or returns from active military duty outside the United States. (4)

California is one of three states, including Rhode Island and New Jersey, to provide paid leave. The California Paid Family Leave insurance program provides up to 6 weeks of paid leave to care for a seriously ill child, spouse, parent, or registered domestic partner, or to bond with a new child. The benefit amount is approximately 55% of an employee’s weekly wage, from a minimum of $50 to a maximum of $1,067. The program is funded through employee-paid payroll taxes and is administered through the state’s disability program. California is one of the only states to provide leave to care for a child, spouse, parent, domestic partner, child of domestic partner, or stepparent. Additionally, the employee is allowed up to 40 hours per year, but no more than 8 hours per month, to participate in children's educational activities.

The District of Columbia does not provide paid leave, however, employees are allowed up to 16 weeks of family leave, plus 16 weeks of medical leave for employee's own serious health condition during a 2 year period. All relatives by blood, legal custody, or marriage, and anyone with whom an employee lives and has a committed relationship is considered when an employee is granted leave. Also, up to 24 hours per year are allowed to participate in children's educational activities. (5)

Future Research and Policy Recommendations

- Research should compare FMLA outcomes for employees in three states with FMLA paid policy to a comparative three states without paid leave.

- Future studies should analyze work productivity, reason for using leave, and how much leave was used.

- Research can be used by policymakers in non-paid FMLA states to determine amount of pay during leave or amount of leave that may be helpful for an employee to take care for themselves or of a family member.

References/Resources:


This policy brief created by: Taylore Mountain, Department of Family Science. Reviewed by: Elaine Anderson, PhD, Instructor for FMSC 750 - Family & Health Policy

Copies of this and other briefs available at:
http://www.hhp.umd.edu/FMST/fis/MDresources.htm
Problem

There has been a recent dramatic increase in family homelessness in the District of Columbia, increasing by more than 25% from 2013.\(^1\)

The city government has had little progress in finding transitional or permanent housing for families and has defaulted to placing them in emergency shelters.

In 2014, \textit{907 families were living in an emergency shelter, almost a 100% increase from 2013}.\(^2\)

Families can face the unfortunate reality of splitting up adolescent sons from the rest of the family due to shelter guidelines. In an effort to protect young families, emergency shelters can require sexually mature males go to all-male shelters even if they do not know anyone there.\(^3\)

This policy can put young males in a traumatic environment without the support and protection of family, where they can be exposed to violence and assault, potentially continuing the cycle of homelessness and violence.

Underlying Causes

Family homelessness is primarily caused by:

- Poverty
- Lack of affordable housing\(^1\)

Homelessness dismantles the basic functioning of families including physical and emotional health.\(^4\) Additionally, research has shown that child homelessness is a risk factor for worse achievement than for peers with stable housing.\(^3\)

Children living in homeless shelters have higher rates of:

- Health problems such as asthma, dermatitis, and ear infections\(^5\)
- Emotional and behavioral problems
- Developmental delays
- Lower levels of academic achievement\(^3\)

On top of these increased risks, dismantling a family while they are in emergency housing causes more critical damage to the wellbeing of the family while stripping away their inherent strengths as a caregiving unit.

What the Research Says

Promoting resilience in children who experience homelessness requires the involvement of positive parenting and child self-regulation.\(^4\)

An important protective factor for children who experience a range of risks is having a close relationship with a competent adult, most particularly a caregiver.\(^6\) This means that a homeless family needs to be intact for it to function properly and be able to provide the child(ren) with a promotive environment.
Policy Recommendations

Short Term

Require the use of private rooms for families to use in emergency shelters.

Rooms should have locking doors that provide privacy and safety from other families staying at the shelter.

In emergency shelters where private rooms cannot be provided, increase the age for adolescent boys to be able to stay with their families.

Increase security when possible to better protect families from other individuals staying in the shelter.

Long Term

Prioritize placing families in transitional housing.

Allocate portion of emergency shelter funding to transitional housing services, including overhead costs, staff time, housing subsidies, and acquiring affordable housing units.

Strengthen social work services to better provide support in finding parents permanent employment and temporary housing for families.

