ONLINE FIRST

New American Children

Supporting the Health and Well-being of Immigrant Populations

Although the United States identifies as a nation built on the human and social capital of immigrants, our current national discourse is not reflective of the centrality of immigrants to our society. Legislation, such as *Arizona* SB 1070, not only misconstrues immigrants as a societal burden but also creates an environment that undermines opportunities for all immigrant families to gain traction and achieve well-being within the context of our society. Children in immigrant families (CIF), 88% of whom are US citizens, are defined as those children residing in a household with at least one foreign-born parent. Children in immigrant families are not only the fastest growing subset of the US population but also the most susceptible to the collateral effects of immigration policy. Because CIF will come to represent an ever-increasing share of our educational institutions and national workforce, it is of great importance that these children follow a trajectory of healthful growth and development. By gaining awareness of the unique characteristics of immigrant households and the readily modifiable disparities that place CIF at risk of poor adult outcomes, pediatricians may exert a profound impact on these children.

Largely driven by births in the Hispanic population, CIF will come to represent one-third of all US children and account for almost all the growth in our national workforce over the next 40 years.[1] Compounding the challenges associated with acculturation, children of immigrants are more likely to experience poverty than their native-born counterparts, with 27.8% of immigrant families below the federal poverty line, compared with 18.6% of native-born families.[2] The failure of our society to support the healthful development of CIF will encumber these children in achieving the social and economic mobility that is necessary for them to escape poverty. As the proportion of senior citizens in the United States climbs toward a historical peak (18.6%) in 2050, immigrant children will be aging into the workforce, where their payroll taxes will be essential to the continued financing of Medicare and Social Security.[1] The aging of the US population, compounded by the continued poverty of immigrant families, would result in higher national spending on means-tested programs, lower state and federal tax revenues, and a workforce unable to support a growing population of senior citizens.[3] It is no longer simply the moral imperative of our nation to support all children in becoming healthy, productive citizens, as our economic viability now hangs on this aim. With the advent of the Affordable Care Act, pediatricians will be the first, and perhaps only, professional institution to encounter these children in their early development, as they go on to change the face of our schools and workforce.

In the interest of supporting the healthful development of CIF, it is essential that pediatricians understand the unique characteristics that distinguish the immigrant household. Children in immigrant families are more likely to benefit from an intact family structure, with 74.7% residing in a two-parent household, as opposed to 68.2% of children in native-born families.[2] Despite the advantages of an intact family to childhood development, immigrant households tend to be among the least educated and poorest in our society. Compared with only 7% of their native-born counterparts, 27% of all foreign-born parents and 47% of parents of Mexican origin have completed less than their high school education.[4] Further, immigrant parents are much likelier to be limited English proficient and to head a linguistically isolated household than their native-born counterparts. More than 60% of all children of immigrants have at least one parent considered to be limited English proficient, and this rate jumps to 81% for children of Mexican origin.[4] Prior to the passage of the Affordable Care Act, CIF were among the least likely members of our society to have health insurance and sufficient access to the health care system.[3]

Their overall socioeconomic disadvantage notwithstanding, CIF have had better than expected outcomes across several indicators of health, compared with children of similar, and sometimes higher, social class. For example, low birth weight and infant mortality are 2 traditional measures of population health in which immigrant mothers have fared better than their native-born counterparts. The well-established concept of the "Immigrant Paradox" chronicles the deterioration of the health and socioeconomic outcomes of immigrant families with acculturation and time within the United States. Rather than allowing these healthful foundations to erode with time, it is important that pediatricians encourage immigrant families to build on their culturally based strengths, while guiding families toward resources that are essential to the healthful development of their children.

Although culturally based foundations have been protective of some aspects of health within immigrant households, the deleterious effects of low household income, limited

parental education, and language barriers place CIF at particular risk of developmental delay, failure to achieve school readiness, and poor academic performance.[5] Rather than dissipating with time, these early disparities in school preparedness have been found to persist and are highly predictive of adult outcomes.[6] Despite the substantial developmental advantages conferred by early childhood center-based programming, immigrant children, specifically those of Hispanic origin, participate at consistently lower rates than their native-born counterparts.[5] This disparity in access to center-based care presents an example of an easily modifiable determinant of childhood development and outcomes.

As the Affordable Care Act affords us unprecedented access to children in immigrant households, pediatricians will be able to meaningfully empower these families and their children through cognizance of the disparities that characterize the early childhood of immigrant children. The American Academy of Pediatrics' *Bright Futures* guidelines articulate the standards of care that pediatricians should apply in actively supporting families, as children seek to develop a sense of identity and self-esteem. Because these standards of care are already incorporated into the medical visit, they provide a practical stepping-stone toward defining the ways in which the pediatric encounter can best respond to the distinct needs of CIF. As the factors that influence the growth and development of children are particularly diverse for CIF, pediatricians have the unique opportunity to empower these children by supporting their process of acculturation in a manner that affirms the maintenance of protective cultural foundations and guides families toward much needed resources.

The benefit of increased access by immigrant families to the health care system will be mediated by the responsiveness of pediatricians to those cultural factors that are protective of health but may also paradoxically drive disparities in usage of needed resources. This cultural responsiveness must occur at both the level of the individual practitioner and the pediatric workforce as a whole. Although CIF represent approximately one-quarter of all children, and most of these children are of Hispanic descent, only roughly 5% of the physician workforce identifies as Hispanic. In employing ethnicity as a loose proxy for cultural and linguistic competence, our health care system must address the discordance between the US population and its health care providers.[7] Presently, the pediatric workforce may not be equipped to provide meaningful, efficient, and cost-effective care to the increase of diverse immigrant families entering our health care system.

Fernando S. Mendoza, MD, MPH
Natalia K. Festa, BA

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Author Affiliations: Division of General Pediatrics, Department of Pediatrics, Stanford University School of Medicine and Lucile Packard Children's Hospital, Palo Alto, California.
Correspondence: Dr Mendoza, MD, MPH, Department of Pediatrics, Stanford University School of Medicine, 770 Welch Rd, Ste 100, Palo Alto, CA 94304-1510.

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