

P E R S P E C T I V E

Policies To Reduce Racial And Ethnic Disparities In Child Health And Health Care

Eliminating racial and ethnic disparities will require multiple interventions throughout the health care system.

by **Anne C. Beal**

ABSTRACT: This paper reviews recent reports that demonstrate disparities in health care for children and current federal efforts to eliminate them. Instead of simply describing disparities, this paper also presents recommendations that can reduce disparities. By reviewing current problems, practices, and recommendations in health care coverage, quality, and provider training, the author maps out a plan for reducing disparities in child health that complements existing efforts. The fragmentation of current and proposed initiatives would benefit from an oversight body based at the U.S. Department of Health and Human Services that would monitor progress and coordinate efforts for eliminating disparities.

WHEN A CHILD IS BORN, the child's health, well-being, and lifespan are determined in part by the color of his or her skin. Research on racial and ethnic health disparities has greatly expanded in recent years, and the existence of disparities in health and health care cannot be denied.¹ In 2002 the Institute of Medicine (IOM) released *Unequal Treatment*, a report that summarized the medical literature and concluded that "evidence of racial and ethnic disparities in health care is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services."² Most recently, the Agency for Healthcare Research and Quality (AHRQ) released the *National Healthcare Disparities Report (NHDR)*, which identified widespread disparities in care for vulnerable U.S. populations.³ This report, to be published annually, will be useful for monitoring trends in health care disparities and progress toward their elimination.

■ **Current efforts to address disparities**

in child health. Recent federal initiatives to address health disparities merit attention. Senators Edward M. Kennedy (D-MA) and Bill Frist (R-TN) cosponsored the Minority Health and Health Disparities Research and Education Act of 2000 (P.L. 106-525), which established the National Center on Minority Health and Health Disparities (NCMHD) at the National Institutes of Health (NIH), funded Centers of Excellence for Research on Health Disparities and Training, and included support for disparities research at AHRQ. In November 2001 Tommy G. Thompson, secretary of the U.S. Department of Health and Human Services (HHS), announced the Closing the Health Gap campaign, a public education and information campaign to raise awareness of health issues in communities of color.⁴ However, among these and other federal initiatives are few proposals for efforts aimed specifically at children.⁵

Closing the Health Gap includes a youth media campaign to promote physical activity

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in children ages 9–13.⁶ The Healthy People 2010 objectives, also sponsored by HHS, include two child health areas (immunizations and infant mortality) among the priority areas addressing disparities.⁷ These efforts are important first steps in addressing disparities among children, but they are limited in their potential to affect other fundamental child health disparities, such as access to pediatric primary care. Proposals to reduce disparities in child health will require a more expansive approach to address the multitude of health issues affecting children of color.

■ **Knowledge gaps.** Both *Unequal Treatment* and the *NHDR* examine racial and ethnic child health disparities. However, there is a “disparity in disparities,” as the evidence of child health disparities is not as well developed as in adult health. For example, in the IOM report’s extensive literature review, only five of the 103 published studies specifically address disparities in children. The authors of the *NHDR* sought to include an analysis of child health disparities and present data on disparities in HIV and AIDS, immunization rates, and dental care, but they conclude that a thorough examination of child health disparities was limited by the lack of data resulting from small sample sizes and few child-specific measures of effective clinical care.

The few areas where we have adequate data on children’s racial and ethnic disparities in health care indicate that children of color experience disparities of equivalent magnitude, persistence, and concern as do adults of color.⁸ Such children have more difficulties than white children with accessing health care, and when they do access care, they receive lower-quality care for needs ranging from primary care to asthma care.⁹

This paper addresses the urgent priorities and unanswered questions regarding racial and ethnic disparities in children’s health and health care. The aim is not to describe disparities but to identify major gaps and deficits in the field, examine key current practices and policies, and recommend improvements for reducing and eliminating disparities.

