

DOCS FOR TOTS

**Moderator: Dr. George Askew
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1:00 p.m. CT**

Operator: Good day, everyone, and welcome to the “Understanding the Causes and Consequences of Disparities Among Young Children” conference call. As a reminder, today’s conference is being recorded.

At this time, for opening remarks and introductions, I would like to turn the conference over to Dr. George Askew. Please go ahead.

George Askew: Good afternoon and thank you for joining us for today’s audio conference. We’re delighted to have participants from across the country, including child advocacy organizations, research-and-referral networks, government agencies and doctors in the Docs for Tots network. My name, as we’ve said before, is George Askew and I’m a pediatrician and founder and Executive Director of Docs for Tots in Washington, D.C.

We have a very informative program today and I’m very pleased to introduce two remarkably accomplished and well-respected colleagues in the early childhood field and the pediatric field. Dr. Glenn Flores, Professor and Director of the Center for Advancement of Underserved Children at the Medical College of Wisconsin and Children’s Hospital of Wisconsin, and Dr. Paul Wise, the Richard E. Behrman Professor of Child Health and Society at Stanford and a core faculty member

at the Center for Health Policy and the Center for Primary Care in Outcomes Research at Stanford School of Medicine.

Dr. Flores will begin our session today by addressing ways in which disparities in the home environment, including family routines, safety measures and reading activities can influence children's health and future school success. After that, Dr. Wise will discuss emerging policy issues that threaten disparity reduction for young children. Once both presentations are complete, we will open up the lines for questions from the audience. If you have not had the chance already, please check www.docsfortots.org and click on our "resources" page to find materials relevant to today's call.

Now, if our speakers are ready, I will hand it off to Dr. Glenn Flores to get us started.

Glenn Flores: Well, good afternoon, and thank you Dr. Askew. And, I'd like to start by thanking the funders of my research, the Robert Johnson Foundation, AHRQ and the Gerber Foundation and, of course, Docs for Tots and Dr. Askew for giving me the honor and privilege of speaking with you today. And, I hope everyone is following along with the slides. I'll try and orientate you to any slides that are a little more complicated than you might expect.

So, lets start with the background. Studies show that the home environment that parents create for a young child, including family routines, safety measures and reading activities affects children's health and their future school success. So, you know, for example, children who have dinner less often with their family are at greater risk for poor school performance, substance abuse, alcohol use, smoking cigarettes and poor diet. The number of hours of television viewed by children is associated with obesity and violent behavior. Turning down home hot-water thermostat settings lowers the rates of tap-water burns in children, and the child's home exposure to books is associated with the development of vocabulary, listening comprehension and reading skills.

The U.S. is experiencing a demographic surge in minority children, so minority children will outnumber non-Hispanic white children by as early as the year 2030. Although recent Institute of Medicine, an agency for healthcare research and quality of reports, called “attention to racial and ethnic disparities in healthcare,” studies in disparities in children are actually rare and prior research has not examined disparities in early childhood home routines and safety.

The study aim was to use a national data set to examine whether racial and ethnic disparities exist in home family routines, safety measures, activities known to affect the health and future school success of young children. The methods were as follows. The data source was the National Survey of Early Childhood Health, or “NCHS” is the acronym. This was a telephone survey that was conducted in the year 2000 of a national random sample of households with children four to 35-months old. It over sampled households of black and Hispanic children. The parent or guardian most responsible for the child’s healthcare was interviewed and 2,068 interviews were completed, for an interview completion rate of 79 percent. The estimates are based on sampling (weights) that generalize the entire U.S. population of children four to 35 months of age.

In terms of the study variables, (by) (vary) and (multi-vary) analyses were done to examine racial and ethnic disparities in the household, including family activities and routines, safety measures and reading activities and resources. The children’s race or ethnicity was defined as “white,” “black,” or “Hispanic” by parental report, and I’m using the terms that they used in this survey and other surveys, so “black” and “Hispanic,” rather than I prefer to use, which is “African-American” and “Latino.” And, due to insufficient sample sizes, subjects from other racial and ethnic groups had to be excluded.

Data were analyzed using (stata) to adjust for household and inter-familial questioning of observations, and multi-varied analyses examined racial and ethnic differences after adjusting for

a wide variety of factors, including insurance coverage, the survey language chosen by the parent – in this case English versus Spanish – the health status, which we dichotomized as excellent and very good versus good, fair and poor, poverty, using the 2000 Federal Poverty Threshold, the child's age, the maternal age, the weekly hours the child spends in childcare, the number of adults in the household and the maternal education.

