

Health Care for Children

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Abstract

Children must be provided with the highest standards in order to maintain their health, rehabilitation and treatment in accordance with the prescribed rights. This includes medical and socio-medical measures, which enable the proper growth and development of children, and this includes institutions such as health care institutions, schools, social and other institutions. This, of course, cannot be achieved without the responsibility of parents for the life and health of their children, which is also legally regulated. Children are thus provided with a full and dignified life, in which their dignity, self-confidence and equal participation in society are promoted.

Key Words: Children; Health Care; Prevention

Introduction:

A relational responsibilities framework for determination of the best interests of a child with respect to a child's medical treatment would recognise that the child is an individual with specific needs, experiences, preferences and interests and entitled to protection of his or her moral and legal rights [1]. Rather than abstract ideas of a seriously ill child, it would ensure that the child as an individual is at the centre of decision-making. The focus would be upon the lived experience of the child, with a chronic or acute illness or life-limiting condition, resulting in embodied rather than disembodied decision-making.

Who usually decides this [2]? When the child is very young, it is usually the child's family. In the event of a dispute, it will be the courts if the case is taken to them, disagreements often occurring either between parents or between the parents and a third party such as a doctor or some other professional who has been looking after some aspect of the child's life, such as a teacher or educational specialist, or if there is uncertainty over the scope of the court's jurisdiction. If a wardship application is made, then as long as this is in force, no major decision can be made with regard to the child's welfare and upbringing without court approval or until a court hearing has taken place or until 21 days has elapsed from the date of the order.

Attention to the importance of nature and human health linkages has increased in the past ten years, both in science and in policy [3]. This relates to health benefits from nature-based health-care solutions, such as reducing stress, improving children's immune systems, and reducing the impact from environmental pollution or climate change. This also relates to health risks, such as pollen allergies or infectious diseases transmitted by ticks and mosquitoes. While knowledge about and recognition of the importance of nature and human health linkages are increasing rapidly, challenges still remain. Among them are building bridges between relevant, but often still rather disconnected, sectors and topics. There is a need to connect researchers in the fields of health sciences, ecology, social sciences, sustainability sciences and other interdisciplinary sciences, as well as for cooperation with governments, companies and citizens. This need is expressed by both health and nature sectors, and is considered crucial by many for facilitating integrated and practice-oriented approaches.

Children's optimal development and growth depends upon promoting key aspects that shape their health and brain function, including adequate nutrition alongside many other factors within their external environment and social health determinants: human



development and life course theories have advanced the evidence base in this regard [4]. The converse is true, i.e., that adverse experiences, such as exposure to violence and abuse in childhood, have been shown to affect the developmental pathway, with intertwined psychological and physiological effects, documented in research on biological embedding, foetal origins research and violence against women. In this manner, health in early life can be viewed as foundational for human development processes, with biological, environment, familial and social factors playing a role.

Medicaid in USA:

Since its original enactment, Medicaid has expanded to cover more uninsured Americans than any other insurance program [5]. After 1996, Medicaid enrollees no longer were required to receive welfare support in order to be a Medicaid beneficiary. Medicaid essentially serves as a broad net that covers those Americans living close to the federal poverty level who are not covered by private insurance plans or Medicare. However, some beneficiaries do jointly have both Medicare and Medicaid. These beneficiaries are known as “dual eligible”. Medicaid provides extra assistance for long-term services excluded under Medicare and further helps these citizens cover Medicare premium costs. Nearly 20 % of all Medicare recipients are dual-enrolled in Medicaid. Medicaid also covers seniors and nursing home residents, low-income children with working or unemployed parents, a wide range of disabled Americans with mental and physical health conditions, and Americans requiring long-term care. Medicaid is currently the nation’s largest source of long-term care funding.

Furthermore, Medicaid serves an expanded role during economic recessions. As more Americans lose jobs and occupation-related health insurance during recessions, they subsequently become eligible for enrollment within Medicaid. The program has no enrollment caps or waiting lists and can therefore absorb more Americans at any given time. According to a report formulated for the Kaiser Foundation, nearly one million more Americans are eligible for Medicaid for every 1 % increase in the nation’s unemployment rate. This cyclical nature of Medicaid enrollment consequently places a strain on public hospital systems. As a result, Medicaid is currently accountable for nearly 33 % of public hospital revenues and nearly 40 % of public health center operating revenues at any given time.

