Racial/Ethnic Disparities in Health-Related Quality of Life and Health in Children Are Largely Mediated by Family Contextual Differences

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Received for publication September 29, 2011; accepted April 14, 2012.

ABSTRACT

OBJECTIVE: To examine (1) racial/ethnic disparities in health-related quality of life (HRQOL), and overall health status among African-American, Hispanic, and white 5th graders in the general population and (2) the extent to which socioeconomic status (SES) and other family contextual variables mediate any disparities.

METHODS: A total of 4824 African-American, Hispanic, and white fifth-graders participating in a population-based, cross-sectional survey conducted in 3 U.S. metropolitan areas reported their own HRQOL by using the Pediatric Quality of Life Inventory Version 4.0 and supplemental personal and social well-being scales. Parents reported these children's overall health status. SES was indexed by parent education and household income. Other family contextual variables included family structure and degree to which English is spoken at home.

RESULTS: Marked racial/ethnic disparities were observed across all measures of HRQOL and health status, favoring white children and especially disfavoring Hispanic children. Most of these disparities were no longer significant after adjusting for SES and other family contextual differences that were observed among these racial/ethnic groups. Only disparities in parent-reported overall health status and self-reported global self-worth remained.

CONCLUSIONS: Racial/ethnic disparities in children's health status are substantial but may be mediated by corresponding disparities in SES and other family contextual variables. Race/ethnicity and family context are related to one another and should be considered jointly in efforts to reduce health disparities in children.

KEYWORDS: disparities; ethnicity; family context; quality of life; race

ACADEMIC PEDIATRICS 2012;12:532–538

WHAT'S NEW

There are marked racial/ethnic disparities in children's health-related quality of life (HRQOL). White children experience better HRQOL than African-American children, who fare better than Hispanic children. However, disparities are substantially reduced and no longer statistically significant when sociodemographics are considered.

INTRODUCTION

AT LEAST 43% of children <18 years of age belong to a race/ethnicity other than (non-Hispanic) white, and these groups are expected to constitute a majority of all children in the United States by approximately 2040. In many studies investigators have found that children from racial/ethnic minority groups experience poorer health than white children. A recent report from the American Academy of Pediatrics,[1] summarizing 111 studies, concluded that "racial/ethnic disparities in children's health…are extensive, pervasive, and persistent, and occur across the spectrum of health…." (p. e979).

However, in the substantial majority of the studies with this conclusion, authors examined the prevalence of specific diseases (eg, asthma, obesity) and other narrow indicators (eg, injuries, immunization) of health, which provides a limited perspective on health in the general child population. In comparison, in relatively few studies have researchers examined disparities in broader indications of health, including populations of *both* African-American

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and Hispanic children.[2–6] Also, these studies confirm racial/ethnic disparities, reporting significantly poorer overall health status for African-American and Hispanic compared with white children as determined by parent report.

One advantage of broader child health status measurement is that it comes closer to the World Health Organization's[7] definition that health is "a complete state of physical, mental, and social well-being, not merely the absence of disease." We propose that children's own reports of their quality of life matches well this broad conception of health. One typical definition states that quality of life for children refers to "well being in multiple domains of life considered salient in one's culture and time, while adhering to universal standards of human rights" (p. 34).[8] When focusing on those aspects of quality life that overlap with the definition of health and typically examined in health research, we refer to health-related quality of life (HRQOL).

Racial/ethnic disparities in HRQOL are important to examine in children not just because HRQOL reflects health broadly but also because it informs about children's essential daily functioning.[8] Physical HRQOL addresses how children are able to engage physically in daily activities; emotional HRQOL captures how they feel about themselves and their lives; social HRQOL reflects how they view their place among other children and the quality of their relationships; and school HRQOL represents functioning in their critical student role of learning key skills and preparing for their adult lives.

Only one published study could be found in which authors examined racial/ethnic disparities in child self-reported HRQOL in a general population sample; they found no differences among African-American, Hispanic, and white groups.[9] However, the absence of differences may have been because the sample comprised all lower socioeconomic status (SES), which might essentially have controlled for SES.

Another limitation in research on racial/ethnic health disparities is that few studies have examined factors contributing to the observed disparities.[6,10–14] We hypothesize that these disparities are largely attributable to the marked SES and other contextual differences that may be present among families in different racial/ethnic groups, such as language spoken at home and family constellation.

Thus, we intended to advance our understanding of racial/ethnic disparities in children's HRQOL and health and begin to examine contributions to the observed disparities by addressing the following research questions: (1) Are there disparities in HRQOL and overall health status among African-American, Hispanic, and white 5th graders in the general population; and (2) To what extent do SES and other family contextual differences mediate disparities among these groups? We focus on children in 5th grade, at an important juncture between childhood and adolescence and just before the transition from elementary to middle school.

METHODS

We used data from Healthy Passages Wave I, a multisite longitudinal community cohort study of adolescent health and health behaviors and their correlates initiated in 2004.[15] Institutional review boards at each study site and the Centers for Disease Control and Prevention approved this study.

PARTICIPANTS

The sample frame included 5th-graders at public schools with ≥25 students enrolled in regular classrooms in schools in: (1) 10 contiguous public school districts in and around Birmingham, Alabama; (2) 25 contiguous public school districts in Los Angeles County, California; and (3) the largest public school district in Houston, Texas. More than 99% of students in regular classrooms attended public schools in these areas. To ensure adequate sample sizes of non-Hispanic African-American, Hispanic, and non-Hispanic white students, we took a random sample of schools by using probabilities that were a function of how closely a school's racial/ethnic mix corresponded to the site's racial/ethnic target, as detailed elsewhere.[15]

Information was disseminated to the 5th-grade children in 118 selected schools, with 11,532 students, to bring to their parents (or caregivers). Permission to be contacted was provided by 6663, of which 5147 (77% of permitted, 45% of sampling frame) completed both a parent and a child interview. Exclusion criteria included not attending a regular academic classroom or having a parent who could not complete interviews in English or Spanish. The 6% who were not identified by their parents as being African-American, Hispanic, or white (see below for racial/ethnic classification) were excluded from the analysis, which resulted in 4824 in the final sample with the unweighted (and weighted) distribution of 36% (30%) African-American, 38% (47%) Hispanic, and 26% (23%) white, 51% (49%) females, and child age $M = 11.12$ ($SD = .56$). Additional demographics appear in Table 1.

PROCEDURES

Two trained interviewers completed the full Healthy Passages assessment protocol with a child and one of his/her parents (mother, 88%; father, 6%, other, 6%) separated in private spaces at their home or a research facility using both computer–assisted personal interview and computer-administered self interview methods.[15] The parent could choose whether material would be presented in English or Spanish (prepared using standard back-translation).

VARIABLES

The following variables were used in this study.

Dependent Variables

Health-Related Quality of Life (HRQOL) was measured with the self-report form of the Pediatric Quality of Life Inventory Version 4.0 (PedsQL),[16] a widely used, well-validated measure of children's HRQOL. For example, in a study involving 5653 children,[9] the PedsQL demonstrated high construct validity, with healthy children reporting significantly greater HRQOL in all domains than chronically-ill peers. The PedsQL provides 6 scores,

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