Child Health Inequality: Framing a Social Work Response
Virginia Rondero Hernandez, Salvador Montana, and Kris Clarke*

Numerous studies acknowledge that the well-being of our nation hinges on the health of its people. There is specific concern about children because they represent the future. Ignoring children's health needs can compromise their educational preparedness, occupational pursuits, productivity, and longevity. Current science demonstrates that developmental, emotional, or behavioral limitations experienced during the early years of life and over the life course are associated with poor adult health outcomes. Poverty, restricted access to health insurance and health care services, cultural and linguistic barriers, neighborhood conditions, and racial and class inequalities exacerbate poor health outcomes and contribute to child health inequality. To respond to the complexities and threats of child health inequality, social workers must be sensitized to the physical and material constraints that support them and join forces with other disciplines in comprehensive approaches to reduce and prevent them. This article focuses on current knowledge about child health inequality and recommends how social workers can effect change in this area through practice, policy, and research that adheres to the profession's ethical principles and standards and promotes the public health.

**Keywords:** children; health disparities; health inequality; health inequity; public health

Social epidemiology, a branch of public health research methodology, has helped to shape the definition of health inequality. Its major concepts include the following: maintaining a population perspective, the social context of behavior, contextual multilevel analysis, a developmental and life course perspective, and general susceptibility to disease (Berkman & Kawachi, 2000). The *population perspective* infers that health is affected by individual characteristics and the characteristics of one's population group (Berkman & Kawachi, 2000; warnecke et al., 2008). Health behaviors (and health beliefs) are also affected by one's social context of behavior, in that these behaviors are "socially patterned and often clustered with one another" (Berkman & Kawachi, 2000, p. 7). Contextual multilevel analysis is used to assess the multiple factors and effects of population group characteristics; social context; and pathways of proximal, intermediate, and distal determinants of health. Proximal determinants include population characteristics such as, income, class, race; intermediate determinants relate to social context, including neighborhood and social relationships; and distal determinants reflect societal influences such as the social condition of a population (Li, McMurray, & Stanley, 2008; warnecke et al., 2008). A *developmental and life course perspective* provides "a lens" through which social factors—such as early life influences that occur at critical points in human development, the cumulative effects of disadvantage over the life course, and material and physical constraints—are understood to affect adult health outcomes (Berkman & Kawachi, 2000; Nepomnyaschy, 2009; Yoo, Slack, & Holl, 2009). General susceptibility to disease presumes a reciprocal relationship between body and brain, in that biological processes mediate the production of hormones produced by the brain in response to psychosocial stress, cumulative disadvantage, risks, and harmful exposures in the social context (Adelman, Herbes-sommers, & smith, 2008; Berkman & Kawachi, 2000; Center on the developing Child at Harvard University [CDCHU], 2009; Li et al., 2008; Shonkoff, Boyce, & Mcewen, 2009). This condition, in turn, converges with proximal, intermediate, and distal determinants of health to produce population-based health differences, disparities, and inequalities (Li et al., 2008; warnecke et al., 2008).

The conceptual framework of social epidemiology is strikingly similar to social work's person-in-environment and multi-systemic perspectives. Together they inform a working definition of child health inequality:

Child health inequality is composed of observable and verifiable outcomes of health that are unequally

---

*Virginia Rondero Hernandez, PhD, LCSW, ACSW, is associate professor, Department of Social Work Education, and faculty researcher, Central California Social Welfare Evaluation, Research and Training Center (SWERT), California State University, Fresno, 5610 North Campus Drive, Fresno, CA 93740; e-mail: virginiorh@csufresno.edu. Salvador Montana, PhD, is assistant professor, Department of Social Work Education, and faculty researcher, SWERT, California State University, Fresno. Kris Clarke, PhD, is assistant professor, Department of Social Work Education, California State University, Fresno. An earlier version of this article was presented at the Central California Children’s Hospital 2010 Annual Conference, February 12, 2010, Madera, CA.
distributed across child populations, threaten to compromise or erode the optimal development and well-being of children and adolescents, and result from bio-psychosocial influences over the life course that are shaped by pervasive cultural values, economic structures, and political decisions mediated by adults.

