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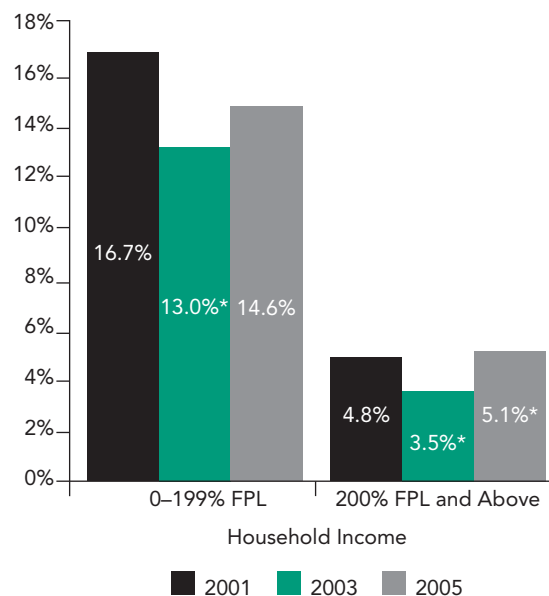
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Trends in the Health of Young Children in California

David Grant and Samantha Kurosky

When it comes to school readiness, children's health matters. Healthy children are better prepared to learn, concentrate and develop the skills needed to succeed in school—and throughout life. Although good health supports learning among children of all ages, it is particularly important during early childhood when a crucial period of rapid physical and emotional growth occurs between birth and age five. Therefore, providing children early on with an environment conducive to healthy development and learning lays the foundation for a successful future.

Exhibit 1
Uninsured All or Part of the Past 12 Months by Income, Children Ages 0-5, California 2001, 2003 and 2005



* Difference between year and previous year is significant at $p < 0.05$.

Source: 2001, 2003 and 2005 California Health Interview Surveys

Not all children, however, have this opportunity. Research shows children living in poverty, with poor health status or low-quality childcare, are more likely to have developmental and learning delays.¹ Many of California's three million children ages 0-5 grow up in environments where their health may limit their social, emotional and academic development.

This brief examines trends in key health indicators for children ages 0-5 in California between 2001 and 2005, based on data from the California Health Interview Survey (CHIS). Conducted every other year since 2001, CHIS is a statewide survey that provides information on health conditions, health behaviors, access to health care, and use of services among children, adolescents and adults in California. Examining CHIS data from multiple survey years provides valuable information on California's progress toward better health and school readiness for young children.



First 5 California funded the research and development of this policy brief.

Gaps in Health Insurance Coverage Greatest Among Low-Income and Latino Children

In 2001, one in 10 children ages 0-5 in California lacked health insurance for all or part of the previous year. This proportion declined significantly in 2003, but remained statistically unchanged relative to 2005. Among those with gaps in coverage, more than two-thirds were from low-income families (below 200% of the federal poverty level; Exhibit 1). The increased enrollment of low-income children in public insurance programs countered a potential increase in uninsured rates.^{2,3}

Disparities in coverage exist among racial and ethnic groups. While white and Asian children have the fewest gaps in health coverage (5.4% and 5.3% respectively in 2005), Latino children consistently have the most.⁴ In 2001 and 2005, the percent of Latino children who were uninsured for all or part of the previous year, 16% and 15% respectively, was approximately three times that of any other racial or ethnic group. Significantly lower rates of employment-based

coverage among Latinos compared to other groups accounts for much of this difference.

