Children's health

Children's Health: Health care disparities in children Introduction All children require high-quality health care and are gravelyessential for some. Children’s health care functions as that of adults in many ways. For instance, the chronic illness incidence in children is rising, leading to a considerable illness burden with a high cost. Short-term and long-term effects are greatly influenced by the way chronic conditions are dealt with not only for the usual diseases, for example asthma, but also for rarer conditions such as cystic fibrosis, sickle cell and cancer disease (Perrin & Homer, 2007). Feeg (2006) indicates that many nurses who look after children work in children's hospitals that are normally comparative with underserved and over-represented poor patients for their general health care and are mainly reliant on Medicaid steadiness to receive care. Children’s barriers to health care Some children might face obstacles to health care due to their race or ethnicity. Disaggregating insurance coverage patterns within families by ethnicity and race discloses significant disparities that are veiled in the statistics for the entire population of the United States. For instance, there was close to a ten-percentage point decrease in complete coverage for Hispanic two-parent families who had access to work-based insurance (Vistnes & Schone, 2008). There is segregation for insurance coverage in terms of abuse perpetrated to the child. Regardless of the substantial service requirements of abandoned and maltreated children, the history of abandonment, physical abuse, and neglect is not linked with any insurance line over time (Perrin & Homer, 2007). This implies that for those parents who cannot afford payment for their children in such conditions, their children are barred from receiving treatment. Residential isolation shapes health effects of children through various pathways. First, it augments the

minorities' susceptibility to adverse neighborhood environments including substandard municipal services, crime, lack of adequate accessibility to healthy food outlets and environmental problems. Furthermore, it leads to separation in health care settings, which in turn is linked with differences in the quality of treatment including that of children (Acevedo-Garcia, et al, 2008). Despite racial and residential segregation, poor health policy implementation and development also causes barriers to children’s treatment. Many policy makers, particularly in times of budget axing, do not focus on the service requirements of children treatment. Moreover, many policy makers are very busy with budget responsibilities hence they are protected from the penalty of financial policy that outweighs services responsibilities (Feeg, 2006). Children in ‘ child wellbeing framework’ who have families that get cash support through Temporary Assistance for Needy Families or food stamps are particularly at risk for Medical assistance disenrollment. This occurs when their families stop getting this assistance hence becoming unable to access adequate treatment. Regardless of the fact that the connection between Medicaid eligibility and receipt of welfare benefits was eradicated in 1997, the existence of managerial information systems that constantly connect persons who receive all forms of public help accounts for such insurance loss (Perrin & Homer, 2007). Policy Framework The Government of United States has developed a policy through which it aims at eliminating these obstacles. More than 70% of national support flows through Medicare and Medicaid. At present, poor children get some protection through State Children's Health Insurance Programs and Government Medical assistance. Actually, these strategies have mostly helped in covering children who are not insured for health care. A good

example is the National Association of Children's Hospitals (Feeg, 2006). Moreover, housing mobility strategies all through the nation have helped low-income families who obtain housing aid to move to better neighborhoods. This is by offering them pre- and post-move information and housing search counseling to simplify their transference to prospect neighborhoods (Acevedo-Garcia, et al, 2008). Enhancement of the responsibility of the children's health care system will entail wide changes in the entire system. Effecting this change will require sufficient leadership across all stages and systems concerned with children's health care and an unreserved dedication by those who offer care, finance care, and receive care. Leaders must perceive that the existing system does not meet children's needs and must therefore take action (Perrin & Homer, 2007). Conclusion The alarming rates of racial segregation, residential segregation, poverty and poor policy issues mean that children's health services ought to address health needs of children. Moreover, providers of child health care should improve the proficiency of children caregivers and synchronize a wide collection of community services. This is because children are often dependent on caregivers and community resources. References Acevedo-Garcia, D. et al. (2008). Toward a Policy: Relevant Analysis of Geographic and Racial/Ethnic Disparities in Child Health. Health Affairs, 27, 2, 321-333. Feeg, V. D. (2006). How Slashing Medicaid Hurts Children and Children's Hospitals. Pediatric Nursing, 31, 6, 444-445. Perrin, J. & Homer, C. (2007). The Quality of Children's Health Care Matters: Time to Pay Attention. The New England Journal of Medicine, 357, 15, 1549. Raghavan, R. et al. (2008). Longitudinal patterns of health insurance coverage among a National Sample of Children in the Child Welfare System. American Journal of Public Health,

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