I. Adolescent Health Care Services are Vital to Regional Prosperity

Investing in the health of young people is vital to regional prosperity. Critical decisions regarding childbearing, educational attainment, and career goals, many carrying lifelong consequences, are made between the ages of 10 and 21. The choices adolescents make during this intense and often difficult period closely reflect the opportunities, support mechanisms, and guidance available to them.

Each dollar invested in comprehensive adolescent health services enhances personal health and productivity, and helps to lower the long term public costs of health care. Unfortunately, investments in adolescent health care are often woefully underfunded, despite the fact that they provide extensive social and economic benefits to communities. Perhaps this is because policymakers and economists are largely unaware of the full economic impact of neglecting the health care of adolescent populations. And yet, the negative consequences of ill health, left untreated during adolescence, can permanently lower human capital and quality of life. Problems neglected in adolescent populations can lead to a myriad of long-term economic and social costs that detract from regional prosperity.

Without adequate adolescent support networks and services, young people are far more likely to experience serious health problems, teen pregnancy, diminished academic performance, and reduced economic opportunity. The unmet need for adolescent health services is greatest among low income and minority youth because they have less access to services. This is particularly true in New York City where adolescent morbidity is
exceptionally high and access to health care services is exceptionally low. While it is often easy to blame the health problems of low income minority teens on a lack of personal responsibility and/or cultural factors, evidence clearly shows that where inner city minority youth receive high quality adolescent appropriate services, their health outcomes are often comparable to those of white adolescents in the broader population.

The human cost associated with denying adolescents health care is likely to be one of the most serious negative legacies of the current health care crisis and the continued restructuring of health care markets. The financial squeeze caused by the restructuring of health care markets - characterized by declining rates of Medicaid and private insurance coverage among adolescents, and compounded by declining reimbursement rates among those that do have coverage - has caused many institutions to scale back services for the uninsured. The current shortage of adolescent services has serious implications for the health care system and leads to increased demand for services at the remaining institutions that continue to serve the uninsured. As a consequence, those whose mission it is to provide services to underserved adolescents are finding it increasingly difficult to stretch resources far enough to provide services to all those who seek them. The recent experience of The Mount Sinai Adolescent Health Center clearly illustrates the financial squeeze imposed by the economic realities of changing health care markets.

The long-term costs of deferred care, and the health consequences of untreated adolescent illnesses, will lead to a growing strain on a shrinking pool of health care providers that serve a growing pool of uninsured adolescents. The immediate expansion of public support for adolescent health care services is thus a critical component of efforts
to address the current health care crisis. The early provision of comprehensive, confidential, multi-disciplinary adolescent-specific services to young people, regardless of their ability to pay, can substantially lower the human and economic costs associated adolescent health risks.

II. Adolescent Health Care Needs and the Costs of Unmet Need

Although adolescents, in general, have lower rates of morbidity for most illnesses, they have much higher susceptibility to a number of health concerns that can lead to large preventable private and public health care costs if early interventions are not provided. Their lack of access to primary, reproductive and mental health services, as well as health education, during this critical transitional period can have devastating life long consequences that take a heavy human and economic toll.

For example, adolescents have the highest incidence of STDs and complications resulting from STDs\(^1,2\), unwanted pregnancies and complications of pregnancy, mental and physical health problems associated with sexual/physical abuse\(^3,4\), and avoidable injuries. Left unchecked, these adolescent health problems can lead to serious health consequences. The future social and economic costs associated with failing to provide adolescents with access to primary health care services can be enormous. The postponement or denial of basic health care services to adolescents can lead to increased emergency room utilization\(^5,6\), increased public expenditures on acute care as well as long-term chronic care\(^7\), increased social services case loads, and a decline in the human capital of the labor force, resulting in lost worker productivity and a diminished tax base.

Ready access to health care providers that offer confidential adolescent-specific services can greatly improve adolescent health status and psychological well-being. The
most effective way to address adolescent health care needs is to provide comprehensive and multidisciplinary services including primary care, reproductive health care, mental health and health education in a single location. Comprehensive health centers provide a critical transitional source of care for youth that are at a stage of development when their health care needs are very different from those of children, but while they are still in need of greater guidance and support than fully independent adults.