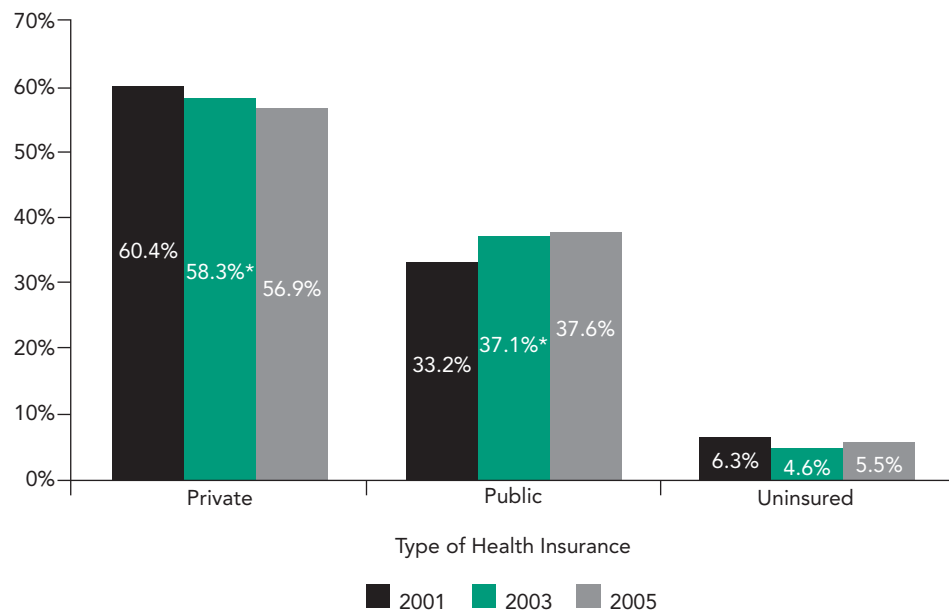
Many parents whose children are uninsured are unaware of the public health coverage available to them. To address this issue, First 5 California's Health Access for All Children Initiative helps to connect parents to available public health insurance programs. The initiative sponsors county-level education, outreach, and assistance to enroll children in Medi-Cal, Healthy Families, and Healthy Kids through a coalition of Children's Health Initiative participating counties.

Shrinking Private Health Insurance Coverage, Increase in Use of Public Programs

Although the majority of young children in California continue to rely on private health insurance coverage (employment-based or privately-purchased health plans), the proportion is decreasing. This decline has been offset by an increase in public coverage (Medi-Cal or Healthy Families). Between 2001 and 2005, the percent of children ages 0-5 covered by private health insurance decreased three percentage points, while public coverage

Exhibit 2

Type of Health Insurance Coverage, Children Ages 0-5, California 2001, 2003 and 2005

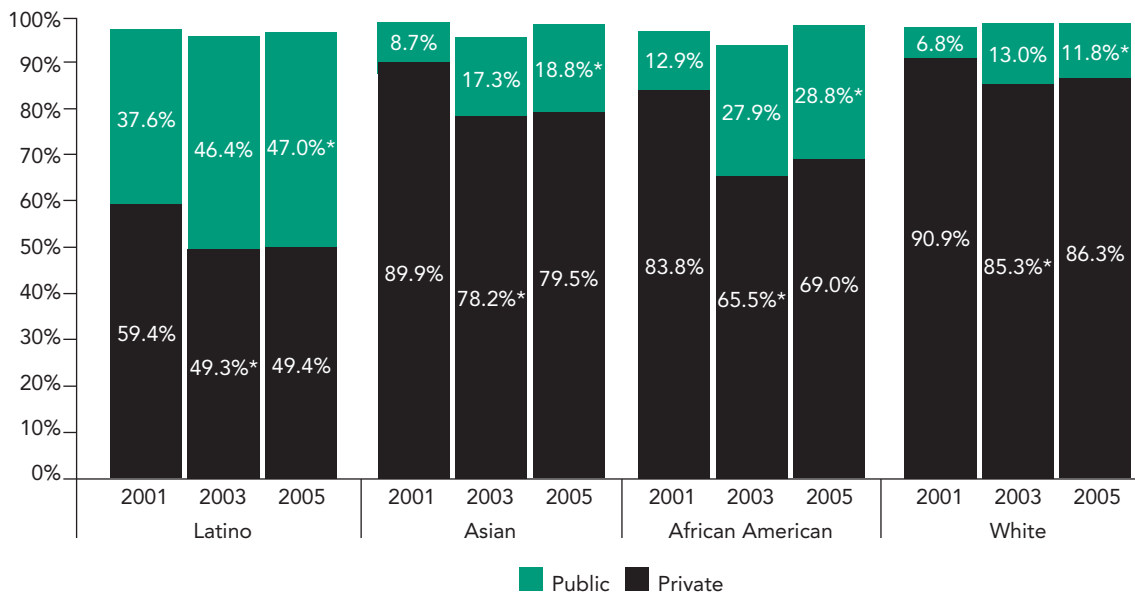


* Difference between year and previous year is significant at $p < 0.05$.

Source: 2001, 2003 and 2005 California Health Interview Surveys

Type of Usual Source of Care by Race or Ethnicity, Children Ages 0-5, California 2001, 2003 and 2005

Exhibit 3



* Difference between year and previous year is significant at $p < 0.05$.

Note: Children with other or no usual source of care are not shown.

