Utilization of Health Care by Foster Children: Application of a Theoretical Model

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Foster children are among the unhealthiest in this nation, and their health care is grossly inadequate for their needs. This paper uses a model developed by Aday and Anderson (1975) to explore the reasons for the discrepancy between need and services in this population. The health care utilization model conceptualizes utilization to be a product of three factors: relevant health care policy; the structure of the health care system; and certain characteristics of the population, including need, enabling factors, and predisposing factors. It is demonstrated that foster children suffer disadvantages in each area that discourage their appropriate use of the health care system. Given projections for a substantial growth in the foster care population in the future, and the likelihood that this growth will occur disproportionately among children with significant health problems, the paper suggests a framework for improving the use of health care for foster children by using each level of the model, and provides suggestions for evaluation and research.

At least 75 percent of America's more than 340,000 foster children (Ooms, 1990) have significant health problems (Swire & Kavaler, 1977; Schorr, 1982; Moffatt, Peddie, Stulginskas, Pless, & Steinmetz, 1985; Hochstadt, Jaudes, Zimo, & Schachter, 1987). Research done to date is somewhat difficult to evaluate given different methodologies and sample sizes. For example, some studies (e.g., Moffatt et al., 1985; Simms, 1989) have used...
clinical examinations to diagnose health problems, while others (McIntyre & Keesler, 1986; White & Benedict, 1985) have used record reviews. Nonetheless, a review of the literature demonstrates that foster children have high rates of developmental delay (e.g., Hochstadt et al., 1987; Simms, 1989); dental problems (e.g., Swire & Kavaler, 1974); growth problems (e.g., Hochstadt et al., 1987; Simms, 1989), and mental health difficulties (e.g., Frank, 1980; Keane, 1983).

Over the small number of available studies, the proportions of children with any serious or chronic health problem have ranged from 6 (White & Benedict, 1985) to 86 percent (Moffatt et al., 1985). Moreover, there is consensus that due to increased efforts to keep children in their own families whenever possible, the proportion of foster children with health problems has been increasing in recent years, and is likely to continue to do so (e.g., Schorr, 1989).

Despite well documented health problems, it has been demonstrated that foster children do not receive adequate health care. Often, recommended schedules for well-child care are not followed for foster children (White & Benedict, 1985; Klee & Halfon, 1987). In many cases, health problems of foster children are simply unrecognized by some or all of the adults who are responsible for these children (Adams-Tucker, 1984; Moffatt et al., 1985). Even when problems are detected, timely referrals may not be made for assessment or diagnosis (Klee & Halfon, 1987; Simms, 1989). Timely compliance with recommendations after diagnosis also may be a problem. Finally, it is believed by many that the services that are received by foster children, especially mental health services, are not appropriate to their particular needs and situation (Klee & Halfon, 1987; White, Benedict & Jaffe, 1987).

A Theoretical Model for Predicting Health Care Utilization by Foster Children

Several researchers (notably Schorr, 1988; White, Benedict, & Jaffe, 1987; Steinhauer, 1988) have suggested that poor health care utilization by foster children may be a function of factors such as health care policy, the foster care system itself, and individual characteristics of the foster children and their families; but research has not adequately addressed how particular social, systemic, or individual factors may lead to inadequate use of health care. This paper will present a framework for understanding the low health care utilization of foster children using the model proposed by Aday and Andersen (1975).

Aday and Andersen's (1975) model conceptualizes health care utilization as a function of three factors: health policy, health care delivery
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system characteristics, and population characteristics (See Figure 1). Health policy guides and supports legislation, health programs, and funding mechanisms. The structure of the health delivery system determines how services are organized and situated in the community. Finally, population characteristics influence how members use available health care resources. The remainder of this paper will describe the Aday and Andersen model as applied to the health care utilization of foster children.

