When we think about children, we envision cute, innocent little people who have not a care in the world. Though optimistic, this vision is unfortunately not reality. Today, more and more children are suffering health disparities due to their socioeconomic status and race. Disparities are an issue of equity—what makes an affluent white child more important to care for than a low-income minority child? The foundations of adult health and success are laid early in childhood, so the health impact of early development and education lasts a lifetime. Since health disparities caused by socioeconomic status and race are becoming more and more pronounced, they affect children in more areas than just health. Thus society needs to make eliminating disparities a widespread priority. Most disparity research to date has documented differences and mechanisms for differences, but more solutions need to be found. After all, if our children are not thriving in the present, our country will not be able to thrive in the future.

According to the National Institute of Allergy and Infectious Diseases, health disparities are gaps in the quality of health that mirror differences in socioeconomic status, racial background, and education level. These disparities could arise from a variety of factors, including access to health care and increased risk of diseases ("Minority Health"). In layperson’s terms, health disparities are differences in health across populations that are caused by differences in the populations themselves. Some disparities are unavoidable, such as each individual’s genetic structure, but others are potentially avoidable, especially if they revolve around low-income areas or unequal access to care.

Urban areas are the best regions in which to study health disparities and their effects. Across the country, these populations vary greatly in affluence, education level, and racial/
ethnic composition. The diversity in populations of Kansas City makes health disparities especially prevalent—according to the Census Bureau, in 2010 59.2% of all Kansas City citizens were white, 29.9% were black, and 10.0% were Hispanic or Latino. 87.1% of citizens were high school graduates, while only 30.9% had a college diploma. Perhaps the most shocking: 18.8% of people were below the typically accepted poverty level (US Census Bureau). With the vast differences in individuals, widespread disparities are not surprising.

Both adults and children can suffer the effects of disparities. In adulthood, disparities may correlate more directly with personal choices. After all, those adults are the ones who control their wealth and education level. Socioeconomic status is one of the most powerful factors in disparities because it can influence the extent to which the other factors provide protection or present risks. For example, poverty is strongly associated with multiple risk factors for poor health, whereas affluence can provide protection against similar fates. Education level can also influence health, not only in the ability to understand provider instructions, but also in shaping future occupational opportunities to become more affluent (Kreger et al.).

However, not all factors can be controlled, and these uncontrollable factors can lead to different levels of care and health outcomes. For example, studies from the Centers for Disease Control and Prevention report that the risk for diabetes and heart disease was much higher among African Americans and Hispanics than among whites (Collie-Akers et al.). In this study, when all other variables were accounted for, only the difference in race predicted patient outcomes. One’s ethnic background is not controllable, yet still has an important impact on health.

The association between socioeconomic status or race and health is seen in children as well as adults. However, disparities suffered during childhood are arguably more detrimental to the individual. Children are more vulnerable than adults because their brains and bodies are still developing. Society is constantly striving to improve the health of children through
immunizations, proper nutrition and physical activity, and providing them with education to prepare for the future (Rubin et al.). However, these efforts may be for naught if children cannot overcome the adversities they face due to predetermined variables.

Socioeconomic status is shown to be the most significant factor in predicting health outcomes and health disparities. Children’s socioeconomic status is mostly assessed by parental characteristics: education, occupation, and income. In this way, children ultimately do not have a choice in their health status. Unlike adults, they cannot change their socioeconomic status, which makes them a more at-risk population. Poor social and economic circumstances affect health throughout life: people further down the social ladder usually run at least twice the risk of serious illness and death (Kohlhuber et al.). Low-income children have higher rates of mortality, higher rates of disability, and are more likely to have multiple conditions. They also were far more likely to be in fair or poor health compared with other children. And when low-income children have health problems, they tend to suffer more severely (Kreger et al.).