Source: 2001, 2003 and 2005 California Health Interview Surveys

increased nearly five percentage points (Exhibit 2). This trend has kept the overall health insurance rate for children relatively unchanged between 2001 and 2005.

Due to the high cost of insurance premiums for families—and fluctuating unemployment rates—many parents find it more difficult to insure their children through employers or privately-purchased plans.^{5,6} Additionally, the percentage of employers offering health benefits to their employees dropped nine percentage points between 2001 and 2005, reducing access to employment-based insurance.⁷

More Children Rely on Community Clinics As Their Usual Source of Care

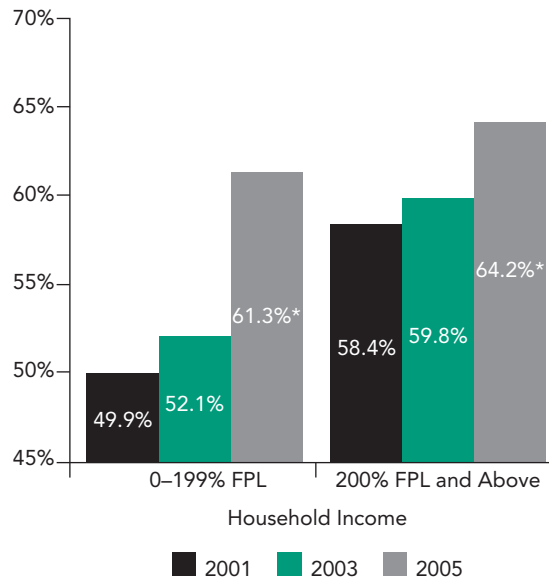
In 2005, nearly all children ages 0-5 in California (97%) had a usual source of care—a regular place to go to for health services and medical care. Although this proportion has stayed consistent since 2001, there was a significant shift in the type of place usually visited. Between 2001 and 2005, the percent of children attending a private doctor's office as their usual source of care decreased almost

nine percentage points, while those attending a public clinic or hospital as their usual source of care increased nearly nine percentage points.

Differences in the number of children using a physician's office as a primary source of care exist among income, racial and ethnic groups. Children from higher-income families are more likely to receive care at a private physician's office, while lower-income children are more likely to attend a community clinic. These differences are attributed to the high cost of care, insurance status and availability of services in different communities.⁸ White children consistently have the highest proportion of those attending a private doctor's office for their usual source of care, while Latino children have the lowest. Latino children consistently report the highest usage of community clinics followed by African Americans, Asians and whites. Between 2001 and 2005, all racial and ethnic groups showed a significant decrease (5-15%) in use of a doctor's office as a usual source of care and an increase (5-17%) in use of community clinics as a usual source of care (Exhibit 3).

Exhibit 4

Visited A Dentist Within the Past 12 Months by Household Income, Children Ages 2-5 and One Year Olds with Teeth, California 2001, 2003 and 2005



* Difference between year and previous year is significant at $p < 0.05$.

Source: 2001, 2003 and 2005 California Health Interview Surveys

This shift from private doctors' offices as a usual source of care to community clinics is consistent with health insurance trends moving from private to public coverage. These trends indicate that not only are cost and service burdens shifting from the private to the public sector, but primary care may be disrupted as well.

Increase in Dental Visits

Tooth decay—the most prevalent health problem among young children—can lead to pain, infection, impaired speech, premature loss of teeth and weight loss. Each year, over 5.1 million school hours are lost due to dental problems, making it the main reason for missing school.⁹ Fortunately, tooth decay is preventable and treatable through regular dental visits and practicing good oral hygiene. The American Academy of Pediatric Dentistry recommends children visit a dentist shortly after getting their first tooth and no later than their first birthday.

Between 2001 and 2005, dental visits within the past year increased (55% to 63%) among one year olds with teeth and children ages 2-5. This positive trend holds among all income, racial and ethnic groups. California has made great strides in increasing access to dental care for low-income children who face difficulties accessing preventative care.¹⁰ In 2001, half of low-income children ages 2-5 visited the dentist in the past year compared to 58% of their higher-income peers (Exhibit 4). This difference narrowed from 8% to 3% by 2005 when 61% of low-income children visited the dentist within the past year compared to 64% of higher-income children.

To increase dental visits among young children, First 5 California invested \$10 million in the Early Childhood Oral Health Initiative. This initiative increases access and use of dental care by connecting children and their families with dental professionals. This initiative also funds training programs for parents and health care professionals to improve oral health among young children.

