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# The health care access and utilization of homeschooled children in the United States

Alissa Cordner\*

Brown University, Sociology Department, Box 1916, Providence, RI 02912, USA

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### ABSTRACT

Although the population of homeschooled children in the United States is large and growing, little is known about their access to and utilization of preventive health care services. This paper compares the health care access and utilization of homeschooled children and public school children in the United States using data from the nationally-representative 2007 National Survey of Children's Health. Using logistic regression models, this study finds that homeschooled children were significantly less likely than public school children to have access to a medical home, to visit a health care professional annually, and to receive the Human Papillomavirus vaccine. They were not statistically less likely to have health insurance, to receive annual dental care, or to receive Tetanus or Meningitis vaccinations. This research suggests that public health practitioners, medical providers, researchers, and educators should be attentive to the health care needs of homeschooled children.

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### Introduction

The population of homeschooled children in the United States is large and growing, but little is known about their levels of health care access or utilization. The National Center for Education Statistics estimates that in the United States there were approximately 850,000 homeschooled children in 1999 and 1,500,000 homeschooled children in 2007 (NCES, 2008; Princiotta, Bielick, & Chapman, 2006). This means that in 2007, 2.9% of school-age children were homeschooled (NCES, 2008: 1). Today's homeschooling movement contains a broad spectrum of children and families, ranging from the countercultural left to the Evangelical right (Gaither, 2008; Knowles, Marlow, & Muchmore, 1992). Homeschooling is currently legal in all 50 states, though there is no nationwide tracking of homeschooled children and legal requirements for homeschooling families vary significantly (Yuracko, 2008). This lack of consistent tracking makes the population difficult to study, especially since homeschooling parents may not want to be contacted or monitored by the government (Hill, 2000).

The majority of homeschooling parents decide to homeschool to provide religious or moral instruction, to impact their children's academic outcomes, or because of concerns about the school environment (NCES, 2008). Only 2% of parents in 2007 indicated that their child's health need was their primary reason for

homeschooling (NCES, 2008). A survey investigating parental vaccine beliefs found that, across different schooling types, homeschooling families expressed the greatest concern for vaccine safety and the least trust in government policies or medical opinions on vaccinations (Kennedy & Gust, 2005).

No published studies to date have investigated the health care access and utilization of homeschooled children. Research on their vaccination status and levels of health care access have been identified as gaps in the medical and public health literatures (Choi & Manning, 2009; Wallace, 2000). Additionally, public health, pediatric, and legal scholars have argued that homeschooled children may be at risk for negative health outcomes because they lack the health "safety net" of vision screenings, hearing screenings, examinations for medical conditions such as asthma or blood lead levels, and vaccination monitoring provided by public schools (Cooper & Sureau, 2007; Drazin, Guevarra, Schuler, & Silverberg, 2004; Khalili & Caplan, 2007; McMullen, 2002). Researchers have also expressed concern about their rates of vaccination and access to medical screenings (Abbott & Miller, 2006; Choi & Manning, 2009; Klugewicz & Carraccio, 1999).

### Data and methods

This study uses the 2007 National Survey of Children's Health (NSCH) to examine whether homeschooled children have different levels of health care access and utilization than children attending public schools.

\* Tel.: +1 541 231 8032.

E-mail address: [alissa\\_cordner@brown.edu](mailto:alissa_cordner@brown.edu).

## Data

Data was analyzed from the 2007 NSCH, directed by the Health Resources and Services Administration and conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics (Blumberg, Foster, Skalland, Chowdhury, & O'Connor, 2009; National Center for Health Statistics, 2007). The NSCH was designed to fill gaps in existing knowledge about child health and well-being, and to provide reliable and representative information about children's health at the state and national levels. The survey conducted random-dialing land-line telephone interviews from April 2007 to July 2008 with over 91,000 households with children ages 0–17. Interviews were conducted in English, Spanish, Mandarin, Cantonese, Vietnamese, and Korean. In households with multiple children, one child was selected at random. The overall weighted response rate was 46.7%. Questions covered household and parental characteristics; child and family behaviors; neighborhood characteristics; access to physical, mental, and dental health care; and parent-reported measures of physical, dental and mental health. All measures in the 2007 NSCH were parent-reported, by the parent with the most knowledge of the child. Weighting statistics based on key demographic variables from the American Community Survey allow for population-based estimates. Additional information on study design and implementation is available elsewhere (Blumberg et al., 2009).

