Achieving Optimal Health and Healthcare for All Children:

How We Can Eliminate Racial and Ethnic Disparities in Children's Health and Healthcare

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Surge in the Diversity of U.S. Children

Racial/ethnic minority children currently comprise 43% of all US children, equivalent to 31.8 million.[1] Conservative estimates indicate that half of all children in the US will be minority by 2040.[2] Recently released US Census data indicate that in 2008, almost half (47%) of children less than five years old were minority.[3] Approximately 55.4 million Americans (20%) speak a language other than English at home and 24.5 million Americans (9%) have limited English proficiency (LEP);[4] among schoolchildren (5-17 years old), 10.9 million (20%) speak a language other than English at home and 2.8 million (5%) are LEP.[5]

Racial/Ethnic Disparities in Children's Health and Healthcare

Despite the dramatic population growth of minority children, racial/ethnic disparities in children's health and healthcare are extensive, pervasive, and persistent. A recent comprehensive technical report by the American Academy of Pediatric's Committee on Pediatric Research documented children's racial/ethnic disparities across the spectrum of health and healthcare, including in mortality, access to care and use of services, prevention and population health, health status, adolescent health, chronic diseases, special healthcare needs, quality of care, and organ transplantation.[6]

The aims of this paper are to: 1) summarize the key racial/ethnic disparities in children's health and healthcare; and 2) propose evidenced-based policies targeting the elimination of these childhood disparities.

A recent nationally representative analysis revealed that minority children experience multiple disparities in medical and oral health, access to care, and use of services.[7] In addition, certain disparities were found to be particularly marked for specific racial/ethnic groups, and multiracial children were noted to experience many disparities. Disparities documented for one or more minority group included increased odds of suboptimal health status, overweight, asthma, activity limitations, behavioral and speech problems, emotional difficulties, uninsurance, suboptimal dental health, no usual source of care, unmet medical and dental needs, transportation barriers to care, problems getting specialty care, no medical or dental visit in the past year, ED visits, not receiving mental healthcare, and not receiving prescription medications. Certain disparities were particularly marked for specific racial/ethnic groups: for Latinos, suboptimal health status and teeth condition, uninsurance, and problems getting specialty care; for African-Americans, asthma, behavior problems, skin allergies, speech problems, and unmet prescription needs; for American Indian/Alaska Native children, hearing/vision problems, no usual source of care, ED visits, and unmet medical and dental needs; and for Asians/Pacific Islanders, problems getting specialty care and not seeing a doctor in the past year. Multiracial children also experienced many disparities.

One of the most dramatic and far-reaching healthcare disparities experienced by minority children is lack of health insurance coverage. Almost 10 million US children (<18 years old) - equivalent to 13% - have no health insurance.[8] In contrast to an

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uninsured rate of only 7% among white (non-Latino) children, Latino children, at 20%, and African-American children, at 12%, have a substantially greater risk of being uninsured.[9] Indeed, the number of uninsured Latino children (3.2 million) now exceeds the number of non-Latino white children (3.1 million), and Latino and African-American children account for 57% of all uninsured children in America, even though they comprise only 37% of the total population of US children.[10] Among the 2.3 million poor US children without health insurance, Latino and African-American children account for 69% of the uninsured, equivalent to 1.6 million children.[11] Citizen children in households headed by immigrant non-citizen parents (who are predominantly Latino) are also at significantly higher risk of being uninsured, with uninsurance rates of 34%, and approximately double the odds of being uninsured, compared with US-born citizen children with at least one citizen parent.[12]

Disparities in lacking health insurance are particularly concerning because: 1) most uninsured children are eligible for but not enrolled in Medicaid or the Children's Health Insurance Program (CHIP); and 2) there is substantial evidence that providing health insurance to uninsured children results in significant improvements in their health and healthcare. Between 62-70% of all uninsured US children - equivalent to approximately six million - are eligible for but not enrolled in Medicaid or CHIP.[13] Among low-income children, it is estimated that 84% of the uninsured are Medicaid/CHIP eligible but not enrolled.[14] Multiple studies document increased access to care after providing uninsured children with CHIP, Medicaid, or analogous insurance coverage, including a significant increase in the proportion of children with a usual source of preventive and sick care, regular physician, medical home, reported ease of getting needed healthcare, parental ability to obtain phone advice, getting an appointment the same or next day after a call, <30 minutes travel time to the provider's office, and access to specialty care, mental healthcare, and prescriptions.[15] Providing insurance to uninsured children also results in significant reductions in unmet needs for medical care, mental healthcare, eyeglasses, and prescriptions, and increased visits for preventive specialty care; improved quality of care; enhanced parental and physician satisfaction with care; reduced parental worry about children; higher immunization rates; higher screening rates for anemia, lead, vision, and hearing abnormalities; improved health status; reduced emergency department (ED) visits for asthma; and reduced hospitalizations.[16]

Evidenced-Based Approaches to Eliminating Healthcare Disparities in Children

Give the demographic surge of diversity in our nation, what can be done to address the extensive, pervasive, and persistent racial/ethnic disparities in children's health and healthcare?