Health Policy

Until recently there was no Federal or state policy addressing the issue of the health of foster children (White et al., 1987). Public Law 96-272 (the Adoption Assistance and Child Welfare Act of 1980), the major piece of legislation that institutionalized the concept of "permanency planning" and theoretically defines and guides the purpose and direction of foster care in this country, does not address the issue of health or health care for foster children.

Many foster care agencies have routinely provided some health services to foster children (e.g., Schorr, 1981). However, there have been no standardized procedures to ensure that all foster children receive appropriate health care, or to define what services should be provided. For example, Schorr's (1981) queries of public child welfare agencies in Maryland in 1979 found that none of the agencies routinely monitored the health care received by foster children, and that only about half had a standardized format for recording health care information. Klee and Halfon's (1987) survey of 14 California counties found that although severe medical and mental health problems were addressed, services were frequently unsatisfactory and it was rare for agencies to provide either routine psychological assessments, or treatment of more routine health problems. Kavaler and Swire's (1983) survey of the health needs of foster children in New York City found that foster children received inadequate routine care, treatment, and follow up. Moreover, they found extreme variability in the quality of the services that were provided.

Recent policy formulations have resulted in large part from litigation against state departments and individual caseworkers, alleging poor services and malfeasance (Schorr, 1989). Several Federal court decisions have recognized the rights of foster children to receive adequate services to meet their needs (Moffatt et al., 1985; White et al., 1987), beginning with the first judicial recognition in 1983 of foster child-health care issues in G.L. v. Zumwalt (See discussion in Schorr, Neff & LaAsmar, 1984).

The formulation of policy also has resulted from demands by professional groups for standardization of health care for foster children, e.g., the American Academy of Pediatrics Committee on Adoption and Dependent
Care (Committee, 1977). The Child Welfare League of America (1988) also recently issued standards regarding health care for children in foster care that are currently being used by some states to implement new policies. However, policies regarding health care for foster children remain poorly defined and vary among communities in terms of the types of services that are mandated, how and when those services must be delivered, and the type of documentation that is required.

A critical element of any health care policy concerns the means of financing services. The health care of foster children is largely financed by Medicaid under the Social Security Act, the provisions of which have had both positive and negative effects. Guaranteed financing has reduced the necessity for agencies to procure funding from other sources, and does provide guaranteed reimbursement for basic medical services for foster children.

However, the enactment of Title IV-E also means that the only providers who are available for foster children are those who accept Medicaid; this limitation produces numerous difficulties including a shortage of participant providers (Klee & Halfon, 1987). Participation by pediatricians in the Medicaid program fluctuates over time and is affected by issues such as reimbursement rates and administrative requirements (Perloff, Kletke, & Neckerman, 1986). Medicaid reimbursement rates have not kept pace with market rates because of state efforts to control costs (Waxman, 1989), and it is believed that Medicaid participation by pediatricians and providers is declining (Halfon & Klee, 1987; Schorr, 1989). Other programs that could supplement the financing of health care for foster children, such as the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT), Supplementary Social Security Income (SSI) funds, and Maternal and Child Health Block Grant funds, are not widely used (Schorr, 1989).

As a result of the shortage of providers, access to care is often noted as a problem. Schorr’s (1981) survey of foster care personnel revealed that the most common problem cited in obtaining needed health care for foster children was finding physicians who would accept Medicaid (Schorr, 1981). Likewise, Klee and Halfon (1987) noted that while mental health services are the most often needed by foster children, few mental health providers are willing to accept Medicaid. The shortage of residential mental health placements is particularly felt by foster children, who often have severe emotional problems and require such extraordinary services.

In summary, health care policy for foster children is lacking at the Federal, state, and local levels. Further, the health care financing system, Medicaid, may not be adequate for promoting appropriate health care utilization.
The Structure of the Health Care System

The structure of the health care system refers to the physical and administrative organization of service delivery, including characteristics of the system that make services more or less available and accessible. Important factors include procedures for entering and remaining in the system, such as administrative requirements for determining eligibility for services; as well as the distribution and quantity of health care resources.

