

**American Academy of Pediatrics
Council on Community Pediatrics
Rural Health Special Interest Group**

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Presentation about Pediatrics in the Border to the Rural SIG AAP

As the number of Hispanics increases in the U.S., both due to immigration and a higher birth rate for Hispanic groups, many pediatricians I come across, mention the fact that the problems related to care in the “Border” have really become a national phenomenon and the “Border” should maybe go all the way to Chicago or Wisconsin, as there are Migrant groups of poor Hispanics working all kinds of low paying jobs throughout the country.

Indeed there are a series of problems that are common to poverty wherever it exists and independent of the ethnic group it affects, there are also problems derived from the language difficulties that derive from the encounter of providers that do not speak the language and do not understand the culture and that, also affects different ethnic groups throughout the country. There are also problems of decreased access to care or insurance or even resources and they also affect the whole country, worse now than before and with no improvements in sight.

So what makes the “Border” so unique, and why it needs special considerations. I will mention just some of the most important reasons:

1. In the “Border” there is a lot more, of all the above!!

Hispanics are the majority of the population, reaching close to 80%. Many of these are first generation and it is well known that the first generation immigrant frequently contribute to the enrichment of a few “entrepreneurs” at the expenses of low income and no direct contribution to the local or State tax base. They are frequently “undocumented” (an euphemism for illegal) and they are fearful to stand for their rights and have literally no access to the services, but only in cases of emergencies. Their children, of course, go to the public schools, stretching the limited dollars that reach the different districts, take advantage of WIC but have no access to preventative care except for the vaccines that are administered in the City County Health Department and by some “free” services and clinics, some of the FQHC provide sporadic care, but only by exception these children are able to have a “medical home”. It is well known that as they become legal, better educated, know the system better, they move away from the border looking for better possibilities and indeed become an important contribution to the economy wherever they happen to be. Table 1

Uninsured Texan Population by Race or Ethnicity: 2000

Race/Ethnicity	Number Insured	Number Uninsured	Percent Uninsured within Race/Ethnicity Category	Percent of Total Uninsured
Anglo/Other	10,261,933	1,420,140	12.2%	31.6%
African American	1,809,689	487,617	21.2%	10.8%
Hispanic	4,474,763	2,592,896	36.7%	57.6%

Total	16,546,384	4,500,653	21.4%	100.0%
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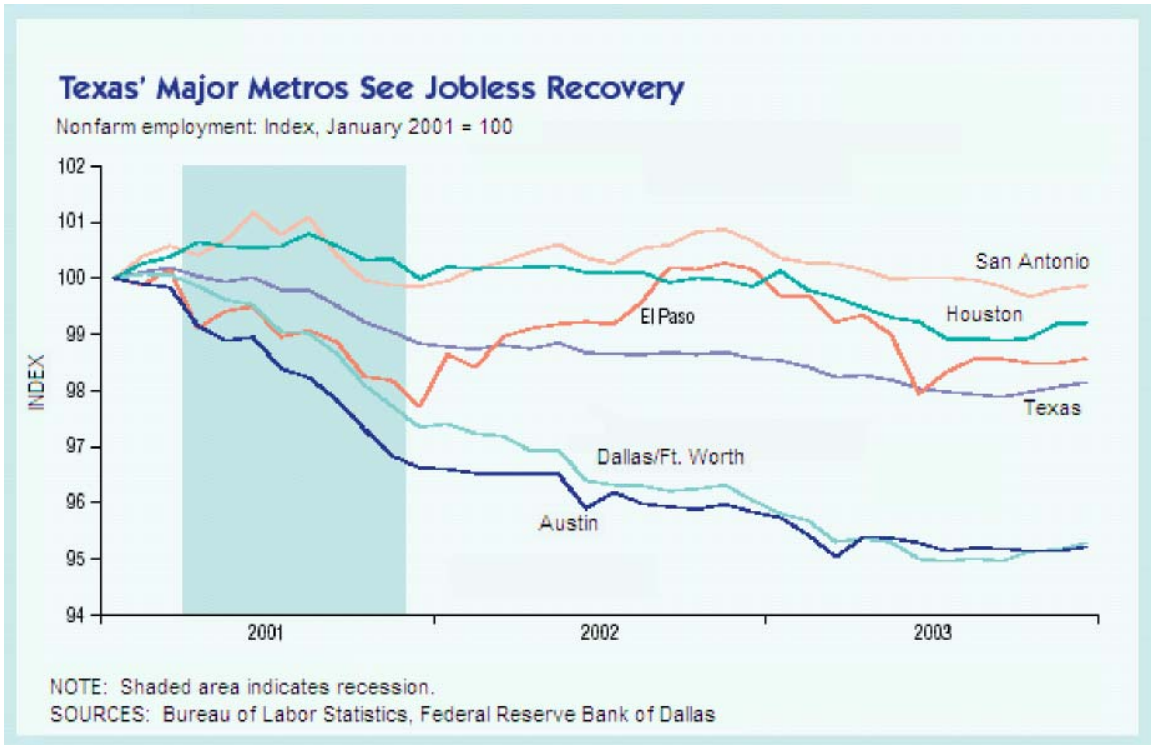
Source: 2000 Demographic Profile of Texas Uninsured Population Based on March 2001
 CPS.Research and Forecasting Department, Texas Health and Human Services Commission