Consistently Collect Race/Ethnicity and Language Data on All Patients

Racial/ethnic and linguistic disparities in children's health and healthcare cannot be identified, monitored, addressed, or eliminated without consistent collection of race/ethnicity and language data on all patients. The most recent data available on US health plans, however, reveal that 33% of health plan enrollees (equivalent to 28.7 million enrollees) are covered by plans that do not collect race/ethnicity data.[17] Another national survey of 272 hospitals revealed that only 39% collect data on patients' primary language,[18] and no statistics are available on what proportions of hospitals or health plans collect data on English proficiency. Parental limited English proficiency (defined as a self-rated ability to speak English less than "very well," as per the U.S. Census[19]) is superior to the primary language spoken at home as a measure of the impact of language barriers on children's health and healthcare.[20]

- **Data on race/ethnicity (by parental self-identification), the primary language spoken at home, and parental English proficiency should be collected on every pediatric patient**

Monitor and Publicly Disclose Disparities Data Annually

The Agency for Healthcare Research and Quality (AHRQ) has issued an annual national healthcare disparities report since 2003.[21] Annual monitoring and public disclosure by states, counties, health plans, Medicaid and CHIP programs, hospitals, and clinics would contribute substantially to the identification, tracking, targeting, and reduction/elimination of health and healthcare disparities in children

- **Children's health and healthcare disparities should be monitored and publicly disclosed annually at the federal, state, local, health-plan, and institutional levels**

Provide Continuous Health Insurance Coverage to ALL Children

Minority children account for over two-thirds of the approximately 10 million uninsured children in America.[22] A study of the reasons why Latino parents are unable to insure their uninsured children revealed that the major obstacles include lack of knowledge about the application process and eligibility (especially misconceptions about work, welfare, and immigration), language barriers, immigration issues, income, hassles, pending decisions, family mobility, misinformation from insurance representatives (being told insurance is too expensive and parents must work), and system problems (including lost applications, discrimination, and excessive waits).[23]

Disparities in insurance coverage could be reduced or eliminated by enacting policies that employ evidence-based strategies targeting these obstacles. Automated enrollment strategies have proven highly effective in numerous public and private benefit programs, resulting in substantial increases in program participation and reductions in administrative costs and erroneous eligibility determinations.[24] Medicaid- and CHIP-eligible uninsured children could be more efficiently identified by examining lists of children receiving other need-based assistance; for example, more than 70% of low-income, uninsured children are in families participating in Food Stamps, the National School Lunch Program, or WIC.[25] The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows for Express Lane Eligibility, in which eligibility for Medicaid and CHIP can be met using data from other need-based programs. So, for example, children in families receiving Food Stamps can automatically qualify for Medicaid or CHIP, and data indicate that 99.9% of children on Food Stamps would meet Medicaid or CHIP income qualification requirements.[26] Children who receive free school lunches also can automatically meet Medicaid and CHIP income requirements, allowing 96% of them to qualify for Medicaid or CHIP.[27] Maintaining coverage for eligible, enrolled children is also critical, and can be achieved through strategies employed successfully by states such as Louisiana, including renewing children's coverage without requesting information from parents when eligibility appears certain based on third-party data from public programs and other sources, and making it easy for parents to provide missing information via toll-free phone numbers and the internet when automated renewal is not possible.[28]

The U.S. Department of Health and Human Services (HHS) recently released $25 million in grants to help senior and individuals with disabilities and their caregivers to apply for special assistance through Medicare (including the Medicare Part D Prescription Drug Program, the Low-Income Subsidy Program, and the Medicare Savings Program), and an additional $5 million for a national resource center to support these efforts, the National Center for Benefits Outreach and Enrollment.[29] These efforts are specifically intended to target and provide one-on-one assistance to the most vulnerable.[30] Substantial reductions in insurance disparities for children could be achieved by providing similar major funding, and establishing an analogous National Center for Children's Benefits Outreach and Enrollment.

