

PROJECT THRIVE



Linking Policies for Child Health,
Early Learning, and Family Support

www.nccp.org/thrive

thrive@nccp.org

Project THRIVE *Short Takes* highlight topics of interest and importance to state maternal and child health leaders and their partners building State Early Childhood Comprehensive Systems (ECCS). Each *Short Take* summarizes the issue, relevant research, and related resources.

Project THRIVE is a public policy analysis and education initiative for infants and young children at the National Center for Children in Poverty (NCCP) funded through a cooperative agreement with the Maternal and Child Health Bureau, Health Resources and Services Administration, of the U.S. Department of Health and Human Services.

The National Center for Children in Poverty (NCCP) uses research to inform policy and practice that promote the economic security, health, and well-being of America's low-income families and children.

SHORT TAKE NO. 4

Reducing Disparities Beginning in Early Childhood

The Issue

Research shows that many disparities in health and well-being are rooted in early childhood. These disparities reflect gaps in access to services, unequal treatment, adverse congenital health conditions, and exposures in the early years linked to elevated community and family risks.¹ Early health risks and conditions can have long-range implications for physical, emotional, and intellectual development as well as health. Their contribution to disparities in health status, disabilities, and educational achievement is well documented.² But many risks can be addressed in the early years, starting with quality prenatal care and interventions in the earliest stages of life. Thus, literally, reducing disparities begins with babies.

Risks for disparate outcomes disproportionately affect young children, low-income children, and minority children.³ Poverty brings risks for children of all races; however, racial/ethnic status is an independent risk factor.⁴ Young children are more likely than older children to live in families without economic security. Of the 10.2 million U.S. children ages birth through 5 years, 42 percent lived in low-income families (with income below twice the federal poverty level—FPL) and 20 percent lived in poor families (income below 100 percent of FPL) in 2005. (See Figure 1.) Minority young children also are overrepresented among the 2.2 million U.S. children ages birth through 5 who live in extremely poor families (income below 50 percent of FPL). The younger the child, the more harmful poverty is to developmental outcomes.⁵ Below we highlight patterns of disparities in both risks and outcomes, and access and treatment.

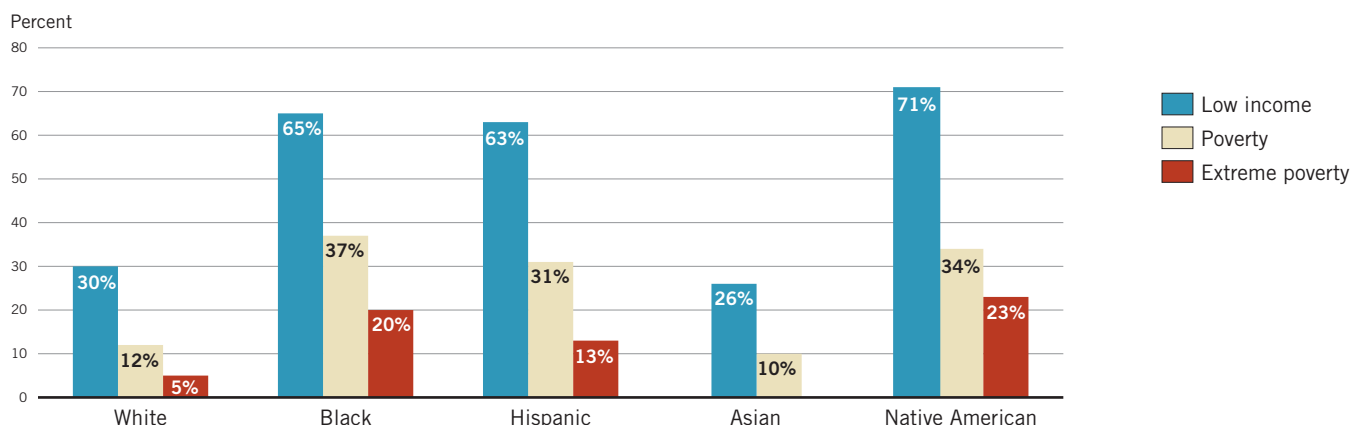
What Research Says About Disparities with Origins in Early Childhood

