

Health Status of Harlem's Children:

Improving, but Lagging Far Behind the Rest of the City

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A Report by The Children's Health Fund

Executive Summary

Harlem is a community in transition. An influx of new resources and investments has brought new energy and economic development to Harlem, with hopeful signs that circumstances will improve for community residents.

The children of Harlem have been disadvantaged by disparities in access to needed health care services. Though improvements have been made, health care statistics still show a grim profile of both child and adult health indicators:

- Children in Harlem are nearly twice as likely as children elsewhere in the city to be hospitalized for injuries
- Lead poisoning in Harlem exceeds the rest of the city by 20 percent.
- Although child immunization rates have shown remarkable improvement, Harlem children's immunization status at 24 months lags behind the rest of the city by 12 percent.
- Asthma hospitalizations in Harlem, despite consistent reductions over the last decade, are still 50 percent higher than New York City as a whole.
- Long waits for dental visits are endemic due to only 7 percent of general dentists and 29 percent of pediatric dentists accepting Medicaid patients.
- Sixteen percent, approximately 12,500 of Harlem children aged 5-17 show signs of emotional disturbance, but there are only 3,150 treatment slots available. Overall, barely one-fourth of children get the mental help they need.

These health indicators are the result of not only lack of services, but also health care disparities that exist for African American and Latino communities in New York and the effects of poverty when accessing care. But there is hope through progress. Continuing efforts to ensure appropriate availability of high quality, comprehensive health and mental health services will facilitate progress in eliminating health disparities and bridging the prevalent child health access gaps.

Community members, organizations, and providers have worked diligently to improve the health, health care, and health outcomes for Harlem's children. Clearly, positive change has resulted and more work is to be done.

In an effort to contribute to that positive change, the Harlem Children's Health Project (HCHP) has been established. The HCHP is a combined effort of The Children's Health Fund, Harlem Children's Zone, Columbia University's Mailman School of Public Health, and New York-Presbyterian Hospital. The HCHP's mission is to provide children with access to quality comprehensive health services and to empower families to make healthy lifestyle choices. More than just another school based health center in Harlem, the HCHP aims to bring clinicians, educators, and the community together to help children get-and stay-healthy and increase their chances of success in school and life, now and into the future.

Introduction

The Harlem community is clearly changing. New businesses are opening; the real estate market is booming; the Apollo Theatre is beautifully renovated. However, a great deal of work remains to be done to address disparities in health conditions and outcomes that still disproportionately affect poor and minority children and families.

Health access barriers are an insidious, undermining force that reduces the chances for success for children, particularly those from economically disadvantaged communities such as Harlem. Children born to mothers who have had inadequate access to pre-natal services are beginning life without the baseline of health advantages they deserve.

Children who do not have full, regular access to primary care are less likely to have the benefit of diagnostics that can facilitate early identification and treatment of medical and developmental concerns. Children afflicted with chronic conditions like asthma, which has potential to significantly impact school attendance, ability to participate in recreational programs and educational performance, need appropriate access to ensure successful management of their illness.

Recognizing that significant progress has been made toward improving health access in Harlem, it is important to continue efforts to ensure appropriate availability of high quality, comprehensive health and mental health services. These efforts must be built on the understanding of ongoing health challenges and the commitment to successful integration of new health resources into the existing fabric of community institutions,

Progress in the Community's Health

The rate of infant mortality, which reflects deaths during the first year of life per 1,000 live births, is one important standard indicator of child health. The 1990 infant mortality rate in Harlem was 27.7, which is extremely high by any standard. The Northern Manhattan Perinatal Partnership points out that in 1990, Harlem represented 4.6% of infant deaths in New York City despite comprising only 1.5% of the city's population. The rate for New York City had declined, from 13.1 in 1989 to 12.1 in 1990. So Harlem's infant mortality rate was more than double that of New York, at a time when New York's rate was 25% higher than the national average.¹

Jump ahead a decade, to 2001. Harlem's infant mortality rate was 13.1, more than double the city's rate of 6.1. Just two years later, following more than a decade of continual improvement, the city's infant mortality rate increased, to 6.5. Harlem's rate declined to 7.3, less than 10% higher than New York City.²

This progress is consistent with much improved delivery of prenatal care. Access to prenatal care is associated with fewer low birth weight deliveries, which in turn reduces infant mortality. In 1994, one-third of pregnant women had late or no prenatal care. By 2001 this was reduced to 11.6%. This represents tremendous improvement, but it is still a problem compared to New York City's far better access, with 7.2% receiving late or no prenatal care.