Medicaid is a joint program between the federal government and the state governments. The federal government, through its Centers for Medicare and Medicaid Services (CMS) agency under the US Department of Health and Human Services, authorizes each state-sponsored Medicaid program. States in turn have the responsibility of implementing and administering Medicaid. CMS specifically sets guidelines and regulations, recommends policy changes, and implements amendments to state-level plans. However, the states have the ultimate responsibility of drafting a Medicaid plan that details eligibility categories and requirements, benefits that will be covered for Medicaid recipients, and how the Medicaid program will be administered in each state, as long as these guidelines fall within the minimum guidelines established by the CMS. States are also responsible for maintaining transparency by providing readily accessible information about the rules, policies, eligibility requirements, and benefits received for potential Medicaid beneficiaries. Furthermore, each state is required to run a “medical care advisory committee” which

oversees the development of new policies and any changes in Medicaid administration on the state level.

Child Protection:

Schools play a major part in the lives of most children from the age of three or four onwards [6]. Children of school age in Western societies probably spend more direct time with their teachers than they do with their parents. Educational services have normally tended to play a very limited role in child protection work in the past, despite their centrality in children’s lives. Education welfare officers can act to facilitate this process. Thus, there are better procedures than before and also a greater awareness of abuse than used to be the case. Nevertheless, there are still very difficult issues for teachers in making referrals. With younger children in particular, there may be fears that parents with whom the school will in all likelihood continue to work following a referral, will become alienated. Older children who choose a teacher to divulge abuse to may feel that their confidences have been betrayed.

Individual teachers may have little ongoing contact with social workers and, therefore, be uncertain about trusting them to act appropriately. In these circumstances, it is obvious why it is of key importance to have a well-informed and trained link worker who maintains regular contact with social workers and other professionals. Good communication depends on trust and a sense of predictability about the way in which others will respond to information passed on.

There are, of course, many other professionals involved in safeguarding children – probation officers, housing officials, youth and community workers and social workers from a wide range of voluntary agencies and associations. Probation officers have a key role in respect of offenders with histories of violence and sex offences. Housing officials often hold important information passed on by other tenants. Youth workers and Connexions advisors work closely with adolescents and their advice and help is often sought as a result. Social workers in voluntary child care agencies. All these professional people need to have at least a working knowledge of the child protection system – the recent government publication on how cases should be referred on to key child protection personnel will no doubt help in this respect.

Disabilities:

No single consensus definition of disability exists that suits all governmental, regulatory, societal, and individual purposes [7]. Defining disability – specifically, identifying characteristics that qualify as disability – became important many centuries ago, as human communities coalesced and began helping members who could not subsist without that aid. Supporting small children, orphans, widows, and older people seemed obvious societal responsibilities, as did helping persons with severe disability. But here problems arose: as early as the Renaissance, European authorities dismissed some of their citizenry as lazy, angling to avoid work or malingering by faking disability. Differentiating meritorious persons with disability from undeserving slackers proved challenging until the nineteenth century, with the invention of new diagnostic tools. Through these putatively objective assessments, using new technologies such as stethoscopes, ophthalmoscopes, spirometers, and radiographs,



health care providers could distinguish persons with “real” disabling conditions from those feigning disability. The medical model of disability arose from this emerging medical authority, viewing “disability as a problem of the person, directly caused by disease, trauma or other health condition, which requires medical care ... Management of the disability is aimed at cure or the individual’s adjustment and behaviour change.” Obtaining medical care became the primary imperative, with people adapting on their own to loss and limitations.

Disabilities are heterogenous, so much so that grouping all disabling conditions together is almost meaningless. Some disabling conditions are present at birth and last a lifetime, such as cerebral palsy, spina bifida, and certain conditions related to chromosomal factors; the extent of impairments caused by these congenital conditions varies widely. Others occur suddenly, such as with serious injury or acute illness, and may resolve over time or persist until death. Yet other functional impairments progress gradually – perhaps with sporadic exacerbations – over years. Some conditions have stable or constant functional deficits across time, such as congenital blindness or deafness, and do not necessarily require medical intervention but would require communication accommodation. In contrast, other congenital conditions, such as intellectual disability and some developmental disabilities, may benefit from rehabilitation therapy, assistive technology, and other supportive services and have functional impairments that can progress over time.

