Policy Brief

Addressing Health And Educational Disparities in Young Children

Traci Sawyers, September/October 2014

THE PROBLEM

Despite many years of national efforts by the federal government to eliminate disparities in both health and educational achievement, they continue for young children in the United States who are marginalized or discriminated against because of race, class, ethnicity or culture. These disparities are a major barrier to improving the health and well-being of the nation's young children. [1]

Childhood is a time of significant physical, cognitive, social and emotional development. In particular, pregnancy and early childhood are critical periods of opportunity or vulnerability that can have lasting impacts.[2] Similarly, there is significant evidence that gaps in educational achievement emerge long before kindergarten.[3] That is true for cognitive skills related to math and reading, and for social and emotional skills like being able to pay attention and control emotions. Both healthy development and educational success are well recognized as powerful predictors of health and productivity in adulthood. In addition, reducing health and educational disparities is about equity for children and their fundamental right to grow up healthy, happy and to thrive. [4]

BACKGROUND

When it comes to health and educational disparities among young children in the United States, poverty is almost always mentioned hand-in-hand with race and ethnicity. The National Institutes of Health defines health disparities as "differences in the incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist among specific population groups in the United States."[5] In the field of education, "achievement gap" refers to the disparity in academic performance between groups of students – specifically racial and ethic minorities and those from low-income families. [6]

Not all differences in children are considered disparities. The term disparity is used to identify unjust or unfair differences that are potentially avoidable.[7] Disparities based on race and ethnicity are believed to be the result of factors such as racism, unequal access to health care, and a lack of culturally and linguistically appropriate health services.[8] At the same time, the poor are routinely targets of discrimination, and frequently viewed as a nuisance and financial burden. Racial, ethnic and socioeconomic discrimination often involves patronizing attitudes, social exclusion, demeaning

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verbal and non-verbal behaviors, hostility, lowered expectations and blame.[9]

With regard to health disparities, children in marginalized groups have higher rates of mortality and disability and are more likely in poor health compared to their white and more affluent counterparts.[10] Asthma and obesity are two conditions which disproportionally affect children in marginalized groups because of their likelihood to live in substandard housing, be exposed to poor air quality, have limited access to physical activity, healthy food and more.[11]

Early childhood is the period when the most brain development occurs. Therefore, what happens during the earliest years has lifelong implications on school success and beyond, as well as on mental and physical heath.[12] Even small disparities in these early years can have long-lasting impacts on children's growth and development.[13] Research has also found that poverty occurring early in a child's life (age two to four) is associated with significant and negative effects on health and school readiness outcomes.[14] In addition, poor health in childhood leads to chronic adult illnesses and poor health such as obesity, diabetes, cardiovascular disease, early death and more. [15]

Ethnic, racial and socioeconomic educational disparities mirror health disparities in that they follow a pattern in which children in marginalized groups underperform academically compared to their white counterparts or those from more affluent families.[16] In the years since the 1954 *Brown* vs. *Board of Education of Topeka* ruling, the national gap in average test scores between white and black children is still significant but has narrowed.[17] However, the achievement gap between children from the highest- and lowest-income families has increased and is now twice the size of the black-white achievement gap. [18]

Educational disparities that exist in early childhood continue throughout K-12 education and are reflected in reading and math test scores, the number of students repeating grades, the number of students being suspended and expelled from school, dropout rates, graduation rates and enrollment in college.[19]

Research has found the achievement gap begins well before a child enters kindergarten.[20] A recent report from the Annie E. Casey Foundation called "Race for Results," examined 12 indicators that measure racial variations in areas such as health, education and family environment. The report found "children ages 3 to 5 enrolled in nursery school, preschool or kindergarten" was a key variable linked to success. Research continues to suggest that increasing both the participation in and the quality of early childhood educational experiences can increase school readiness, especially for this population. However, access to high quality care and education remains elusive for many children in marginalized groups.[21]

Educational and health disparities are intertwined in early childhood and impact future health and well-being. Research shows that children learn best when they are physically and emotionally healthy.[22] Conversely, children who have health problems have a hard time focusing and often miss school and fall behind.[23] The lack of academic achievement also impacts health by limiting future employment opportunities and therefore perpetuating poverty. It is associated with risky health behaviors in adolescence and adulthood, such as smoking, lack of exercise, poor diet, teenage pregnancy and involvement in crime.[24]

Therefore, education and health disparities must be addressed together and at the earliest possible time in a child's life.