The results were as follows, so we're on slide eight, for those following along, and this slide summarizes the characteristics of four to 35-month old children in the United States in the year 2000 and your first column is the characteristic. Your second, third and fourth columns are the means or proportions for white, black and Hispanic children respectively, and your final column is the P value. So, you can see, in terms of the mean age and months, there wasn't much difference between the three groups, at about 20 to 19 months, and there wasn't any difference in the gender among the three groups.

And, when you start to look at some of the other characteristics, you can see, for example, that the mean number of adults in the household was somewhat greater in the Hispanic families at 2.4 versus two and 2.1 in blacks and whites respectively. You can also see that the minority age of the mother on average was much lower, so the mean maternal age in years was about 27 for the minority groups and 30 for white groups. In terms of the mother not being a high school graduate, you can see that was low for the white families and 11 percent versus 20 percent of the black and 49 percent of the Hispanic families. The mother being married, the highest percent was white families at 81 percent, followed by Hispanics 58 percent and blacks 32 percent.

In terms of the family income being at or below the poverty level, you can see only 13 percent for white families, but about half of both black and Hispanic family households. And then, in terms of the proportion uninsured, you can see substantially higher rates for Hispanic children at 31 percent and black children at 18 percent versus nine among white children. Private insurance, of course, reflects the inverse of that, so you have 72 percent for whites, 32 percent for blacks and

29 percent for Hispanics, and then the highest rates of public insurance incurred in the two minority groups. Finally, on this slide you can see, in terms of the child's health being excellent or very good, so the highest ratings is 90 percent among whites, but significantly lower in the minority groups at 79 and 72 percent respectively.

What about early childhood disparities to family activities and routines? So, on slide number nine, the first column is the family activity and routing, and then it's the same structure as the prior slide, where you have the proportions or means for whites, blacks and Hispanics respectively, and then the final column is the P value. You can see that most of these findings were statistically significant. So, in terms of the child's meals being at the same time daily, it's significantly more likely in the white families at 80 percent versus 70 percent among Hispanics and 65 percent among blacks.

Similarly, in terms of the family eating lunch or dinner together less than daily, you can see lowest rates in whites and, actually, Hispanics at 42 and 43 percent, but 50 percent of black families. Interestingly, parents playing music or singing to the child daily occur most often in the black families at 84 percent, followed by Hispanics at 76 percent – sorry, followed by whites at 76 percent and Hispanics at 65 percent. And, then in terms of the parent taking the child on outings daily, it occurred least often in Hispanic families at 26 percent versus 39 and 44 percent for whites and blacks.

In terms of the mean daily hours the child watches TV, you can see that blacks had the highest rate. And, again, these are very young children, four to 35 months old, and you can see that they were watching 2.4 hours on average, compared with 1.6 in whites and Hispanics, and that's statistically significant when you do the (parawise) comparisons between either black and whites or blacks and Hispanics. Then, in terms of the child going to bed at the same time daily, occurred slightly more often in the whites versus the other groups, at 76 versus 69 and 65 percent. And,

then the parent would like to spend more time with the child actually occurred more often in the minority groups at 29 percent versus 20 percent for whites.

In terms of disparities in home safety measures and reading activities and resources, this is the same set up as the prior slide – we're on slide 10 now – you can see first the first column is the safety measure or reading activity and resource, and then the following three columns are whites, black and Hispanics respectively, either percentages or means, and in the final column is the P value, and all these comparisons are statistically significant.

What you see here is that, for example, having a stair gate installed occurred most often in the white households at 82 percent, but only 67 percent of Hispanics and 62 percent of blacks. Similarly, having safety latches and locks on cabinets, 85 percent of whites versus 78 and 73 percent in Hispanics in blacks. Padding the hard and sharp surfaces, however, occurred more often in the minority families at 58 percent versus 46 percent of whites. And, then putting stoppers or plugs in electrical outlets, although was high rates across the board, occurred more often in white families at 95 percent versus 91 percent in both minority groups. And, in terms of turning down the hot water thermostat setting, it occurred in 56 percent of white families, 60 percent of Hispanics families, but only 45 percent in blacks.