Disparate Risks and Outcomes in Early Childhood

Health

- **Low birthweight and preterm birth.** Being born at low birthweight or premature places a child at risk for poor development.⁶ In 2004, U.S. low-birthweight rates showed continuing racial/ethnic gaps: 7.1 percent for

Figure 1. Young children by race/ethnicity and income status, 2005



Note: These data come from two NCCP publications: Douglas-Hall, A.; Chau, M.; & Koball, H. (2006). *Basic facts about low-income children: Birth to age 3* <www.nccp.org/publications/show.php?id=679>, and *Basic facts about low-income children: Birth to age 6* <www.nccp.org/publications/pub_680.html> and from analysis of the U.S. Current Population Survey, Annual Social and Economic Supplement, March 2006. Estimates include children living in households with at least one parent and most children living apart from both parents (for example, children being raised by grandparents).

whites, 13.4 percent for African Americans, 7.5 percent for American Indian/Alaska Natives, 7.9 percent for Asian/Pacific Islanders, and 6.9 percent for Latinos.⁷

- **Oral health.** More than one-in-four (28 percent) preschool children have experienced tooth decay. Between 1994 and 2002, a 15.2 percent increase in disease was noted among the nation’s youngest children ages 2 through 5 years, representing an additional 600,000 preschool-age children affected.⁸
- **Obesity.** The trend in obesity among U.S. children is alarming, and low-income and minority children face excess risks.⁹ In 2004, 13.9 percent of 2- to 5-year-olds were obese or overweight, indicating a need for early intervention.¹⁰
- **Asthma.** Among poor and minority children, asthma care is more likely to be of lower quality and lack continuity.¹¹ Asthma prevalence, morbidity, and mortality are higher among African-American than white children.¹²

Social Emotional Development and Mental Health

- **Maternal depression.** Low-income and minority women are disproportionately likely to be affected by maternal depression, with rates reaching as high as 40 percent. The effects of maternal depression on children range from poor bonding to lower reading and language scores to higher incidences of later mental health issues and depression.¹³

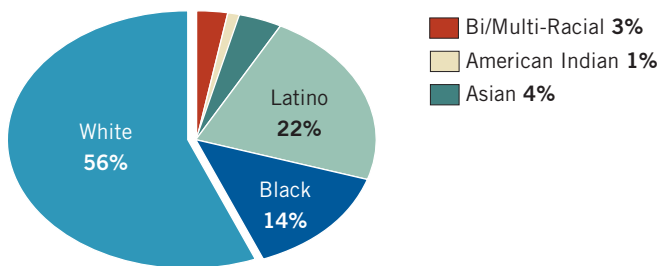
- **Mental health and social-emotional development.** Young children from low-income and minority households are at increased risk for mental health and developmental problems.¹⁴
- **Children with multiple risk factors.** National surveys indicate that about one-third of U.S. young children (3.1 million) have two or more risk factors for poor health and development. (These are typically indicated by characteristics such as race/ethnicity, maternal education, family poverty, and maternal mental health.) The likelihood of having either poorer health or higher developmental risk increases with each additional risk factor. One risk factor yielded nearly twice the risk, two risk factors over three times the risk, three risk factors nearly five times the risk, and four risk factors 14 times the risk for being in poor health or having a developmental delay.¹⁵
- **Children in the child welfare system.** Data from the National Survey of Child and Adolescent Well-Being indicate that both toddlers (41.8 percent) and preschoolers (68.1 percent) who had contact with the child welfare system had high developmental and behavioral needs; however, few children were receiving services for these issues (22.7 percent overall).¹⁶
- **Exposure to family violence.** In 2003, violent disagreements were most prevalent among black households (15.1 percent), followed by “other” (12.1 percent), Latino (11.3 percent), and white (8.6 percent)

households. While demographic and cultural factors may influence disagreement styles, parental stress seems most closely associated with and instrumental to the development of violent disagreements.¹⁷