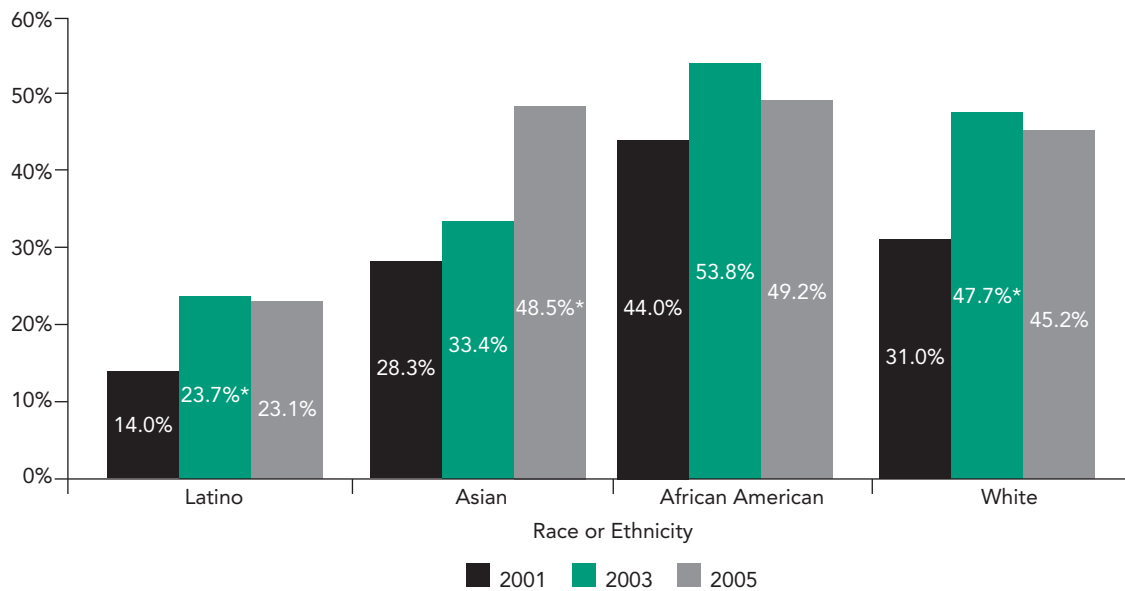
Preschool Enrollment Increasing

Childcare plays an important role in the early development and socialization of young children. Some types of childcare, such as preschool and Head Start programs, have been shown to prepare children socially and academically for school. In California, the percent of three and four year olds attending preschool or Head Start has increased since 2001. In 2001, 25% attended preschool or Head Start programs at least 10 hours a week. By 2003, this proportion increased to 37% and stayed constant through 2005. Although this increase means over 300,000 more children received preschool education, three out of five children ages three and four were not enrolled in preschool in 2005.

Preschool enrollment is lowest among low-income children. In 2001, 14% of low-income three and four year olds were enrolled in preschool or Head Start at least

Attends at Least 10 Hours of Preschool A Week by Race or Ethnicity, Children Ages 3-4, California 2001, 2003 and 2005

Exhibit 5



* Difference between year and previous year is significant at $p < 0.05$.

Source: 2001, 2003 and 2005 California Health Interview Surveys

10 hours a week compared to 34% among their higher income peers. In 2005, enrollment increased among both income groups; however, the proportion of low-income children (21%) was half that of higher income children (48%).

Enrollment in preschool or Head Start programs has increased among all racial and ethnic groups; however, the proportion of enrollment within each group varies (Exhibit 5). African-American children consistently had the highest enrollment in preschool between 2001 and 2005, peaking at 54% in 2003. Latino children had the lowest preschool enrollment between 2001 (14%) and 2005 (23%), although it is increasing. Asian children experienced a significant increase in preschool enrollment between 2003 and 2005 (16%) while proportions within other groups remained static.

Access to quality preschool is a top priority of First 5 California. Together with 58 county commissions, First 5 has invested nearly one billion dollars in preschool

programs. The goal of First 5-sponsored preschool efforts is to increase the number of available spaces for children in high-quality preschool programs, as well as improve health and developmental assessments, curriculum and nutrition in existing preschools.