Increase number of social workers and other human service workers per shelter so that caseloads are lighter and professionals can spend more time with each family and be more accessible to the family.

Develop and implement services in shelters that provide parents with positive parenting education, and children with self-regulation exercises that promote positive adaptation.

References:


This policy brief created by: Allyson Pakstis, MPH, Doctoral Student, Family Science Department
Reviewed by: Elaine Anderson, PhD, Instructor for FMSC 750 - Family & Health Policy
Suggested Citation:
The Protective Effects of Father Involvement: Implications for Policy and Programs

Background

Children born to teen mothers face heightened risks for poor educational, behavioral and emotional outcomes. A major contributor to developmental risk for these children is the elevated rates of maternal depression among teen mothers. Fathers may be a protective resource for children born to teen mothers, even as early as the first 6 months of life. (1)(5)

What We Know About Fathers

- Children with involved fathers tend to have better developmental and behavioral outcomes, including:
  - positive outcomes for children’s cognitive development and educational success
  - fewer behavioral and mental health problems over the life course
- Among non-residential fathers, those who provide financially are also likely to visit, take part in caretaking activities, and take responsibility for parenting decisions (2)
- Young, non-residential, minority fathers are most involved with their children shortly after birth and during infancy
- Early research suggests that high father involvement may buffer children with high-risk mothers from developing negative or problematic behaviors (2)

Depression & Teen Mothers

- Studies have documented high rates of depression in minority teen mothers
- Maternal depression during a child's infancy has immediate and longitudinal effects at least into adolescence
  - depressed mothers are specifically less sensitive to infant distress
  - infant distress is of particular significance in the development of later behavioral, social and emotional functioning

The Study

- 122 adolescent mothers and their infants enrolled in a quasi-experimental trial of a comprehensive pediatric primary care program
- Mothers ranged in age from 13 to 19; all were African American; all fathers were under age 25
  - approx. 20% of mothers had graduated high school, and 62% were currently enrolled
  - 52% of fathers had graduated high school or obtained their GED
- Mothers answered questions about their infants' temperament and their babies' fathers' level of engagement and responsibility, and completed the CES-D self-report depression scale (1)

Results

- Almost one third of teen mothers in this sample reported clinical level depressive symptoms
- Contrary to popular stereotypes of low-income African American young fathers, mothers reported that 78% of fathers were at some point engaged with their children, and 71% took some responsibility for their children; 72% of fathers were both engaged and responsible
- Father engagement and responsibility were significantly negatively correlated with mother-reported infant 'Activity' and 'Distress to Limitations' (distress while confined, unable to perform a specific action, or involved in caretaking activities); mothers' depressive symptoms were significantly positively correlated with infant 'Distress to Limitations' and 'Sadness'
- Infant 'Distress to Limitations' was significantly associated with both father involvement and maternal depression
What does it mean?

- Father involvement, particularly fathers taking financial responsibility, was associated with lower infant distress
- In this sample, young fathers' engagement protected children from the negative influence of maternal depression on infant distress
- Father involvement can be protective for children of teen mothers; fathers can buffer children, even as infants

Policy Recommendations

Service Provision

- Broaden the definition of 'family' in policy language to include non-residential and/or non-custodial fathers
- Increase funding for 'responsible fatherhood' initiatives in low-income minority communities
- Adjust the legislative focus from 'marriage above all else' to 'healthy parenting'

Poverty Reduction

- Enable fathers to provide financially by improving the financial child support system to encourage adherence and increase support to children while also reducing fathers' economic burden
- Increase funding for job skills and vocational training programs for young fathers

Mental Health

- Include mental health service and treatment options (for mothers, fathers, and couples) in the standard sequence of pre-natal and post-partum medical treatment
- Develop a targeted, population-specific public awareness campaign to highlight warning signs of post-partum depression and other mental health problems

Getting Schools Involved

- Develop father-specific parenting classes for expectant and new young fathers
- Connect young fathers to one another to establish support networks through organized, thematic programming
- Highlight fathering and its impact over the life course in comprehensive sex education programming

References/Resources:


This policy brief created by: Deirdre Quinn, Family Science Doctoral Student, for FMSC 750: Family & Health Policy
Reviewed by: Elaine Anderson, PhD, Instructor for FMSC 750 - Family & Health Policy
Drug Use and Pregnancy:
State Response to the Child Abuse Prevention and Treatment Act

Drug Use and Pregnancy

Babies exposed to drugs in utero are at risk of poor birth outcomes such as low birthweight. Among pregnant women aged 15-44, 5.4% were current illicit drug users based on data averaged across 2012 and 2013. Though this rate is lower compared to non-pregnant women, drug use among pregnant women is often underreported for fear of losing their children or criminalization.