And, when we look at the parent reading to the child, you can see that this occurred daily in 61 percent of white families, 46 percent of black families and only 29 percent of Hispanic families. In terms of reading lessons daily, again, 36 percent in whites, 49 percent in blacks and 56 percent in Hispanics. And, the never reading to your child occurred in only three percent of white households, five percent of black households and 15 percent of Hispanic households. Another way to look at this is to look at the mean number of children's books in the household and you can see that the mean number in whites was 83, for blacks only 41 and for Hispanics only 33.

Now, of course, to really make the definitive assessment that there is a racial and ethnic disparity going on, you need to adjust for all of those independent variables that we mentioned earlier, so the following slides look at the (multi-vary) analyses, and the first one, which is slide 11, looks at disparities in family activities and routines in young U.S. children. The first column is the measure, and then your second and third columns are the odds ratios, and 95 percent ((inaudible)) for blacks and Hispanics respectively and the comparison group is white. So, anything over one that doesn't include one and the (convent center) would be statistically significant.

And, what we found was that the child's meals being not the same time daily occurred about twice the odds for black families and it was about the same for Hispanic and whites. Similarly, the family eating lunch or dinner together less than daily occurred at about twice the odds for blacks versus whites. In terms of the family never eating lunch or dinner together it was four times the odds for the black families and over three times the odds for the Hispanic families in comparison to the white families. And, then the mean additional daily hours a child watches TV versus white children, after you adjust for everything, you can see was 0.7, so it's really about 45-minutes more in the black households and that's, again, after you adjust for a wide variety of factors.

The next slide we look at (multi-very) analyses of disparities in home safety and reading activities and resources, and you can see that not putting up stair gates occurred at twice the odds for both black and Hispanic families versus white families. When you look at not installing cabinet safety latches and locks, and not turning down the hot-water thermostat settings, the black families were at significantly greater risk versus the white families at about double odds for both. And, then the parent reading to the child less than daily occurred at double the odds for both the minority groups versus whites. Put another way, when we looked at the mean number of children's books in the home versus white children, you can see that there were, on average, 30 fewer children's books in the home for blacks and 20 fewer for Hispanics in comparison to whites.

Now, another thing to look at would be was there in impact in terms of parent survey language, so slide 13 summarizes our multi-varied analyses, in terms of the parent survey language and home disparities for young U.S. children. So, what you're looking at here in the first column are the measures that we just discussed, but here the second column summarizes odds ratios at 95-percent (confidence) intervals for children whose parents were surveyed in Spanish versus those whose parents were surveyed in English and you can see a lot of disparities here. So, first of all, in terms of the child's meals not being at the same time daily, you can see children of parents surveyed in Spanish had double the odds versus children of parents surveyed in English. Similarly, there was triple the odds for the parent taking the child on outings less than daily.

On the other hand, padding hard and sharp surfaces actually occurs more often for these families, but then you see that there's about triple the odds for these children of not putting a stopper or plug in the electrical outlets, and then for parents surveyed in Spanish versus those surveyed in English the children, turns out, are at much greater risk of not being read to every day. So, in this case, the parent reads to the child less than every day occurred at four times the odds, and the parent never reading to the child also occurred at four times the odds. And, here we see the greatest differentially, in terms of the mean number of children's books in the home, at 39 fewer in children whose parents were surveyed in Spanish versus those surveyed in English.

In conclusion, young minority children experience multiple disparities in home family routines, safety and reading activities and resources known to impact health and school success. Black children are twice as likely to not have meals at the same time daily and to eat lunch or dinner together with their family less than daily. Minority children are three to four times more likely to never eat lunch or dinner together with their family. Black children watched average of about 40-minutes more of TV daily. Minority parents are twice as likely to not put up stair gates. Black parents are more likely to not install cabinet safety locks and to not lower hot-water thermostat

settings. Minority parents are twice as likely to not read to their child daily. Black families averaged 30 fewer children's books at home and Hispanic families 20 fewer than white children.

And, multiple disparities also were noted for children of parents completing surveys in Spanish, including higher odds of not having meals at the same time daily, not having stoppers and plugs in electrical outlets, being read to less than daily, never being read to and having fewer children's books at home. So, there were several implications of this research. First, disparities in the home environment could contribute to disparities in older minority children, and even minority adults, including school dropout, drug abuse, obesity, violence, unintentional injury and low-educational attainment and poverty.

And parents and pediatricians, however, can work together to implement a few simple measures that could be important steps in reducing these disparities, which include children more frequently eating meals together with their family, children watching fewer hours of television, parents ensuring that home safety measures are in place, parents reading to children every day and ensuring that households have a variety of children's books.

Thank you.