**Health Disparities, Inequality, and Inequity**

To operationalize this working definition and be prepared to respond to child health inequality, social workers in all arenas need to be familiar with the themes, terms, and arguments reflected in the literature. Health disparities occur where there is a disproportionate representation of a health condition relative to the size of the population. Carter-Porkas and Baquet (2002) stated that health disparities “should be viewed as a chain of events signified by a difference in: (1) environment, (2) access to, utilization of, and quality of care, (3) health status, or (4) a particular health outcome that deserves scrutiny” (p. 427). Infant mortality is a health disparity in the United States that affects non-Hispanic black people at double the rate of other racial and ethnic groups (Macdorman & Mathews, 2008). Asthma, accidental injury, exposure to toxins and tobacco, mental functional impairments (such as mental illness, autism, and neurological disorders), and overweight and obesity are other widely recognized child health disparities (Institute of Medicine [IOM], 2009; National Institute of Child Health and Human Development [NICHHD], 2007) that affect children from racial minority, low-income, and rural backgrounds at disproportionate rates (Centers for Disease Control and Prevention [CDC], 2009b; Garland et al., 2005; National Center for Chronic Disease Prevention and Health Promotion [NC-CDPHP], 2009; Wagstaff, Bustreo, Bryce, & Claeson, 2004; Yoo et al., 2009).

The term “health inequality” is used more widely by the international community to discuss disparities or inequalities in health outcomes. It is defined as “differences in health that are not only unnecessary and unavoidable, but, in addition, are considered unfair and unjust” (Whitehead, 1999, p. 5). The term health inequality is strongly aligned with the concepts of health inequity and social injustice (Carter-Porkas & Baquet, 2002). The PBS television series *Unnatural Causes: Is Inequality Making Us Sick?* has broadened debate about health inequity in the United States by proposing that political and economic inequalities translate into health inequality and that social and economic inequities are at the root of many chronic health conditions, in adults and children alike (Adelman et al., 2008).

**Factors Contributing to Child Health Inequality**

**Poverty**

Poverty is a primary factor in the development of child health inequality. In 2008, the families of 13.5 million children in the United States lived below the federal poverty level ($22,025 for a family of four) (deNavas-Walt, Proctor, & Smith, 2009). Over one-third (36.8 percent) of children under 18 years of age experienced extreme forms of poverty; more families with children under 18 experienced more poverty in 2008 than in 2007, reflecting the effects of the economic recession (deNavas-Walt et al., 2009). These economic circumstances have concrete and far-reaching consequences for children, families, and our nation as a whole. Not having enough money for one’s family and not knowing where the next meal will come from or where one will sleep at night elevates stress hormone levels in children (Adelman et al., 2008; CDCHU, 2009; Shonkoff et al., 2009). Unabated stress due to impoverished conditions can interrupt child neural activity and brain development, compromising a child’s health and mental health, learning abilities, and adult health outcomes (Adelman et al., 2008; CDCHU, 2009). Poverty and economic insecurity can also affect the mental health of parents, producing psychological distress, anxiety, and depression. These conditions can negatively affect the interactions and relationships between parents and their children (CDCHU, 2009).