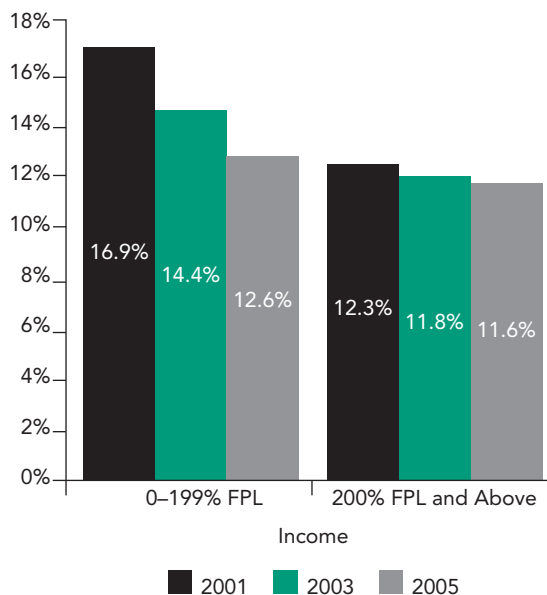
Steady Decline in Childhood Overweight

An “overweight” child is one whose weight is above the 95th percentile on national growth charts after adjusting for age and gender.¹¹ These children are at an increased risk of developing asthma, diabetes and sleep apnea, as well as heart disease, hypertension, cancer and stroke if weight problems persist into adulthood.^{12,13} The prevalence of overweight children is increasing nationwide, nearly tripling among children ages 2-5 during the past three decades (5% in 1980 to 14% in 2004).¹⁴

Despite the national trend, the prevalence of overweight children ages 0-5 has dropped slightly in California from 14% in 2001 to 12% in 2005. Disparities in overweight

Exhibit 6

Percent Reporting Overweight by Income, Children Ages 0-5, California 2001, 2003 and 2005



Note: "Overweight" refers to children whose weight is above the 95th percentile on national growth charts for their age and gender.

Source: 2001, 2003 and 2005 California Health Interview Surveys

children decreased along the dimensions of income, race and ethnicity. Lower-income children were more likely to be overweight compared to higher-income children in 2001 (17% and 12% respectively); by 2005 this difference decreased to 1% (Exhibit 6). African-American and Latino children ages 0-5 have the highest prevalence of being overweight. Between 2001 and 2005, the percentage of Latino children who were overweight decreased significantly from 18% to 14% respectively. The prevalence of overweight African-American children, 15% in 2005, was statistically unchanged during that time.

Through a public education and outreach campaign, First 5 California has been addressing childhood obesity in young children. The campaign included English- and Spanish-language television, radio, print and billboard advertisements; nutrition and

fitness programs; and community outreach aimed at informing parents of young children about healthy eating and exercise. Through its School Readiness programs, First 5 California has partnered with local organizations in high-risk areas to educate parents about healthy food choices and increasing their children's physical activity.

Discussion and Recommendations

Positive trends in oral health, early education, access to health care, and decreasing overweight among young children in California show promise and progress, but the gaps remaining suggest that a lot of work needs to be done. The increasing cost of health insurance, economic difficulties, and language and cultural barriers are contributing to adverse health consequences and delayed care among California's most vulnerable populations. In particular, low-income and Latino children face multiple obstacles and consequently bear a disproportionate burden of health problems. To improve the wellbeing of all children, state and local leaders, policymakers, health professionals and community organizations must collaborate to develop strategies to address these barriers. Actions should include policies and programs designed to enhance early education, improve medical and dental care, increase health insurance enrollment, educate parents on childhood health issues and prevention, promote healthy diets and physical activity, and eliminate health disparities. Recommendations include:

- **Continue expansion of early education opportunities.** High-quality preschool is a pathway to future success. It provides children with skills that support learning and social development. However, the majority of three and four year old children in California are not attending preschool, with the lowest rates of enrollment among low-income children. Expanding access to affordable preschool programs, retaining qualified teachers, and including school readiness activities in curricula will help the benefits of preschool reach more children.

- **Prioritize oral health.** California has made significant progress in oral health by increasing timely dental visits among children across all income, racial and ethnic categories. However, almost two in five children have not been to a dentist in the past year indicating a continued effort to connect children with dental care is needed.
- **Increase access to quality health care.** The burden of health coverage is shifting from private to public insurance programs, resulting in an increase in community clinic use for primary care. Although the recent expansion of public health coverage has helped many children obtain the care they need, waning State and Federal support puts future care in jeopardy. Reforming California's health care system to guarantee coverage of all children is essential for ensuring access to, and utilization of, quality health care services.
- **Invest in community clinics.** Low-income children have poorer overall health status and utilize community clinics for primary care at three times the rate of higher-income children. Ensuring that public health care settings have adequate prevention and medical care programs can improve the health of the most vulnerable children. With an increasing number of children relying on public health clinics for primary care, it is important to strengthen community clinics so they have adequate staff, training, supplies and services to meet demand.
- **Promote healthy food choices and physical activity.** The prevalence of overweight is decreasing among young children. To continue this progress, outreach efforts should focus on educating parents about strategies to improve their child's diet and physical activity through increasing fruit and vegetable intake, decreasing soda consumption, encouraging regular physical activity, and limiting television viewing. Adopting a comprehensive food policy with nutritional

standards in childcare settings can also help promote healthy food choices and eating behaviors.