Implications for Pregnant Women Who Abuse Drugs

- Drug use during pregnancy has been associated with low birthweight and poor cognitive and neurodevelopment.

- Parental drug use has been one of the main reasons children have been removed from the home. Drugs can impede parental decision-making and the parents' ability to protect their children.

- Parents affected by drug use may neglect their child's needs, become involved in criminal activity that jeopardizes their safety, or spend money on drugs instead of the household.

- The Child Abuse Prevention and Treatment Act (CAPTA) is a federal policy that was enacted to address drug use during pregnancy. This legislation empowered states to define child abuse and neglect as well as develop a process that promotes the best interest of the child. CAPTA considers prenatal drug use to be child abuse.

State Response to CAPTA

States vary considerably for reporting and addressing drug use during pregnancy:

- 4 states (IA, MN, ND, KY) require health care professionals to test for prenatal drug exposure if they suspect abuse.

- 18 states (AL, AR, CO, FL, IL, IA, IN, LA, MN, NV, OK, RI, SC, SD, TN, VA, WI, TX) consider drug use during pregnancy to be child abuse.

- 3 states (MN, SD, WI) consider drug abuse during pregnancy grounds for civil commitment.

- 19 states (AR, CA, CO, CT, FL, KY, IL, LA, MD, MN, NE, NY, NC, OH, OR, PA, RI, VA, WA) have created or funded drug treatment programs for pregnant women.

- 15 states (AK, AZ, IL, IA, LA, MD, MA, MI, MN MO, ND, OK, RI, UT, VA) require healthcare professionals to report suspected prenatal substance abuse. This information can be used in child welfare proceedings.

- 1 state (TN) allows assault charges to be filed against a woman who uses "certain substances" during pregnancy. Women are charged with possession of a controlled substance, delivering drugs to a minor (via umbilical cord), assault, manslaughter, and child abuse/neglect.
**State Implementation Issues**

- States do not determine testing and screening protocols and policies, individual hospitals and health centers have their own procedures on how they choose who to test. Health centers in different areas may have varying policies on screening and testing women suspected of drug use.

- Varying screening procedures based on "suspicion" results in differential treatment of pregnant women and a bias against poor, urban, and women of color.4,6

- There are inconsistencies across states in the testing procedure with some focusing on the mother while others test the newborn.

**Special Case: Bias In Reporting Florida**

In a study conducted with pregnant women enrolled in prenatal care in Florida, the rate of substance abuse by both black and white pregnant women were similar.1 Florida reporting guidelines do not require documentation of drug use, rather only "suspicion," leading to variation in reporting. This variation became evident when a significantly higher proportion of black women compared to white women were reported, even when drug use was similar.4 There should be consistent criteria for documentation, to reduce use of suspicion based on race.

**Policy Recommendations**

- Develop testing protocol that is evidence-based for prenatal drug use

- Universal screening for every woman in prenatal care

- Consistent state guidelines for addressing prenatal drug use in regards to testing, reporting, and support programs both within states and across states

- Increase interventions promoting family cohesion such as community-based drug treatment programs with parenting classes

**Policy Recommendations (cont).**

- Cultural competency training for health care providers

- Incorporate substance use education and support services into postnatal care

**References/Resources:**


7. Schempf A.; Strobinio, D.M. Illicit Drug Use and Adverse Birth Outcomes: Is It Drugs or Context?. Journal of Urban Health: Bulletin of the New York Academy of Medicine, vol 85 no. 6