Health care in the United States is not pro-

vided by a single coordinated system. Instead, the health care system is a patchwork of purchasers, providers, regulators, and others. Thus, efforts to improve care and reduce disparities will require a multifaceted approach that affects different sectors in the health system. This paper presents opportunities for addressing disparities by improvements in health care coverage, the quality of care delivered to children of color, and provider training.¹⁰

Health Care Coverage

Lack of health insurance is a major hindrance to accessing care, and racial differences in uninsurance serve as the first step in producing health care disparities by limiting access, regardless of the quality of care.¹¹ Children without health coverage are less likely to have a regular doctor or to receive preventive care, and are more likely to have unmet medical needs.¹²

■ **The gaps.** National surveys show that rates of uninsurance vary by race and ethnicity, with 37 percent of Hispanic children reporting a period of no coverage in the past year. This is followed by 23 percent of African American and 20 percent of white children.¹³

The State Children’s Health Insurance Program (SCHIP) was designed to provide coverage to children whose families have low incomes but who are not eligible for Medicaid. However, states have encountered difficulties with recruiting and retaining eligible children to SCHIP. It is estimated that fewer than half of all eligible children are enrolled in SCHIP, although the number of children who are insured increased by 5.4 million between 1996, the year before SCHIP started, and 2002.¹⁴

■ **Current practices and policies.** Some states increased enrollment by raising awareness of SCHIP and simplifying the enrollment process.¹⁵ Interventions such as linking SCHIP enrollment with enrollment in other services, allowing people to register over the phone, and simple income eligibility documentation all facilitate participation.

■ **Recommendations.** In the current fiscal environment, states cannot provide coverage to all eligible children. However, in the ab-

sence of universal health care, the provision of coverage through Medicaid and SCHIP is the most feasible alternative. If every child who was eligible for either Medicaid or SCHIP was enrolled, coverage would be provided to 6.7 million children, 75 percent of those who are now uninsured.¹⁶ This would have a greater impact on health care for children of color, because they are more likely than white children to be uninsured and to have had no regular source of care prior to SCHIP enrollment.¹⁷

Each state determines SCHIP income eligibility criteria; caps range from 133 percent to 400 percent of the federal poverty level, with thirty-nine states having caps of at least 200 percent.¹⁸ States vary in their rates of uninsurance; uniform requirements for SCHIP eligibility would reduce these variations and would reduce rates of uninsurance overall. If all states enrolled all uninsured children up to 200 percent of poverty, then 6.6 million uninsured children (75.2 percent) would have coverage. If the uniform SCHIP eligibility cap were raised to 300 percent, then 7.9 million uninsured children (90.3 percent) would be covered.¹⁹ This would have a particular impact on children of color and would provide coverage for 20 percent of Hispanic children with family incomes below 200 percent of poverty, 11 percent of low-income African American children, and 9 percent of low-income white children.²⁰

Although SCHIP expansions would raise the program's costs, further analyses are needed to determine the best methods for increasing enrollment and the degree to which increased costs attributable to higher enrollment would be offset by savings in uncompensated and emergency care.

Quality Of Child Health Care

Once children of color get access to care, they may experience poor-quality care. This may be caused by bias and poor care delivered

by individual providers, but it also may be caused by poor-quality care in the health systems that serve children of color. Programs such as Medicaid typically reimburse at below-market rates, and most safety-net health systems suffer from chronic underfunding and shortages in resources. As a result, they are less able than better-funded health systems to provide high-quality care.

Quality improvement efforts within health systems that serve children of color would re-

duce disparities in health care, which are essentially disparities in quality. Whether the issue is access and use, immunization rates, or appropriate management of asthma, providers with fewer resources are less able to deliver high-quality care.

Framing health care disparities as a quality issue offers many advantages. Disparities in health care are often treated as an issue that is sep-

arate from health care quality in general. However, if the health care system is allowed to provide poor-quality care to any segment of the pediatric population, then all children are at risk for receipt of such care. The child health care quality movement needs to identify and address threats to health care quality pertinent to children of color, to meet its goal of improving care for all children. Also, efforts to reduce disparities can use the language, tools, and methods developed to improve health care in general, applying them to care for children of color.

