Advocacy centered on access to health care for children is a straightforward business. The goal is clear: children need readily available, comprehensive, continuity-based, family-friendly, and child-friendly health services to meet a range of well-accepted objectives, including prevention, screening, acute care as needed, management of chronic conditions, and anticipatory guidance. Pediatricians refer to such a health care environment as a "medical home." Children who, for any reason, are unable to access such care are considered medically underserved. Although wide-ranging barriers interfere with access to medical homes for millions of children, particular populations remain at high risk for chronically poor access. These are precisely the groups that require focused and sustained attention from advocates and policymakers.

The fact is that serving vulnerable populations, such as homeless children, involves more than designing good programs, important as this may be. Often, the greater challenge is to understand and manage the barriers that keep such families from being able to utilize whatever services might be available.

This paper proposes a strategic approach for programs dealing with health care services for severely medically underserved children. Accordingly, it is important to begin by attempting to understand the functional or operational definition of "health care access" and to derive therefrom a clear sense of the specific barriers that impede access.

WHAT IS "ACCESS"?

What is "access"? Unfortunately, the answer to this question may very much depend on who is being asked. Many elected officials, health policy types, and
even journalists hear “access” and think “insurance,” believing that if an individual has a decent health insurance and coverage package, she or he has access. Families struggling to secure health care for their children, and health care professionals working with vulnerable, disadvantaged populations, generally realize there are far more complex aspects to the question of finding a medical home for children than simply the finance issue. This is not meant to understate the importance of making sure that there is a way of establishing and paying for essential health services. Put another way, a “free” rail pass for an area not served by a train system is not useful.

The other perceptual problem that afflicts many lawmakers or members of the press has to do with a poor understanding of the quality and array of services actually available versus what is truly needed in a given community or for a particular population. The issue of access to emergency medical services is a case in point. If information is lacking regarding the need for a full range of pediatric screening, preventive, and health maintenance services, then the apparent availability of basic emergency care may be interpreted as representing full access for children. Of course, nothing could be farther from the truth. Other than true emergency care, emergency departments are not—and should not—be viewed as appropriate venues for delivery of comprehensive child health care.

Today, in fact, millions of children in the US have both health insurance and access to emergency services, but do not have access to health care that (1) meets current pediatric standards, (2) responds to their unique medical or social situations, or (3) provides the right levels of care at appropriate intervals. In addition, for 11 million uninsured and millions more only partially insured, proper care may simply be unaffordable.

**THE CHILDREN'S HEALTH FUND'S EXPERIENCE**

In 1987, the Children's Health Fund (CHF) initiated a mobile-based health care program for profoundly underserved and indigent children in New York City's homeless shelter system. This flagship program, the New York Children’s Health Project, now part of the Division of Community Pediatrics at Montefiore Medical Center, utilizes entirely self-contained pediatric “clinics on wheels.” Although clearly recognizing that, in an ideal world, children would be much better served in a “fixed-site,” stable, neighborhood-based clinical setting, that simply has not been possible for the majority of the 10,000 children residing in the system’s squalid shelters and welfare hotels.

Although many of the facilities we visited in 1987 were in reasonable proximity to public or hospital-based clinics, substantial barriers to these services were a