George Askew: That was wonderful, Dr. Flores. Thank you very much. Now we'll turn it over to Dr. Wise.

Paul Wise: Thanks so much, George. It's really a pleasure to be here. Thanks for inviting my participation.

Dr. Glenn has, as usual, has done an extremely good job documenting that disparities exist, but, more importantly, defining some of the mechanisms by which they operate. I'm going to do something a little different, which really involves taking this step back and looking at some of the

major threats to our ability to address these mechanisms of disparity creation, a step back that in many ways will examine what I feel is perhaps the greatest overall threat to traditional child health programs in the United States that we've seen in probably four decades.

The first slide for me outlines the three challenges – it's actually the second slide. The first challenge I'm suggesting is a basic disrespect for pediatric clinical capability. The second challenge is the disrespect for the evolving epidemiology of childhood, basically no recognition that the epidemiology of childhood need has changed over time and, third, a disrespect for the special needs of children in the policy arena. There's a lot of disrespecting going on here and it's basically because – my general feeling is that the recognition of the special requirements of child health are going unmet and, in many ways, because of a general lack of concern and respect for the special requirements of childhood.

What I'd like to do is address these three challenges and go into somewhat more detail, particularly about ways that we may be able to confront them.

The next slide just outlines challenge one, the basic disrespect for the contributions of clinical care. Even among people who worry about disparities in childhood, there's often a lack of recognition of how important clinical care has been in shaping improved patterns of child health, in general, but particularly in reducing disparities in child health outcomes. And, to address what I think is really the core reason why there's a general disrespect for the contributions of clinical care, it's useful to just take step back and look at an example of a differential outcome and really examine, in a sense, how do you get a disparity in child health? How do you get a disparity in health outcomes in general?

The next slide just provides an example of differential mortality and this is just a table of an example of differential mortality. You have three groups of people, group one, group two, group three, similar exposure, but widely divergent outcomes. Three percent of group one die, 14

percent of group two die and 54 percent of group three die, similar exposure, widely divergent outcomes.

Now, how could something like this happen? Well, the first possibility is that there are differences in underlying risk in the population. Group one could be a low-risk group, group two could be a moderate-risk group and group three could be, in fact, basically a high-risk group. Group one could be young adults, group three could be frail or elderly, and virtually any serious exposure would be likely to give you differences in outcome.

So, the first possibility is that you can get a differential outcome like this – and go to the next slide – and it's just through differential risk. That's possibility one. The next slide brings back the table and allows us to examine it for alternative explanations. And, one alternative explanation is that the risk in all three groups could be exactly the same, but given that you have an effective intervention to offer that there are differences in access to that intervention. Group one got the intervention, group three did not, such that you would get these wide differentials in outcome.

So, a second possibility is that – next slide – is that you have differential access to an effective intervention. Now, the next slide brings us back to the table, looking for other explanations. Now, basically, we could all come up with many other alternative explanations of how you can get a differential outcome like this, but basically I would then put them into one of two categories – differential access or differential risk, because – next slide – differential risk and differential access are really the only two mechanisms by which differential outcomes can occur, and we know that they often travel together, like two birds caught in the same gust of wind, but they're not the same thing.

Now that example, that table could have been an infectious disease outbreak, it could have been a toxic exposure, but, in fact, what it was – next slide – was the sinking of the Titanic. The next slide brings us back to the table again – first class, second-class, third class, female passenger

list for the sinking of the Titanic. Now, what happened with the sinking of the Titanic, differences in underlying risks, or differences in access to an effective intervention? It was, in fact, differences in access to an effective intervention. They loaded the lifeboats by deck. Next slide. You all saw the movie, and remember when Leo was trying to get up the staircase, but the gates blocked access to moving up to the lifeboats. That actually happened and, in fact, the boats were loaded by deck, by class.

Now, I use the example of the sinking of the Titanic, one, because it's a great illustration of differential mortality, but it's also a useful reminder that social class can affect who lives and who dies when you least expect it. If we take the lessons of the Titanic and bring it back to our issues around child health and, obviously, I think so, or else I wouldn't have presented it.

But, if you move to the next slide, it basically presents sort of a triangular little framework, or thinking about how, in fact, disparities in outcome are generated. You have differential risk contributors, you have differential access, but what's this thing in the middle? You basically need to have some measure of efficacy of the intervention in question and that's because an intervention wholly without efficacy really who cares whether (there's) differences in access to it. If the intervention doesn't do anything, then do you really care where there are differences in access to it – no. But, what happens when efficacy of the intervention is high – then differences in access to it will dominate disparities in outcome. When efficacy is low differences in underlying risk status will dominate disparities in outcome. So, for different risk-intervention (dyads) access will play either a very powerful role or not a powerful role at all, basically a minimal role.