A description of the most pressing adolescent health care needs is presented below. The discussion highlights the costs associated with unmet need and the potential social and economic benefits gained by providing comprehensive adolescent health care services.

**Reproductive Health Care Services**

Every year 1 million adolescents between the ages of 15 and 19 become pregnant in the United States, and without publicly funded family planning programs, there would be an additional 380,000 pregnancies among this age group each year. Improved contraceptive use was largely responsible for the 9% drop in teen pregnancy rates in the United States between 1988 and 1995. For every dollar spent to provide publicly funded contraceptive services, an average of $3 is saved in Medicaid costs for pregnancy related health care and medical care for newborns. Removing funds for family planning would lead to an additional 155,000 births to teen mothers each year, many of whom would become eligible for social services. Despite the tremendous benefits provided by family planning services, Title X funding for such programs has fallen in real terms by 61% since 1980. In fact, evidence suggests that Federal government programs spend
275 times more on services for families begun by teens than they spend on teen pregnancy prevention programs.\textsuperscript{12}

Health education and counseling, in tandem with reproductive health services can be very effective in lowering pregnancy rates among adolescent females. One study found that pregnancy rates fell by 50\% among young women attending a community based pregnancy prevention program\textsuperscript{13}. Evidence from the Mount Sinai Adolescent Health Center also demonstrates that adolescents receiving age appropriate primary and reproductive health care services are far less likely to become pregnant than their peers in the general population of New York City. The figure below shows pregnancy rates for Mount Sinai Adolescent Health Center’s teens aged 15-19, and compares them to pregnancy rates at the city, state and national level. In New York City there are 157 pregnancies per 1000 African American teenagers between the ages of 15-19 each year, while at Mount Sinai the comparable rate is 57, 64\% lower. Similarly, the pregnancy rate is 66\% lower among Latinos utilizing AHC’s services, than for the City as a whole. Over 92\% of AHC’s patient population falls into at least one of these two groups.
Pregnancy rates among African American and Hispanic adolescents attending the Mount Sinai Adolescent Health Center are well below pregnancy rates among white adolescents as a whole for NYC, and are roughly on par with white adolescents upstate (see Figure 1). This evidence clearly suggests that the availability of confidential adolescent appropriate reproductive health services is more important than race in determining teen pregnancy rates within a population.

AHC has a pregnancy clinic and also accepts walk-in appointments for pregnancy testing among non-patients. Even when including these pregnancies, the rate of pregnancy among AHC patients is still 45% lower for African Americans and 48% lower for Latinos than in the broader population of New York City.

Assuming that these two groups are representative of African American and Hispanics in the broader population of NYC, the decrease in pregnancy rates translates
into roughly 750 averted pregnancies each year. In fact, the number of averted pregnancies is likely to be even larger since most of the patients at AHC come from the poorest neighborhoods of NYC, such as the South Bronx, where pregnancy rates have been estimated to be over 200 per 1000 teens aged 15-19\textsuperscript{14}.

The human and economic benefits of averting pregnancies are clear. One study conducted in Canada, where health care costs are substantially lower, estimated that the average cost of medical services related to an unwanted pregnancy is $1,289\textsuperscript{15}. At this cost, the reduced pregnancy rate would lead to a savings of almost $1,000,000. And yet the savings are likely to be even greater. The lower pregnancy rates at the Mount Sinai Adolescent Health Center lead to at least 300 fewer births to teenage mothers annually, saving the City roughly $800,000 in public expenditures on prenatal and delivery services alone\textsuperscript{1}. Clearly, averted births also provide dramatic benefits in terms of reduced need for social services for teen parents. But most importantly, the reproductive health services provide improved economic and social prospects for adolescents that are able to postpone childbearing until they are ready for parenthood.