Early Childhood Development and School Readiness

- **Parenting practices and home safety.** Data from the National Survey on Early Childhood Health shows disparities in safety measures and home routines in the reports of Latino and African-American parents. In addition, this national survey reveals significant differences in family routines and parenting practices associated with positive early childhood development.¹⁸
- **School readiness.** On average, minority children arrive at school with lower levels of school readiness than white children. Research indicates that these disparities can largely be attributed to income status.¹⁹ Discrimination by teachers and other educators also may contribute to racial/ethnic disparities in school readiness and academic achievement.²⁰

Figure 2. Young children by race/ethnicity, 2005



Source: Data prepared by the National Center for Children in Poverty, based on U.S. Census, Current Population Survey statistics.

Unequal Treatment and Inequitable Access to Services

- **Health coverage.** Health coverage has been shown to reduce disparities. Yet minority children remain less likely than their counterparts to have health coverage, public or private.²¹ Moreover, research has shown that there is no significant socioeconomic variation in the relationship between family structure and physician visits or usual source of care, once health insurance status is taken into account.²²

- **Use of health care by low-income immigrant families.** A study of families with babies enrolled in Medicaid in Washington State found that infants with parents whose primary language is not English were half as likely to receive recommended preventive care as infants whose parent's primary language is English. This disparity was persistent across groups of white, Latino, and African-American infants, but not in Asian-American infants.²³
- **Childhood immunization.** The immunization gap between minority and white infants and toddlers has narrowed, but rates among minority children remain lower.²⁴ Non-Latino black and American-Indian/Alaska-Native children had the lowest preschool immunization rates for each of the major vaccines in 2003-2004.²⁵
- **Routine source of health care and medical home.** Having a routine source of health care is one indicator of quality and continuity of services. National data indicate that poor children under age 5 are less likely to visit a doctor's office or health maintenance organization (HMO) for sick care than their more affluent counterparts (54.1 percent compared to 81.1 percent).²⁶
- **Satisfaction with health care services.** In the National Survey of Early Childhood Health (NSECH), parents of African-American and Latino children report higher rates of unmet need for early childhood development services in pediatric care. In addition, minority parents are less satisfied with their children's pediatricians. Latino parents were twice as likely as white parents to feel that their child's provider never or only sometimes understood their child's specific needs.²⁷
- **Guidance from and communication with pediatric health providers.** The NSECH data also reveal disparities in pediatric providers' patterns for discussing selected topics with parents. For example, in talking to minority families, pediatric providers were more likely to discuss community violence and household alcohol or drug use. Moreover, Latino and African-American parents averaged significantly fewer telephone calls to pediatric provider practices than whites (2.0, 3.1, and 4.3 average calls, respectively).²⁸
- **Care for children with special health care needs.** Nationally, African-American children are twice as likely to not be in excellent or very good health, compared with white children (79 percent versus 90 percent).²⁹ Yet health care providers are almost twice as likely not

to refer minority children to specialists, even after adjustment for insurance coverage, health status, and other relevant factors.³⁰ A study of managed care found a lower likelihood of specialty referrals and consultation for African-American children with special health care needs.³¹