Disparities Continue

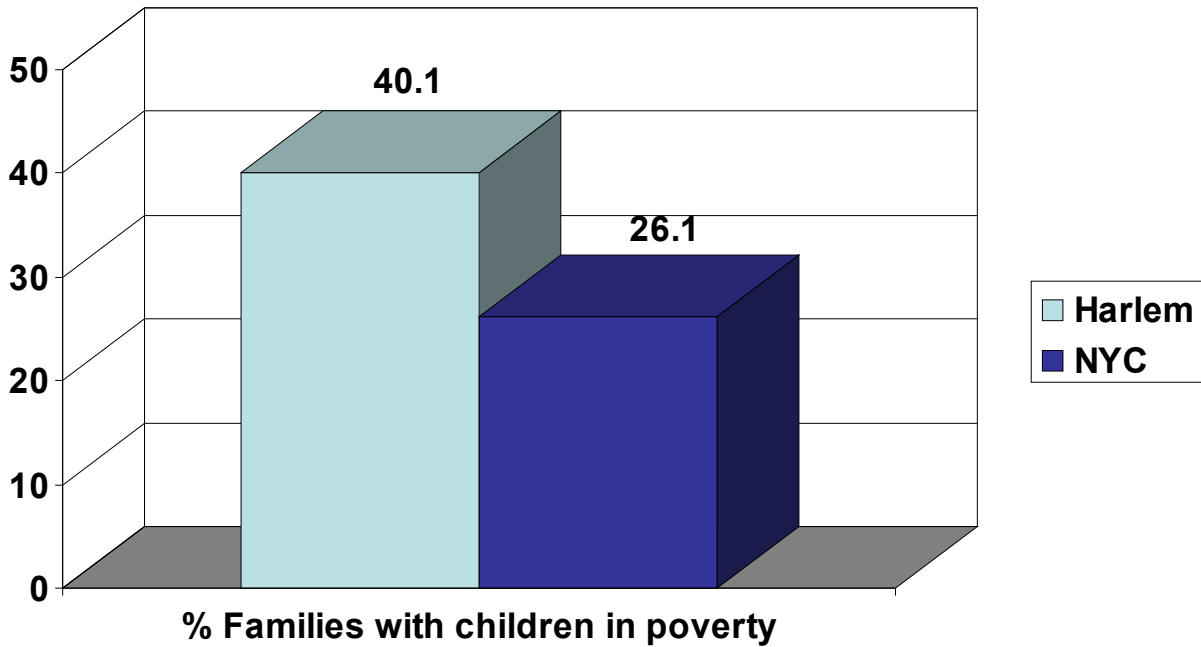
Data on health conditions in Harlem tell the story of a community making progress but still lagging behind New York City as a whole. These health disparities are consistent with the national picture. The federal Agency for Healthcare Quality and Research, in its 2003 report, found that African-American and Latino patients:

- Receive lower quality health care than white patients;
- Are less likely to receive standard preventive health tests that can prevent or identify early heart disease and cancer;³
- Have a higher prevalence of serious cardiovascular disease, have less access to cardiac procedures, and have a higher rate of deaths attributable to cardiovascular disease.⁴

The Institute of Medicine (2003) has similarly documented barriers to accessing care – language, culture, transportation – which disproportionately affect racial and ethnic minorities, even if they have health insurance. And minority patients are more likely to lack consistent, full-year health insurance. Assuming care is obtained, for minority patients it is too often less than optimal.⁵