WHAT IS BEING DONE

In 2012, 123,951 children lived in Vermont and 09.4 percent were children of color: 90.6 percent were white; 3.3 percent were two or more races; 2.3 percent were Hispanic; 0.3 percent were American Indian/Alaska Native; 1.7 percent were Black; and 1.7 percent were Asian.[25] Since 1989, at least 6,645 men, women and children have come to Vermont through a federal refugee resettlement program.[26] That 25-year total includes Bosnians and Vietnamese who arrived in the 1990s or early 2000's; Bhutanese, many from refugee camps in eastern Nepal who arrived beginning in 2008; and Africans escaping violence in Somalia, Burundi, Congo, Rwanda, and Sudan over many years. These have also included Czechs, Bulgarians, Iranians, Albanians, Cubans, Haitians, Kosovars, Ethiopians and more. Hundreds of additional non-English-speakers from poor countries have also come to Vermont seeking asylum or as ordinary immigrants. In addition, 44 percent of children under six in Vermont live in low-income households. [27]

There are many initiatives both nationally and in Vermont that address health and educational disparities. One of the four overarching goals of the *Healthy People 2020* initiative is "to achieve health equity, eliminate disparities and improve the health of all groups."

The federal Office of Minority Health was created in 1986 and was reauthorized by the Affordable Care Act (ACA) in 2010. The mission of the Office of Minority Health is to improve the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities. The federal Office of Minority Health's *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (CLAS) standards are recognized as best practice and are increasingly informing cultural competency training and assessment in within Vermont state agencies and family service providers.

The Vermont Office of Minority Health and Health Disparities is charged with development and implementation of Vermont's Strategic Plan to eliminate health disparities in the delivery of health prevention and health care services to Vermonters. Its mission is to reduce and eliminate racial and ethnic health disparities through partnerships, education, and advocacy.

The Vermont Department of Health's Refugee Health Program promotes the physical and mental well-being of refugees living in Vermont. The Refugee Health Program, in collaboration with the state refugee coordinator, community partners, health care providers, Health Department district office staff, and the Vermont Refugee Resettlement Program, works to ensure refugees have access to primary care physicians and obtain a domestic health screening within 30 days of their arrival in the United States. The Refugee Health Program identifies areas of concern for newly resettled refugees, and works with community partners to provide the information these new Vermonters need.

In addition to the Vermont Refugee and Resettlement Program, the Association of Africans Living in Vermont and the Somali Bantu Association also provide support, interpretation services and

advocacy to immigrants and former refugees largely in Chittenden County.

In 2010, the American Academy of Pediatrics issued a policy statement on health equity and children's rights outlining the pediatrician's role in ensuring that social and environmental determinants of health are addressed through clinical practice, child advocacy and policy formulation to promote health and eliminate inequities that result in child health disparities.[28]

Child Care Resource in Vermont also has a New American Child Care Initiative underway in partnership with the Association of Africans Living in Vermont and others that help former refugee and immigrant women become legally exempt child care providers. Not only does this diversify the child care workforce and increase the availability of culturally appropriate care for refugee and immigrant families, but it supports the women in starting their own businesses.

In addition, the five-year Vermont Project LAUNCH (Linking Actions for Unmet Needs in Children's Heath) initiative, funded by the federal Substance Abuse and Mental Health Services Administration and being piloted in Chittenden County, focuses on young children's health and positive social and emotional development with a particular focus on outreach to immigrant and former refugee families and reducing health disparities.

While the numerous activities related to the K-12 achievement gap are beyond the scope of this policy brief, initiatives and supports to target gaps before kindergarten entry are currently in place. Head Start and Early Head Start in particular have long addressed the early onset of achievement disparities between economically disadvantaged children and their more advantaged peers and have also been at the forefront of addressing racial and ethnic disparities in early childhood.[29]

In 2014, Vermont was awarded $36.9 million in federal funding over four years through the Early Learning Challenge (ELC) grant to build a high-quality, accessible early childhood system in the state that would increase the quality of child care and pre-kindergarten (pre-K) programs and ultimately ensure that children are ready for kindergarten. In the 2012-2013 school year, 38 percent of Vermont children were deemed "not ready" for kindergarten in 2012-2013 and 32 percent of third graders in Vermont were reading below grade level.[30] Among children living below the poverty level, that rate increased to 45 percent. The ELC grant will bring additional focus and significant resources to create a high quality early learning and development system to support all children.