Care for low-income children. The characteristics of the health delivery system as it pertains to foster children must be understood within the two-tiered system that characterizes the health care of poor children in general. Low-income families do not enjoy the free choice and wide selection of providers that are available to more advantaged families. Rather, they generally must rely upon public clinics or hospitals or a limited number of private providers who either accept Medicaid or who provide "charity care."

The health services providers used most often by the poor do not facilitate continuity of care. Disadvantaged children are less likely to have a "usual provider" of care and more likely to obtain most of their health care in Emergency Rooms and hospital outpatient departments (Kasper, 1987). This pattern of care does not promote continuity or preventive services (Alpert, Heagarty, Robertson, Kosa, & Haggerty, 1968; Dutton, 1979; Levy, Bonanno, Schwartz, & Sanofsky, 1979), which are considered to be necessary for optimal health care (American Academy of Pediatrics, 1988).

Resources for specialized treatment and services for poor children are even more scarce (Klee & Halfon, 1987). For example, there is a nationwide shortage of mental health resources for children, which may be felt most acutely by adolescents and children in state custody (Knitzer, 1984). Residential care, which may be indicated for children with very serious mental health problems, is also scarce (Klee & Halfon, 1987; Silver, 1989) and very expensive.

Foster care as a complication. The deficiencies in the health care system that interfere with the health care of low-income children are further exacerbated for foster children because of the additions of problems in the social service system, and the complications of interactions between those two systems. Thus, a majority of children who enter foster care do so with health histories that are characterized by the discontinuous, inadequate, and crisis-oriented approach described above.

Most foster children lack the benefit of a complete health history upon entering care (White & Benedict, 1985; Klee & Halfon, 1987); and the foster care system is not equipped to obtain widely scattered records.
Even when records are obtained, they often "present a confusing and incomplete picture regarding educational and other services" (Molin, 1988, p. 247). Each move to a new foster home usually involves moves to new schools and health care providers, presenting many opportunities for records to be lost in transfer (White et al., 1987). Moreover, poor record-keeping and frequent changes in placement and caseworkers often allow children’s health problems to "get lost" before action is taken (Schorr, 1981; Schorr et al., 1987). Immunization information is particularly lacking (Swire & Kavaler, 1977); foster children may be immunized repeatedly due to missing records (Klee & Halfon, 1987).

In addition, the peculiar circumstances of foster children lead to needs that the health care delivery system cannot accommodate. For example, when a child is placed in foster care, he or she often needs immediate access to health care (White et al., 1987) due to the emotional stress associated with the crisis of placement. Rarely is such immediate access possible in the public sector.

Finally, the structure of the health care and foster care systems are ill equipped to monitor children’s needs and services over time. Many children experience multiple changes in placements and providers while in care, and neither system generally has adequate personnel or expertise to monitor children’s well-child and immunization schedules, and to be certain that all recommendations for treatment and follow-up by various providers are met.

Yet the problem goes beyond structural limitations and fragmentation of care. The provision of adequate health care services for foster children requires recognition of their unique needs (Schorr, 1982; White et al., 1987; Molin, 1988), which result from an interplay among their individual competencies and vulnerabilities, past and current stresses, and their involvement in the child welfare system. Providers must be aware of what foster children endure in terms of frequent changes of caretaker, emotional upheavals associated with family visits, and other aspects of foster care. Klee and Halfon (1987) provide evidence that providers often are not knowledgeable of the system in which these children are caught, and that many are insensitive to the peculiar needs and problems of these children. Indeed, few providers have the opportunity to understand the complexities of the social service and legal systems in which foster children live.