Taking an example from adult health care, Ashwini Sehgal reported results of a Medicare quality improvement project that targeted appropriate use of hemodialysis.²¹ This effort improved technical aspects of hemodialysis, particularly regarding adequate hemodialysis dosages. In addition to overall improvements, the project reduced disparities in receipt of hemodialysis between African Americans and whites from a ten-percentage-point difference in 1993 (36 percent versus 46 percent) to a

“If the health care system is allowed to provide poor-quality care to any segment of the pediatric population, then all children are at risk for receipt of such care.”

three-percentage-point difference in 2000 (84 percent versus 87 percent). The goal of the project was not to reduce disparities, but quality improvements in care for all had a particular impact on care for African Americans and reduced disparities. Future quality improvement efforts for child health conditions can be monitored to determine whether they also reduce disparities.

Addressing health care disparities through quality improvement makes disparities a mainstream rather than a marginal issue. It also increases opportunities for political support, because the issue is framed as assuring high-quality health care for all children (an issue that few can protest), rather than a special-interest issue.

■ **Gaps in public settings.** Children of color are more likely to be insured through public programs such as Medicaid and SCHIP. Nearly half of African American children receive public health insurance, as do 38.3 percent of Hispanic children and 18.4 percent of white children.²² As a result, quality improvement efforts channeled through publicly funded health plans will have a strong impact on racial and ethnic disparities in health care quality. In a recent study, Joseph Thompson and colleagues found that Medicaid managed care plans did not perform as well as commercial plans on a variety of pediatric clinical measures.²³ The Medicaid plans had lower performance rates for childhood immunization (54 percent Medicaid versus 69 percent commercial) and an inadequate number of well-child visits in the first fifteen months of life (31 percent of Medicaid plans did not provide an adequate number, compared with 53 percent of commercial plans). Neither group of plans had optimal performance on these measures. This shows that there is much room for improvement in the quality of health care provided to children in general and through public plans in particular.

■ **Current practices and policies in Medicaid and SCHIP.** Medicaid and SCHIP promote improvements in care through initiatives that include patient registries, case management, physician feedback, and aligning fi-

ancial incentives with clinical performance. Quality monitoring and improvement occur in state Medicaid programs, but priorities are also set at the state level. One disadvantage of this is that Medicaid-based quality improvements are not coordinated across all states. However, it allows for the development of quality improvement efforts that are particularly responsive to local needs.

■ **Current practices and policies in the safety net.** Community health centers (CHCs) provide health care services to low-income families, and more than 65 percent of CHC patients are people of color.²⁴ CHCs provide good-quality care, and studies show that their patients have outcomes that are comparable to those in private settings.²⁵ In 1998 the Bureau of Primary Health Care launched Health Disparities Collaboratives, an initiative designed to improve care in CHCs for asthma, diabetes, depression, and cardiovascular disease.²⁶ This initiative is being evaluated by AHRQ and the Commonwealth Fund; preliminary results show promising improvements in care.²⁷ If this proves to be a successful model for improving care, future efforts can focus on more child health conditions.

■ **Gaps in private settings.** Children of color receive most of their health care in private physicians' offices (66 percent for Hispanic children and 69 percent for African American children).²⁸ Therefore, to improve the quality of health care delivered to these children, efforts will have to target private as well as public settings.

A recent review of the quality of children's health care found several major gaps in the quality of care for all children, in addition to racial disparities in quality.²⁹ Current child health care quality measures are not designed for monitoring disparities. A recent systematic review of health care quality measures found that none of the measure sets that use administrative data had race and ethnicity measures; however, the survey-based measures of patient experience did include race and ethnicity.³⁰

■ **Current practices and policies in private settings.** Organizations such as the Institute for Healthcare Improvement (IHI) and

National Initiative for Children's Healthcare Quality (NICHQ) are recognized leaders in improving health care quality, particularly in ambulatory settings. Their earlier efforts focused more on the private sector, but the IHI later served as a major collaborator with the Bureau of Primary Health Care's Health Disparities Collaboratives for improving care in CHCs. NICHQ recently began to highlight quality disparities; by highlighting the needs of children of color and addressing the clinical conditions that are more prevalent in this population (such as asthma), NICHQ will serve as an important source of quality improvement to reduce child health disparities.