Caveats About What Research Does Not Tell Us

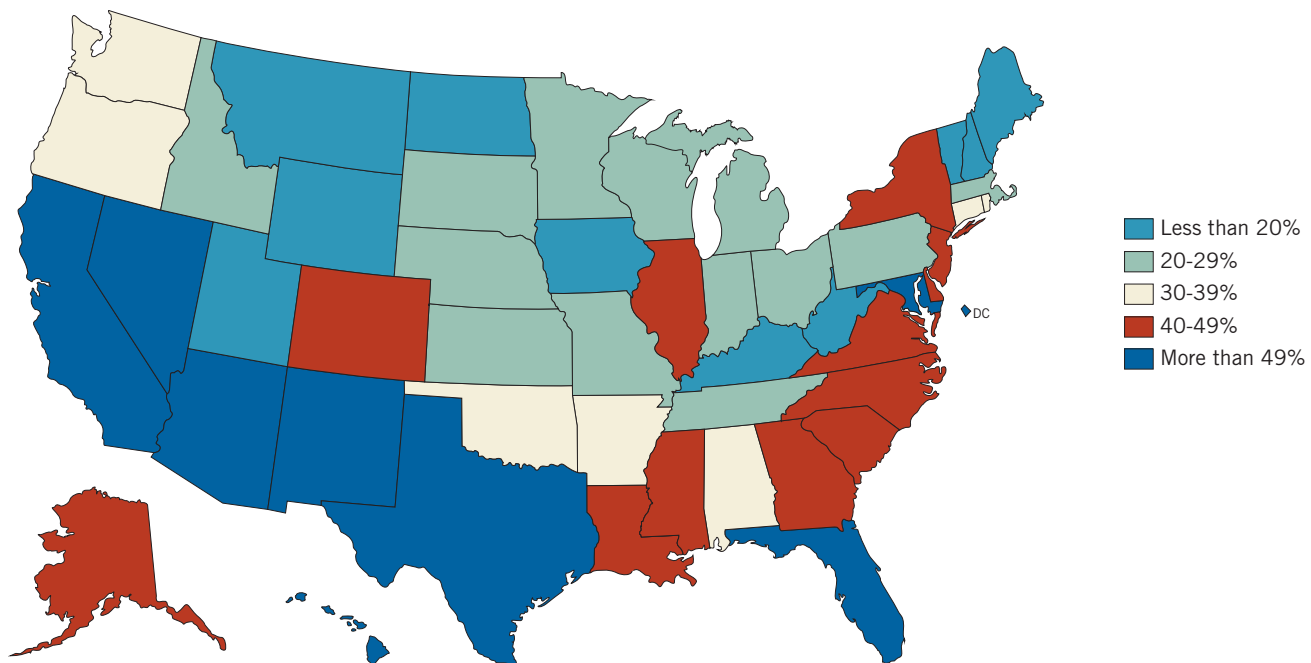
While we can document some disparities in early childhood health and development, substantial gaps exist in national datasets and research generally that limit our understanding of the full scope of racial/ethnic and income disparities.³² Too few data systems have traditionally measured racial/ethnic and income disparities. The challenge in documenting disparities is even greater when the focus is on children, and less still is known about how younger children experience racial/ethnic disparities in health care.³³

The Role of State Early Childhood Comprehensive Systems (ECCS) in Reducing Disparities

The state ECCS initiatives have strong potential to advance strategies for reducing disparities in early childhood and to have an impact across the life span. State ECCS initiatives can do this through their role in raising awareness, promoting intentional strategies to link services and systems, including health, mental health, early care and education, family support, and parenting education. Opportunities exist in each of these core system components.

The potential ECCS strategies listed below describe how ECCS initiatives can become informed, embed efforts in ECCS plans, improve the cultural competency of services, and promote community supports to reduce disparities.

Figure 3. Young children who are nonwhite, non-Hispanic, 2005



Source: Data prepared by the National Center for Children in Poverty, based on U.S. Current Population Survey, March Annual Social and Economic Supplement, 2004-2006.

Potential ECCS Strategies

Influence understanding of the issues

- Link early childhood systems development efforts to programs and projects aimed at undoing racism and eliminating poverty.
- Increase awareness of racial and ethnic disparities in early childhood health care among the general public and key stakeholders, including health and early care and education professionals who routinely serve young children.