Hospitals:

Pediatric patients not only receive care in many environments within a free-standing children’s hospital but also across a variety of non-children’s hospital settings [8]. These locations include pediatric wards within adult hospitals, community and academic centers, urgent care centers, and outpatient office settings. This range creates an inconsistency in provider experience that may be detrimental to patient care. There are more than nine million children seen in the emergency room each year for traumatic injuries, with more than 80% of them cared for in a non-children’s hospital setting.

Multidisciplinary training in the operating room requires a variety of providers with varying areas of expertise, situational awareness by team members, high-stake communication, and shared decision-making. Training to care for the pediatric trauma patient is no different. Traumatic injury remains the leading cause of pediatric mortality, and the teams entrusted with their care must meet a high standard of team dynamics. These teams may commonly involve members who do not commonly work together (i.e., surgeons, emergency room physicians, emergency room nurses, pediatric critical care physicians, anesthesiologists, respiratory therapists, radiology technicians, paramedics).

Environmental Health:

Traditionally a disease associated with aging, cancer is even more devastating when it strikes children [9]. The good news about childhood cancer is the increasing success in treatment. However, the very bad news is that childhood cancer rates appear to be increasing at a rate of 10% each year. Leukemia and tumors of the central nervous system combined account for approximately 50%. The list of possible causes of children's cancer includes genetic abnormalities, ultraviolet and ionizing radiation, electromagnetic

fields, viral infections, certain medications, food additives, tobacco, alcohol, and industrial and agricultural chemicals. Clearly, the environment is playing an important role.

Children are not just little adults. They are different organisms in many ways, particularly with regard to their exposures and responses to the environment. Their status as developing organisms, their heightened biological sensitivity, their diet, and their unique exploratory nature enhance their vulnerability to many toxic threats in their environments.

To review, toxicology is the study of the negative effect of a physical stressor (chemical, biological, or radioactive) on a biological system—a cell, tissue, organ, organ system, or organism. The key variables in determining the relationship between an exposure to a stressor and a health effect are (1) the “dose” of the exposure, (2) the duration of the exposure, (3) the toxicity or strength of the toxin, and (4) a variety of host factors (such as age, sex, weight, health status, other exposures). Environmental toxins can enter the human body via ingestion, inhalation, and dermal exposure. People may ingest toxic chemicals in their drinking water as well as in foods and other beverages. Air pollution toxins, both indoor and outdoor, are absorbed in the lungs, and some toxic exposures, such as solvents and some pesticides, can be absorbed through the skin.

In the twenty-first century, some of the biggest risks to children’s health are environmental [10]. As the risks of contracting a contagious disease have been reduced, though certainly not eliminated, more and more parents are, rightfully, concerned about harms from the environment, both known and unknown. Today American children are most at risk from heavy metals (lead, mercury, and arsenic), air pollutants (including, in addition to heavy metals, sulfur dioxide, and PAHs [polycyclic aromatic hydrocarbons]), and pesticides and other toxic chemicals (PCBs and endocrine disruptors like BPA). While historically all American children were exposed to lead through atmospheric exposure to emissions from leaded gasoline, today the children most at risk are poor, primarily African-American and Latino children living in cities, who, as a result of their poverty, are much more likely to live in rundown housing, where they are exposed to lead on a daily basis, with devastating physiological, cognitive, and behavioral consequences. The single most important action to improve the health of America’s children would be for the government to mandate, and fund where necessary, the total abatement of lead from all homes in the United States. This is an issue where prevention is both cost-effective and a moral imperative. We simply cannot continue to condemn generations of low income children, already at risk of poor health because of inadequate nutrition, lack of access to health care, the stress of living in poor neighborhoods, and a greater incidence of child abuse, to a lifetime of physical and intellectual impairments.