■ **Recommendations.** Monitoring disparities in care requires the collection of data on patients' race and ethnicity combined with stratified reporting of quality measures by race and ethnicity. Demographic measures also can include the primary language of patients, and for children, their parents, because of the role limited English proficiency plays in poor outcomes of care.³¹ David Nerenz and colleagues, in preliminary work in this area, found that health plan data can be used to identify enrollees' race and ethnicity; they linked these measures to quality indicators for the production of a disparities report card at the health plan level.³²

If all currently accepted measures of quality, such as the Health Plan Employer Data and Information Set (HEDIS), the Consumer Assessment of Health Plans (CAHPS), the AHRQ quality indicators, the Centers for Medicare and Medicaid Services (CMS) quality indicators, and the National Quality Forum performance measures, were reported stratified by race and ethnicity, this would greatly expand the ability to monitor disparities in care. It would also address the "disparity in disparities" issue by linking improved ability to identify child health disparities with the growing ability to monitor the quality of care for all children.

Quality measures are evaluated with regard to accountability, where it is clear which parties are responsible for the results, for validity, where it is accepted that the measures truly re-

flect the quality of care given to patients, and for "improvability," where health systems and providers are able to improve their performance on those measures. Reporting these measures by race and ethnicity allows those who are responsible for the disparate outcomes to use quality improvement tools and activities to improve their performance and reduce disparities.

Health Care Providers

In addition to the need for improving the technical components of care, there is a need to improve interpersonal aspects of care, improve cross-cultural interactions and communication, and increase patients' involvement. All providers must be trained to improve their cross-cultural interpersonal interactions to engage patients from all racial and ethnic backgrounds equally. At the same time, the racial and ethnic diversity of health care providers needs to be increased.³³

■ **Gaps in training.** Training health care providers to improve cross-cultural interactions can reduce disparities in those interpersonal components that result in greater patient satisfaction, engagement, and cooperation with health care regimens. Such training can target all health care providers, particularly physicians and nurses.

■ **Current practices and policies.** Cultural competency is an emerging field in medical practice and education.³⁴ The Liaison Committee on Medical Education (LCME) requires all medical schools to include cultural competency training in their curricula. This allows all students to gain experience in caring for diverse patient populations. Training continues after medical school, and the Accreditation Council for Graduate Medical Education (ACGME) includes responsiveness to diverse patient groups among its core competencies. Cultural competency standards in medical education will improve the ability of future physicians to care for diverse patient populations, but the training is not available to physicians already in practice.

■ **Recommendations.** Physicians receive their license to practice at the state level and

undergo periodic license renewal. One of the requirements for medical license renewal could be participation in cultural competency training. As an example, New York State has specialized training requirements for licensure and requires all physicians to participate in training to identify child abuse.³⁵ Similar requirements can be adopted for cultural competency training and would reach all physicians in practice within one renewal cycle.

■ **Gaps in workforce diversity.** Physicians of color play a critical role in reducing disparities, because they are more likely to serve in low-income and underserved communities, care for Medicaid patients, and care for patients of color.³⁶ Studies show that when African American patients have African American physicians, they report greater participation in medical decision making.³⁷ Other research shows that when patients have physicians who speak their language, they have improved physical functioning, better psychological well-being, better health perceptions, and less pain.³⁸

There is a need to increase the number of underrepresented physicians, dentists, and nurses of color.³⁹ In 2001, 11 percent of students accepted to medical school were from underrepresented racial and ethnic groups, while approximately 25 percent of the U.S. population was from these groups.⁴⁰ As students go through the educational pipeline toward a medical degree, there is a sharp drop in the proportion of underrepresented students at each level of training, with the number finally bottoming out at 4.6 percent of medical faculty.