The NSCH is well-suited for research on the health care of homeschooled children because parents were asked whether their child attended public school, was homeschooled, attended private school, or was not enrolled in school. This allows for comparison across schooling types.

## Study sample

The sample for this study was restricted to 61,784 children between ages 6 and 17 with values on all included covariates. Sample sizes for analyzed outcomes differ due to legitimate skips or missing values on those outcome measures, as discussed below. Of this sample, 52,429 (84.86%) were enrolled in public school, 1470 (2.38%) were homeschooled, 7767 (12.57%) were enrolled in private school, and 118 (0.19%) were not enrolled in school (unweighted percentages). These last two categories were combined into one 'Other School' category ( $n = 7,885$ , 12.76%) because this study is only interested in comparing homeschooled children to public schooled children.

## Measures

This study analyzed measures of health care access and utilization. The outcome of *insurance* ( $n = 61,784$ ) indicated whether the child had public or private health insurance. Insurance was included in all other models as a covariate because it increases a child's utilization of health care services (Halterman, Montes, Shone, & Szilagyi, 2008; Rose, Lantz, House, & Mero, 2006). The 2007 NSCH included a section of 11 questions permitting assessment of whether children had access to a *medical home* ( $n = 59,589$ ) (Blumberg et al., 2009). This section was developed using the medical home definition of the American Academy of Pediatrics (2002) as care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.

Annual *medical care* ( $n = 61,424$ ) described whether the child saw a doctor, nurse, or other health care professional for any kind of preventive medical care in the previous 12 months. Annual *dental care* ( $n = 61,587$ ) described whether the child saw a dentist for preventive dental care during the previous 12 months. Questions about three vaccinations for relevant age ranges were included in

the NSCH. Households with children ages 12 to 17 were asked about *Tetanus* ( $n = 32,961$ ) and *Meningitis* ( $n = 27,353$ ) vaccinations, and households with girls in this age range were asked about the *Human Papillomavirus (HPV)* vaccination ( $n = 16,203$ ).

*Schooling type* was identified using dummy variables for public school enrollment, homeschooling, or other school status (attending private school or not being enrolled). All multivariate models included child- and family-level covariates known to impact health care access and utilization. Child-level covariates were *gender*, *age*, *immigrant status*, and *race/ethnicity* (Flores & Tomany-Korman, 2008b; Huang, Yu, & Ledsky, 2006; Liu, Probst, Martin, Wang, & Salinas, 2007; Weinick & Krauss, 2000; Yu, Huang, & Kogan, 2008). Family-level covariates were *family structure*, highest level of *parental education*, whether *English was the primary language* spoken in the home, *U.S. region*, *urban residence*, and *household income* (Flores & Tomany-Korman, 2008a; Gorman & Braverman, 2008; Heck & Parker, 2002; Kenney, McFeeters, & Yee, 2005; Lichtenstein, Sharma, & Wheat, 2005; Weinick & Krauss, 2000; Yu et al., 2008). Notable from this extensive literature is that higher socioeconomic-status, two-parent households, US-nativity, younger age, and White racial identification are all associated with better health care outcomes. Children living in rural areas, and living in all regions of the U.S. other than the Northeast have worse health care outcomes. According to recommended imputation procedures for national weighted analysis, the variable for urban residence assigned children for whom this value is missing to the most likely outcome based on their state of residence (Blumberg et al., 2009). The variable for derived income was recoded to six categories: below 100% of Federal Poverty Line (FPL), 101–199% FPL, 200–299% FPL, 300–399% FPL, 400% FPL and greater, and a final category for Missing Income, since 4333 children in the analyzed sample were missing an income value.

Models also included several health-specific measures. The child's *overall health* was included because some children are homeschooled specifically for health reasons (NCES, 2008) and because children in poor health may require more frequent medical visits. Children with 'good' health were reported by their parents to be in good, very good, or excellent health; children in 'poor' health were reported to be in fair or poor health. *Children with Special Health Care Needs (CSHCN)* had medical, behavioral, or other health conditions lasting for 12 months or longer and requiring health services beyond those needed by children normally (Newacheck & Kim, 2005). Finally, two variables were included to account for characteristics of the homeschooled population: whether the child attended *religious services* at least weekly, and the *number of children* in the family.