- **Community outreach and education.** Parents continue to play the most important role in the health outcomes of their children. By increasing parents' knowledge and awareness of childhood health issues, they will be better equipped to recognize and prevent health problems affecting their child. Intervention programs should incorporate outreach and health education strategies aimed at teaching parents about good nutrition, how to increase physical activity, improving oral health, health insurance options and preschool enrollment.

Data Source

2001, 2003 and 2005 California Health Interview Surveys (CHIS 2001, CHIS 2003 and CHIS 2005), and Child Public Use Files [computer files]. Los Angeles, CA: UCLA Center for Health Policy Research, January 2007.

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Notes

- 1 Loeb S, Fuller B, Kagan SL and Carrol B. Childcare in Poor Communities: Early Learning Effects of Type, Quality and Stability. *Child Development*, 2004, 71(1), 47-65.
- 2 Brown ER, Lavarreda SA, Rice T, Kincheloe JR and Gatchell MS. *The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey*. Los Angeles, CA: UCLA Center for Health Policy Research, 2005.
- 3 Brown ER, Lavarreda SA, Ponce N, Yoon J, Cummings J and Rice T. *The State of Health Insurance in California: Findings from the 2005 California Health Interview Survey*. Los Angeles, CA: UCLA Center for Health Policy Research, 2007.
- 4 Estimates for African Americans are unstable due to small sample size and therefore not reported.
- 5 Brown ER, Lavarreda SA, Rice T, Kincheloe JR and Gatchell MS. *The State of Health Insurance in California: Findings from the 2003 California Health Interview Survey*. Los Angeles, CA: UCLA Center for Health Policy Research, 2005.
- 6 Brown ER, Lavarreda SA, Ponce N, Yoon J, Cummings J and Rice T. *The State of Health Insurance in California: Findings from the 2005 California Health Interview Survey*. Los Angeles, CA: UCLA Center for Health Policy Research, 2007.
- 7 Kaiser Family Foundation and Health Research Educational Trust (2005). *Employer Health Benefits. 2005 Annual Survey*. Menlo Park, CA: Henry J. Kaiser Family Foundation.
- 8 Inkelas M, Halfon N, Uyeda K, Stevens G, Wright J, Holtby S and Brown ER. *The Health of Young Children in California: Findings from the 2001 California Health Interview Survey*, Los Angeles and Sacramento, CA: UCLA Center for Health Policy Research and First 5 California, July 2003.
- 9 U.S. Department of Health and Human Services, Office of the Surgeon General. (2000). *Children's Oral Health*. Retrieved April 11, 2008, from http://www.cdc.gov/OralHealth/publications/factsheets/sgr2000_fs3.htm
- 10 Watson RW, Manski RJ and Macek MD. The impact of income on children's and adolescents' preventative dental visits. *The Journal of the American Dental Association*, 2001, 132(11), 1580-1587.
- 11 Most studies use the Body Mass Index (BMI) as the measure of childhood overweight; therefore, it is not directly comparable to rates in this report. BMI is a useful measure for determining overweight among young children because it takes into account both weight and height/length. It is problematic, however, when data is collected from parental reports rather than a direct physical measurement. Therefore, CHIS uses "overweight for age" to determine childhood overweight.
- 12 Centers for Disease Control and Prevention. (2007). *Overweight and Obesity*. Retrieved April 11, 2008, from <http://www.cdc.gov/nccdphp/dnpa/obesity/childhood/prevalence.htm>
- 13 Serdula MK, Ivery D, Coates RJ, Freedman DS, Williamson DF and Byers T. Do Obese Children Become Obese Adults? A Review of the Literature. *Preventative Medicine*, 1993, 22, 167-177.
- 14 Centers for Disease Control and Prevention. (2007). *Overweight and Obesity*. Retrieved April 11, 2008, from <http://www.cdc.gov/nccdphp/dnpa/obesity/childhood/prevalence.htm>