**Lack of Health Insurance**

An estimated 7.3 million U.S. children under 18 were without health insurance in 2008 (deNavas-Walt et al., 2009). Approximately 15.7 percent of this total consisted of children living in poverty, compounding the effects of this social condition even further. The Children’s Health Insurance Program reauthorization Act of 2009 (P.L. 111-3) will incrementally reduce the number of uninsured children by 4.1 million by 2013 (Families USA, 2009). However, a substantial number of children will remain underinsured or completely uncovered. Medicare coverage is only available to children with end-stage renal disease (Centers for Medicare & Medicaid Services [CMS], 2009), and
Medicaid only covers children who qualify on the basis of family income and residency status (CMS, 2010). Although Medicaid and the state Children’s Health Insurance Programs (CHIP) have expanded health care coverage to families affected by the recession (Families USA, 2009), undocumented children are still denied health insurance due to federal legislation that prohibits their parents from receiving federal subsidies to purchase coverage at their own cost and enroll their children in Medicaid (Henry J. Kaiser Family Foundation, 2008). Implementation of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) should dramatically reduce the number of uninsured children over the next four years as health care coverage expands to include families with incomes greater than 400 percent of the federal poverty level through employer-based coverage, private plans, CHIP, and Medicaid (Families USA, 2010).

Restricted Access to Health Care
Geographic distance from services and lack of transportation, especially for rural communities, affect access to care and aggravate child health inequality (Acevedo-Garcia, Osypuk, McArdle, & Williams, 2008). Cultural differences, language differences, and varying degrees of health literacy continue to function as access barriers (Agency for Healthcare Research and Quality [AHRQ], 2009). Consumers’ culturally based beliefs and attitudes about health do not always match those of providers, leading to misunderstandings and medical noncompliance (AHRQ, 2009). Resorting to the use of family members or nonprofessionals to translate vital health information can jeopardize patient care and education (Rondero Hernandez, 2009). Health literacy in the language and level of education of the consumer is difficult to achieve, yet key to increasing health care access and reducing health disparities (Rudd, 2002).

Racial and Class Inequalities
The study of child health inequality has led to more open scientific discussion of the role of racism and classism in infant and child health outcomes (Lu & Halfon, 2003; Wagstaff et al., 2004; Yoo et al., 2009). Unnatural Causes: Is Inequality Making Us Sick? (Adelman et al., 2008) demonstrated how the social context of communities contributes to health inequality and how race and socioeconomic status (SES) influence health outcomes. High infant mortality rates persist among African American women, even among women from higher socioeconomic and educational backgrounds (Adelman et al., 2008). Current survey data on pediatric health reports higher obesity rates among children from lower income households (CDC, 2009b, 2009d). Youth from racial and ethnic minority groups are disproportionately affected by higher prevalence rates of chronic disease, such as asthma, overweight, type 2 diabetes; sexually transmitted diseases; teenage pregnancy; injury; violence; and forms of mental distress, including anxiety, depression, and suicide attempts (CDC, 2009c). According to Syme (2008), not caring about the problem of racial and social class inequalities in health outcomes will result in higher morbidity and mortality rates and increase the burden of health care systems. His observations are supported by evidence of the growing economic burden health inequality places on our nation (LaVeist, Gaskin, & Richard, 2009).

Parental Decision Making
Public health research on the ethical and policy implications of child health has prompted discussion about the role of parent decision making in reducing child health inequality. Blacksher (2008) acknowledged that parents are within their constitutional rights to make decisions on behalf of their children. However, she also argued that children are sometimes made even more vulnerable when parents make decisions that compromise their children’s health. Deleterious parental decisions—such as child abuse and neglect, not using seat belts, smoking around children, and drinking alcohol or taking drugs while pregnant—are well-known to social work, and society has developed sanctions for parents who endanger their children. However, parents may be restricted in the decisions they can make to improve their children’s health or may be unaware of the relationship between their decisions and child health outcomes. For example, parental decisions may be constrained by social, economic, or physical circumstance, such as poverty, lack of health insurance, living in disorganized neighborhoods, limited access to fresh fruits and vegetables, and ineligibility for government assistance (Cecil-Garb & Grogan-Kaylor, 2009; Li et al., 2008; Nepomnyaschy, 2009; Yoo et al., 2009). Likewise, parents may not perceive the relationship between macro-level forces—such as food policies, advertising campaigns, and the media—and health beha-
viors, including getting immunizations, injury prevention, knowing what triggers asthma, and encouraging sound nutrition and physical activity to avoid overweight (CDC, 2009a, 2009e; Bladis, 2006). Although it is important to take into account parental decisions in relationship to child health outcomes, SES, neighborhood, community, and environmental conditions must also be assessed, because sometimes the only alternative parents have is to live with the choices available to them (Blacksher, 2008; Prevention Institute, 2009).

