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Journeying Beyond the Balcony to the Block Party and Up to 50,000 Feet: Disparities in Children's Health and Healthcare

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Journeying Beyond the Balcony to the Block Party and Up to 50,000 Feet: Disparities in Children's Health and Healthcare

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Racial/ethnic minority children will outnumber white children in the US by the next decade.¹ In 2012, for the first time in our nation's history, minority children accounted for more births than white children.² In the state of Texas, 67% of children—equivalent to over 4.6 million—are minorities,³ and in Harris County (home to Houston, TX), 77%.⁴

Despite this demographic surge across the US, a recent technical report from the American Academy of Pediatrics examining 56 years of the literature documented that racial/ethnic disparities in children's health and healthcare are extensive, pervasive, and occur across the spectrum of health and healthcare.⁵ An even more recent secular-trend analysis of national data concluded that minority children continue to experience multiple disparities in medical and oral health and healthcare, most disparities persist over time, and although disparities in use of services decreased, 10 new disparities arose.⁶

In his article in this issue of the *Journal*, Dr. Jean L. Raphael calls attention to the dramatic increase in the number of studies examining "pediatric disparities."⁷ Unfortunately, a limitation of the article is the presence of two all-too-common errors in the field of 1) not defining what is meant by "disparities" (definitions can range from any differences between populations [Agency for Healthcare Research and Quality] to differences in health which are unnecessary, avoidable, and considered unfair and unjust [World Health Organization]); and 2) not specifying which disparities domain is being referred to, which can include race/ethnicity, socioeconomic status (SES), gender, language, immigration status, urban/rural status, special healthcare needs, lesbian/gay/bisexual/transgender populations, and other categories. To have meaningful discussions about disparities and how to eliminate them, precision in definitions and target populations is paramount.

Study after study from decades of research document that even after adjustment for SES (including family income and educational attainment), racial/ethnic minority children experience a multiplicity of disparities in healthcare.^{5,6} Regrettably, disparities researchers may unnecessarily pit racial/ethnic disparities against SES disparities, alleging that racial/ethnic disparities are "attenuated" or disappear after SES adjustment. Of course, proper multivariable adjustments for SES may attenuate or eliminate racial/ethnic disparities in selected cases, just as proper multivariable adjustments for race/ethnicity may attenuate or eliminate SES disparities in certain instances. To structure the field as a "competition" between SES and race/ethnicity is counterproductive, sets both fields back, and ultimately makes us stray from the fundamental

issue about how we improve the health and healthcare of all children at risk.

Certain populations continue to be relatively neglected in research and policy on health and healthcare disparities. Although 61 million Americans speak a language other than English at home, 25 million have limited English proficiency (LEP), and federal regulations require provision of language services to all LEP persons, only 13 states provide third-party payer reimbursement for medical interpreters, and LEP patients (including millions of children and their families) continue to experience disparities in access to care, health status, use of health services, patient-physician communication, satisfaction with care, clinical research, and patient safety.⁸ The children of parents with low literacy also experience disparities,⁹ but not enough attention has been devoted to pediatric health literacy and numeracy. Immigrant children experience many disparities,^{10,11} but frequently are left out of research and the national policy discourse on disparities.

The article in this issue of the *Journal* rightly highlights the urgent need for new perspectives on pediatric disparities. The analogy of getting a view of the “dance floor” of disparities from the “balcony,” however, may summon potentially negative connotations of an invitation-only event which only can be correctly interpreted by academicians observing the masses from a privileged perch. As aptly illustrated by Georgia high-school students fighting segregated proms,¹² substantive and concerted action is needed to eliminate disparities.

Researchers and policymakers need to journey “beyond the balcony” by participating in the “block party” in the communities most hard hit by pediatric disparities. Community-based research that includes the input and participation of the children and families experiencing the disparities holds great promise for eliminating disparities. For example, Latino children are at greatest risk for lacking health insurance coverage. Focus groups of uninsured children resulted in the identification of barriers to insurance coverage and potential solutions to these disparities.¹³ A randomized, controlled trial (RCT) of a community health-worker intervention based on these findings resulted in the elimination of this disparity.¹⁴

Researchers and policymakers also need to take in the unobstructed “50,000-foot” view of how the interactions of families, healthcare providers, communities, healthcare systems, cities, counties, states, and nations can both generate disparities and offer solutions for disparities elimination. For example, minority children are disproportionately affected by asthma disparities, including African-American children being much more likely

than white children to be hospitalized and to die from asthma. An RCT documented that Parent Mentors—trained minority parents who have asthmatic children— are significantly more effective than traditional asthma care at improving minority children’s asthma outcomes, at low cost and with substantial cost savings.¹⁵ An ongoing community-based RCT of the effects of Parent Mentors on insuring uninsured minority children (compared with traditional state outreach and enrollment methods) already is revealing that children assigned Parent Mentors are significantly more likely to obtain health insurance, enjoy better health status, have a usual source of care and the same source of sick care and preventive care, receive all needed specialty care, to not suffer from depression, to have higher emotional functioning score, to have parents recommend the child’s healthcare provider to friends, and to have parents report feeling that the doctor takes the time to understand the child’s specific needs.¹⁶ This model, of families helping families to improve children’s health in communities with the greatest need and with benefits to healthcare systems and society, may prove to be a potent tool for leveling the playing field. Indeed, Healthcare Empowerment Zones (providing resources, special programs, and community-based participatory approaches) should be funded and established in communities/regions with the greatest disparities for children. For example, initial evaluation of the Harlem Children’s Zone, targeting asthmatic children in a 60-block radius of Central Harlem, revealed significant reductions among participants in school absences and ED and unscheduled physician office visits for asthma, and improved asthma management practices and strategies.¹⁷