And, for different interventions, basically, the role of differential risk or differential access will change. And, people ask me all the time, "is access to healthcare important to reducing disparities?" And, I hate to give the answer, but the answer is, well, it depends, and what it depends on is the efficacy of the intervention, because if the intervention is of high efficacy watch

out. Differences in access will generate huge disparities in outcome. When efficacy is low the differences in underlying risk will dominate disparities in outcome.

And, the logic basically suggests that as efficacy grows so to does the burden on society to provide that efficacy to all those in need, and that's why pressure on health insurance and access to care is only growing in the face of enormous really explosive growth in our clinical capability, our growth in efficacy.

Now, you notice that there's no distinction made here between low-tech interventions or high-tech interventions. There's no distinction made between preventive interventions or therapeutic interventions. There are not even any distinctions made in social forces or medical forces, social models and influence or medical models, or biologic models that influence. It's basically because it really doesn't matter. What is crucial is efficacy.

Now, let me give you an example of why I suggest that these kinds of distinctions between low tech, high-tech prevention, therapeutic, social, medical really aren't very important in thinking about disparity creation and reduction. Go to the next slide – phenylketonuria. Phenylketonuria is completely biologic. It's a 100-percent genetic disorder that creates pretty significant neurologic morbidity and ultimately severe morbidity and mortality in kids. It's a 100-percent genetic disorder, but yet all disparities in PKU outcome in the United States today are social in origin. How did that happen? How did we transform something that's completely genetic into something – to disparities that are completely social in origin? And, the way we've done that – the pivot, if you will, in this transformation is that we have extremely efficacious interventions, namely newborn screening that picks up the existence of this genetic disorder PKU, and dietary alteration that removes the amino acid, the offending amino acid out of the diet, and so that kids with PKU can grow up really extremely well, go on to have families and live a very useful, meaningful life.

Now, this is an important example of how something that's 100-percent genetic, 100-percent biologic is made completely vulnerable to social influences once efficacious interventions are available. So, I don't really understand the sharp distinctions between social factors, biological factors, medical factors, because they're all intensely in play. They're all intensely interactive in the real world, so we have to recognize is wherever efficacy exists so to does the burden on society to provide it equitably to all those in need.

Let me give you a few real-world examples that we studied. One is neonatal intensive care, a very high-tech kind of intervention. The fastest way to generate or widen disparities in infant mortality is to create social differences in access to neonatal intensive care. Why, because neonatal intensive care is extremely efficacious in reducing infant mortality. And, I mention this because what we're seeing now is the (deregionalization) of neonatal intensive care based on the ability to pay. If you have good insurance you get shipped to the tertiary facility, neonatal intensive care unit, but if you are uninsured, and even in some places you're on Medicaid, what happens is that you sit in a community hospital at six or 700 (grams), in need of a neonatal intensive care until an "indigent bed," quote, unquote, opens up in a tertiary facility. The fastest way to widen disparities in infant mortality is, in fact, to create those kinds of social differences and access to neonatal intensive care.

So, back to sleep (care) (pain), it's very low-tech intervention, but highly efficacious. And, what happened there was what we've seen is a widening of disparities in sudden infant death syndrome in places where information about putting children to sleep on their side or their back has been more accessible, if you will, to families that are better educated, suburban communities. And, this low-tech differential in access is actually wide in disparities and sudden infant death syndrome in many parts of the country.

Another low tech, highly efficacious example is immunization, and now what we've seen is really a complete collapse in traditional disparities in invasive pneumococcal disease in children

basically because of the introduction of highly efficacious immunizations against invasive pneumococcal disease. So, again, we have examples of where clinical capability is crucial in generating, widening or reducing disparities in care, and it doesn't matter whether it's high-tech or low-tech preventive or therapeutic. The real crucial issue is whether it's efficacious or not.