**Significant Child Health Inequalities and Emerging Responses**

**Infant Mortality**

In 2005, the national infant mortality rate was 6.86 infant deaths per 1,000 live births, with very preterm birth the primary contributing factor (very preterm birth is defined as 34 to 36 completed weeks of gestation, compared with late preterm birth, which is defined as before 32 completed weeks of gestation, and preterm birth, which is defined as before 37 completed weeks of gestation) (Macdorman & Mathews, 2008). During the same year, rates of infant mortality were higher among women from ethnic minority groups and were double the national rate among non-Hispanic black women at 13.63 infant deaths per 1,000 live births (Macdorman & Mathews, 2008). Racial and ethnic disparities in the rates of preterm birth and infant mortality have historically been attributed to maternal behavior and medical risk, lower income and education levels, and limited access to resources (Nepomnyaschy, 2009; Yoo et al., 2009). However, more recent studies have offered alternative explanations, including the effects of chronic stress and bodily “wear and tear” imposed by the burden of racism. Adelman et al. (2008) offered persuasive evidence to support that chronic exposure to stress hormones can affect human biology and trigger preterm birth and increased risk of infant mortality, suggesting a link between racism, biology, and infant health (Krieger, 2008; Lu & Halfon, 2003). In response to these findings, Lu et al. (2010) have proposed a “life course model” for reducing racially based differences in infant mortality rates. This model assesses critical periods of development and early life events of a mother, with an emphasis on the wear and tear she experiences over time. This model also includes a “12-point plan” for closing the gap between black and white birth outcomes that addresses family and community systems and social and economic inequities (Contra Costa Health services, 2009). Social workers are educated in the life course perspective and forms of discrimination that can compromise the well-being of minority populations. Subsequently, they are prepared to engage in, contribute to, and evaluate local collaborations that implement this model and others developed to reduce racially based differences in infant mortality.

**Overweight and Obesity**

Approximately 17 percent of school-age children were estimated to be obese or overweight in 2006 (CDC, 2009b). Children who are overweight face a greater risk of health problems that can extend into adulthood and of comorbid health conditions such as type 2 diabetes, high blood pressure, high blood lipids, asthma, sleep apnea, orthopedic problems, and depression (CDC, 2009b). Certain segments of the child population are more deeply affected than others. Childhood overweight and obesity are prevalent among African American children (CDC, 2009b), and some data indicate that Latino school-age children are more highly affected by overweight and obesity and engage in more sedentary behaviors and less physical activity (CDC, 2009b; Leigh & Wheatley, 2009). The effects of childhood overweight and obesity are now evident at the preschool level, where, in a recent study, one out of seven low-income, preschool-age children met the criteria for obesity (CDC, 2009d). Tackling childhood overweight and obesity implies change at various levels. Parents, schools, neighborhoods, and communities at large can be jointly enlisted in combating this epidemic by promoting healthy eating and healthy lifestyles in future generations (Blacksher, 2008; Prevention Institute, 2009; Stroup, Johnson, Proctor, & Hahn, 2009). Currently, 41 communities in 25 states and Puerto Rico have been selected to participate in the Healthy Kids, Healthy Communities initiative to develop and implement healthy eating and living and environmental change projects (Robert wood Johnson Foundation [RWJF], 2010). The RWJF has placed special emphasis on engaging communities at highest risk for childhood obesity on the basis of race, ethnicity, income, and geographic location. Social workers can make direct contributions to such initiatives by partnering in needs assessment, prevention intervention, policy analysis, and program evaluation activities.
Asthma