**Characteristics of the Population-At-Risk**

Aday and Andersen’s model emphasizes that family and individual characteristics of foster children also affect their appropriate use of health care. Important characteristics include need, predisposing factors, and enabling factors.
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Need factors. In addition to their documented high rates of mental and physical health problems, foster children also are predisposed to a number of health effects that are related to poor parenting and family problems prior to placement. Children are most often placed in foster care for reasons of neglect, abuse, abandonment, sexual abuse, or other serious parental inadequacies (including mental illness, alcoholism and drug abuse) (Kadushin & Martin, 1988). All of these factors clearly have adverse effects on children's mental and physical health, either directly (e.g., injuries) or indirectly (e.g., growth and developmental delays). Moreover, the foster care experience may exacerbate any health problems that existed at placement, particularly mental health problems. For example, placement itself is extremely traumatic for most children (White et al., 1987; Schorr, 1989); multiple placements are likely to increase the child's emotional problems (Molin, 1988; Steinhauer, 1988).

Predisposing factors are those "immutable" properties such as socio-demographic variables that should not independently affect the use of health care in an equitable system, but which in fact are inextricably tied to both health and health care in this country. For example, it is well documented that minority status (Kleinman, Gold & Makuc, 1981) and low family income are related to both poor health (Starfield, 1989; Dutton, 1985; Shah, Kahan, & Krauser, 1987) and reduced levels of health care utilization in children (Wolfe, 1980; Orr, Miller, & James, 1984).

Research on the determinants of health care utilization by children emphasizes that children's access to the health care system depends primarily on their parents (Levy et al., 1979). Parental (usually maternal) characteristics that have been found to affect children's utilization of health care include maternal education, family income and size (Newacheck & Halfon, 1986), maternal employment (Cafferata & Kasper, 1985; Alexander & Markowitz, 1986), maternal knowledge of acute illnesses (Horwitz, Morgenstern, & Berkman, 1985), and certain psychological factors such as maternal psychological distress (Tessler & Mechanic, 1978), daily stress (Alexander & Markowitz, 1986) and social support (Horwitz et al., 1985). Maternal use of and attitude toward health care are also significant (Cafferata & Kasper, 1985; Newacheck & Halfon, 1986; Tinsley & Holtgrave, 1989). Thus, health care utilization by children is largely determined by their primary caretakers.

It is this reliance on adults that complicates the health care utilization of foster children. Although foster children theoretically have several adults who are concerned about their welfare (i.e., biological parents, foster parents, caseworkers, attorneys, and judges), individual and system barriers prevent the consistency and continuity that are required for proper health care.
Most biological parents may remain concerned about the well-being of their children, but they frequently have little contact with their children (Schorr, 1989) and rarely are involved in their children's health care during foster placement (Kufeldt, 1982). Moreover, they are often unwilling or unable to participate in their children's health care due to their own difficulties (Kadushin & Martin, 1988). Finally, due to their lack of contact with their children, their own stresses, and lack of knowledge, biological parents may not be in a position to identify their children's health needs.

Some research has suggested that poor families also possess different attitudes toward health care, such as placing less value on preventive care (Davis, Gold & Makuc, 1981). (Others point out that these different attitudes are more likely to be due to the fact that the services available to poor families are less desirable.) Whatever the reasons, because foster children are disproportionately poor and from minority groups, they are likely to enter the foster care system with histories of poor health and inadequate health care. Indeed, Moffatt et al.'s (1985) examination of 900 foster children revealed that nearly half had not seen a physician in the previous year.

Foster parents also are generally unable to offer continuity; foster placements are usually temporary and often brief, and a child may be replaced many times during his or her stay in foster care (Schorr, 1989). Thus the foster parent lacks the long-term perspective that is necessary to monitor and protect a child's health. Moreover, foster parents often are not informed of foster children's health problems (White & Benedict, 1985; Halfon & Klee, 1987; Schorr, 1989). In some cases, foster parents may be unable or unwilling to devote the time and attention required to obtain services for their foster children (Klee & Halfon, 1987), particularly if they question the approach being taken to the child's problem (Molin, 1988).