This next slide is another example, but it's an important reminder for all of us. This is a study that was published in "Lancet" a few years ago, looking at the age of death for children with Down's Syndrome in the United States. And, it grouped the kids, not only by racial group, white and other, and the other here is primarily African-American, but also whether they had congenital heart disease. And, what you see is basically in the upper two lines, the diamond and the circle, that dark circle, with the (stickled) lines in between, are children without congenital heart disease. You see that they live longer, but you also see a disparity between white and the other group, but look down at the bottom. These are kids with congenital heart disease, and what you saw was there was virtually no disparity pretty much up until the early '90s, and then you see this huge growth in the disparity and survival, with white children with Down's with a congenital heart disease surviving much better than children who – primarily African-American and other minority groups.

And, why we don't know specifically why this happened, we think that, in fact, what this is a reflection of the growing capacity to address congenital heart disease (and) (children's) willingness to use it, children with Down's Syndrome, what you've seen is the creation of a disparity that never existed in a rather high-tech arena of care. Again, another reminder that we need to be very cautious as we think about how clinical capability can widen, reduce or generate from scratch disparities in clinical outcome.

Challenge two is the special epidemiology of childhood. Now, I'm not going to go into detail here. The next slide just identifies the major trends. And, over the last 40 years we've really seen a sharp reduction in serious, acute, primarily infectious diseases, primarily because of the

introduction of an important new arena of immunizations. The likelihood that a well child is likely to get acutely ill, seriously ill, hospitalized and dies is really vanishing small, at this point.

We've also seen a slow but steady rise in chronic disease and the prevalence of chronic disease, like asthma, but a range of others, as well. And, what it's created is a kind of dichotomization in the epidemiology, where you have a very large group of kids that are increasingly unlikely to ever get seriously ill, and then a smaller group that is increasingly dominating hospitalization, healthcare expenditures and non-injury-related mortality in the United States.

And, even with this chronic disease, we need to remember that for children serious illness is rare. If I were to have a heart attack right now, virtually any community hospital would be pretty good at dealing with an old geezer like me having a heart attack, because it's pretty common. But, when's the last time a community hospital like that has seen a child with sickle cell disease and acute chest syndrome – very rare. And that implies that regionalized services for kids with specialty requirements, particularly kids with chronic disease, it's very important for children much more so than it is for kids.

And, we see the importance of chronic disease in the next slide, which is a calculation of the excess African-American child mortality as compared to whites for two different time periods. The pie graph on the left is for the early 1980s, the right for 2001, and basically what we see is, number one, that homicide is an important contributor to African-American excess child mortality. But, what the growth industry has been is non-injury-related chronic disease for African-American kids. In fact, it's been true for all poor kids that chronic disease has become really the growth industry of disparity creation in the United States for children over the past 20 years.

The third challenge – next slide – is the disrespect for needs of children in policy arena. Now, health policy – next slide – has increasingly been defined – next slide – as cost containment. That, for most of – particularly the young people in the audience may not realize that wasn't

always the case, that we used to actually worry about trying to improve health outcomes. Now the fundamental concern seems to be cost containment.

Next slide – and you can see, particularly from public programs, this is a slide of Medi-Cal expenditures, which is the Medicaid program in California – basically mimics what’s happened throughout the United States that for Medicaid expenditures the growth has been, number one, people who are over 65, and (they) (have) seniors here, but also for disabled adults who are not seniors that – in fact that the growth in public expenditures for Medicaid, and virtually all other public expenditure programs, has not been about children. In fact, you can add up all the healthcare for kids in NICUs, all the healthcare for kids with very serious chronic disorders, in fact, you can add up all the kids with chronic disease, all their healthcare throughout the United States with all payers, and it’s basically a rounding error for Medicare. In other words, what we’re talking about, in terms of expenditures for children, is really peanuts.

And, yet what we’ve seen is enormous pressure being put on children’s programs, particularly Medicaid. And, the biggest problem that I worry about with Medicaid is the next slide, which I’ve labeled “the SCHIP’ing away at Medicaid,” and that is that SCHIP, which is the State Children’s Health Insurance Program, which was developed in the late ‘90s as a supplement to Medicaid for families that were earning too much to qualify for Medicaid, you know, a very useful and important thing, but then now SCHIP is being used as, in fact, an alternative to Medicaid. Governors like it because of the factors that are labeled on this slide that, first of all, it’s not an entitlement. It’s a block grant. Now, what does that mean? It just means that Medicaid, if you’re eligible, you get it, and the budgets have to increase to cover the expenditures associated with the need of eligible children and families.

A block grant program, like SCHIP, is just a pot of money that’s set aside and you basically do the best with that amount of money, and that’s why there are kinds of waiting lists, cutbacks in services in SCHIP programs that would be impossible to make in Medicaid.