\textbf{Counseling Services for Pregnant or Parenting Teens}

Of the more than one million teen pregnancies every year, roughly 55\% are carried to term, leading to a birth to an adolescent parent\textsuperscript{8}. Unintended pregnancies to teen mothers are associated with a lack of prenatal care, low birth weight and high infant morbidity/mortality. Adolescent mothers are seven times more likely to live in poverty than their non-parenting counterparts, and their children are less likely to have access to health insurance, and will experience greatly reduced lifetime health and economic prospects.\textsuperscript{16,17,18} In addition, a lack of access to health care, particularly among
adolescents, prevents many young women from obtaining adequate prenatal care (see Figure 2). This fact contributes to the very poor health indicators for maternal and child health in the U.S. which ranks worst among 13 industrialized countries for low-birthweight deliveries and neonatal and infant mortality.19

Counseling and health education can lower the rate at which pregnant teens carry

![Figure 2: Percentage of Pregnancies with Late or No Prenatal Care, 1998](image)

*Source: Duffy, Niev and Angela Diaz, “Cost Effectiveness of Reproductive Health Care Services at a Comprehensive, Multidisciplinary Urban Adolescent Health Center”, Working Paper, Mount Sinai Adolescent Health Center, Mount Sinai School of Medicine, New York, March 2002. Data provided by the Bureau of Biometrics, NYS DOH

![Figure 3: Percentage of Teen Pregnancies Resulting in a Birth to an Adolescent Mother Aged 15-19, 1998](image)

their pregnancies to term, improving the life prospects of both the young woman and her future family, when she makes an active decision to begin childbearing. Evidence from the Mount Sinai Adolescent Health Center, presented in Figure 3, indicates that health education and counseling services provided to pregnant teens can reduce the rate of teen parenting. The rate at which both African American and Hispanic Adolescents carry to term is 16% lower at the Center than it is for their counterparts in NYC as a whole. Note that the rate of parenting among Hispanics at the Adolescent Health Center is below that for whites in NYC, a fact that runs counter to the common perception that the high parenting rates among Hispanic adolescents is a cultural phenomenon.

Adolescents that seek pregnancy outcomes counseling at the Mount Sinai Adolescent Health Center and choose to carry their pregnancies to term are referred to Mount Sinai Hospital for prenatal care and delivery. All teen parents are offered parental skills training following the birth of their child and are counseled on nutrition and appropriate care for infants and children.

**STD Screening and Treatment Programs**

Each year in the United States 3 million adolescents under the age of 19 contract a sexually transmitted disease. One of the most prevalent STDs is Chlamydia, and the majority of new cases each year are among adolescents. Estimates show that roughly 10% of sexually active adolescent females in the United States are infected with Chlamydia Trachomatis, double the rate for women of all ages in the U.S. National rates are boosted by extremely high prevalence rates in economically disadvantaged neighborhoods, where estimates range as high as 15-26%. Studies show that the risk of
Chlamydial infection is many times higher for African American adolescents than for White adolescents\textsuperscript{22}.

The direct and indirect costs of Chlamydia total over $2 billion annually\textsuperscript{23,24}. The human costs are also enormous; among those with untreated Chlamydia infections, 20-40\% will develop PID, leading to high rates of chronic pain, ectopic pregnancies, and infertility\textsuperscript{17}. But even more disturbing are the implications that extremely high Chlamydia prevalence rates have for the spread of HIV. Current infection with Chlamydia raises the risk of HIV infection by 3 to 5 times\textsuperscript{25}. Since adolescents living in communities with the highest Chlamydia rates are also likely to be living in communities with the highest HIV rates, they experience much higher exposure to the risk of HIV infection.

Because Chlamydia rates are so high among adolescents, the Center for Disease Control and Prevention recommends universal screening of all adolescents aged 20 years and under. A broad based, publicly funded regional approach designed to reach all youth within each community is a critical component of a successful effort to eliminate the disease. A number of studies clearly demonstrate that such programs are highly effective in reducing Chlamydia rates within a population\textsuperscript{7,25,26,27}. Unfortunately, due to the very limited public funding for these programs, Chlamydia rates among economically disadvantaged teens remain alarmingly high\textsuperscript{28}. Though New York City and State have no comprehensive public health policy for reducing the prevalence of Chlamydia, a number of health care facilities have implemented routine screening for the disease.