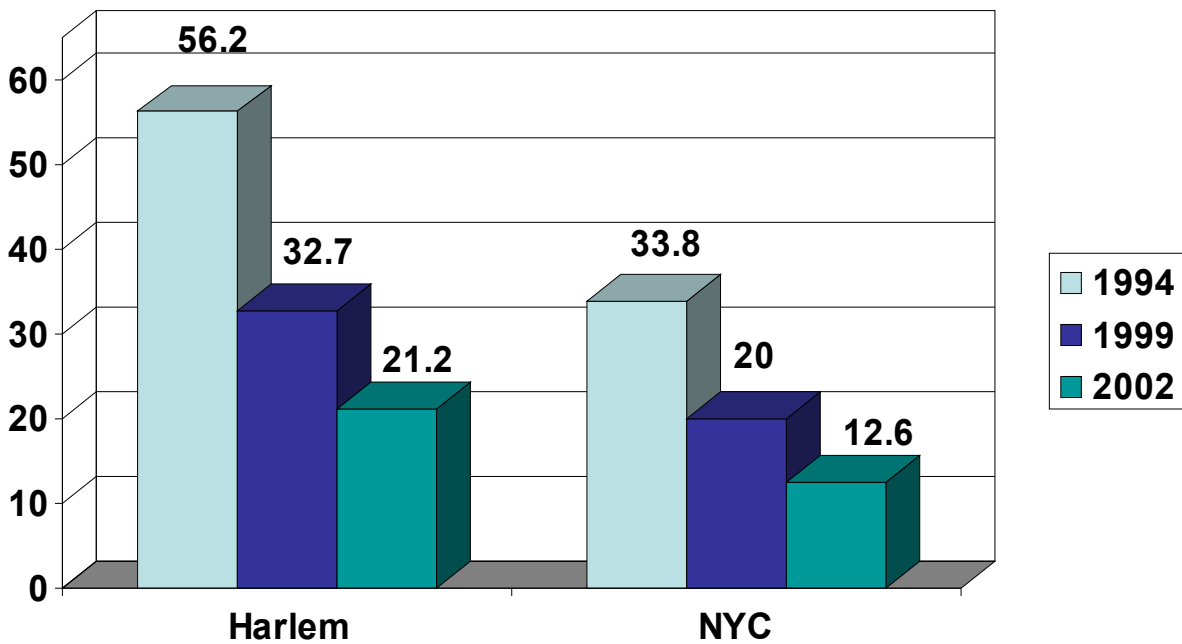
While the focus of these health disparities reports is on racial and ethnic minority patients, the findings are applicable to all poor patients. The disproportionate representation of poverty in Harlem is shown in Table One.

Table One: Harlem remains a poverty community within NYC



Despite years of consistent progress, the income gap between Harlem's children and those of New York City as a whole remains substantial, as seen in Table Two.

Table Two: Percent of children in poverty is improving – but disparities remain



The New York City Department of Health has carefully documented the impact of these issues on the city's poor and minority families. In 2001, the life expectancy for the city's poorest residents was eight years shorter for the wealthiest. For African-Americans, life expectancy (2000) was 69 years compared with 75 for whites. And by far the leading causes of death in the city's lowest income neighborhoods were heart disease and cancer – two conditions for which screening and preventive care are least available to the poor (2001).⁶ Overall, Harlem has one of the highest mortality rates in the United States.⁷

As part of its effort to address the problem of health disparities, the city Department of Health tracks health conditions in several of the city's highest risk communities, including Central Harlem. Among the findings:

- More than one adult in four in Harlem is obese, which is associated with a higher prevalence of diabetes;
- Harlem residents are less likely than those elsewhere in the city to have a personal doctor, are twice as likely to lack health insurance, and 20% more likely to go without needed health care;
- Children in Harlem are nearly twice as likely as children elsewhere in the city to be hospitalized for injuries;
- Lead poisoning remains a problem in Harlem, exceeding the city by 20%.⁸