The second thing that people are advocating for SCHIP for is that it allows states to have much more autonomy. They basically can say, “well, we don’t have the federal governments telling us what kinds of benefits, what kind of services we need to provide. We can decide on our own.” And, almost always, the states are coming up with basic care, well-childcare programs, where insurance is provided to kids for well-childcare immunizations, but they may not even cover hospitalized care, and certainly don’t cover a lot of the kinds of care that kids with serious chronic illness requires. Medicaid covers most of those kinds of services, although not completely.

And, the last is that SCHIP allows what (is) now finally being called “consumer-driven plans,” where you have very large deductibles, or very high copays, for certain kinds of services, so that basically you have to – families would have to pay out-of-pocket the first \$3,000 of family expenditures before the government program would kick in – these health insurance programs would kick in. The idea is that the consumers would then use their money more wisely, because it’s their money for the first \$2,000 or \$3,000. Well, hello, most of these families basically, particularly when they’re poor, act like they’re uninsured. In other words, the first thing that they drop are immunizations and well childcare, and they begin to act exactly what you (would) expect for uninsured families.

So, there’s a great danger right now in advocating for SCHIP in an uninformed way. We’re all supportive of SCHIP and other kinds of supplemental programs, but we need to make sure that our advocacy for SCHIP does not, in fact, undermine advocacy for Medicaid.

And, to summarize my call here is that we need to strengthen our advocacy. We need to be more informed in the way we advocate for children, because, in many respects, the threat to the traditional core services for child-health programs, for poor kids in the United States are now under the greatest threat, I believe, that we’ve seen in the last 50 years. Medicaid is on the verge of beginning to unravel and we just barely got through the last Congress without a complete

transfer of autonomy from Medicaid to an SCHIP kind of model. And, my suggestion is that to do this we have to first recognize that efficacious clinical care of all forms is critical, including high tech, low tech, preventive, as well as therapeutic and our advocacy must have a wide embrace.

Secondly, that we're going to need to recognize that poor children with chronic disease are a growing problem and that in our advocacy for basic child healthcare, well-child healthcare, for children that we do not throw under the bus, poor kids who have significant chronic illness. It's a growing portion number of kids, but, more importantly, they are more and more the (sub) (straight) for our child health programs in pediatric practice throughout the United States. And, lastly, we need to protect kids in the policy arena. Virtually all child health policy in the United States now is being dictated by adult health policy concerns. That's new. We used to be able to talk about and fight about child health policies, about whether – what the direction for children are to be.

But, now cost containment basically has pushed kid's interests right off the table because they don't cost a lot of money, therefore they're not players in this discussion. And, our advocacy and my suggestion today is that the child health community, child health welfare community needs to come together with a more informed and a stronger focused advocacy position, that we need to have better understanding of the epidemiology and a stronger commitment that responds to this changing epidemiology of childhood, while, at the same time, be better informed and more thoughtful about how we respond to the changing political dynamics of health policy reform. It also underscores why conversations that we're having today and why groups like Docs for Tots is going to be so crucial in helping to generate this kind of more informed and strength of advocacy in the years to come. So, thank you.

George Askew: Well, thank you both. This is George Askew again at Docs for Tots. Thank you both for a very informative and thought-provoking set of presentations. I imagine our audience is excited

to ask questions, so I will turn it over to our moderator to explain the procedure for asking questions.

Operator: Thank you. The question-and-answer session will be conducted electronically. If you would like to ask a question, you may do so by pressing the star key, followed by the digit one, on your touch-tone phone. If you're using a speakerphone, please make sure your mute function is turned off to allow you signal to reach our equipment. Once again, that is star one on your touch-tone phone at this time to ask a question. And, we'll pause for just one moment.

Once again, please press star one, at this time, to ask a question.

George Askew: This is George Askew again. I'll take the prerogative to ask the first question. As advocates – this is to both Paul Wise and Glenn Flores. As advocates, in your opinion, what should we – what specific areas or issues would you suggest we focus our – we focus our efforts on, in the coming year, to have the greatest impact on early childhood health and development outcomes? And, I know that there's a wide variety of things and I don't want to limit you so much, but I really want to know if there are things that you really think early childhood advocates should be paying close attention to specifically.

Paul Wise: OK, go ahead.