2. The educational level in the Border is lower than the State and even lower than the country as a whole. Table 2

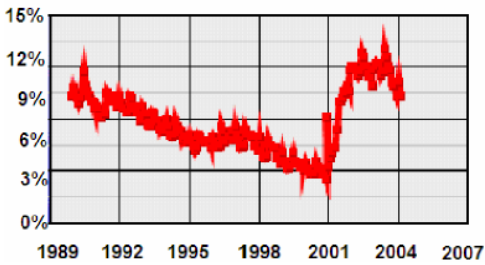
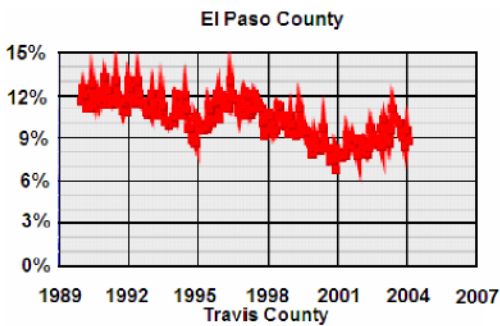
Educational Attainment Levels in the Borderlands for 2000

Population (25 yrs. and older)	14-County Immediate Border Region	32-County Sub-Border (LaPaz Region)	43-County Texas Border Region	Texas	211-County Non-Borer Region
Without a High School Diploma	43.2%	43.2%	33.6%	24.3%	22.2%
With some College but no degree	17.6%	17.5%	20.7%	22.4%	22.7%
With an Associate's Degree	4.1%	4.0%	4.9%	5.2%	5.3%
With a Bachelor's degree	9.3%	9.1%	11.2%	15.6%	16.6%
With a Post Graduate Degree	5.0%	4.9%	6.3%	7.6%	7.9%

3. The unemployment and sub employment is higher. table 3

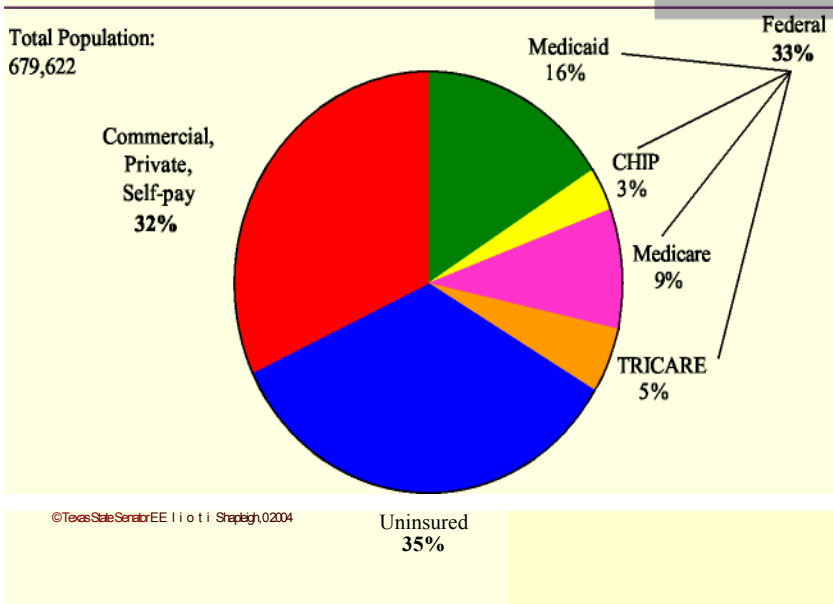


Unemployment Rates



4. The uninsurance rate is higher in the children's group, about 50% are receiving some sort of government insurance, there is about 20% of children that are uninsured and the rest have some form of indemnity insurance, mostly PPO. Evidently the State Medicaid and SCHIP Reimbursement cover about 45% of the expenses of running a practice, (Medicaid Reimbursement in Texas has not been adjusted since 1991, even more in 2003 was decreased by 2.5%) This issue alone makes it very difficult to recruit and retain providers and develop programs, particularly sub specialists that can have better incomes and a more appropriate lifestyle. Table 4 and 5