Use data and monitoring to guide planning

- Analyze your state's data on disparate risks, access, and outcomes.
- Include measures of race/ethnicity in performance monitoring and indicator sets.
- Encourage your state Medicaid and SCHIP agencies to use data on race/ethnicity.³⁴
- Use small area analyses, geocoding, and similar approaches for measuring disparities.³⁵
- Conduct analyses to identify and measure unequal treatment.

Improve child and family services

- Adopt strategies to increase and monitor the cultural and linguistic competency of providers and services. This includes integrating cross-cultural and cultural/linguistic competency training into early childhood education and health workforce training.
- Assure that parent education materials are translated into relevant languages for local families, as well as support the use of translation and interpretation services where community need exists.
- Support the use of community (lay) health workers in a variety of early childhood service settings.
- Promote consistency and equity of care through the use of evidence-based guidelines for health care, early learning, family support, and other programs and services.

Improve community supports

- Support local early childhood systems development in communities with high concentrations of poor and

minority families. This might mean directing limited resources for local systems to communities at higher risk.

- Assist communities in assessing risks and strengths/assets.
- Focus on improving the quality of services available in low-income and minority communities.
- Offer incentives for community development projects aimed at reducing disparities—both racial/ethnic and income disparities.

Conclusion

Addressing disparate risks and conditions in early childhood health, care, and education is an important way to reduce disparities affecting low-income and minority adults, lower poverty rates, and improve overall health and education indicators. Addressing disparities early in life is also cost-effective; the long-term result of improving health and educational status is reduced health care costs and fewer years lost to disability or mortality. This work is not only socially and morally the right thing to do, but it will also yield human and fiscal dividends across the lifespan.

Children and families are affected by poverty and racism in complex, interconnected ways that can best be addressed by systemic strategies. It is difficult, if not impossible, to solve the problems caused by one factor without addressing the other associated factors. Creating effective job training and placement programs is limited if parents do not have access to quality child care for their children. Improving educational programs will not improve academic outcomes if children are hungry and suffering from food insecurity. Monitoring and measuring rates will not reduce disparities in outcome if unequal treatment is not addressed. Despite the complexity of the challenge, reducing the disparate risks and conditions of early childhood is the way to truly improve health outcomes for children and adults over the long term, and ECCS grantees can play a leadership role.