Disparities in Child Health

Among the ways to assess child access to health care are tracking whether they are up-to-date for immunizations, and monitoring their asthma hospitalizations. Asthma is one of

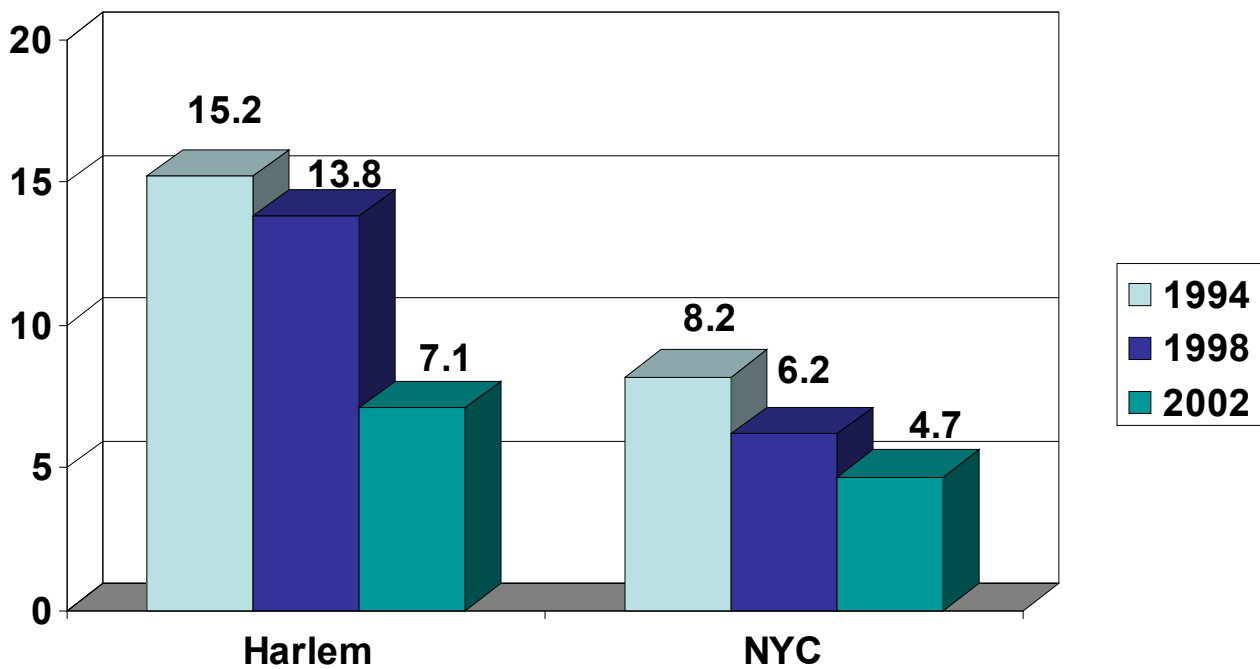
the most common childhood chronic conditions, and one which disproportionately affects minority and poor children. With proper management, however, asthma can be well controlled. Hospitalizations and emergency room visits can be prevented. By these standards, there are serious child health access problems remaining in Harlem.

The immunization rate in Harlem has been improving at least since 1999, when the Northern Manhattan Start Right Coalition began its intensive focus on the issue. From 1999-2005, this program has led to a 30% improvement in immunization status, with African-American children in Harlem having a higher up-to-date for immunization rate than the national average for African-American children (at age 19-35 months).⁹ Nonetheless, current data from the New York City Department of Health show that in Harlem, immunization status at 24 months of age lagged behind the rest of the city by 12%.¹⁰