Estimated 2000 Insurance Mix for El Paso County

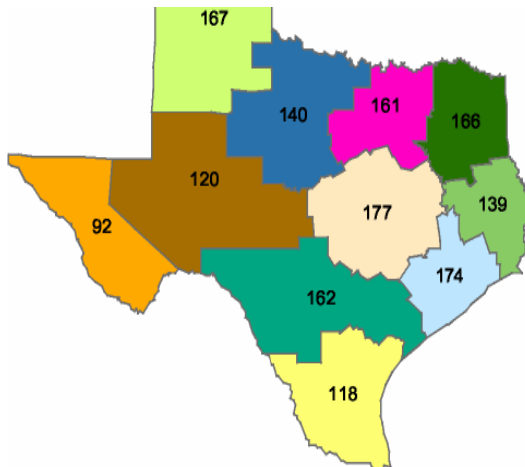


Adjusted Weighted Medicaid and CHIP Capitation Rate Disparities*

	Bexar County	Dallas County	El Paso County	Harris County	Lubbock County	Tarrant County	Travis County
TANF** children (Over 1 year)	\$71.00	\$84.00	\$90.00	\$82.00	\$91.00	\$85.00	\$83.00
TANF Adults	189.00	198.00	181.00	177.00	210.00	185.00	171.00
Pregnant Women	335.00	302.00	272.00	247.00	230.00	259.00	342.00
Newborns***	408.00	338.00	369.00	443.00	385.00	386.00	350.00
Expansion Children (Over 1 year)	73.00	112.00	77.0	96.00	84.00	87.00	82.00
Federal Mandate Children	65.00	64.00	54.00	69.00	76.00	73.00	68.00
CHIP****							

Source: Health and Human Services Commission
 *FY 2004 HMO Rates by Service Delivery Area and Risk Groups, **TANF-Temporary Aid to Needy Families, ***Includes TANF Child and Expansion Children 1 Year and Under, ****CHIP-Children's Health Insurance Program

Physicians per 100,000 Population in Texas Regions, 2001



In 2001
 Statewide Average:
 160 per 100,000
 10 Most Populous States: 199
 per 100,000
 National Average: 221 per
 100,000

SOURCE: Texas State Data Center, Texas Department of Health, & Texas State Board of Medical Examiners; Bureau of Health Professions, Website: www.bhpr.hrsa.gov; 2001 data

5. The challenges get compounded by a series of other factors that are characteristics of the care provided to poor, migrant populations such as;
- a. The pathology is frequently compounded by late consultation and a situation or problem that would have been easy to resolve early becomes complex when seen late.
 - b. The expenses of the care for children are higher, as there are many children without a medical home and do not receive the preventative care, so needed particularly here by groups that have limited concept of the importance of anticipatory guidance and health education, therefore many children use the Emergency Room as their “site of care”.
 - c. The care for these children require translators and also people that will do the “cultural” interpretation of what is said.
 - d. There is limited concept of continuity of care and therefore the children frequently get lost from follow up, making it harder to provide continuity , particularly in CASHCN.
 - e. Health care here is reactive and not proactive and the change in culture is compromised in a segment of the population that is highly motile.
 - f. Many of the patients are cared for on both sides of the Border with different standards of care when children are seen by general practitioners on the Mexican side as usually the pediatricians do practice a good level of care. The issues of care across both sides for children that are not legal residents have been directly affected by further enforcement of the border crossings after 9/11, so the children frequently use the medicines they purchase across the Border, self and inappropriate medication and all its complications make practice frequently very difficult.
 - g. There are still over 1000 children in El Paso alone, that are delivered by lay midwives (allowed to practice by law), frequently some of these newborns end up in the ICN at a cost of hundreds of thousands of dollars and with enormous personal and familiar suffering of a child with permanent handicaps in many occasions.
 - h. The lack of awareness of the resources and the system make this situation sometimes desperate and not rarely ends with tragic consequences.
 - i. Frequently the County Hospital is accessed by children that are brought from across the Border extremely critical. The County Hospital in February this year had 65% of uncompensated care!!! Therefore the scarce resources get stretched even more. There is no cost shifting either for the County Hospital or for the pediatricians that frequently end up with a practice that is 90% Medicaid and where the only way of survival is to work long hours and see a large number of children frequently sacrificing a component of education where it is needed.

Unquestionably the issues are even more complex, but this adversity has motivated innovations that have impacted the quality and access to care, but the funding of many of these ventures has been a continuous struggle as the situation is continuously changing and the need increases more than the solutions are forthcoming. Furthermore, there has been a chronic and continuous unwilling from the authorities to look at the problem with the far sight needed to invest with long term results and outcomes in mind, but there is a continuation of investment on acute care particularly in the Emergency Room based system instead of investing in primary care to every child that attends school and is a resident (legal or illegal) so that we can intensify the educational programs, improve the access to care and health education, creates medical homes for

every child and eventually increases the educational levels and outcomes for these children so that the society in the Border can some day break the vicious cycle of poverty and dependency and become integrated to mainstream America.

If the Border was the 51st State it would be the poorer State in the Union by far and would resemble more the economy of a developing country. There is no way to get out of these conditions of poverty unless the education, health care and the employment situation in the Border is improved and realistic provisions are made to address the problem of the thousands of undocumented who live here for generations sometimes without existing for the purpose of health care.