The ultimate legal responsibility for obtaining health care for the foster child lies with the foster care agency, and that responsibility is discharged by the caseworker. However, lack of continuity again characterizes the child-caseworker relationship; caseworkers have high rates of turnover (Schorr, 1988), and over time, individual children may have numerous caseworkers (Halfon & Klee, 1987). Due to this lack of continuity and large caseloads (Klee & Halfon, 1987; Schorr, 1989), caseworkers often see children infrequently (Simms, 1989), are unfamiliar with their needs and histories, and fail to notice their health problems (Frank, 1980). In other cases, large caseloads may mean that the caseworker must set priorities that result in only the most serious problems being addressed properly.
An additional problem is that foster care caseworkers are often ill-prepared to recognize mental health and other problems (Schorr, 1981; Pardeck, 1985). At one time a majority of foster care workers were professional social workers with Masters degrees; however, fewer than 10 percent are now so trained (Schorr, 1989). Thus caseworkers may be unaware of the implications of certain medical, developmental, and environmental events for children's health. Adams-Tucker (1984), for example, found that 56 percent of children who were identified as sexually abused by child protection services were not referred for any mental health services, and that African-American children, especially males, received disproportionately fewer referrals than white children and females. When White and Benedict (1985) asked caseworkers, natural parents, and foster parents about the health of foster children, they found that caseworkers evaluated the children as healthier than either the natural or the foster parents, perhaps because of caseworkers' failures to recognize health problems.

It is unlikely that pediatricians can provide the continuity that foster children need for protection of their health. There is no information about the attitudes of physicians and other providers regarding caring for foster children, but it is likely that attitudes are not positive. Pediatricians prefer active involvement of caretakers, complete historical information, and cooperation by parents; they may not be pleased with the difficulties of caring for foster children where these factors are not present. In any case, pediatricians have neither the time nor the long-term perspective to guard the health of foster children.

_Eabling factors_ describe the individual and community attributes that promote health care utilization, and that theoretically might mediate the effects of negative predisposing factors. For example, a major individual factor determining access to health care is health insurance. Other individual enabling factors include available personal time during health care facilities' operating hours, and personal transportation resources. Community attributes promoting utilization include convenient public transportation, and inviting public facilities with flexible clinic hours. The exact nature of community enabling factors would depend upon community attributes such as size, urban vs. suburban or rural, and other factors.

Other enabling factors relate to the nature of the facilities used by the poor. Some have argued that the research indicating that the poor value health care less than more advantaged families fails to acknowledge that the characteristics of public facilities make it less valuable, due to the crowded offices, long waits and inconvenient hours (Orr, Charney, & Straus, 1988) that often characterize public clinics. Discourteous treatment by some staff (Brown, 1988), complicated registration procedures,
and means tests also are common in public health clinics. To the extent that the public health care facilities available to the poor are less desirable, they constitute an "enabling" factor that discourages the acquisition of health care by the poor.

One might expect that placement in foster care, which transfers responsibility for the care of the child to the state, would restore equal access to health care. Benedict, White, Stallings, and Cornely (1989) did not find this to be the case. They examined predictors of health care utilization among 417 Baltimore children in foster care (between 1982 and 1983) whose foster parents were of the same race. They found that white foster children used about twice as many health care services (including mental health services) as African-American children, despite similar health needs.

In sum, foster children do not have the benefit of the most important ingredient in proper health care utilization: continuous relationships with adults who will monitor and protect their health. Although there are many adults with whom the foster child is associated, none is equipped to assume the consistent, continuous responsibility that is necessary to ensure that foster children receive appropriate health care.

Conclusions

The application of Aday and Andersen's (1975) model suggests that the three factors that shape the health care utilization of foster children do not promote, and sometimes impede, acquisition of appropriate health services. First, health care guidelines for foster children are not uniformly mandated by Federal or state policy; such policies are only now being developed at the community level in response to litigation. Second, the existing structure and organization of the health care delivery system do not accommodate the extraordinary needs of foster children. In particular, the funding mechanism for health care for foster children discourages participation by providers, and makes it difficult to locate adequate and appropriate resources for foster children. Finally, due to family and social circumstances, foster children are predisposed to poor health and inadequate health care, and placement in foster care deprives them of the most important enabling factor for good health in children: continuous adult protectors.