In 1986 the Mount Sinai Adolescent Health Center implemented a routine screening and treatment program to combat the extremely high rates of Chlamydia Trachomatis, a
sexually transmitted infection, among the patient population. In 1985 the rate of infection was 28% for female African American patients and 24% for Hispanics. By 1999 the rates had fallen to 7% and 4%, respectively (see Figure 4). The benefits, both in human and economic terms, of preventive screening and treatment of STDs among adolescents are well established. Health care services that lower STD rates among adolescents can greatly reduce the prevalence of more serious chronic and acute conditions resulting from untreated STDs, such as Pelvic Inflammatory Disease, that carry high human and economic costs.

**FIGURE 4: DECLINING CHLAMYDIA PREVALENCE RATES AT MOUNT SINAI ADOLESCENT HEALTH CENTER: 1985-1999**


**HIV Counseling and Screening**

Though HIV infection rates are declining for the population as a whole, there has been little progress in combating the disease among African Americans, particularly
African American adolescents. Of the 7,200 new cases of HIV reported among 13-24 year olds between January 1994 and June 1997, 63% were African American. HIV is also spreading among females, representing 44% of cases among young people. At least 26% were infected through heterosexual sex. Adolescents in New York State are at exceptionally high risk of being infected with HIV. The HIV rate among teenage military recruits in New York is five times higher than elsewhere in the U.S. Adolescents from economically disadvantaged backgrounds are also far more likely to become infected. Young people in the U.S. Job Corps are 12 times more likely than teenage military recruits to be infected with HIV.

The fact that Chlamydia rates are exceptionally high among African American adolescents is particularly alarming since it increases the risk of HIV infection by three to five times. More research is needed regarding the link between STD rates and the spread of HIV. Health education, HIV counseling and screening, and STD screening and treatment, are badly needed in order to stem the spread of HIV among young African Americans. To ensure the effectiveness of such interventions these services must be provided within an adolescent friendly environment, ensuring absolute confidentiality and provision of services regardless of ability to pay.

**Mental Health Services and Health Education**

Health education and skills building are important components of any adolescent’s healthy development. Adolescents often make important decisions regarding reproductive behaviors based on widespread misconceptions among teens. For example, one commonly held perception among many adolescent females is that it is
not possible to become pregnant the first time one has sexual intercourse. And many females feel that they do not have a right to say no to the sexual demands of a boyfriend.

A combination of poor information and under-developed personal negotiating skills contributes to the fact that over half of all adolescent pregnancies occur within the first six months of sexual activity. Evidence suggests that a majority of adolescents aged 15 and under that engage in sexual intercourse, do so involuntarily, and that a high proportion of teen pregnancies are the result of non-consensual sex. This fact underscores the importance of providing health education and skills building counseling for adolescents even before they become sexually active, particularly for individuals at high risk, such as those with low self esteem and a history of abuse.

Counseling and skills training are critical for adolescents that have experienced abuse. Numerous studies suggest that a full 20-30% of women have experienced sexual abuse as children, the majority by a father or step-father. Reported cases of childhood sexual abuse increased by 322% between 1980 and 1990. Research shows that sexual abuse leads to high risk behaviors and poor developmental outcomes such as impaired cognitive, social, emotional, and psychological development. It has also been linked to multiple substance abuse and teen pregnancy. Those who have been sexually abused often have lower self esteem and are more likely to experience sexual, physical, and/or emotional abuse later in life and are less likely to be consistent users of contraception and often engage in high risk sexual behaviors.

Early support services to help create a safe environment, enhance self esteem, and build skills that will help an adolescent negotiate more effectively within relationships, are critical to recovery. Such support services are often as critical to an adolescent’s
health as are medical services, and often are the screening tool that indicates the need for closer medical attention.