In 2007, 5.6 million school-age children and youths (5 to 17 years old) were reported to experience asthma (NCCDPHP, 2009). Asthma is the third leading cause of school absenteeism and a leading cause of hospitalization among children and adolescents (CDC, 2009a). It is triggered when children do not take their medications consistently, physically exert themselves, or are exposed to pollutants, including cigarette smoke, dust mites, molds, chemicals, and particulate matter in the air (NCCDPHP, 2009). Children from low-income households, racial and ethnic minority backgrounds, and inner-city environments are disproportionately affected by asthma and asthma-related deaths (NCCDPHP, 2009). Asthma can be controlled when properly diagnosed and managed. This outcome assumes that children and their families have access to medication and health care and are educated about asthma and how to manage it, including taking the necessary precautions to keep the family living environment as pollutant-free as possible. This is not always the case. Children disproportionately affected by asthma frequently experience difficulties accessing health care and prevention services (AHRQ, 2009), compounding barriers to controlling asthma. The Harlem Children’s Zone (HCZ) Asthma Initiative operates in a 60-block area of New York where one-third of the children experience asthma or asthma symptoms (HCZ, 2009). The HCZ partners with parents to develop home-based interventions to reduce environmental triggers, such as indoor dust, indoor mold, and tobacco smoke. As a result, daytime and nighttime asthma symptoms, school absenteeism, emergency room visits, and asthma-related hospitalizations have dramatically decreased (HCZ, 2009). The HCZ Asthma Initiative is considered an exemplary model, where parental autonomy is respected and “good options” (for example, a safe neighborhood; mentoring, social, educational, and medical services) sustain the commitment of parents to improve the health of their children (Blacksher, 2008).

Mental Health

An estimated 10 percent to 20 percent of children in the United States have mental disorders that impair their level of functioning (Miles, Espiritu, Horen, Sebian, & Waetzig, 2010), and at least 20 percent of children between one and six years of age are affected by at least one mild impairment (IOM, 2009). Growing concern about the mental health of children in the United States is supported by emerging evidence that stressful social environments can affect the biological architecture of the developing brain, prompting emotional difficulties that, if left untreated, can turn into serious mental health problems (IOM, 2000; National scientific Council on the developing Child, 2008). Historically, mental health treatment services for children have been administered and delivered by separate systems (for example, community mental health or substance abuse services, juvenile justice system, child welfare system). In 1983, Congress legislated and funded the Child and Adolescent service system Program, which provided funds and technical assistance to U.S. states and territories to develop systems of care for children and youths experiencing emotional health disorders (Pires, 2002). System of care values and principles emphasize interagency collaboration, child and family-centered services, accountability, and use of evidence-based treatment approaches (Pires, 2002). A recently released report from Georgetown University advanced the discussion of how to address child mental health by recasting this topic into a public health framework. Miles et al. (2010) proposed that using a population perspective will reduce child mental health problems and optimize the mental health of all children through prevention efforts at multiple levels. Social workers across the nation are involved in systems of care and cross-collaboration efforts to integrate service delivery for children with mental health problems, especially those involved in multiple service systems (for example, child welfare, juvenile justice), where children of color and low-income households are overrepresented (Hornberger, Martin, & Collins, 2006). Their expertise can enrich local collaborations that emphasize public health concepts, multilevel approaches, continuum of care principles, and cultural competence, all of which align with social work practice in health care settings (NASW, 2005).