Dr. Raphael’s article cogently underscores the dearth of intervention studies targeting pediatric disparities. What else can we do to eliminate disparities in children’s health and healthcare? Potential solutions include:

- Consistently collect race/ethnicity, SES, and language data on all patients
- Journal requirements that studies routinely analyze data for potential disparities (rather than requirements that analyses by race/ethnicity, SES, and other known sources of disparities be justified, or omitted if not justified)
- Monitor and publicly disclose disparities data annually at the national, local, and health-system levels
- Provide continuous health insurance coverage for **all** children
- Secure medical and dental homes for **all** children
- Guarantee that all children have access to needed pediatric specialty care

- Ensure that no child is denied healthcare due to language barriers or immigration status
- Address health and healthcare disparities as part of the national healthcare quality discussion
- Diversify the healthcare workforce to better reflect the changing demographics of children in the US
- Increase funding for research on pediatric health and healthcare disparities
- Design, implement, and evaluate innovative interventions which eliminate pediatric health and healthcare disparities

REFERENCES

- ¹ Frey WH: America's diverse future: Initial glimpses at the U.S. child population from the 2010 Census. Washington, DC; The Metropolitan Policy Program at the Brookings Institution [http://www.brookings.edu/~media/Files/rc/papers/2011/0406_census_diversity_frey/0406_census_diversity_frey.pdf].
- ² Tavernise, S. Whites account for under half of births in U.S. New York Times May 17, 2012. URL: <http://www.nytimes.com/2012/05/17/us/whites-account-for-under-half-of-births-in-us.html?pagewanted=all&r=0>
- ³ American Community Survey. Children Characteristics. Texas. 2011 American Community Survey 1-Year Estimates. URL: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_1YR_S0901&prodType=table
- ⁴ American Community Survey. Children Characteristics. Harris County, Texas. 2011 American Community Survey 1-Year Estimates. URL: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_1YR_S0901&prodType=table
- ⁵ Flores G, American Academy of Pediatrics Committee on Pediatric Research. Technical Report: Racial and ethnic disparities in the health and healthcare of children. *Pediatrics* 2010;125:e979-e1020.
- ⁶ Flores G, Lin H. Trends in racial/ethnic disparities in medical and oral health, access to care, and use of services in US children: Has anything changed over the years? *International Journal for Equity in Health* 2013; Jan 22;12:10. doi: 10.1186/1475-9276-12-10. URL: <http://www.equityhealthj.com/content/pdf/1475-9276-12-10.pdf>
- ⁷ Raphael JL. Observations from the balcony: Directions for pediatric health disparities research and policy. *Journal of Applied Research on Children: Informing Policy for Children at Risk* 2013;4:Article 7. URL: <http://digitalcommons.library.tmc.edu/childrenatrisk/vol4/iss1/7>
- ⁸ Flores G. The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research and Review* 2005;62:255-299.
- ⁹ Sanders LM, Thompson VT, Wilkinson JD. Caregiver health literacy and the use of child health services. *Pediatrics* 2007;119:e86-92.
- ¹⁰ Stevens GD, West-Wright CN, Tsai KY. Health insurance and access to care for families with young children in California, 2001-2005: differences by immigration status. *J Immigr Minor Health* 2010;12:273-281.
- ¹¹ Institute of Medicine. *From Generation to Generation. The Health and Well-Being of Children in Immigrant Families*. Hernandez DJ and Charney C, Eds. National Academy Press; Washington, DC: 1998.

¹² Strauss V. Georgia students fight segregated proms. The Washington Post 2013; April 5. URL: <http://www.washingtonpost.com/blogs/answer-sheet/wp/2013/04/05/georgia-students-fight-segregated-proms/>

¹³ Flores G, Abreu M, Brown V, Tomany-Korman SC. How Medicaid and the State Children's Health Insurance Program can do a better job of insuring uninsured children: The perspectives of parents of uninsured Latino children. *Ambulatory Pediatrics* 2005;5:332-340.

¹⁴ Flores G, Abreu M, Chaisson CE, Meyers A, Sachdeva RC, Fernandez H, Francisco P, Diaz B, Diaz AM, Santos-Guerrero I. A randomized trial of the effectiveness of community-based case management in insuring uninsured Latino children. *Pediatrics* 2005;116:1433-1441.

¹⁵ Flores G, Snowden-Bridon C, Torres S, Perez R, Walter T, Brotanek J, Lin H, Tomany-Korman S. Improving asthma outcomes in minority children: A randomized, controlled trial of parent mentors. *Pediatrics* 2009;124:1522-1532.

¹⁶ Flores G. Community Health Workers, *Promotores*, and Parent Mentors: Innovative, Community-Based Approaches to Improving the Health and Healthcare of Children. In, Shapiro L, ed. *Big Ideas 2012: Children in the Southwest*. Washington, DC: First Focus; 2012. Available at: <http://www.firstfocus.net/sites/default/files/BI2012%20-%20HealthOutreach.pdf>

¹⁷ Centers for Disease Control and Prevention (CDC). Reducing childhood asthma through community-based service delivery--New York City, 2001-2004. *MMWR Morbidity and Mortality Weekly Report*. 2005;54(1):11-14.