Comprehensive health care programs like that at the Mount Sinai Adolescent Health Center routinely screen new patients for a history of abuse and other warning signs that would indicate greater vulnerability to experiencing violent or high-risk situations. Though this requires a greater expenditure of time with each patient, it also greatly improves the chances that an adolescent will receive the support services necessary for healthy development.

Without sufficient support networks for adolescents, the emotional stresses that family economic hardship imposes on young people, as well as the violence and/or abuse they may experience at home, in school, or on the streets, may lead to destructive behaviors or even mental illness. According to information obtained from the New York State Department of Health, mental illness among adolescents appears to be on the rise in New York State. Though a dramatic increase in adolescent hospitalizations for mental illness since 1990 (see Figure 5) may partially reflect the shorter duration of hospital visits, it is unlikely to explain the full increase in admissions.18,37 Earlier interventions with counseling and support services for troubled adolescents may help to prevent tremendous human costs among high-risk teens and avert costly hospitalizations.
The early provision of comprehensive, confidential, multi-disciplinary adolescent-specific services to young people, regardless of their ability to pay, can substantially lower the human and economic costs associated with adolescent health risks.

III Adolescent Access to Care.

Poor adolescent health outcomes are, at least in part, directly attributable to a lack of access to primary and reproductive care. This is especially true among low income inner city adolescents. And yet, the large disparities in health outcomes, including teen pregnancy rates and STDs, across racial/ethnic groups are often attributed to the perceived high risk behaviors and cultural attitudes of inner city populations. The available evidence contradicts this perspective. Evidence, including that presented in the
charts above, clearly demonstrates that where low income minority youth receive high quality adolescent appropriate services, their health outcomes are often comparable to white adolescents. In fact, the poor health outcomes of low income and minority adolescents are likely to stem from their severe lack of access to adequate health services.

Sadly, the current health care crisis and the restructuring of health care markets are increasing barriers to adequate adolescent care. Although young children are targeted by a number of new health care initiatives, older adolescents are finding it increasingly difficult to obtain adequate services, especially those between the ages of 18 and 21. The following are a few of the reasons that adolescents, particularly those within “high risk” populations, experience restrictions on their access to care:

![Figure 6: Rates of Uninsured in the U.S., Early and Late 1990s](chart)


- Adolescents are at greater risk of being uninsured and the rate of uninsured is growing fastest for adolescents and young adults. In 1997 17.9% of adolescents aged 13-18 years old were without any form of health insurance. Individuals
without health insurance, disproportionately adolescents, are far less likely to obtain primary care. A broad literature documents the poor health status associated with the lack of health insurance among adolescents. Adolescents are less likely to obtain care, and are more likely to be in fair or poor health if they are uninsured, poor, and/or are non-white.

- In response to the rapidly rising numbers of children without health insurance, policy makers expanded Medicaid eligibility for children in the late 1980s and created the CHP program in the mid to late 1900s. However, increases in Medicaid coverage during the late 1980s and early 1990s were largely reversed by national, state and local welfare reforms that made it more difficult to apply for Medicaid benefits after 1996. One study found that in New York State, declines in Medicaid were most rapid among those under the age of 18, and that declines in Medicaid coverage between 1995-1997 were associated with a rise of 1.3 percentage points in the share of uninsured children between 1996 and 1998.

- Though teens up to the age of 18 may be eligible for Medicaid/CHIP, their parents must sign their enrollment forms, leading to an additional barrier to services and a loss of confidentiality.

- Although expansions in Medicaid eligibility in the late 1980s increased the numbers of children enrolled in the program and helped to slow the increase in proportions of children with no insurance, older adolescents benefited far less from the new programs. Unfortunately, adolescents over the age of 18 are ineligible for these programs, are less likely to be covered by their parents’ insurance and have little chance of obtaining health care benefits through an employer.

- Older adolescents, who would be able to self enroll, must report household income when applying for Medicaid, and are often ineligible because a parent’s income exceeds the Medicaid limit. In addition, asking a parent for documentation of their income may be problematic and eliminates the confidentiality most adolescents need when obtaining services. There may also be a lack of information concerning how to apply for public health insurance or even whether or not an adolescent is eligible for it. Adolescents are less likely to know about available sources of health care.