**This policy brief was created by:**

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Copies of this and other briefs available at:

http://www.hhp.umd.edu/FMST/fis/MDresources.htm
Importance of Maternal Mental Health

It has been well documented that psychological distress and various mental health diagnoses occur at higher rates among low-income individuals compared to their higher-income counterparts (e.g., Pratt, Dey, & Cohen, 2007). Most people with mental health problems do not receive treatment, and the treatment gap is greater among the economically disadvantaged versus those who are financially better off (Wang et al., 2005). Studies focused on low-income women and particularly low-income mothers paint a stark picture. An analysis of the 2002 National Survey of America’s Families found that although almost one-fourth of low-income mothers in the sample were in poor or very poor mental health (as determined by scores on the “Mental Health Inventory-5,” less than one-tenth of the mothers had received any mental health treatment in the past year (Loprest & Nichols, 2008).

Poor maternal mental health is problematic not only for the mother but also for the family members who rely on her to provide and care for them. Poverty and maternal mental health have been shown to interact to negatively influence child development, including academic achievement, cognitive functioning, and social development (Duncan & Brooks-Gunn, 1997; Duncan, Brooks-Gunn, & Klebanov, 1994).

Previous studies have revealed a range of perceptual and instrumental barriers to mental health treatment for low-income women. Perceptual barriers included the belief that treatment is unnecessary or would not be beneficial (Anderson, et al., 2006), women's fear of having professionals judge them to be inadequate mothers (Copeland & Snyder, 2010), and negative interactions with their children’s service providers. Instrumental barriers included lack of transportation, child care, insurance, or treatment affordability (Anderson, et al., 2006; Copeland & Snyder, 2010).

Maternal Mental Health in the Three City Study

A study of ethnographic data from the Welfare, Children, and Families: A Three-City Study analyzed a subsample of 20 low-income mothers with mental health problems to understand how they experienced and coped with mental health. A prominent finding was the high prevalence of family comorbidity, or the co-occurrence of health problems in more than one member of a family. Mothers had to negotiate their own health issues while dealing with multiple health problems of their children. This frequently meant neglecting their own health needs in order to navigate children’s doctor’s appointments, advocate for children in schools and other environments, and arrange childcare for sick kids while attempting to maintain employment. Most of the mothers in the sample were open to mental health treatment; seventeen of the mothers (85%) reported that they had sought out some sort of mental health treatment at some point in their lives. However, dealing with chronic life stressors such as poverty and child illness often diverted mothers’ attention away from their own mental health needs, making traditional treatment difficult to sustain.

At the same time as family comorbidity generated barriers to mental health treatment, mothers talked about how it triggered or exacerbated their mental health problems. In some cases, mothers experienced
guilt related to perceptions that they had caused or contributed to their children’s health conditions. Most mothers also experienced psychological distress related to raising their children in poverty and being unable to meet all their children’s needs.

In Their Own Words

"Sometimes I feel sad. Sometimes I feel just tired. Sometimes I just feel that I’m not doing a good job as a mother and a provider. Sometimes it's just so overwhelming."

"I had got so depressed with myself that I didn’t comb my hair, I just sat...My mother dies, I lost my job, stuff just, you know the ball just dropped. Stuff just happened for three years. My son went to jail, he got six years. My other son got sick...you know, stuff just happened..."

Policy Recommendations

Expand the range of mental health services to meet the needs of low-income mothers

Adapt traditional therapy to include making regular home visits, providing therapy in locations such as community centers, scheduling sessions in the evenings and on weekends, providing vouchers for transportation, and making child care available.

Ensure the mental health workforce is equipped

Train mental health therapists in the following skills and competencies:
- Regulation of the stress response system and development of effective and relevant coping strategies
- Cultural competence to work with low-income and marginalized populations
- Proficiency in traumainformed care in order to help and not harm clients who have been directly or indirectly affected by trauma

Reach mothers through children's providers

Train health care professionals who work with children in low-income communities to identify mothers' mental health needs and refer them for treatment as appropriate. More family-oriented services may need to be developed.