The disproportionate impact of obesity and its associated health problems on minority adults has its roots in childhood. Low income communities like Harlem have less access to supermarkets or other stores that sell fresh fruits and vegetables, and children have fewer opportunities in their community for outdoor physical activity.¹¹ This is reflected in disparities in prevalence of childhood obesity. For example, 20.5% of African-American youth 12-19 years of age are obese compared to 12.8% white, as are 17.6% of children 6-11 years old compared to 12% white.¹² Obesity emerges as a problem in early childhood, as has been shown in a recent Department of Health report. In New York's Head Start programs, which serve predominantly low-income 3 and 4 year olds, 27% are obese, and another 15% are overweight.¹³

Harlem has one of the highest documented childhood asthma rates. The Harlem Children’s Zone study found a 30% rate of asthma (either previously diagnosed or presentation with asthma-like symptoms).¹⁴ Consistent with the city’s health disparities data, asthma hospitalizations in Harlem, despite consistent reductions in the past decade, are still 50% higher than for New York City. These trends are shown in Table Three.

Table Three: Despite Progress, Disparities in Asthma Hospitalization Remain (rate per 1,000 children).



Oral Health

Poor access to dental care has been called a “hidden crisis” among Harlem adults. In a survey asking participants to select common symptoms of diseases and health conditions that most affected them from a list of 50, dental problems (teeth and gums) were most

often cited, at 30%. And dental problems were most often reported by people with the lowest income.¹⁵

Similarly, a large study of children in Pennsylvania's public schools found dental caries (tooth decay) to be the most prevalent disease in the population. The study included more than 6,000 children ranging in age from 6 to 21 years of age.¹⁶ At the local level, a study of adolescents in northern Manhattan, including Harlem, showed that the prevalence of dental problems there is higher than typical in the country, often requiring tooth extraction or root canal therapy.¹⁷

These problems also start early. A study of children in Head Start found that 28% had at least one decayed tooth. For children on Medicaid, only 7% of general dentists and 29% of pediatric dentists accepted that insurance.¹⁸ Other problems cited to explain why so few children on Medicaid receive even minimally acceptable dental care include long waits for an appointment and difficulty with transportation.¹⁹

Mental Health

Estimates of the number of children who need mental health services vary widely. Identification of mental health problems is at best inconsistent and often done only when conditions are very serious and intervention is urgently required. The U.S. Surgeon General issued a comprehensive report on children's mental health, noting in detail the racial/ethnic disparities which lead to higher prevalence in poor and minority communities. This was followed by Surgeon General's Conference on Children's Mental

Health and an Action Agenda to address these problems, which cited a general estimate of the prevalence of serious emotional disturbance of 10%.²⁰

The Children's Hospital of New York-Presbyterian, Child and Adolescent Psychiatry estimate 16% of Harlem's children between 5 and 17 years of age show signs of serious emotional disturbance sufficient to meet diagnostic criteria. Translated into population-based need, this means that nearly 12,500 school-age children need mental health services -- for whom there are only 3,150 treatment slots available.²¹

This situation is all too typical. In its comprehensive study of mental health costs and utilization for children, researchers at RAND Health found that African-American and Latino children are least likely to get treatment when needed. Overall, barely one-fourth of children get the mental health help they need. Failure to provide services early is reflected in the fact that adolescents (12-17 years of age) account for about 60% of mental health expenditures while comprising only 35% of the population.²²

A consequence of late identification and intervention for child mental health problems is that conditions are more serious, and the child is older, when intervention finally occurs. Too often this leads to children and youth entering the juvenile justice system, where they receive punishment rather than treatment. Reports from the U.S. Department of Justice show that at least 16% of prison inmates are mentally ill, with the rate among incarcerated youth being 2 to 4 times higher, depending on the diagnostic criteria used. As many as 80% of adolescents in the juvenile justice system may be diagnosed with conduct disorder, and at least one in five is seriously emotionally disturbed.²³

Another condition often diagnosed late, or missed altogether, is learning disability. Reports on the national level by Harvard University, and locally by Advocates for Children of New York City, have documented the continuing trend of over-representation of minority students in self-contained special education programs, often without effective interventions provided. Under similar circumstances, African-American children were found to be almost 3 times more likely than white children to be considered mentally retarded.²⁴ Nationally, African-American students have a high school graduation rate only 2/3 as high as do white students. In New York State, the disparity is even greater.²⁵