- Many clinics have minimum fees for visits, lab tests, and medications. Even where these fees are low, they may prohibit many teens from obtaining services. Even where doctors are willing to provide services free of charge, registration counters at hospital outpatient services and clinics which enforce these minimum fees serve as gatekeepers that may prevent many young people from obtaining services.
• A lack of confidentiality is frequently cited as the principal barrier to adequate access to care for adolescents. Although such notification violates their legal right to confidential services, many insurance companies continue to send notification of services to the insurance holder, usually a parent. In many cases, fear that a parent will be notified of an appointment prevents many teens from seeking care. Though school based clinics offer extremely valuable health care services to adolescents they often lack the degree of confidentiality required by teens or may not offer a full range of services including reproductive health care. Independent adolescent clinics that accept referrals from school provide more confidentiality and comprehensive care, and increase the effectiveness of school based clinics in ensuring that adolescents have adequate access to care.

• Few services are designed specifically for adolescents or are staffed with providers with the specialized expertise and knowledge for working with this population. The health care needs of adolescents are very different from those of children, but adolescents are still in need of greater guidance and support than fully independent adults.

• Doctors’ office hours are usually during school/work hours and do not permit the flexibility needed to address the needs of adolescents.

• Since the 1980s many programs for teens have experienced funding cuts. For example, funding for family planning services, used heavily by teens, has fallen by 61% in real terms since the early 1980s.

As a consequence of the poor availability of adolescent health care facilities, adolescents must often travel long distances to find quality health care services that meet their needs.

The broad regional distribution of the patients using the Mount Sinai Adolescent Health Center, depicted in the map on the next page, provides a clear example of this phenomenon.
IV. The Deepening Crisis in New York City

For a variety of reasons, a number of them listed below, New York City appears to have exceptionally severe problems associated with an overburdened health care system and a lack of access to health care services.

- New York State has the highest degree of income inequality in the country and much of its poverty is concentrated in its inner cities\textsuperscript{51}. The very high poverty rate and the high concentration of minority groups in communities with few resources are among the factors that contribute to limited access to care and poor health status among adolescents in New York City\textsuperscript{52}.

- New York City has far higher rates of uninsured individuals than in the U.S. or New York State, and the rate of uninsured is growing more rapidly than elsewhere in the state.\textsuperscript{16}

![Figure 7: Rising Uninsurance Among Adolescents Aged 15-21](image)


- Because the uninsured are more likely to be in fair or poor health, morbidities tend to be higher in New York City where there is a high concentration of the uninsured, boosting the need for services.\textsuperscript{40}

- The poor health status of minorities contributes to the relatively poor health indicators for New York City when compared with the state as a whole. Even after controlling for insurance status, minorities appear to have less access to
health care services and higher levels of morbidity and excess mortality (see Figures 8 and 9). Numerous studies have linked the poor health status of minorities living in the inner cities to higher levels of stress and economic hardship.

**FIGURE 8: PERCENTAGE BY WHICH AFRICAN AMERICAN ADOLESCENT MORTALITY RATES EXCEED WHITE ADOLESCENT MORTALITY RATES (AGES 10-24)**

[Graph showing percentage differences in adolescent mortality rates between races.]

*Source:* Author’s calculations from data obtained from Bureau of Biometrics, NYS DOH and Claritus, Inc.

**FIGURE 9: PROBABILITY OF SURVIVAL TO AGE 65, FOR A GIRL AT AGE 15**

[Graph showing survival probabilities for different racial groups.]

New York State, and particularly New York City, has a high proportion of immigrants, many of whom are not well integrated into the health care system either because they are without health insurance, are ineligible for social services, or face additional barriers including those created by language limitations. Non-citizens are far more likely to be uninsured than U.S. citizens.