## Statistical methods

All analyses were conducted in Stata 10.0. Bivariate and multivariate logistic regressions included sampling weights to calculate population-level results. Results are presented as Odds Ratios (OR) and derived 95% Confidence Intervals (CI) that compare homeschooled children to the reference category of public school children.

## Findings

Table 1 presents weighted descriptive statistics of children in the 2007 NSCH by schooling type. The vast majority of all children in the NSCH were in good health, and approximately one-quarter of children had CSHCN-status. Homeschooled children were mostly non-Hispanic White (80%), lived in two-parent households (80%) with high levels of parental education (78%), and lived in urban environments (74%). Half of homeschooled children lived in

**Table 1**  
Descriptive statistics of children by schooling type.

	All students, n (%)	Public school, %	Homeschooled, %	Other school, <sup>a</sup> %
<i>Characteristic</i>	61,784	52,429 (87.07)	1470 (2.37)	7885 (10.57)
<i>Race/ethnicity</i>				
Hispanic	7133 (19.2)	20.3	6.7***	12.2***
Non-Hispanic White	43,149 (57.6)	55.8	79.5***	67.3***
Black	6260 (15)	15.4	7.2***	13.2***
Other race	5242 (8.3)	8.4	6.6*	7.3***
<i>Family structure</i>				
Two parents	40,966 (63.1)	61.2	79.9***	75.4***
Step parents	5889 (10.2)	11.0	3.3***	4.9***
Single mom	10,542 (19.9)	20.6	13.4***	15.3***
Other family structure	4387 (6.8)	7.2	3.4***	4.4***
<i>Parental education</i>				
Less than high school	3866 (8.9)	9.8	4.3***	3.3***
High school	10,301 (23.7)	25.2	17.9***	11.9***
More than high school	47,617 (67.4)	65.0	77.9***	84.8***
<i>Family income<sup>b</sup></i>				
Poverty	5873 (15.1)	16.3	12.0***	6.5***
Low income	9361 (19)	19.7	32.0***	10.7***
Middle income	10,542 (17.1)	17.7	16.7	11.8***
Upper income	9291 (13.2)	13.0	15.3*	14.9***
Wealthy	22,384 (28.4)	26.2	17.8***	48.6***
Income missing	4333 (7.1)	7.1	6.2	7.4
<i>Nativity status</i>				
U.S. born	59,641 (94.4)	94.0	97.8***	97.0***
Foreign born	2143 (5.6)	6.0	2.2***	3.0***
<i>Health</i>				
Good health	60,215 (96)	95.7	96.9*	98.4***
Poor health	1569 (4)	4.3	3.1*	1.6***
<i>Child with special health care need</i>				
No	47,193 (76.9)	76.6	73.9*	79.5***
Yes	14,591 (23.1)	23.4	26.1*	20.5***
<i>Urban/rural residence</i>				
Urban	46,249 (85.9)	84.4	74.2***	91.3***
Rural	15,535 (15.1)	15.6	25.8***	8.7***
<i>Region</i>				
West	15,296 (25.2)	25.5	22.6*	23.2***
Midwest	16,109 (22.5)	22.5	22.7	21.7
South	19,399 (35.2)	35.1	45.0***	33.4**
Northeast	10,980 (17.2)	16.9	9.7***	21.7***
<i>Children in household</i>				
1–2	45,188 (61.5)	61.5	49.8***	63.6***
3 or more	13,596 (38.5)	38.5	50.2***	36.5***
<i>Attends religious services at least weekly</i>				
No	28,599 (44.5)	47.6	26.3***	22.7***
Yes	33,185 (55.5)	52.4	73.8***	77.4***
<i>Health care access and utilization measures</i>				
Insurance, n = 61,784	56,948 (92.2)	89.9	90.4	94.5***
Medical home, n = 59,589	34,247 (57.5)	52.0	45.1***	62.8***
Medical visit in last year, n = 61,424	51,869 (84.44)	84.7	74.9***	87.3***
Dental visit in last year, n = 61,587	56,362 (91.5)	88.1	89.8*	94.6***
HPV vaccine <sup>c</sup> (girls ages 12–17), n = 16,203	3304 (20.4)	18.8	5.8***	22.5***
Meningitis vaccine (ages 12–17), n = 27,353	9673 (35.4)	38.2	32.9***	46.2***
Tetanus vaccine (ages 12–17), n = 32,961	27,774 (84.3)	85.1	77.1***	87.1***