Toxic Exposure

It has been estimated that children in the United States are exposed every day to combinations of 70,000 to 75,000 chemicals in air, land, water, and food (Mott, 1996). Children have a heightened susceptibility to toxic exposure because they are developing rapidly, both physically and mentally, making them more vulnerable to
permanent health damage than adults (Anderson, Diwan, Fear, & roman, 2000; National research Council, 1993). Current research indicates that air pollution has a greater impact on health outcomes than water or land pollution (Agarwal, Bantergnsa, & Bui, 2009) and that exposure to toxins during pregnancy may affect a child’s mental health over time (Williams & Ross, 2007). It is difficult to test the results of toxic exposure on children because of the obvious ethical concerns (Mushak, 2002). However, the research plan for the National Children’s Health study, launched in 2003 in over 100 communities across the United States, provides a clear outline of the different categories and definitions of diverse toxins affecting children. This study should demonstrate the association between the environment and disease in children and shed light on the various chemical, physical, and biological factors known to contribute to disease causation and severity of disease in children (NICHD, 2007).

Community social work is a fruitful avenue for confronting issues of environmental injustice and toxic exposure in children by organizing neighborhoods and communities. Local struggles, such as the Richmond, California, environmental justice fight against the Chevron refinery (Choy & Orozco, 2009), show how culturally and ethnically diverse organizations can join with social workers and activists to challenge toxic exposure.

**Large-scale Efforts to Reduce Child Health Inequality**

**Poverty Reduction**

One approach to addressing child health inequality and other domains of child well-being is poverty reduction. Poverty reduction is defined as either nationally sponsored policies or locally organized efforts to mitigate the effects of poverty, such as poor health and substandard housing, using measurable outcomes as indicators of progress. Poverty reduction as a national strategy gained popularity in 1999, when British Prime Minister Tony Blair pledged to end child poverty within a generation by cutting it in half by 2010 and eradicating it completely by 2020 (Collin, 2007). In an effort to meet these goals, the British government has enacted a series of antipoverty policies and initiatives for at-risk groups, including children, single parents, and low-skilled workers. Brazil, Colombia, Ecuador, and Guatemala have also implemented poverty-reduction efforts (for example, education, health and nutrition programs) in regions that have historically experienced high and persistent poverty to affect future poverty and improve intellectual and economic productivity (Barrientos & santibañez, 2009). No federally sponsored and coordinated national poverty-reduction strategy exists in the United States. However, a number of U.S. cities and regional communities have implemented poverty-reduction initiatives (Circles Campaign, n.d.; Northwest Michigan Council of Governments—Michigan works, n.d.), and three states—Connecticut, Minnesota, and California—have initiated state-sponsored assessments to better understand poverty’s effects on their economies and the well-being of children and adults (Center for American Progress, 2007).

**Place Matters**

Place Matters is a national initiative to eliminate health disparities by addressing social determinants that affect health. It seeks to “improve the health of participating communities by addressing conditions that lead to poor health” (Joint Center for Political and Economic Studies Health Policy Institute [JCPESHPI], 2008). To date, Place Matters has engaged 16 communities (also known as design Teams) across the United States to begin the transformative task of improving public health. Sites were selected on the basis of the proportion of minority populations residing in communities and their indicators of health. The objective of Place Matters is to engage neighborhoods in examining the “upstream” influences that contribute to health disparities in a community (Gehlert, Mininger, Sohmer, & Berg, 2008). Upstream influences are macro-level forces in the social environment that influence health—such as rates of violent crime, low household income, and neighborhood organization—as compared with downstream, micro-level influences, such as genetics, stress hormone functioning, disease, and psychosocial conditions. Several Place Matters sites have dedicated their efforts to reducing child health inequality. For example, the Prince George’s County, Maryland, design team is focusing on developing sustainable strategies to address childhood obesity and youth mental and behavioral health. Infant mortality, youth violence, and exposure to environmental toxins are being addressed by other community design teams in different states (JCPESHPI, 2008).
In the late 1990s, numerous experts called for new data to better understand child health and development and suggested that a large longitudinal study of children was needed to fill gaps in knowledge about environmental influences on child health and development. Passage of the Children’s Health Act of 2000 (P.L. 111-148) authorized Congress to appropriate funds for the National Children’s study (NCs), which was initiated in 2003 and currently has 105 study sites in 79 metropolitan areas (urban, suburban, and small cities) and 26 rural communities across the United States (NICHHD, 2007). The NCs is collecting data on conditions and outcomes for more than 100,000 children from birth to age 21 to better understand the role of environmental factors in health and disease (NICHHD, 2007). This study will also allow scientists to find differences among groups of people in terms of their health, health care access, disease occurrence, and other issues so that these differences can be addressed. This new knowledge should contribute greatly to transdisciplinary efforts between social work and health-related disciplines to reduce child health inequality.