Rigorous evidence from a recent randomized trial documents that the most effective way to insure uninsured Latino children is through active, community-based outreach and enrollment strategies, such as use of community-based case

managers.[31] Case managers resulted in the elimination of insurance disparities for Latino children, with 96% obtaining health insurance, compared with 57% insured with traditional Medicaid/CHIP outreach and enrollment strategies, and children receiving the intervention were significantly more likely to obtain their insurance faster, to have higher parental satisfaction, and to be continuously insured.[32]

Ensuring that children have continuous health insurance coverage is crucial, given that children who experience gaps in their insurance in the past year are significantly more likely than fully insured children to have delayed care, unmet medical care needs, unfilled prescriptions, no usual source of care, and no well-child visit in the past year.[33]

To truly cover all uninsured children in America, we will need to extend health insurance coverage to immigrant children - both documented and undocumented. Compared with US-born citizen children, undocumented immigrant children are more than four times more likely to be uninsured, and significantly more likely to have no usual source of care other than the ED, and to have made no doctor or dental visit in the past year.[34] Failure to provide health insurance to the uninsured affects all Americans. Local governments often have to take resources out of other programs to provide medical care for the uninsured, including reallocating tax funds planned for highway construction, and closing health facilities.[35] A recent report estimated that about 37% of healthcare costs for the uninsured — equivalent to $42.7 billion — went unpaid last year, a cost that was shifted to insured Americans through higher premiums, resulting in US families and businesses paying an additional "hidden health tax" of $1,017 for family health care coverage.[36] Low-income immigrant children who have health insurance, however, are substantially less likely to use EDs for care and more likely to have well-child visits in the past year.[37]

- **Automated enrollment, Express Lane Eligibility, and automated renewal should be standard components of Medicaid, CHIP, and healthcare reform**
- **Analogous to recent Medicare initiatives, major funding should be provided for Medicaid and CHIP outreach, enrollment, and benefits assistance for children and families, and a National Center for Children's Benefits Outreach and Enrollment should be established**
- **Proven effective community-based outreach and enrollment strategies for insuring uninsured children, such as use of community-based case managers, should be adopted on a large scale by Medicaid, CHIP, and healthcare reform**
- **Continuous coverage of children - through such mechanisms as automated coverage renewal and active, community-based outreach and re-enrollment strategies - should be a fundamental element of any healthcare reform**
- **Future healthcare reform should retain or enhance critical components of current Medicaid and CHIP programs, including consumer protections, language services, standards on access to care and cultural competency, comprehensive benefits, and limited or no cost sharing**
- **Insurance coverage ultimately needs to be extended to all children , including both documented and undocumented immigrants, to reduce healthcare costs and improve outcomes for all Americans and to ensure citizen children living in immigrant households are fully covered**

Medical and Dental Homes for All Children

A medical home is defined as primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective,[38] and the same definition applies to a dental home. Minority children, however, are significantly less likely to have either a medical[39] or dental[40] home.

- **Any new healthcare reform should ensure that all children have a medical and a dental home**
- **Medical and dental homes for children can be increased through continued support and expansion of federally qualified health centers and other safety-net providers, and providing incentives and loan repayment programs for primary care providers based on the number of patients who are receiving care in medical and dental homes**

Disparities and the National Healthcare Quality Discussion

It has been convincingly argued that racial/ethnic disparities can be fundamentally framed as a quality-of-care issue.[41] For example, African-American pediatric heart transplant patients have double the odds of transplant failure, lower transplant survival rates, a median transplant survival time that is six years lower, a median age at heart transplant that is five years greater, and a higher likelihood of transplant donor-recipient mismatch, compared with their white counterparts.[42] Numerous other studies document racial/ethnic disparities in quality of care, including for primary care, vision care, kidney transplants, dialysis, appendicitis, pneumonia, and gastroenteritis.[43]

- **Racial/ethnic disparities are a quality-of-care issue that needs to be part of the national healthcare quality dialogue**

All Children Should Receive Needed Pediatric Specialist Care

Children with asthma who receive care from a specialist have significantly fewer ED visits and hospitalizations and a greater likelihood of asthma care that is consistent with national practice guidelines,[44] but a recent study[45] revealed that only 17% of African-American and Latino children with asthma have an asthma specialist, and poor minority asthmatic children are twice as likely as their non-poor counterparts to have no asthma specialist. Indeed, national data document that among infants and toddlers, Latinos and African-Americans are twice as likely as whites to not be referred to specialists by their healthcare providers, even though these young minority children have significantly worse health status.[46]