An Effective Intervention Model: Comprehensive School-Based Health Care

There is evidence that the school-based health center model – establishing a pediatric clinic within a school – effectively bridges multiple barriers to accessing health care.²⁶ Data from East Harlem school-based health centers show that asthma is by far the most common chronic condition treated, with students with asthma making on average twice as many visits to the school health center.²⁷ Asthma treatment in school-based health centers, especially if linked with care from primary care providers in the community, is associated with reduced emergency room visits and hospitalizations for asthma, as well as improved school attendance.^{28, 29}

School-based monitoring of body mass index and other risk factors in predominantly African-American urban schools has proven to be effective in screening for the metabolic syndrome, a potential precursor of type 2 diabetes.³⁰ Because their services can be integrated with health education, physical education, and other multi-disciplinary

services, school-based health centers have also proven effective in reducing obesity and potentially preventing associated health conditions.^{31,32} This approach has proven to be not only clinically effective but extremely cost-effective as well.³³ School-based health centers have also been shown to effectively intervene with the early antecedents of child and adolescent obesity, reducing risk factors through nutrition education, impact on school meals, and parent participation.³⁴

Schools have also proven to be an effective location for dental services.³⁵ Not only is tooth decay the most common chronic disease of childhood, it is one with serious potential health and social consequences including missed school days, activity restrictions, infections, and tooth extractions. Long-term potential impact includes increased risk of cardiovascular disease and stroke.³⁶ It is not surprising that early access to dental care not only provides improvements in health status and quality of life, but is associated with economic savings to society as well.³⁷

In addition to bridging access gaps for children needing mental health services, school-based intervention has proven to be as effective, based on clinical indicators of improvement, as community-based mental health services (if available).³⁸ Schools that provide on-site mental health services refer fewer students for special education.³⁹ Improvements are not limited to school performance. Based on a standard measure, children with serious emotional disturbance who receive school-based intervention show better functioning at home and better regulation of mood, with reduced depression and less self-injurious behavior.⁴⁰ A comprehensive review studies from school-based mental health programs shows effective outcomes for substance abuse, depression,

impulsiveness, poor peer relations, and school absenteeism.⁴¹ With this track record, it is not surprising that the American Academy of Pediatrics has issued a Policy Statement recommending that health care professionals, educators, and mental health professionals collaborate to implement this effective model to provide needed interventions for children with psychosocial, emotional and behavioral problems.

Recommendations:

Acknowledging the progress that has been made in health service delivery in the Harlem community, The Children's Health Fund recommends

1. Increase access to pediatric primary care;
2. Increase capacity and access to child and adolescent mental health services;
3. Increase capacity and access to oral health services, especially for patients on Medicaid;
4. Integrate comprehensive health care from multiple sources by networking community-based providers in the various disciplines – health, mental health, oral health, social and preventive services – that families need;
5. Develop new access points to health care. CHF recommends the school-based health center model as one that has a proven record of efficacy and which can achieve the goals we outlined above.

The Children's Health Fund Harlem Children's Health Project

Despite the economic growth in the Harlem community, and despite the clear and measurable improvements in health, there is still more to be done to resolve the lingering health disparities that affect Harlem's children and families. Issues that need to be addressed are access to quality health care (a medical home for all children), intensive services to treat asthma and reduce hospital use, targeted interventions to prevent obesity

and its health consequences, and better access to dental and mental health services. There is evidence that these goals can be met through a comprehensive school-based health center that focuses on these issues, involves parents, and integrates school-based services into a seamless model of care which includes providers already in the community.

Partnering these health services with an innovative charter school, Harlem Children's Zone's Promise Academy on 125th Street and Madison Avenue, will be powerful in its ability to enhance the well-being of the children and families who participate. This is the model and goal of The Children's Health Fund Harlem Children's Health Project.

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