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A Call to Improve the Health and Healthcare of Latino Children

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The face of our nation is changing as seen in our children. In 2050, one in five Americans will be an immigrant and 35% of US children will be Latino.¹ Life-course research demonstrates the powerful influence of early child health and experiences on adult health and the need address child health disparities in order to promote population health.²

Ample research demonstrates that health and healthcare disparities exist for Latino children, children whose parents have Limited English Proficiency (LEP) and poor children.^{3–5} Disparities can be found in multiple health outcomes; preventable health conditions which disproportionately affect Latino children include obesity and dental caries.^{6,7} Additionally, Latino children are at risk of delayed diagnosis of conditions for which effective treatments exist, such as autism spectrum disorder and attention deficit hyperactivity disorder.^{3,5}

While nine out of ten US Latino children are US citizens, sixteen percent live in households headed by LEP adults, i.e., who speak English less than “very well”.⁸ LEP patients not only face challenges in accessing care, but once in care often have difficulties in explaining their illness, understanding clinicians’ recommendations, and participating fully in the development of a treatment plan. Language barriers have been associated with a wide range of negative patient safety and quality outcomes, such as inadequate treatment of pain, prescription of fewer medications as well as medical errors and overdoses.⁹ Limited health literacy often co-occurs with LEP and is thought to be an important mediator of healthcare

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utilization and health outcomes. LEP and poverty also co-occur and increase the risk of health disparities. Thirty-five percent of all US children living in poverty are Latino.⁸

Limited health literacy and difficulty navigating the U.S. health care system are not challenges unique to Latinos and must be addressed in order to reduce health disparities. The healthcare system must be linguistically and culturally competent as well as accessible. Areas for improvement detailed below include community engagement, interpreter availability, workforce diversity, healthcare access and inclusiveness of research efforts. The initiatives described require collaboration among pediatric clinicians, community members, health system administrators and insurers.

First, clinicians, health care delivery systems, and policymakers must engage community members including patients/families with LEP and limited health literacy in the design, implementation and evaluation of health information and services. For example, hospital and clinic advisory boards representative of the patients served can provide critical insight. Local outreach efforts to build trust and increase cultural awareness are required to bridge the gap between availability and utilization.

Second, interpreter services must be universally accessible in clinical settings. The use of trained, professional interpreters mitigates the negative effects of language barriers on patient safety and healthcare quality.¹⁰ Appropriate language services are associated with improved patient satisfaction, fewer errors in communication, better adherence to medications and improved clinical outcomes.⁹ Title VI mandates, but does not fund, adequate language services for Medicaid and Medicare recipients.¹¹ It is time to advocate that third-party-payers reimburse for interpreter services in the 38 states where this is not the case. Tracking patient satisfaction and interpreter utilization rates in conjunction with patient demographic information is necessary to assure adequate utilization and quality. Other tangible demonstrations of linguistic competence are proper multilingual signage and phone access, appropriate documentation of patients' LEP status and preferred healthcare language and the availability and use of well-translated versions of commonly used materials such as discharge paperwork, consent forms and educational materials.

Third, clinical care improvements require a culturally competent and more inclusive workforce. Enhancing workforce diversity could speed healthcare improvements. Clinicians are not currently representative of the patient population.¹² Latino children who are able to pursue higher education will help reduce this disparity. Improvements, however, must not be delayed until these children join the professional ranks especially given that in 2010 Latinos had the highest high school dropout rate of any racial/ethnic group, with 5.8% of native born and 18.1% of foreign born Latinos leaving high school without a diploma.⁸ The pursuit of improved healthcare quality is a responsibility of clinicians and policy makers who are Latino and non-Latino alike. Lessons in cultural competence and cultural humility should be included in the training of all healthcare employees and team members from physicians and nurses to receptionists and security staff. One example of a workforce diversity initiative is the Program for Medical Education for the Latino Community at the University of California, Irvine, designed to train physicians, "to be culturally sensitive and linguistically competent to address the specific needs of California's Latinos."^{13,14}

Fourth, a culturally and linguistically competent healthcare system will address disparities only if it is also an accessible healthcare system.¹⁵ As seen with the implementation of the Children's Insurance Program, enrolling into insurance does not reliably result in receiving care. Studies show that among children eligible for public health insurance, Latino children are more likely to be uninsured.¹⁶ In a study of barriers to care for Maryland Latinos, knowing where to go for care was second only to ability to pay.¹⁷ Outreach services may be required to enroll people into care, as well as into insurance. On a related note, the well-being of children depends on the health of their caretakers and the Affordable Care Act will not be a comprehensive solution for the Latino population. Those who are legally in US less than 5 years may not be eligible for public health insurance while those who are undocumented cannot buy into exchanges even if able to pay the full premium.¹⁸ Mixed status families may be reluctant to participate in order to avoid unwanted attention.¹⁷ Continued efforts are needed to ensure access to health insurance and health care for children and families.

Finally, participation in ongoing child and family health research needs to better reflect the US population. Many clinical trials do not include diverse racial and ethnic populations, LEP individuals or their children.¹⁹ Similarly, many research instruments have not been tested across diverse racial and ethnic groups or in languages other than English. Attention to the development and validation of measures as well as translational research specifically for and/or inclusive of Latinos is needed. Investigators should make reasonable accommodations to include LEP participants, particularly when LEP persons constitute a sizeable portion of the sample population. Institutional review boards should monitor and discourage the reflexive exclusion of non-English speakers. Increased use of appropriate interpreter services when providing clinical care may make clinician scientists more comfortable recruiting non-English speakers in research.

Ten years ago, JAMA published, "The Health of Latino Children: Urgent priorities, unanswered questions, and a research agenda."⁹ A decade later there is greater urgency to address what can no longer be considered unanswered questions, but rather unmet responsibilities. It is time to set a course towards a healthier future for all of America's children.

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Abbreviations

LEP limited English proficiency

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