Support poverty alleviation as a mental health care strategy

Poverty alleviation is an essential mental health care strategy and ought to be elevated as a central component of U.S. mental health care policy. Among the poverty alleviation policies and strategies that ought to be considered are the following:

- Expand affordable child care options, including child care subsidies and Head Start / Early Head Start
- Create family-friendly workplace policies such as expanded paid and unpaid leave to cover more workers, and particularly low-wage workers
- Align workforce development policies to economic realities to help low-income workers access better paying jobs. Strategies include apprenticeships, paid internships, and a variety of training options

References:


This policy brief created by: Allison Schroeder, Family Science Doctoral Student, for FMSC 750, Family & Health Policy
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American Military Caregiving: Implications for Policy and Programs

**Problem Defined**

According to the Department of Veterans Affairs, approximately 3.8 million veterans are receiving compensation for service-connected disabilities in the United States. The number of veterans requiring VA services increased substantially since 2011 due to U.S. engagement in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Veterans are returning from deployment facing health challenges rarely experienced by veterans of previous wars.

Advances in medical technology have resulted in troops (with more devastating injuries) surviving longer. The nature of the wounds sustained dictate that long-term care will be required. The RAND study (2014) estimates that there are approximately 5.5 million caregivers supporting military veterans in the United States. Roughly 1.1 million of these caregivers are helping persons who served post-9/11. Caring for loved ones who have experienced traumatic injuries can be very challenging. Ensuring that these caregivers have access to the assistance needed, has become of critical importance on both a federal and state level.

**Who are the Military Caregivers?**

While only 29% of caregivers report having a choice in taking on the caregiver role, these duties are often selflessly assumed by spouses, parents, children, extended family members, friends, coworkers, and neighbors of the disabled veteran (Figure 1). The RAND study (2014) indicated that, while pre-9/11 caregivers resemble civilian caregivers, marked differences were found among the post-9/11 caregivers. The report identified that post-9/11 caregivers were more likely to:

- **Be a Unique Population**
  
  A spouse, younger, non-white, veteran of military service, employed, not connected to a support network

- **Provide Care for Unique Recipients**
  
  Younger, non-white, employed, mental health or substance use diagnosis, greater physical mobility

- **Face Unique Challenges**
  
  Serve as case manager navigating multiple health systems, advocate for quality care, poor relationship quality (possibly due to age and length of relationship), facing a lifetime of continuous care

**The Heavy Burden of Caregiving**

Balancing the needs of the care recipient with other family and work-related responsibilities results in negative health outcomes, greater family strain, and work-related problems for military caregivers. Studies indicate that military caregivers suffer disproportionately from mental health concerns and emotional distress. Thirty-three percent of post-9/11 military caregivers lack health care coverage to obtain treatment for their own physical and mental health issues. Studies show the medical costs...
caring for disabled veterans in excess of $3 billion. The costs associated with the loss of work productivity (~3.5 days per month) are listed at $5.9 billion among post-9/11 caregivers. Figure 2 displays the adverse effects self reported by caregivers.

Figure 2: Health Challenges

Source: RAND, 2014

Service and Resource Utilization

The RAND study (2013) reported that 15 to 30 percent of caregivers used direct assistance and social service programs within the last year. Of the programs provided specifically for military caregivers, benefits were limited and geared to older veterans, thus excluding 80% of caregivers from receiving them. Relatively few programs offered caregivers financial stipends to help compensate for loss of income related to caregiving responsibilities. Since military caregivers tend to lack a social support network, post-9/11 caregivers were more likely to use mental health resources, and use them more frequently, than other groups.

Caregiving Concerns

The top 7 concerns reported by at least two-thirds of military caregivers are:

1. Not knowing what to expect medically with the veteran’s condition; 2. Not being aware of Department of Veterans Affairs (VA) services that could help; 3. Not knowing how to address PTSD or mental illness (among those who report that such a condition is present); 4. Difficulty getting through bureaucracies in order to obtain services; 5. Not knowing where to obtain financial assistance; 6. Not knowing where to turn to arrange a break from caregiving; 7. And not knowing where to obtain specialized care

Policy Recommendations

Empower Caregivers

1. Provide high-quality education and training to help military caregivers understand their roles and to teach them necessary skills.
2. Help caregivers get health care coverage and use existing structured social support.
3. Foster caregiver health and well-being through access to high-quality services.
4. Ensure that caregivers have access to services based on the tasks and duties they perform, rather than their biological relationship to the care recipient.