**Implications for Social Work Practice**

**Practice**

Social workers can contribute to the reduction of child health inequality by incorporating a population perspective into assessment activities. This approach compliments the profession’s biopsychosocial perspective and is consistent with research on social determinants of health. Such an approach can result in robust social work assessments that take into account local health behaviors and health beliefs and how they are shaped by social context. Sources of stress, cumulative disadvantage, and risks that jeopardize child health should also be assessed. Social work’s multi-systemic perspective on social problems would enrich this activity and assist social workers in devising interventions that target determinants of health associated with health inequality. For example, a social worker assigned to a community where asthma rates are disproportionately high among children from low-income backgrounds may learn that a government-funded health insurance plan that covers most of the families in the area pays for only one asthma inhaler at a time. The worker may also know that not having a second inhaler at school may discourage a parent from sending a child to school if asthma attacks have been frequent. This situation may prompt a micro-level intervention to find resources for a second inhaler to encourage regular attendance, reduce student absenteeism, and increase asthma management. Using a population perspective could also prompt a mezzo-level intervention of engaging families in the neighborhood to discuss asthma triggers (for example, poor air quality, physical exertion, indoor dust and mold, tobacco smoke) as a means of increasing asthma management. Knowledge about local asthma prevalence rates, air quality issues, and health insurance provisions would also equip a social worker for macro-level, transdisciplinary efforts to improve local child health and academic outcomes. All of these efforts may serve to inform other communities in which the prevalence of asthma is disproportionate to the general population, based on specific population characteristics such as age, gender, race, ethnicity, or SES. Similar approaches can be used for other health and mental health conditions and would be especially beneficial for children involved with multiple systems and where children of color and low-income backgrounds are often overrepresented (Briar-Lawson, Naccarato, & drews, 2009; Hornberger et al., 2006). In addition to assessment and intervention activities, social workers can also create stronger linkages with health-related disciplines and work with them to develop outreach and intervention activities designed to address disease prevention and health promotion by using evidence-based practices that are culturally relevant and linguistically appropriate.

**Policy**

Using person-in-environment and multi-systemic perspectives helps social workers to identify the merits and shortcomings of policies and services and equips them to influence policy decisions at local, state, and federal levels (NASW, 2005). There is a range of policy-related issues that exacerbate child health disparities, including “the fragmentation and misalignment of services...differing eligibility criteria, funding streams and legislation that dictates the type and duration of services” (Briar-Lawson et al., 2009, p. 315). In addition, the ways that health services are organized, financed, and paid for often dictate what services are available to children and families (darnell & Lawlor, 2006). The systems of care movement was a direct response to the fragmented delivery of mental health services to children and has led to broader policy discussion about the need to integrate policies and streamline service delivery for families (Milesetal.,
A proposed solution that is currently being discussed is non-categorical funding across agency and program boundaries (as opposed to categorical funding based on eligibility criteria offered by a singular source). Non-categorical funding is considered a viable solution for containing costs and increasing access to services for children who might otherwise go unserved (Miles et al., 2010; Pires, 2002; Rondero Hernandez, 2009). Social workers can offer valuable input to policy discussions related to non-categorical funding and other proposed policy changes designed to enhance child health and well-being and reduce child health inequality. They can also have a positive influence on other policy responses that seek to remediate child health inequality by advocating for appropriate assessments and interventions that protect children and strengthen families rather than punish them for behaviors mediated by income, family dynamics, culture, food policies, the media, and marketing schemes (Blacksher, 2008; Darwin, 2008). Social workers can also engage in policy practice activities, such as policy analysis, developing alternate policy proposals and political processes (for example, lobbying) in community, organizational, and legislative settings to effect change and reverse injustices in health care policies affecting children. These activities will become increasingly important as our nation implements health care reform, ensuring that intended legislation is not undermined. Social workers can actively contribute to the reduction of child health inequality by monitoring states’ participation in and implementation of health care reform.