Those with no insurance and limited access to care, particularly in the city, are more likely to develop chronic and acute conditions, such as Pelvic Inflammatory Disease, that require hospitalization. They are also more likely to make expensive, non-reimbursed emergency room visits for Ambulatory Care Sensitive conditions.

Among the insured in New York City, relatively few have private insurance, and a relatively high proportion are covered by Medicaid. Though individuals covered by Medicaid have better access to health care than the uninsured, they are more likely to experience barriers to care than those with private insurance.

The dramatic decline in Medicaid coverage in New York City which has resulted from both national and local welfare reforms, has led to an increase in self-paying patients, and thus rates of non-reimbursement. Harsh new Medicaid enrollment policies imposed by the Mayor’s office in NYC led to rapid declines in Medicaid coverage. Though a successful Federal lawsuit may help to relax some of the City’s stringent Medicaid application requirements, a large share of those patients eligible for Medicaid currently

![Graph showing rates of uninsured: citizens versus non-citizens.](image-url)

have no health insurance, placing a growing financial strain on health care institutions providing care to the poor.

The high level of vulnerability of New York City’s population and the poor availability of services, increases the financial pressure on the few facilities that do provide services to vulnerable adolescent populations who are unable to pay for the services they receive. As a consequence, those whose mission it is to provide services to underserved adolescents are finding it increasingly difficult to stretch resources far enough to provide services to all those who seek them.

IV. The Crunch: The impact of the continuing health care crisis on health care providers that serve uninsured adolescents.

Health care providers pay for a large and growing share of the cost of health care services for adolescents. The changing financial landscape for health care providers is well illustrated by hospital discharge insurance data over the last decade. According to SPARCs hospital discharge data, between 1992 and 1999, the rapid decline in Medicaid coverage was accompanied by a rise in the share of self pay hospital discharges of over 50%, or 5.1 percentage points, from 8.9% to 14% (see Figure 11).

Evidence suggests that rates of self-pay appear to have grown most rapidly for some preventable illnesses that are more common among those with little or no access to primary health care. For example, Figure 12 shows that the rate of self-pay among adolescents aged 15-21 hospitalized for pelvic inflammatory disease in New York City doubled from 13.1% in 1992 to 26% in 1999. Self-pay among adolescent mental health discharges rose by 91%, between 1990 and 1999, so that hospitals must now absorb the cost of caring for one out of six of such patients.
In order to find the resources necessary to provide services to the uninsured, health care providers shift revenues from insured patients to cover the costs of the
uninsured, a practice called “cost-shifting”. However, the restructuring of health care markets is making this practice increasingly difficult.

While hospitals have experienced a decline in the proportion of adolescent patients that are covered by traditional Medicaid, they have also witnessed a strong shift among those that do have Medicaid coverage into Medicaid HMOs, which often impose more stringent reimbursement levels and restrictions. A similar shift has occurred for those that are privately insured, among whom a growing share are enrolled in managed care companies/HMOs that set strict caps on the fees charged by hospitals. Under managed care, cost-shifting becomes much more difficult. For providers, the dramatic rise in managed care enrollment in NYC has been accompanied by a precipitous fall in more traditional, and relatively lucrative forms of coverage, in particular, fee for service Blue Cross/Blue Shield (as seen in Figure 13 below). As a consequence of declining reimbursement rates, many private hospitals can no longer afford to care for the uninsured and as a consequence are reducing care provided to those that cannot pay.

FIGURE 13: ADOLESCENT HOSPITAL DISCHARGES BY TYPE OF INSURANCE, NYC

The financial problems of public and not-for-profit private health care facilities that treat a disproportionate share of the uninsured are worsened by the fact that they must accommodate the growing numbers of the uninsured turned away by other not-for-profit and private hospitals. As a consequence, facilities that serve the poor are shouldering a growing share of the costs of the uninsured at a time when public monies for health care are stagnating or even shrinking in real terms. The strain on health care providers that provide services to uninsured adolescents will continue to increase as the restructuring of health care markets continues and the proportion of adolescents with no health insurance continues to increase.