Socioeconomic factors can lead to these negative outcomes in multiple ways by impacting educational opportunities for children, environmental pollutants, and housing conditions. Across American cities, the school systems in low socioeconomic communities are often under-resourced, which negatively affects students’ academic progress. In Kansas City, the school system has only recently regained provisional accreditation after being unaccredited for two years due to excessively poor performance (Robertson). How are students supposed to learn and succeed if their school system is not flourishing? Additionally, the low-income housing that many students live in is typically cramped quarters in parts of town where pollution is prevalent, which increases their susceptibility to different conditions (Kohlhuber et al.). Not only do children who live in impoverished areas receive worse education, but they also are more likely to become ill than their affluent counterparts.
Children also suffer the results of racial or ethnic disparities. These are most prevalent when examining differences among Caucasians, African Americans, and Hispanics. Dr. Glen Flores examined racial and ethnic disparities in medical and oral health, access to care, and use of services across the nation. He found that minority races were more likely to be uninsured, with the uninsured rate for whites being 6%, 21% for Latinos, and 7% for African Americans. Minorities also have increased odds of suboptimal health status, obesity, asthma, behavioral and speech problems, no usual source of care, and unmet medical needs, with certain disparities being more prevalent in certain races (Flores et al.).

Asthma provides an interesting example to illustrate these disparities. According to the American Academy of Allergy, Asthma, and Immunology, one in ten children are currently diagnosed with this chronic disease. Low-income children are disproportionately more likely than their affluent peers to be affected. Asthma prevalence was also higher among multiple races, black, and American Indian children than in white children (American Academy of Allergy, Asthma, and Immunology). When controlling for all other variables, studies have found that these populations are more susceptible. However, no studies to date have documented specific mechanisms for these differences. These findings, though specifically studied with the population of asthmatics, are noticed with many other diseases as well.

Childhood diseases affect more than just childhood health. According to a study published in the Journal of Health Economics, individuals who suffered worse health during childhood have significantly lower educational progress, poorer health, and lower socioeconomic status as adults (Case et al.). As unfortunate as it may be, it makes sense: children who suffer worse health are more likely to miss school days for illnesses or medical appointments. This can cause students to be physically or psychologically unable to complete assignments or exams, as well as increase the likelihood that the student will not participate in activities that would allow him or her to bond with their peers (Lê et al.) Also, in a longitudinal study, children who had poor health in one year were typically shown to be in poor health in future years as well (Lê et al.)
A seventeen-year-old Caucasian male, who prefers to remain anonymous, is affected with asthma. “John,” as the patient will be referred to, said that when he was first diagnosed with asthma in the fifth grade, he recalls missing multiple weeks of school due to complications causing pneumonia. He missed two important field trips and had to do piles of homework by himself. After being diagnosed with exercise-induced asthma, he was told that he either needed to be heavily medicated or he could no longer play sports. This diagnosis separated him from his peers who did not understand that he could not do everything that they could do. Of course, he was able to involve himself in other ways, but his original group of friends became harder to sustain. Now he is strapped with the burden of biannual doctor’s appointments for which, again, he usually has to miss school. He says that he is lucky that his asthma is currently well controlled, but many others are not quite so lucky.

These and other barriers perpetuate the cycle of poverty and poor health. If children who are in poor health at one check are still in poor health at the next check, how are they supposed to improve? Furthermore, if children who are in poverty have poor health and do not succeed in school, they are more likely to flounder in the workforce, which keeps them in poverty. If these individuals have kids, their children will be in poverty. Consequently, those children will be more likely to have poor health, which leads to less success in school. The cycle will continue until something breaks it; breaking the cycle needs to be a priority in today’s society.

Reduction or elimination of health disparities in children requires the implementation of many strategies. One of the most common approaches is ensuring that all children have health insurance. Although public health insurance ultimately aims to improve child health, health is shaped by a variety of factors (particularly socioeconomic status), so improving health needs to be multi-faceted.
Medicaid, a state-specific program enacted to ensure all children have access to health insurance, and the State Children's Health Insurance Program (SCHIP) are initial solutions to this problem. Numerous studies demonstrate that Medicaid and SCHIP coverage is associated with greater access to routine care (as opposed to emergency services). Child participants in these insurance programs also generally use more preventative services instead of reactionary services. This is helpful in minimizing the impact of poor health on overall growth and development. Health insurance predicts whether children get needed care, reduces parental worry, and improves the health status of children, but insurance alone is not enough in the long run (Hughes and Ng).