Analysis of the health care utilization of foster children using the Aday and Andersen model provides a useful framework for examining possible interventions for improving the health status of these children. Aday and Andersen assert that health care can be improved at any stage of the model, including new policy formulations, manipulation of health care system factors, and interventions designed to compensate for the damaging
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histories of foster children. The model thus suggests several directions for intervention and research.

Policy. The difficulties of testing the effects of policy changes upon the health of the poor have been demonstrated repeatedly. Diehr, Richardson, Shortell, and LoGerfo's (1979) review of studies related to policies designed to increase access to care showed generally negative and ambiguous findings on population health measures. Thus many investigators find it more practical to assess intermediate outcomes, such as utilization patterns. One might assess, for example, differential patterns of well-child care and compliance with immunization schedules in states that enact specific guidelines for the health care of foster children, versus those that have no such specific guidelines. The sporadic, state-by-state means by which such policies are being implemented, and the fact that those policies differ among the various states, present unique opportunities for natural experiments that may be used to evaluate the effects of these policies.

Structure. The simple definition and standardization of policy concerning health care for foster children is likely to remove some structural barriers to acquisition of health care. A standardized policy would be likely to mandate certain levels of care for all children, for example, resulting in the creation of services or the provision of access to services in other communities, thereby improving both quality and accessibility of care. Such policies should ultimately address other structural issues that are particularly crucial to foster children's needs, such as emergency (night and week-end) access to health care. Although the elimination of structural barriers to care is not likely to solve all problems with inadequate utilization (Berkanovic, Telesky, & Reeder, 1981), Orr et al. (1984) demonstrated that the simple availability of 24-hour telephone consultation, continuity of provider, and shorter waiting times for appointments can increase health care utilization by urban African-American children.

Elimination of the major structural barriers to care for foster children also may require addressing the broader questions concerning the delivery of health care to the poor. In particular, low rates of participation in the Medicaid program by pediatricians and mental health providers and the existence of inadequate numbers of certain types of services for all low-income children must be addressed, as long as foster child health care is financed by Medicaid.

While some positive systems-level steps have been made that will directly affect availability of health care for poor children (i.e. psychologists and social workers may now receive direct Medicaid reimbursement in many states), some states and communities have chosen to break from the traditional model of health care, in order to serve foster children more
effectively. These innovative programs range from the development of networks of community providers who agree to see foster children as a priority to centralized programs that provide specialty care only to foster children to programs that centralize some services and provide other services within the normal community system. Different community needs mandate a variety of models to meet those needs. Further, some localities are testing relatively simple interventions, such as the centralized health record that is constructed when a child enters care and follows him or her through foster care and into a permanent placement.

Evaluation of existing and new programs is clearly necessary to document the efficacy of specific structural changes and to determine any negative consequences of intervention. For example, while improved health care utilization would be the desired outcome, the implementation of particular changes may have unforeseen effects at other levels, such as adding burdens to already over-worked caseworkers or straining available resources so that other poor children are deprived. Finally, evaluation using multiple outcome measures must document both changes in utilization patterns and satisfaction with care.

Population characteristics. Only major changes in the social structure itself are likely to have any impact upon the factors that predispose poor and minority children to poor health and poor health care utilization. Even addressing the health care disadvantages (as opposed to their overall health) of poor children probably would require a substantial overhaul of this country’s health care system. A major question is whether intermediate interventions at the level of the child and family can be useful, given the chronic stress and inequity experienced by many families. Given the unique situation of foster children, however, and the reality of the current political and fiscal climate, it may be possible that significant gains may be made by addressing the issues of responsibility and continuity.