Another important contribution to closing the achievement gap at kindergarten entry is the 2014 passage of Act 166 that provides free, universal pre-kindergarten for *all* three- and four-year-olds in Vermont. This important new law will increase the quality, availability and number of hours pre-K is available and is the beginning of an effort to build a universal system that offers equal access to high quality programs throughout the state.

RECOMMENDATIONS

There are many important steps that Vermont can take to ensure that all children reach their full potential in life regardless of their race, ethnicity or socioeconomic status. These include:

1) Educate policy makers, the public, and other agencies and organizations about health and educational disparities, their causes, and strategies for effectively addressing them – and particularly about the importance of addressing these issues from the very beginning of a child's life.

2) Continue to increase the quality and availability of early care and preschool programs by increasing state investment in quality child care and preschool. This includes ensuring that children have access to equitable hours of publically funded, high quality pre-K and that pre-K teachers are compensated at levels comparable to K-12 teachers. Think broadly and creatively about funding sources. Early education has to be done right to make a difference in outcomes.

3) Create/support policies that mitigate poverty. Socioeconomic status is clearly correlated with educational and health disparities, and further compounds racial and ethnic disparities.

4) Ensure a prenatal-through-third grade approach and action agenda for all early childhood. These are all critical years that affect children's life-long health and learning trajectories.

5) Increase Cultural and Linguistic Competence (CALC) in health and education. Evidence supporting the link between access to care, improving care, and decreasing health disparities with cultural and linguistic competence service provision continues to grow.[31] Cultural and linguistic competence (CALC) is defined as the ability to provide culturally responsive care regardless of racial/ethnic identity or cultural affiliation. Linguistic competency refers to the ability to communicate effectively with those with limited English proficiency, low literacy levels, low socioeconomic status and disabilities.

6) Expand the use of the Office of Minority Health's *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (CLAS) standards as best practice to inform cultural competency training and assessment in Vermont.

7) Involve the community, specifically Community Health Workers (CHWs), to improve care and address health disparities. CHWs work in association with local health care systems in both urban and rural environments by providing education and outreach. They usually share ethnicity, language, socioeconomic status, and life experiences with those they serve. The move toward affordable care through state and federal health care reform creates new and important opportunities for workers who can help expand cost-effective care and includes a growing appreciation for services that promote prevention and wellness and contribute to the health of young children in ways not achieved through tradition medical services.[32]

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About These Policy Briefs:

This is one in a series of policy briefs designed to focus our collective attention on issues that affect our young children and families. These briefs, as well as an annual *How Are Vermont's Young Children?* report are part of an initiative by Building Bright Futures State Advisory

Council, connected to the Vermont Early Childhood Framework recently unveiled at Governor Shumlin's Early Childhood Summit in 2013. For more information, call Building Bright Futures at 802-876-5010 or find out more on line: www.buildingbrightfutures.org)

About Project LAUNCH:

Project LAUNCH (Linking Actions for Unmet Needs in Children's Heath) is a federal initiative funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The Vermont Department of Health (VDH) received a five-year SAMHSA Project LAUNCH grant in 2012. Project LAUNCH is being piloted in Chittenden County and is grounded in a comprehensive view of health that addresses the physical, emotional, social, cognitive and behavioral aspects of well-being. Building Bright Futures State Advisory Council, Inc. serves as the grantee of VDH for Project LAUNCH implementation.

About the Author:

Traci Sawyers holds a M.A. in public policy from Tufts University and has 25 years experience in child and family policy, maternal/child health and behavioral health. In these areas, she has been a writer, lobbyist, researcher, planner, program administrator, consultant, facilitator, grant writer/administrator, elected official, and organizational director. She is currently the Early Childhood Health Policy Expert for Building Bright Futures and Vermont's Project LAUNCH initiative.