Create a Caregiver-Friendly Environment

1. Incorporate caregivers as part of the health care team in all health care environments catering to military and veteran recipients.
2. Increase public awareness of the role, value, and consequences of military caregiving.
3. Promote work environments that support caregivers, protect them from discrimination, and promote workplace adaptations.

Future Initiatives

1. Make respite care more widely available to military caregivers; including alternative respite care strategies.
2. Invest in research to document the evolving need for caregiving assistance among veterans and the long-term impact of caregiving on the caregivers.

References/Resources:


This policy brief created by: Towanda Street, Family Science Doctoral Student, Department of Family Science, for FMSC 750-Family and Health Policy. Reviewed by: Elaine Anderson, PhD, Instructor

Suggested Citation:


Copies of this and other briefs available at:

http://www.hhp.umd.edu/FMST/fis/MDresources.htm
Supplemental Nutrition Assistance Program (SNAP): Implications for Policy and Programs

Obesity in the United States
Overweight and obesity among adults and children is one of the most important public health issues in the United States. The most recent statistics indicate that about one-third of American adults and 17% of the youth are obese.\(^1\)

Obesity can lead to many adverse health outcomes and social problems. In adults, overweight and obesity are associated with type II diabetes, hypertension, coronary heart disease, stroke, sleep apnea, and gynecological problems.\(^2\)

In obese children and adolescents high blood pressure and high cholesterol can lead to an increased risk for cardiovascular disease.\(^3\) In children obesity is associated with type II diabetes,\(^4\) sleep apnea, and joint problems.\(^5,6\)

Additionally, obesity is associated with major social problems. Obese children and adolescents are at a higher risk of experiencing discrimination and low self-esteem compared to their non-obese peers. Furthermore, obese children are more likely to become obese adults, extending the obesity related risks across their lifespan.\(^7,8\)

Relationship Between Poverty and Obesity
Poverty in the United States is rising. According to the US Census Bureau, 15.1% of Americans lived in poverty in 2010 and the economic crisis in recent years led to 46 million individuals to live in poverty.\(^9\) Studies have shown a positive association between poverty and obesity in the United States.\(^9,10\)

Supplemental Nutritional Assistant Program (SNAP), formerly known as the Food Stamp, is the largest nutrition assistant program in the country providing benefits to millions of low-income households to purchase food.

The main objective of SNAP is to assist low-income families in acquiring an adequate and nutritious diet.\(^11\) SNAP eligibility is determined based on family income and number of family members.\(^12\)

SNAP Participation and Quality of Diet among Adults in the US
Despite the governmental efforts in aiding low-income families to gain and maintain a high quality and nutritious diet, studies have shown these efforts to be ineffective. In a recent study conducted by the Mayo Clinic, a nationally representative sample from the National Health and Nutrition Examination Surveys (NHANES) years 2003-2010 was used to examine the relationship between SNAP participation and quality of diet among participants. From a sample of 4,211 low-income adults between the ages of 20-64, 1,830 individuals participated in SNAP.\(^13\) Compared to the non-participants, the cohort of SNAP participants included a larger number of obese individuals, non-Hispanic blacks, women, less educated, unemployed, uninsured, WIC beneficiaries, residents of larger households. Low-income SNAP participants had on average a significantly lower overall diet quality score compared to their low-income SNAP eligible non-participant counterparts (42.58 vs. 44.36, \(p<0.0001\)). The SNAP participants had a lower level of food security compared to their SNAP eligible non-participant counterparts (54.2% vs. 68.2%, \(p<0.001\)). The researchers, also, found that the low-income SNAP participants had significantly lower average scores for total fruits (1.68 vs. 1.91) and total vegetable (2.62 vs. 2.84) consumption (\(p<0.05\)).\(^13\)
Policy Recommendations