The experience of Mount Sinai Adolescent Health Center depicted on the next page, clearly illustrates the growing squeeze created by declining Medicaid coverage due to harsh enrollment criteria in New York City, rising rates of uninsured adolescents, and increased demand from patients that have lost access to care when other facilities cut services.
A Decline in Public Funding and a Rise in the Demand for Services

Due to welfare reforms, both nationally and locally, there has been a decline in the proportion of the population covered by Medicaid. At the Adolescent Health Center, this has been reflected in a decline in the percentage of medical visits covered by Medicaid from 40% to 25% between 1996 and the year 2000 to date. The decline has been accompanied by a rise in “self-pay” visits, for which the Center receives no reimbursement. At the same time, the demand for all services at the Center is increasing, possibly because those dropped from Medicaid are now being denied access to services elsewhere. Between 1994 and 1998, the number of visits to the Adolescent Health Center grew by 43%. The growing cost of non-billable visits has been absorbed by the Center.
The growing financial constraints facing health care facilities have led many facilities to reduce capacity, make staffing cuts, eliminate community services, and/or deny services to the uninsured. Some are forced to close their doors altogether. Since 1980, 178 hospitals in New York State have closed, merged, or been converted to other uses. Community services for the underserved are often the first programs to be cut. These trends are likely to have serious consequences for the quality of care, both for the insured and uninsured.

VI Policy Implications

Adolescents are disproportionately affected by the current health care crisis in New York State and New York City. Dramatic changes in the structure of health care financing, such as the shift towards managed care and a steadily rising proportion of adolescents with no health insurance, have created serious challenges for health care providers that serve ‘at risk’ youth. As a consequence, the immediate expansion of public support for comprehensive adolescent health care services is a critical component of efforts to address the health care crisis. The following policy initiatives would greatly improve the financial viability of adolescent health services:

- **Discretionary funds at the state and local levels** should be appropriated for comprehensive adolescent health services, on an ongoing basis, since cost savings accrue at both levels.

- **Funding for Clinical Centers of Excellence** - facilities that pioneer effective and innovative strategies for addressing the comprehensive health care needs of ‘at risk’ adolescent populations – can help to promote the further development of high quality and cost effective programs that respond to the
changing health care needs. Funding these centers can also help to expand badly needed training programs for practitioners of adolescent medicine.

- **Efforts to improve the performance of NYC school students** are enhanced by increasing the comprehensive health care services available to students. In his decision regarding *Campaign for Fiscal Equity v. The State of New York*, which requires greater funding for programs to improve the academic performance of New York City youth, Judge DeGrasse relates poor school performance to “health-related conditions, such as asthma”, and suggests as a possible solution “directing adequate funding to programs that help assure higher attendance levels, such as arts, physical education, and school-based health services”. In order to ensure confidential services for students that require them, school-based clinics often rely on their ability to make referrals to independent programs such as the Mount Sinai Adolescent Health Center. As a consequence, appropriations for school based clinics should also include funding to cover referrals to independent adolescent health centers.

- **Minor consent legislation** that permits adolescents to self-enroll for Medicaid coverage of ‘minor consent’ services is an integral part of any long term solution to the funding problems of facilities that serve the rapidly growing pool of uninsured adolescents. Though public health law ensures that adolescents have a right to confidential services, a lack of health insurance frequently impedes their ability to obtain needed care.

- **Medicaid reimbursement rates** should be adjusted to reflect the full cost of providing comprehensive care to adolescents.
The early provision of comprehensive, confidential, multi-disciplinary adolescent-specific services to young people, regardless of their ability to pay, can substantially lower the human and economic costs associated with health risks experienced by adolescents. From a policymaker’s perspective, such expenditures are a bargain, since relatively small early investments in adolescent services can lead to measurable social outcomes and substantial cost savings. They should also be attractive because expenditures on preventive health care are politically more acceptable than expenditures on programs that address the costly consequences of unmet health care needs, such as drug treatment and social support programs.
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1 Assuming the typical public reimbursement rate of $2,800 for prenatal care and delivery services per pregnancy.