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Families, child health and policy

The family is described as the most important social context in which health and illness occur. The family creates the environment where behaviors for health or risk-taking are developed including exercise, diet and substance use. Health has been described as a criterion for family life and as one of the primary purposes of the family.

The challenges to the health of urban children and families have existed throughout our history. Policy including political will is a major determinant of health, meaning individuals and families are unlikely to be able directly to control many of the determinants of health. For decades the political will at the state and national levels to support Detroit to address the health disparities of its citizens has been limited.

Health and urban children

Health conditions more prevalent in urban children living in poverty such as asthma, obesity, lead toxicity and mental health do not occur in isolation from the environment of the family and community. For example, poverty is related to the 16-fold difference in asthma hospitalizations across the U.S. The prevalence of obesity is higher in low-income communities related to the lack of access to affordable healthy food choices, environmental factors such as safety, lack of public transportation and inequality for funding school resources. The concentration of lead poisoning among low-income children is related to income inequality, poor housing, inadequate diet and poor education. Lead poisoning contributes to differences in educational achievement in the U.S. These factors all contribute to the opportunity gap described by Professor Putnam in *Our Kids: The American Dream in Crisis.*

Change agents to address inequity in the health of children and families.

There have been significant advances in knowledge of determinants of health and interventions for health. The characteristics of comprehensive family- and community-based programs to advance health are well described. What is lacking in Detroit and other cities has been the political and social will to implement and sustain these comprehensive programs. To generate the political and social will to address the health inequities in urban children and families across the lifespan, the policy message must be framed in the context that we cannot afford not to improve the environment for families and communities.

From an analysis of research of health intervention programs for urban children with conditions such as asthma and obesity, five characteristics are identified for changing and sustaining health behaviors and health outcomes for urban families. First, programs must be comprehensive and focus on the more inclusive construct of health promotion and on more than one health or risk behavior. Second, programs must start in early childhood and continue through the life span. Third, the interventions must be framed in the broader context of the community, which includes creating the political will for changing the social, education, safety and economic environments. Fourth, health research and programs must be conducted in the context of the family and build on the strengths of families. A fifth characteristic with significant policy implications is that when successful research interventions are scaled up to be integrated and sustained in public health programs, all components making the interventions successful must be translated into the ongoing programs, including professional and community resources used, duration, timing and frequency of the interventions.

To improve the health of urban children and their families, a comprehensive "health in all policies" approach must be implemented with inclusive strategies to address the individual, family, social and environmental factors that affect the child's health-related behaviors. A model is the primary health care provided by Federally Qualified Health Centers.

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