■ **Current practices and policies.** There are several programs in the private sector designed to increase the number of minority physicians. Many of these programs apply for funds from the Health Resources and Services Administration (HRSA) Health Careers Opportunity Program, Centers of Excellence, and Minority Faculty Fellowship Programs. These provide grants to health professions training schools and programs to increase the diversity of health professionals by improving the academic skills and provision of support to disad-

vantaged and underrepresented minority students and faculty. HRSA also gives scholarships, loans, and loan repayments to disadvantaged students and faculty.⁴¹

These programs fall within the health professions activities of HRSA, are often underfunded, and are at risk for being cut. For example, the president's budget for fiscal year 2005 proposed an \$11 million allocation for health professions activities, a 96 percent reduction from \$294 million in 2004 and \$308 million in 2003.⁴² Without adequate support, these programs will not be able to make important advances in diversifying the health care workforce.

■ **Recommendations.** Before any student enters medical school, he or she must be well educated and prepared for the rigors of pre-medical education in college and medical school. Schools in inner-city communities of color do not typically perform as well as schools in more affluent areas. The No Child Left Behind Act of 2001 calls for increased accountability of schools that have not performed well, as well as use of national standards to assure a basic level of competency for all graduates. I propose that communities with documented health disparities and poor school performance be designated "Health and Education Empowerment Zones." Such communities would receive additional federal support provided by the No Child Left Behind Act for improved education and expansion and enrichment of science and health curricula. By linking poor education and poor health, we can identify communities at greatest risk for poor outcomes in both of these areas and provide support that addresses both problems. This will encourage young people from the communities most affected by health disparities to become health care providers. It is likely that those students will ultimately practice in communities that experience the greatest health disparities.

Concluding Comments

The elimination of child health care disparities will require multiple interventions from various sectors in the health care system. This

paper identifies opportunities for improving health care for children of color through expansions in health care coverage, promotion of quality improvements, and provider training. It also includes recommendations for improvements at both the federal and state levels, within health plans and health systems, and within accrediting and licensing structures. The next step for adopting any of these recommendations is to analyze the costs and feasibility of their implementation and the benefits they would provide. Such analyses will inform debates about the costs and benefits of promoting policies to reduce disparities. These recommendations would complement and support current federal initiatives to address disparities.

Despite current interest, there is a lack of coordinated and focused effort to address racial and ethnic disparities. Individual programs have emerged from federal, state, and private sectors, but there is no oversight to ensure their effectiveness. The *NHDR* will be released annually, which provides an opportunity to monitor national trends toward eliminating disparities. However, as in politics, most health care is local, and there is little monitoring of disparities at the local level.

Making use of health care quality reporting and improvement to address disparities leverages systems that are already in place and applies them to disparities in care. Most quality reporting is coupled with an oversight mechanism such as accreditation, purchasing contracts, or informing consumer choice. By incorporating measures of disparities into quality reporting, that oversight can encourage and promote efforts to reduce disparities. In addition, local reporting of quality disparities can be used to monitor national trends.

The overall coordination and monitoring of efforts to reduce disparities can be managed within HHS. Health disparities occur across a range of illnesses and settings. As such, efforts to eliminate them can be embedded in all work and research designed to improve health and health care for all Americans, not just for children of color.

A mandate for HHS to address disparities

will promote research, public health, and health promotion efforts. Such a mandate can be coupled with an advisory council of minority health experts who would oversee the process, promote coordination of efforts across various federal agencies, and receive reports of local efforts to address disparities. Monitoring progress can be done by an annual review and report to Congress, with an evaluation of changes in outcomes as reported by the National Center for Health Statistics and changes in care as reported by the *NHDR*. Several federal efforts to reduce disparities are under way, and an advisory council would facilitate coordination to promote synergy and reduce replication of those activities.

Whether the issue is health care coverage; quality measures; or advances in workforce diversity, regulations, or accreditation that reduce disparities, the number of initiatives and the magnitude of health disparities require coordination to promote the most effective interventions. As a federal agency, AHRQ has found it necessary to include a focus on priority populations, such as children, to ensure that their work addresses children's needs. A federal health disparities advisory council designed to provide coordination and oversight of disparities activities could also include a focus on priority populations, such as children. This would ensure that their unique needs and challenges are addressed within all federal efforts to eliminate disparities.

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NOTES

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42. HHS, "FY 2005 Budget in Brief," 1 March 2004, www.hhs.gov/budget/05budget/healthres.html (22 May 2004).