To better address the problem of the correlation between SNAP participation and low quality of diet among the low-income and poor population, the US Department of Agriculture and local entities could work together to improve families’ knowledge of nutritious foods, availability and accessibility of fresh foods, and families’ food preparation and consumption practices. The following recommendations could take place:

- Identify and address different barriers for low-income residents to purchase and use fresh fruits and vegetables.
- Families participating in SNAP need to receive basic nutrition education, especially on the healthy options that could be purchased using the money provided.
- A larger number of low-income community grocery stores should be incentivized to accept food stamps, so to increase the options families have in food purchasing.
- Local entities should work with SNAP offices to hold weekly farmers markets in different neighborhoods and encourage SNAP recipients’ participation.
- Consider more economic incentives for farmers and grocery stores to sell fresh produce at low prices.
- Educate individuals on how to utilize and include fresh fruits and vegetables into their daily food practices. This could be achieved through food demonstrations at the farmers’ markets and local grocery stores as well as through distribution of recipes at the SNAP offices, grocery stores, and farmers’ markets.

References


This policy brief was created by: Yassaman Vafai. Maternal and Child Health doctoral student.
Reviewed by Elaine Anderson, PhD, Instructor for FMSC 750 – Family and Health Policy.
Immigrant Children Health Care Usage: Implications and Recommendations for Policy

Who has Access to Care?

The Affordable Care Act has increased access to health coverage for millions of Americans, but there are still many who are left uninsured. According to www.healthcare.gov “Health Insurance Coverage is available for most US citizens, US nationals, and lawfully present immigrants”. This excludes the nearly 12 million undocumented immigrants and aspiring citizens.

Under the federal health care law, undocumented immigrants are excluded from getting federal subsidies to buy health insurance and they cannot shop for coverage in the health insurance marketplace. More than half of the population of undocumented immigrants in the US is uninsured. In addition to a lack of policies that help illegal immigrants gain access to the care that they need, immigrant children are affected by their parents’ lack of trust towards government regulated systems and a lack of outreach and education regarding access to healthcare.

Barriers to Care

Research shows that even when family members have legal resident status and have health insurance, they are less likely to go to the doctor and use their medical coverage. Non-citizens are more likely to report having no usual source of health care compared to citizens (Schwartz & Artiga, 2007).

Immigrant Children

Individuals whose parents have immigrated to the United States represent the fastest growing segment of the population under 18. They also make up a large portion of the uninsured population in the United States. Even if the child is a citizen, their parents’ nativity status (having at least one parent who is an immigrant) makes them vulnerable to uninsurance (Passel & Cohn, 2009).
Use of Health Care Systems

Recent research shows that when compared to a control group of 0-5 year old, male, insured, and with native parents children, those with foreign born parents have much lower chances of having visited the doctor at least once in the past 12 months. These odds are even lower if the child does not have US citizenship (Garcia-Perez, 2013).

For every one child of US native parents, you can expect to find 0.91 citizen immigrant child and 0.76 non-citizen immigrant child who visited the doctor one or more times in the last year (Garcia-Perez, 2013).

When the same groups are compared, for every child with native parents, 0.83 citizen immigrant children and 0.36 non-citizen immigrant children with foreign born parents do not have a place of regular care.

These disparities in health care access and usages have been linked to fear of legal ramifications for self or family members, lack of familiarity with complex health care systems, and language barriers. These findings show a need for increased support and outreach to children of immigrants.

Policy Recommendations

Improve Access

- Incorporate parents into the health care systems so kids will have better outcomes
- Provide regular health services to parents in order to increase their children’s number of visits to the doctor and timely treatment of medical conditions
- Expand health insurance coverage to undocumented immigrants

Consumer Education

- Develop programs to educate immigrants on health care access
- Work to make health information accessible to immigrant families, either by translation or increased proliferation of informational materials
- Mandate employers to provide explanations of benefits in multiple languages and encourage informational sessions

Regular Care

- Schools and health insurance companies need to more strictly monitor how often immigrant children and their parents are using medical health services
- Schools, employers, and health insurance companies should require that individuals and families report a place of usual care

References/Resources:


The National Immigration Law Center: http://nilc.org/

Center for Immigration Studies
http://cis.org/HealthCare-Immigration

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