Notes. Data source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007; All percentages are weighted statistics. T-test statistics, relative to public school children: \*,  $p \leq 0.05$ ; \*\*,  $p \leq 0.01$ ; \*\*\*,  $p \leq 0.001$ .

<sup>a</sup> Other school includes private school and not enrolled.

<sup>b</sup> Low income = 101–199% of poverty; Middle income = 200–299% of poverty; Upper income = 300–399% of poverty; Wealthy = 400% of poverty or greater.

<sup>c</sup> Human Papillomavirus vaccine.

families with three or more children, compared to 39% of public school children ( $p \leq 0.001$ ). Nearly three-quarters of homeschooled children attended religious services at least weekly, compared with one-half of public school children ( $p \leq 0.001$ ).

Over 90% of all children had health insurance but fewer had access to a medical home. The majority of children were utilizing preventive health care services, but only 75% of homeschooled children received annual medical care compared to 85% of public school children ( $p \leq 0.001$ ). Nearly 90% of public school and homeschooled children received annual dental care, with slightly higher rates for homeschooled children ( $p \leq 0.05$ ). Vaccination rates differed across the vaccines (all statistically significant,  $p \leq 0.001$ ).

Rates for public schooled children ranged from 19% for the HPV vaccine to 85% for the Tetanus vaccine. Rates for homeschooled children ranged from 6% for the HPV vaccine to 77% for the Tetanus vaccine.

Table 2 presents unadjusted and adjusted Odds Ratios and 95% Confidence Intervals comparing homeschooled and public school children derived from logistic regressions. In unadjusted models, homeschooled children were less likely than public school children to have access to a medical home, to receive annual medical care, and to have received HPV and Tetanus vaccines.

In adjusted models, findings for covariates were largely consistent with previous research on children's health care. Insurance, a higher family income, White racial identification, speaking

**Table 2**  
Unadjusted and adjusted Odds Ratios for health care access and utilization (reference group is public school children).

	N	Homeschooled – Unadjusted OR (C.I.)	Homeschooled – Adjusted OR (C.I.)
<i>Health care access</i>			
Insurance	61,784	1.07 (0.75–1.51)	0.81 (0.55–1.18)
Medical home	59,589	0.76 (0.58–0.99)	0.59 (0.46–0.76)
<i>Health care utilization</i>			
Medical visit in last year	61,424	0.54 (0.42–0.69)	0.55 (0.42–0.72)
Dental visit in last year	61,587	1.19 (0.90–1.56)	1.03 (0.75–1.41)
HPV <sup>a</sup> vaccine (girls ages 12–17)	16,203	0.26 (0.08–0.82)	0.29 (0.10–0.89)
Meningitis vaccine (ages 12–17)	27,353	0.79 (0.44–1.40)	0.94 (0.52–1.70)
Tetanus vaccine (ages 12–17)	32,961	0.59 (0.39–0.89)	0.71 (0.46–1.11)

Note. Data source: National Center for Health Statistics and Maternal and Child Health Bureau, National Survey of Children's Health, 2007. Odds Ratio and 95% Confidence Interval for each outcome. 'Other School' category was included in analyses but not presented in this table. Adjusted ORs included the following covariates: insurance status (except for insurance outcome), child's overall physical health, CSHCN-status, number of children in household, attending religious services weekly, urban residence, region of the US, child's race/ethnicity, household income, family structure, parental education, survey year, age, gender, nativity status, and language spoken in the home.

<sup>a</sup> Human Papillomavirus vaccine.