Clearly natural parents retain the long-term responsibility for their children’s health; this responsibility is affirmed by Public Law 96-272 and by the fact that the majority of foster children do eventually return to their own homes (Kadushin & Martin, 1988). Although in the short-term, most cannot manage their children’s health needs, as evidenced by the foster care placement itself, they must be prepared to assume that responsibility when their children are returned. Foster care agencies must work to keep natural parents involved in their children’s health and health care (White et al., 1987; Molin, 1988), and must provide more health education for parents, as well as services designed to promote appropriate health behavior. Those efforts can be enhanced by longitudinal research to evaluate whether increased involvement has a significant effect on parental
behaviors that will promote their children's health, such as providing consistent well-child care, seeking treatment when problems develop, and complying with medical advice.

Foster parents, too, have a role in protecting foster children's health. Foster parents need additional education and training in the recognition of the range of health problems and in the proper response when they identify problems (Pardeck, 1985; McIntyre & Keesler, 1986; Schorr, 1988). They also need assistance and support from foster care agencies to obtain the goods and services that the children require, and support for advocating on behalf of foster children. Perhaps most simple and least expensive would be the provision of complete information on foster children's health problems to foster parents. Research could demonstrate whether training, education, and increased agency support are associated with foster parents' actions to protect the health of foster children.

The foster care agency and caseworker bear the greatest responsibility and can have the greatest impact in the health of foster children. Identification, tracking and monitoring of foster children's health must be improved. A number of states are already acting to make these recommendations reality. For example, Massachusetts (Schorr, 1988), Maryland, and California have enacted Medical Passport systems. The Medical Passport (referred to by White et al., 1987, as a "health diary") is a permanent record of the foster child's needs and services that follows the child through the foster care system and beyond, and may be used to document the child's health history. The Passport system is a beginning point in a process that also must include increased efforts by caseworkers to obtain all records, improved cooperation by previous and current providers, and other efforts to produce a careful, thorough health history for each foster child.

Caseworkers must be educated and trained to recognize problems (Klee & Halfon, 1987), and they must act forcefully to obtain needed services for children. Health must be a higher priority for caseworkers and agencies in their case planning. In addition, agencies must act to reduce the turnover and caseloads of caseworkers, because even the most capable foster care worker cannot protect children whom they do not know and follow for some time. Increased access to expert health consultation for foster care workers can supplement better education (Fryer, Poland, Bross, & Krugman, 1988).

Research should demonstrate whether better education and training increase caseworkers' general knowledge of the health risks faced by foster children, their recognition of health problems in foster children, the likelihood of seeking treatment for suspected problems, and compliance with recommended schedules for well-child care and with medical advice.
In a similar vein, pediatricians and other health care providers must be more knowledgeable of and sensitive to the peculiar circumstances and needs of foster children (Molin, 1988; Schorr, 1989). Competent care cannot be provided without an understanding of the child’s family background, his or her current legal situation, the extent and nature of current contact with his family, and the agency’s plans for the child, among other factors. To that end, foster care agencies and all related professional organizations must assume responsibility for organizing and educating providers. Evaluation research then should demonstrate greater general knowledge of foster children’s circumstances and problems, enhanced vigilance in treating foster children, and more appropriate care for these children by those providers.

Communities must work to increase the availability of all types of health services for foster children. The recent diversion of resources into the prevention of foster care placement is laudable; when it is possible children are most likely to thrive in their own homes. But foster care will always be a necessity, and the children who are placed are those with the most serious of health needs. Ideally, communities will not wait to be forced by litigation to pay attention to such needs, but should plan to assure adequate and appropriate services based on their own community characteristics, current trends, and future needs.

Finally, the best hope for improving the health and well-being of foster children must lie in improving the foster care system itself. Public law 96-272 demands that timely decisions be made about children’s permanency plans, and about families’ service needs, and that needed services be provided quickly. Diehr et al. (1979) emphasize that above a certain level, health care bears little relationship to health. It is the quality of the physical and social environment and the individual’s personal health habits and lifestyle that are most important. A general improvement of the child welfare system itself, with a broad range of available services and support for families, is likely to result in the most significant improvement in the health and well-being of foster children.
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