Several free clinics in the Kansas City area offer medical care at no or low cost to people who are un- or under-insured. As one of the largest community health clinics in Kansas City, the Kansas City CARE Clinic exists to “promote health and wellness by providing quality care, access, research, and education to the underserved and all people in our community” (KC CARE Clinic). They provide care in general medicine, HIV prevention and treatment, behavioral health, and dentistry, functioning mainly with the help of volunteers and monetary donations from the community (KC CARE Clinic). However, KC CARE and other free clinic services are unequipped to treat children. A survey of a variety of free clinics in Kansas City shows that only a few will treat children under the age of eighteen. It seems odd that the demographic who is in most need of care is the least likely to find treatment.

The lack of free pediatric care does not just occur in Kansas City. In fact, the “Inverse Care Law” is an unofficial principle in healthcare stating that those who need the most care are least likely to receive care. According to Dr. Rahman and her colleagues, community pediatricians are very important in addressing the Inverse Care Law and overcoming health disparities due to poverty and socioeconomic status. These community doctors exist to bridge the gap and provide care to underserved children (Rahman et al.). The authors analyzed five years of data regarding the service changes enacted to tackle inequalities in a range of
conditions, finding that inequalities can be addressed using four quality domains of service provision. These domains provide a foundation for providers to begin to address the Inverse Care Law; however, if these free pediatric services are few and far between, they cannot be helpful.

One clinic that does treat children is the Southwest Boulevard Family Health Care clinic, whose mission is to “provide health care and other supportive services for the poor and vulnerable of the community” (“Family Health CARE”). Their goals are excellence, continuity, and compassion, and they value equality of all individuals, teamwork for best decision-making, and individual development of patients and families. They serve patients from birth with general medical services including chronic disease management, as well as specialized services in obstetrics, ophthalmology, chiropractic, mental health therapy, and dental care. They state that typically about 20% of their population identifies as multiracial, 50% are white, 25% black, 4% Asian, and 1% Native American (“Family Health CARE”). The services they provide and the populations they see are the most vital, which shows that at an individual level, free clinics truly are making a difference.

A systems-level approach to overcoming disparities could be helpful as well. Dr. Marshall Chin worked with Robert Wood Johnson Foundation’s Finding Answers: Disparities Research for Change initiative and evaluated a systems approach for reducing disparities. Data collected from adults shows that if a system examines performance data, trains professionals for diverse populations, and makes reducing disparities a priority (monetarily and otherwise), the system will be more successful (Chin et al.).

Dr. Chin also reviewed interventions implemented so far to reduce disparities in childhood asthma. A systematic review of nineteen different quality-improvement intervention studies showed that these interventions resulted in significant changes in clinical outcomes when patients used case management techniques either at home or with other
trained staff members. For example, the development of written asthma action plans was one intervention that was shown to improve health outcomes. “John” mentioned that he uses an asthma action plan, which consists of taking a peak flow meter reading every day and using those numbers to predict his current health. The authors also evaluate clinical improvements based on family education programs and home-health interventions and their effects on asthma outcomes, and found that interventions that include a strong community outreach component are most effective (Chin et al.). “John” and his family members believe that his action plan and all the asthma education provided by his physician have truly helped him succeed thus far.

Though a systems-level approach seems to be advantageous for patients, truly reducing the source of health disparities requires going beyond the health care system. Fundamentally, this requires addressing the socioeconomic and racial differences that underscore disparities in children (Kreger et al.). This realization caused the U.S. Department of Health and Human Services to launch a comprehensive initiative in September of 1990. The program entitled Healthy People aims to improve the overall health of all Americans. During the past two decades, one of Healthy People’s overarching goals has focused on disparities: in Healthy People 2000, it was to reduce health disparities among Americans; in Healthy People 2010, it was to eliminate, not just reduce, health disparities; and in Healthy People 2020, that goal was expanded even further to achieve health equity, eliminate disparities, and improve the health of all groups (Centers for Disease Control and Prevention).