English in the home, U.S. nativity, urban residence, and residence in the Northeastern U.S. were associated with higher and statistically significant levels of health care access and utilization, though results for several outcomes were inconsistent. For example, Black children were more likely than White children to have an annual medical visit (95% CI = 1.43–2.11), an unexpected finding based on prior research (Flores & Tomany-Korman, 2008b). Full results are provided in Appendix A.

Table 2 demonstrates that homeschooled children had lower levels of health care access and utilization on several outcomes. In adjusted models, homeschooled children did not have lower access to health insurance (OR = 0.81, 95% CI = 0.55–1.18). They were less likely to have access to a medical home than public schooled children (OR = 0.59, 95% CI = 0.46–0.76).

Homeschooled children were significantly less likely to receive annual medical care than public school children (OR = 0.55, 95% CI = 0.42–0.72). However, they were not statistically less likely to receive dental care (OR = 1.03, 95% CI = 0.75–1.41). Results for vaccinations varied. Homeschooled girls ages 12–17 were only 29% as likely as public school girls to receive the HPV vaccine (95% CI = 0.10–0.89). Homeschooled children were not, however, statistically less likely to receive the Tetanus vaccine (OR = 0.71, 95% CI = 0.46–1.11) or the Meningitis vaccine (OR = 0.94, 95% CI = 0.52–1.70).

## Discussion

This paper is the first to statistically analyze homeschoolers' health care access and utilization using nationally-representative survey data. It found that they were less likely to have access to a medical home, to receive annual preventive medical care, and to receive the HPV vaccine, though they were not less likely to have health insurance, to receive annual dental care, or to receive Tetanus or Meningitis vaccines. Homeschooled children are disproportionately White and come from educated, two-parent families with three or more children, traits generally associated with higher access to and utilization of health care services. This highlights the significance of these findings. Replication with other sources of data is needed, ideally including potential explanatory variables unavailable in the 2007 NSCH such as distance to a health care provider or parental car ownership.

This study provides initial confirmation of concerns expressed by researchers and practitioners that homeschooled children may have decreased levels of health care access and utilization (Abbott & Miller, 2006; Choi & Manning, 2009; Klugewicz & Carraccio, 1999). This study is unable to directly take into account different motivations for homeschooling and the complex beliefs families may have about medical care. These are ready topics for future

qualitative research. An avoidance of vaccinations by homeschooled families, and by extension visits to doctors for preventive care including vaccinations, may be connected to their identified distrust of the health care system or the government (Kennedy & Gust, 2005), or a desire to avoid questioning by physicians regarding vaccination decisions. This may explain why homeschooled children are less likely to receive medical care but not dental care. Additionally, the NSCH study population is limited to those households with land-line telephones who choose to respond to telephone surveys. If homeschooling households are more likely to refuse to participate in government-sponsored research programs, the NSCH may undercount and thus misrepresent the homeschooling population and their outcomes. Findings rely on parents accurately recalling and reporting questions on the survey, and are limited by potential nonresponse bias in the NSCH (Blumberg & Luke, 2009). Finally, this study may not be generalizable to other countries, because of the specific legal, philosophical, and religious history of homeschooling in the U.S. and because of country-specific traits of the U.S. health care system. However, homeschooling advocacy organizations publish materials for homeschooling families in dozens of countries (e.g., HSLDA, 2011), indicating that homeschooling is practiced globally.

This subject deserves attention by researchers, public health practitioners, clinicians, and health care and education policy-makers. Public school vaccination requirements play a major role in controlling vaccine-preventable diseases (Omer et al., 2006), but homeschooled children in many states are exempt from these requirements (Khalili & Caplan, 2007). Homeschooled children could be required to follow the same vaccination rules as public schooled children (Choi & Manning, 2009). The medical screenings and services provided by public school districts could be made available to local homeschooled children. Medical providers should respectfully inquire about household schooling decision-making and be vigilant in monitoring the health care needs of homeschooled patients (Abbott & Miller, 2006). The population of homeschooled children is heterogeneous in ways that likely impact their health care access and utilization, and future research should examine the causes and consequences of these lower levels of health care access using more detailed survey data or qualitative interviews with homeschooling families.

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### Appendix A. Supplementary material

Supplementary material related to this article can be found online at doi:10.1016/j.socscimed.2012.02.002.

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