VIEWPOINT

HEALTH AND THE 2024 US ELECTION

Capitated, Multisector, Universal Preventive Health Care for Children and Youth

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It has been nearly 20 years since pediatricians were encouraged to "rethink" well-child care[1] and a decade since the future of well-child care as a component of primary care pediatrics was questioned.[2] Over that interval, changes in preventive care practices have been, at most, modest. Yet the health challenges facing children and youth and the practical barriers faced by pediatricians demand more than modest changes in how health care is provided.

The required transformative change is a formidable task, not least because children's health care is a small part of a health care system skewed by a nearly 9 times greater expenditure for the care of adults. One area ripe for transformative change is the preventive and health-promoting care provided to children and their families. It differs qualitatively from acute and chronic medical care for which practices are primarily designed and from preventive care for adults. With some exceptions, the latter tends to be integrated into visits not specifically designed for prevention and largely focuses on early identification and prevention of chronic illnesses. By contrast, well-child care (WCC) ordinarily occurs as a series of separate, scheduled encounters based on children's age and national immunization schedules and includes a great deal of age-specific and, ideally, patient-specific parent education intended to address developmentally relevant topics and to promote children's long-term health and well-being.

Current Status

Although WCC is a mandated component of Medicaid and the Children's Health Insurance Program and is covered by nearly all commercial insurance, its accessibility, provision, content, and quality have been shown to vary greatly among states, communities, practices, and populations.[3-5] Improvements to care structure and processes have been constrained by traditional patterns of practice and by professional training, licensure, time, and reimbursement. Despite these constraints, many aspects of WCC have been provided with greater efficiency by individuals other than physicians and alternative formats.

Pediatric practices have been tasked with an ever-increasing set of responsibilities in large part because it is the only nearly universal, predictable point of contact with parents of young children during the formative years of early childhood and a common point of contact thereafter. Yet attendance at WCC visits is neither universal nor predictable, especially beyond the first 2 years of life, and even when such contacts occur, they are relatively brief and replete with competing contents. A different approach is needed.

Potential Changes

Carving Out Preventive Services

A stated goal of WCC is "to improve the health and well-being of all children," a goal not unique to pediatrics but shared by public health and other community child- and family-service professionals.[6] This shared responsibility implies interdependence among sectors and argues for a multisectoral, population-based approach to preventive services for all children and youth residing in the US. Consequently, it is suggested here that WCC, which deserves a new name emphasizing multisectorial promotion of optimal functional outcomes, should be redesigned as a conceptually discrete set of universally available services provided by multiple community service sectors supported by alternative, blended funding.

Noninsured Service

Central to transforming WCC should be ceasing to treat it as an insurance product.[7] Insurance is intended to redistribute money for health care from those in good health to those who experience illness and assumes that the need for health care is, in general, disparate and unexpected. It even includes mechanisms, ie, copayment, to discourage utilization, which is antithetical to preventive care. In contrast, WCC is inherently predictable, and as a universal service its funding and distribution of payment can be anticipated. It should be a capitated service, funded by multiple public and private service sectors, with adjustments for population characteristics (eg, child's age and medical and social risks), which would modify content and service schedules. Ideally, ultimately WCC would be financed by a new national revenue stream. Payment would be through a single public payer at the state level. Registries of children and families in pediatric practices and community-based programs, eg, schools, are already being used to direct capitated payments. This allows creative, nontraditional distribution of funds, thus expanding the types and sites of services and professionals.

Shared Responsibility in Communities

Because of their historical role, pediatricians should be deeply engaged in system transformation, but their role in WCC should be modified to emphasize application of their unique opportunities, skills, knowledge, and respected positions in their communities. Although WCC visits have been posited as an opportunity to establish therapeutic relationships, the substantial proportion of children without a medical home, a usual source of care, or a personal doctor or nurse; the substantial number of foregone WCC visits;

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and the growing rates of discontinuity of care argue for different models, including the adoption of team-based primary care. The most successful efforts to broadly improve outcomes for young children have been based in intensive, comprehensive, longitudinal intervention programs. Thus, it makes sense for WCC to be provided by formal partnerships between medical care and other community-based systems, including those involving child care and education staff, mental health professionals, home visitors, community health workers, and others. Most of these potential partners have far more intensive contact and opportunity for continuity and reinforcement of health behaviors, parenting, and child-rearing education than do pediatricians.

While Bright Futures has been a program of the federal Health Resources and Services Administration, its development and dissemination has largely been a function of the American Academy of Pediatrics and so has been viewed primarily as a guide to medical care professionals. However, its original intention was to provide guidance for a multidisciplinary approach to promoting children's health, development, and well-being. Adopting that approach would raise a panoply of challenging issues among which are intersectoral agreement on the intended goals and content of services, eligible clinicians, accountability for services and outcomes,[8] financing and payment processes, and quality assurance. Evolving information technology would need to facilitate communication among these diverse partners and the families they serve. Pediatricians are uniquely positioned, if not necessarily well-resourced, to advocate, monitor, collaborate, consult, and coordinate in the development of such a model. Although governance should rest in the public sector, pediatric practices should remain central. Enhancing practices' capacity would be more efficient than creating an entirely new oversight entity.

Population Health Approach

Finally, a transformative approach to WCC would be best implemented by focusing on populations while continuing to provide individualized care. The increased attention being given to what have been labeled "new" and "millennial" morbidities, such as problems of children's development and behavior exacerbated by the recent pandemic, family dysfunction and parents' poor mental health, and social determinants of health, calls for approaches that reach far beyond pediatric offices.[5] Unlike most medical care in the US, most other existing, publicly financed services have responsibilities for geographically defined populations. Efficient and more effective collaboration for WCC would be facilitated were all community service professionals, including health care clinicians, providing preventive services organized geographically.

Conclusions

The need for enhanced preventive and health-promoting services for children challenges the capacity of pediatric practices and requires a new, transformative model of universal, comprehensive, multisector services in which responsibility and accountability for services is formally divided and coordinated. The division of labor among community-based teams should depend on care content and clinician expertise and availability. Funding for such a community-based model would operate free from traditional, risk-based health insurance. Such a model could serve as a test of concept for universal health care coverage.

ARTICLE INFORMATION

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