Children also confront other environmental hazards; here again, the poor are most at risk. This is because of three major factors. First, they often live close to sources of pollution—such as coal-burning power plants, municipal waste incinerators, and major urban highways. Second, their parents are more likely to work in industrial or agricultural settings where they are exposed to toxic chemicals, which they bring home on their skin and on their work clothes. If they live in rural areas, they may rely heavily on locally caught fish and wildlife, which are likely to have high levels of mercury and lead, respectively. Finally, their parents are least able to afford efforts to mitigate these harms, for example, by purchasing organic food to avoid pesticide residues or buying



nontoxic cleaning products. Indeed, the parents of poor children generally have difficulty affording nutritious and healthful food, which can help mitigate the harms of toxic exposures.

Therapy:

Therapists should always discuss the purpose of the therapy (e.g., to reduce the level of conflict between the child and her parents) and the methods that will be used in the sessions with the child (e.g., talking awhile, followed by playing a game together that the child will bring) [11]. Because a child cannot legally consent to treatment, the voluntariness of the therapy should be maximized by involving her as much as her age and understanding will permit in treatment planning and goal setting. Involving the child actively in treatment planning may also increase her motivation to participate in therapy, thereby reducing the likelihood of premature termination and increasing the effectiveness of treatment. Children who do not want to participate in therapy should not be coerced to do so by therapists. Unless there is a compelling need for treatment and the child's reasons for refusing to be treated are clearly irrational, therapists should point out to parents the futility of conducting therapy with an unwilling client. The limits of confidentiality, which will be discussed below, must also be described very carefully to the child, in a manner appropriate to her age and understanding.

In many states, there are special circumstances in which children do have a legal right to consent to treatment (e.g., if counseling is sought for physical and/or sexual abuse, substance abuse, pregnancy, sexually transmitted diseases, or contraception). These laws vary from state to state, so therapists need to become familiar with the relevant statutes in the state in which they practice. The issue of when adolescents become sufficiently mature to provide self-consent has been a matter of considerable controversy. No clear, empirically validated operationalization of "competence" in children's capacity to provide informed consent has yet been established. In some states, adolescents can legally self-consent for psychological treatment. Also, emancipated minors are generally regarded as adults in terms of their ability to provide informed consent.

Prevention:

Preventive measures in health care have been discussed as a means of avoiding disease or providing early detection for improvement in health with a concurrent minimization of health care expenditures [12]. Inherently, it initially makes sense that, if a disease can be detected early or prevented altogether, the cost of treating it can be reduced or eliminated and overall health care spending should decrease. Yet, this has not been borne out, and debate about potential savings and value of clinical preventive services has become more polarized. Some preventive services can reduce health care costs, but many do not, and others may actually increase health care costs over a lifetime. In a review of the cost-effectiveness of selected clinical preventive services, the evidence does not support the idea that global prevention reduces medical spending, and the vast majority of other clinical preventive services do not save money. In fact, overall costs to the health care system typically go up when disease-preventing strategies are put into practice.

Despite potential overall increased costs, some experts have suggested that clinical preventive services are still worthwhile

when they provide good value, defined as substantial health benefit per dollar spent net of any savings. Applying this concept, many preventive services are cost-effective, even when they do not reduce lifetime total cost. The National Commission on Prevention Priorities reviewed recommended preventive services known to improve health and found that 16 of them increased costs while only five services decreased cost. Only a limited number of services have since been shown to decrease costs and enhance life-years saved: childhood immunization series, smoking cessation advice and assistance, discussion of daily aspirin use to prevent cardiovascular disease, and breast and colorectal cancer screening. Today, research continues to evaluate not only the value of disease prevention and health promotion efforts but also the most effective manner of dissemination and adoption of recommendations. It has been shown that combining targeted campaigns to increase access to preventive services with more comprehensive community programs may yield even greater cost savings.

Conclusion:

In order for children to take care of their own health, it is necessary to teach individuals and groups of children how to recognize risks and adopt healthy lifestyles through good and proper communication, health education and counseling. They should also be encouraged to be independent, responsible and express their own opinions, while adults are obliged to create the necessary conditions to meet children's needs.

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