Endnotes

1. Smedley, B. D.; Stith, A. Y.; & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: Institute of Medicine, National Academies Press <www.nap.edu>.
- Lu, M. C. & Halfon, N. (2003). Racial and ethnic disparities in birth outcomes: A lifecourse perspective. *Maternal and Child Health Journal*, 7(1), pp. 13-30.
- Yeung, W. J.; Linver, M. R.; & Brooks-Gunn, J. (2002). How money matters for young children's development: Parental investment and family processes. *Child Development*, 73(6), pp. 1861-1879.
2. Newacheck, P. W.; Stein, R. E.; Bauman, L.; & Hung, Y. (2003). Disparities in the prevalence of disability between black and white children. *Archives of Pediatrics and Adolescent Medicine*, 157(3), pp. 244-248.
3. Douglas-Hall, A.; Chau, M.; & Koball, H. (2006). *Basic facts about low-income children: Birth to age 18*. New York, NY: National Center for Children in Poverty, Columbia University Mailman School of Public Health <www.nccp.org/pub_lic06b.html>.
4. House, J. S. & Williams, D. R. (2000). Understanding and reducing socioeconomic and racial/ethnic disparities in health. In B.D. Smedley & S. L. Syme (Eds.), *Promoting Health: Intervention Strategies from Social and Behavioral Research* (pp. 81-124). Washington, DC: National Academy Press.
5. See Douglas-Hall, Chau, & Koball in endnote 3.
6. Gortmaker, S. L. & Wise, P. H. (1997). The first injustice: Socioeconomic disparities, health services technology, and infant mortality. *Annual Review of Sociology*, 23, pp. 147-170.
7. U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2007). *Child health USA 2005*. Retrieved March 15, 2007 from <mchb.hrsa.gov/mchirc/chusa_05/index.htm>.
- U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. (2006). Births: Final data for 2004. *National Vital Statistics Reports*, 44(1). Retrieved on March 15, 2007 from <www.cdc.gov/nchs>.
8. Beltrán-Aguilar, E. D.; Barker, L. K.; Canto, M. T.; et al. (2005). Surveillance for dental caries, dental sealants, tooth retention, edentulism, and enamel fluorosis—United States, 1988-1994 and 1999-2002. *MMWR Surveillance Summaries*, 54(03), pp. 1-44. Retrieved on March 15, 2007 at <www.cdc.gov/MMWR/preview/mmwrhtml/ss5403a1.htm>.
9. Haas, J. S.; Lee, L. B.; Kaplan, C. P.; Sonneborn, D.; Phillips, K. A.; & Liang, S. (2003). The association of race, socioeconomic status, and health insurance status with the prevalence of overweight among children and adolescents. *American Journal of Public Health*, 93(12), pp. 2105-2110.
10. U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. (2006). *Prevalence of overweight among children and adolescents: United States, 2003-2004*. National Health and Nutrition Examination Survey (NHANES), 2004. Retrieved on March 15, 2007 at <www.cdc.gov/nchs/products/pubs/pubd/hestats/overweight/overwght_child_03.htm>.
11. Akinbami, L. J. & Schoendorf, K. C. (2002). Trends in childhood asthma: Prevalence, health care utilization, and mortality. *Pediatrics*, 110(2), pp.315-322.
12. McDaniel, M.; Paxson, C.; & Waldfogel, J. (2006). Racial disparities in childhood asthma in the United States: Evidence from the National Health Interview Survey, 1997 to 2003. *Pediatrics*, 117(5), pp. e868-e877.
13. Onunaku, N. (2005). *Improving maternal and infant mental health: Focus on maternal depression*. Los Angeles, CA: National Center for Infant and Early Childhood Health Policy, University of California at Los Angeles. <www.healthychild.ucla.edu/NationalCenter/default.asp>.
- Isaacs, M. R. (2006). *Maternal depression: The silent epidemic in poor communities* (Issue Brief No. 1). Unpublished draft, used with permission.
14. Shonkoff, J. P. & Phillips, D. A. (Eds.) & Committee on Integrating the Science of Early Childhood Development, Board on Children, Youth, and Families, Institute of Medicine. (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press <www.nap.edu/books/0309069882/html>.
15. Stevens, G. D. (2006). Gradients in the health status and developmental risks of young children: The combined influences of multiple social risk factors. *Maternal and Child Health Journal*, 10, pp. 187-99.
16. Stahmer, A. C.; Leslie, L. K.; Hurlburt, M.; Barth, R. P.; Webb, M. B.; Landsverk, J.; & Zhang, J. (2005). Developmental and behavioral needs and service use for young children in child welfare. *Pediatrics*, 116, pp. 891-900.
17. Moore, C. G.; Probst, J. C.; Tompkins, M.; Cuffe, S.; Martin, A. B. (2007). The prevalence of violent disagreements in US families: Effects of residence, race/ethnicity, and parental stress. *Pediatrics*, 119 (Suppl. 1), pp. S68-76.
18. Flores, G.; Tomany-Korman, S. C.; & Olson, L. (2005). Does disadvantage start at home? Racial and ethnic disparities in health-related early childhood home routines and safety practices. *Archives of Pediatric Adolescence*, 159, pp. 158-165.
19. Farkas, G. (2003). Racial disparities and discrimination in education: What do we know, how do we know it, and what do we need to know? *Teachers College Record*, 105(6), pp. 1119-1146.
- Votruba-Drzal, E. (2006). Economic disparities in middle childhood development: Does income matter? *Developmental Psychology*, 42(6), pp. 1154-1167.