Glenn Flores: All right. Well, I would like to echo Paul's very important point. As usual, he really eloquently summarized the conceptual issues. I think it would be tremendously productive for advocates to focus on why it is that suddenly kids have been dropped, for the most part, from the policy agenda and there's such a huge focus on adults, and that's really condemning us to a less rich future for many generations to come and, also, that chronic diseases are increasingly dominating all aspects of care, but more so for kids now, because it just wasn't on the scene as much before.

I would also encourage new ways of thinking and solution-oriented thinking. So, you know, in the disparities field sometimes people get tired of hearing, “oh, yes, here’s another disparity, and we’ve heard so many of them and you guys don’t give us any solutions.” So, I would encourage advocates to think about how can we empower parents and how can we empower communities better. And, I’m hoping that my talk suggested some of the ways that, for example, parents and pediatricians can work together by doing some really simple things, and they sound like common sense, but they’re not put out there as mechanisms that could reduce or eliminate disparities.

So, you turn off the TV. You have meals with your kids. I mean it’s just such a potent tool, and I see it in my own family, with a nine-year old and two-and-a-half-year old, you know, that it has impact, in terms of we discuss things, you enhance their vocabulary. Obviously, there’s an influence on a diet, and then later on you see a link with school performance, and substance abuse, and alcohol use, smoking cigarettes, even sexual debut, postponing the age. And, you know – so you do that. You turn off the TV, you eat with your kids, you make sure that there are simple safety mechanisms in place, turning down the hot-water settings and plugging up the outlets.

And, then reading is just so potent. There’s so many studies that show starting to read to your child at six months of age – that’s a huge downstream impact, whether you’re looking at achievement as far out as the third grade, and you can easily see the cascade that starts with, OK, you read to your child, they’re more prepared for school, they do better in school, they’re going to go to a better college, they’re going to make more money, do better, be healthier and live a better life. Conversely, if you don’t read to your child, they’re not prepared for school, they’re more likely to be labeled special ed, they’re more likely to dropout, they’re more likely to be poor. And is very clear, when you’re poor it really compromises your health and healthcare. So, I think that would be critical.

And, there's sort of a new vista now of doing community-based participatory research, so ask in the communities what are their major issues, what are their obstacles, and then coming up with some innovative ways to approach those disparities. We've had some great success in using community-based case management in insuring uninsured kids, and I was honored to then have that be presented in a Congressional research briefing.

And, now because of the change of the Congress' orientation, a bill that was introduced before, based on work on community health workers, now probably will pass Congress. Congressman Solis is going to be reintroducing that in the next session, and so those are examples of how each and every one of you can think about innovative community solutions, and then try to apply those solutions and hopefully change policy.

Paul Wise: Let me fully embrace what Glenn is suggesting, and also, I would say a national level, identify really two issues that I think are going to be addressed over the next year, but also are of absolute critical nature for anybody worried about kid's health and well being. The first is Medicaid. We need to not take Medicaid for granted. It is under threat and could easily unravel, even in a Democratic Congress.

We need to think about how SCHIP, when it comes up for reauthorization next year, will be fashioned in ways that could, in fact, undermine Medicaid. I think people need to refocus on Medicaid, particularly for children, because there may be a lot of opportunity to change Medicaid, particularly in its relation to SCHIP over the next year. And, if we're not careful, it's going to look a lot like giving the states enormous autonomy to figure out how much money they want to spend on children, as opposed to the traditional way, which is having federal guarantees for the kinds of benefits and the amount of money that is being spent.

The other issue coming up is the No Child Left Behind legislation and how that relates to young child education and young child support services, particularly Head Start and a whole other arena

of other titled programs, which has not really been addressed very well, but there's growing dissatisfaction with the way the Bush Administration has funded the No Child Left Behind legislation, and there may be very much a focused bipartisan effort to provide more adequate funding and will provide opportunities to link the No Child Left Behind legislation to Head Start, to other kinds of very young child education support and early intervention services. So, I think we need to focus heavily on that, as well. I would clearly focus on Medicaid and the No Child Left Behind arena. I think they're under threat and they're going to be in play.

George Askew: Thank you very much. Are there any other questions?

Operator: There are no questions from the phone audience at this time.

George Askew: Great. Well, since there are no further questions and we're actually near out of time, I want to thank all of you for your participation today, and a special thanks to my friends and colleagues, Dr. Flores and Dr. Wise. On behalf of Docs for Tots, have a happy and safe holiday season and thank you for joining us and we look forward to connecting with you again in the coming year.

Operator: That does conclude today's conference call. We'd like to thank you all for your participation and have a great day.

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