- **All children should have access to and receive needed specialist care**
- **Reducing disparities in specialty care may require increasing Medicaid and CHIP specialist reimbursement rates to match Medicare or private insurer rates**

No Child Should be Denied Healthcare Due to Language Barriers

Patients who face language barriers are much more likely than those without language barriers to have impaired health status, no usual source of medical care, lower rates of preventive services, non-adherence with medications, a greater a diagnosis of more severe psychopathology and higher rates of leaving the hospital against medical advice among psychiatric patients, a lower likelihood of being given a follow-up appointment after an ED visit, an increased risk of intubation among children with asthma, a greater risk of hospital admissions, an increased risk of drug complications, higher resource utilization, lower patient satisfaction, and more medical errors.[47] Under Title VI of the Civil Rights

Act of 1964, denial or delay of medical care because of language barriers constitutes discrimination and requires that recipients of Medicaid or Medicare funds provide adequate language assistance to patients with limited English proficiency. Only 12 states and the District of Columbia, however, currently provide third-party payer reimbursement for medical interpreter services through Medicaid and SCHIP.[48]

- **National third-party reimbursement should be provided for medical interpreter services, not only in Medicaid, CHIP, and Medicare, but also in all insurance plans**

Diversify the Healthcare Workforce

Regardless of community income, communities with high proportions of African-American and Latino residents are four times more likely than others to have physician shortages, but African–American physicians are significantly more likely to care for African-American and Medicaid-covered patients, and Latino physicians are significantly more likely to care for Latino and uninsured patients.[49] The most recent data, however, document that under-represented minorities (African-Americans, Latinos, American Indian/Alaska Natives, and Native Hawaiian/Pacific Islander) are disproportionately rare in the physician workforce, compared with the general population: for example, under-represented racial/ethnic minorities comprise 28% of the US population, but only 7.5% of all medical school faculty.[50]

- **Efforts are needed to increase the diversity of medical, dental, osteopathic, nursing, and other health professions schools**

More Research is Needed on Disparities in Children

Compared with research on racial/ethnic disparities in the health and healthcare of adults, little attention has been paid to disparities in children. For example, only five of 103 studies in the Institute of Medicine's landmark review of the literature on healthcare disparities specifically addressed disparities in children's healthcare.[51]

- **Funding for research on racial/ethnic disparities in the health and healthcare of children should be increased by federal agencies, including the National Institutes of Health, AHRQ, the Maternal and Child Health Bureau, the Department of Health and Human Services, and the Centers for Medicare and Medicaid Services**

- **A comprehensive review by the Institute of Medicine is needed of children's healthcare disparities**

Innovative Solutions are Need to Eliminate Children's Disparities

Due to high rates of asthma-associated morbidity in the children of Central Harlem, the Harlem Children's Zone Asthma Initiative was established to reduce asthma morbidity through improved surveillance, healthcare use, and healthcare service delivery for children age ≤13 years old residing in a 60-block radius of Central Harlem.[52] Early evaluation revealed significant reductions among participants in school absences and ED and unscheduled physician office visits for asthma, and improved asthma management practices and strategies.[53] In another study of minority children with asthma, a randomized trial of parent mentor - experienced minority parents of asthmatic children who receive specialized training to help other minority parents and children with asthma from the same communities - revealed that parent mentors can reduce children's wheezing, asthma exacerbations, ED visits, and missed parental work days, while improving parental self-efficacy.[54] These outcomes are achieved at a reasonable cost, and with net cost savings for high participants.

- **Geographic Information Systems (GIS) and other health information technology should be utilized to identify communities and regions experiencing particularly dramatic racial/ethnic disparities in children's health and healthcare**
- **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**
- **Federal and state funds should be provided for innovative, family-centered, community-based interventions that target the elimination of children's disparities, and successful interventions should be incorporated into Medicaid and CHIP as best practices**

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About First Focus:

First Focus is a bipartisan advocacy organization that is committed to making children and families a priority in federal policy and budget decisions. Children's health, education, family economics, child welfare, and child safety are among the core isue areas around which First Focus is working to promote bipartisan policy solutions.

While not the only organization working to improve public policies that impact kids, First Focus approaches advocacy in a unique way, bridging the partisan divide to make children a primary focus in federal policymaking. First Focus engages a new generation of academic experts to examine issues affecting children from multiple points of view in an effort to create innovative policy proposals. First Focus convenes cross-sector leaders in key states to influence federal policy and budget debates, and to advocate for federal policies that will ensure a brighter future for the next generation of America's leaders.

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