20. Shonkoff, J. P. (2007). *The science of early childhood development: Closing the gap between what we know and what we do*. Paper presented at the joint meeting convened by the federal Head Start, Child Care, and the Maternal and Child Health Bureaus, January 18, Washington, DC.
21. Shone, L. P.; Dick, A. W.; Klein, J. D.; Zwanziger, J.; & Szilagyi, P. G. (2005). Reduction in racial and ethnic disparities after enrollment in the state children's health insurance program. *Pediatrics*, *115*(6), pp. e697-e705.
- Stevens, G. D.; Seid, M.; Mistry, R.; & Halfon, N. (2006). Disparities in primary care for vulnerable children: The influence of multiple risk factors. *Health Services Research*, *41*(2), pp. 507-531.
- Holahan, J.; Cook, A.; & Dubay, L. (2006). *Characteristics of the uninsured: Who is eligible for public coverage and who needs help affording coverage?* (Kaiser Commission on the Uninsured Issue Brief). Washington, DC: Kaiser Commission on Medicaid and the Uninsured and the Kaiser Family Foundation. Retrieved June 29, 2007 from: <www.kff.org/uninsured/upload/7613.pdf>.
22. Heck, K. E. & Parker, J. D. (2002). Family structure, socioeconomic status, and access to health care for children. *Health Services Research*, *37*(1), pp. 173-186.
23. Cohen, A. L. & Christakis, D. A. (2006). Primary language of parent is associated with disparities in pediatric preventive care. *Journal of Pediatrics*, *148*(2), pp. 254-8.
24. Barker, L. E.; Chu, S. Y.; Shaw, K. M.; & Santoli, J. M. (2006). Disparities between white and African-American children in immunization coverage. *Journal of the National Medical Association*, *98*(2), pp. 130-135.
25. See U.S. Department of Health and Human Services in endnote 7 and Holahan, Cook, & Dubay, in endnote 21.
26. See U.S. Department of Health and Human Services in endnote 7.
27. See Flores, Tomany-Korman, & Olson in endnote 18.
28. Ibid.
29. See U.S. Department of Health and Human Services in endnote 7.
30. See Flores, Tomany-Korman, & Olson in endnote 18.
31. Shenkman, E.; Wu, S. S.; Nackashi, J.; & Sherman, J. (2003). Managed care organizational characteristics and health care use among children with special health care needs. *Health Services Research*, *38*(6p1), pp. 1599-1624.
32. Krieger, N.; Chen, J. T.; Waterman, P. D.; Rehkopf, D. H.; & Subramanian, S. V. (2005). Painting a truer picture of US socioeconomic and racial/ethnic health inequalities: The public health disparities geocoding project. *American Journal of Public Health*, *95*, pp. 312-323.
33. See Flores, Tomany-Korman, & Olson in endnote 18.
34. Llanos, K. & Palmer, L. (2006). *Using data on race and ethnicity to improve health care quality for Medicaid beneficiaries* (Issue Brief). Hamilton, NJ: Center for Health Care Strategies, Inc. Retrieved on March 15, 2007 from: <www.chcs.org/usr_doc/Using_Date_to_Reduce_Health_Disparities.pdf>.
- Martin, C. (2007). *Reducing racial and ethnic disparities: A quality improvement initiative in Medicaid managed care toolkit*. Hamilton, NJ: Center for Health Care Strategies, Inc. Retrieved on March 15 from: <www.chcs.org/usr_doc/Racial_&_Ethnic_Health_Disparities.pdf>.
35. See Krieger et al., in endnote 32.
- See also Krieger, N.; Chen, J. T.; Waterman, P. D.; Soobader, M. J.; Subramanian, S.V.; & Carson, R. (2003). Choosing area-based socioeconomic measures to monitor social inequalities in low birthweight and childhood lead poisoning: The public health disparities geocoding project (US). *Journal of Epidemiology and Community Health*, *57*(3), pp. 186-99.