Increasing the magnitude of these goals allows the country to feel like we have accomplished previous goals; however, that pleasant feeling is not reality. It is not feasible for us to advance our goals as a country when previous goals have yet to be met. Healthy People 2000 focused on reducing disparities, which may have been done, but not well enough to begin “eliminating” disparities or “achieving equity” (Centers for Disease Control and Prevention). Yes, these are lofty goals that society needs to accomplish; however, if a goal is
difficult to reach, progress toward its completion is much slower. Many programs have been started to achieve the goals of the initiative, but they need to be widespread in order to be effective.

Innovative programs working to attain the Healthy People goals have emerged in both the public and private sector. Blue Cross Blue Shield of Florida is the leading effort behind increasing cultural competence training. They offer a program called Quality Interactions: A Patient-Based Approach to Cross Cultural Care, which trains physicians to go through a ten-step interaction process to diagnose and propose appropriate treatment plans. This program was implemented in July 2005 and has yielded positive results thus far: over 90% of physicians who have gone through the training agree that the information presented has increased their awareness and understanding of the subject, ultimately improving their ability to treat patients in different cultures (Kreger et al.). With results like this, why has the program not been implemented across the country?

On the other side of the country, Blue Cross of California, a state-sponsored business, began a Comprehensive Asthma Intervention Program (CAIP) to serve their diverse low-income population in California. The CAIP was designed to enhance the strengths and reduce the weaknesses of other asthma management programs. The program includes statewide incentives for participating physicians and pharmacists in addition to county-specific programs tailored to meet local needs. Over a four-year period after this program was implemented, the use of appropriate asthma medication rose from 56% to 66.4%. Additionally, for members continuously enrolled in the program, asthma related hospitalizations decreased by 60% and asthma related emergency room visits by 46% from 2004 to 2005 (Kreger et al.). Again, these results show incredible promise for the equalization of populations across the country. Why has this program not been implemented beyond California?
These and all of the other programs formed throughout the country need to be functioning in all cities. There are two major ways to help programs aimed at reducing disparities expand across the country: through grants and community support. First, grant funding would help incentivize investments into the programs. Money is always a limiting factor in any venture, so if funding was provided, companies would be more willing to grow their current programs and to expand their research of new programs. Federal, state, and local governments need to make this funding a priority. If adverse health problems are causing children not to thrive, the future of our country is in jeopardy.

In 2005, the mayor of Boston took the initiative to launch a $1 million grant program aimed at reducing racial disparities in the city. Any organization working to reduce disparities could apply for the money, and if granted, they got to implement their program designs. The city found that all the considerations that went into implementation led to additional programs that increased the chance to effectively address disparities (Kreger et al.). If all cities implemented grant programs like this, or if they were implemented at the state or federal level, results would likely be even more encouraging.

The other way to overcome barriers to implementation is by partnering with community organizations. Many local groups would love to make a real difference, but are limited by resources. If they were provided with the ideas or the data, they would do everything they could to implement the programs as designed. Also, each organization would be experts on its particular community, so they would know how to best implement the changes.

One example in Kansas City is a collaborative community initiative known as the Kansas City Chronic Disease Coalition. In an empirical case study, Dr. Vicki Collie-Akers documented and analyzed community changes, like reducing chronic disease risk or targeting specific minority populations, and found that the coalition facilitated 321 community changes in a four-year period (Collie-Akers et al.). This organization has been successful thus far, but they
have had to discover and implement a variety of community changes in order to determine which ones were successful and which were not. If they just had to apply programs developed somewhere else, they could be even more effective. This organization is also sizeable—many other smaller community action groups cannot make as large a difference unless they can work together to enact pre-designed plans. Ultimately, spreading programs across the country will require cooperation, and local organizations are the best partners for large corporations.

Society as a whole needs to make a change to eliminate health disparities. If the next generation is suffering health disparities and poor health outcomes now, their futures will be infringed upon. Through funding and community involvement, society can begin to address disparities due to socioeconomic status and race that affect children beyond just health. Previous implementations have been successful, but must be more widespread. Since the cycle of poverty and poor health perpetuates itself, we must do everything possible to break it now, lest it be even harder to do so in the future.
Works Cited


“John.” Personal Interview. 19 Nov. 2014.