Research
Social work can help move the research agenda on child health inequality forward in several areas—specifically, community needs assessment, epidemiological research, and the evaluation of programs implemented to reduce health inequality. This will require familiarity with current and emerging health science, policy research, and evaluation of health trends to assess whether interventions designed to reduce health inequality do indeed work. For example, Miles et al. (2010) stated that a public health approach in the area of children’s mental health must be based on an accurate assessment of the health of a population and informed by community needs that are locally driven. Social workers are educated in the principles of needs assessment and can make valuable and culturally relevant contributions to local initiatives informed by their practice at micro, mezzo, and macro levels. Social workers can prepare for more involvement in public health approaches to reduce health inequalities by becoming more familiar with biostatistics and epidemiological research related to child health inequality. For example, the National Center for Health statistics (http://www.CDC.gov/nchs/surveys.htm) lists a number of national surveys and databases that contain current statistics or public use data, including statistics on child health and well-being indicators (Federal Interagency Forum on Child and Family statistics, 2009). Survey and data sites can also be found at state and local levels. Exploring these sources will equip social workers with data that can be used for research and evaluation purposes and give the profession a stronger knowledge base for engaging in local initiatives to reduce child health inequality. This knowledge will also prepare social workers for health policy research on the prevalence of child health inequality in their communities and increase the efficacy of evidence-based interventions used locally. These efforts can eventually help to influence national and state policies that target upstream, macro-level influences that produce downstream benefits for populations affected by health inequality.

Recommendations
In order to increase parity and influence of social work in public health approaches and partnerships to reduce child health inequality, social workers need to be familiar with the philosophical assumptions of the social epidemiology framework and best practices in disease prevention and health promotion. They must remain current in their knowledge about policies related to child health and proficient with research and evaluation strategies in this arena. Social workers must also stay abreast of large-scale efforts to reduce poverty, efforts to improve community environments, and findings that emerge from national studies on child health. Social workers should also become familiar with other disciplines’ perspectives on how to support the “developmental health” of our nation (Keating & Hertzman, 1999), research on social determinants of health (Marmot & Wilkinson, 2003), and critiques of U.S. health policies that have historically placed the responsibility for health outcomes on individuals, with little consideration of the influences of SES (Tesh, 1988) and physical environments (JCPESHPI, 2008). Social workers
should also familiarize themselves with sources that demonstrate the importance of culturally relevant interventions (Contra Costa Health services, 2009; Fadiman, 1997; Garcia & Duckett, 2009) and contemporary viewpoints on the role of social work in public health. Social work section of the American Public Health Association (2010) also is a valuable resource for understanding social work and public health. In addition, child and Sable (2006) have outlined the common approaches and values of public health and social work, identifying points of intersection where these two disciplines (and other allied health professions) might partner in transdisciplinary efforts to promote community health and disease prevention, a need voiced by Gehlert et al. (2008).

Conclusion

Current research reflects that health inequality is increasing the vulnerability of child health in the United States today. This state of affairs threatens not only the immediate and temporary viewpoints on the role of racism in the development of health and disease prevention, a need voiced by Gehlert et al. (2008). Current research reflects that health inequality is increasing the vulnerability of child health in the United States today. This state of affairs threatens not only the immediate and temporary viewpoints on the role of racism in the development of health and disease prevention, a need voiced by Gehlert et al. (2008).

References

Climate.16-2-11.pdf


