

The Health of Young Children in California

FINDINGS FROM THE 2001 CALIFORNIA HEALTH INTERVIEW SURVEY

Prepared by
Moirá Inkelas, PhD
Neal Halfon, MD, MPH
Kim Uyeda, MD, MPH
Greg Stevens, PhD
Janel Wright
UCLA Center for Healthier Children, Families and Communities

Sue Holtby, MPH
Public Health Institute

E. Richard Brown, PhD
UCLA Center for Health Policy Research

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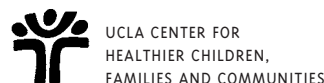
In November 1998, California voters passed Proposition 10, adding a 50 cents-per-pack tax on cigarettes to fund education, health, child care and other programs for expectant parents and children during their first five years of life. That mandate is carried out by First 5 California (also known as the California Children and Families Commission) and 58 First 5 County Commissions. Since its inception, First 5 California has focused attention on the importance of health and early childhood education and development for school readiness and life-long learning potential. Recognizing that improving the quality of and access to early education and health care has a profound impact on how well a child will do in school and later in life, First 5 California's statewide efforts are focused on the development of more comprehensive early childhood services, including voluntary Preschool for All and universal health insurance.

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The Authors



This report was prepared by researchers in the UCLA Center for Healthier Children, Families and Communities. They include Moira Inkelas, PhD, who is Assistant Director of the Center and Adjunct Assistant Professor in the UCLA School of Public Health; Neal Halfon, MD, MPH, who is Director of the Center and Professor of Public Health, Pediatrics, and Public Policy; Kimberly Uyeda, MD, MPH, who is Assistant Clinical Professor of Pediatrics; Gregory Stevens, PhD, who is a researcher at the Center, and Janel Wright, who is a research assistant at the Center.

Two other researchers collaborated on the report: Sue Holtby, MPH, a Senior Research Scientist in the Public Health Institute; and E. Richard Brown, PhD, the Director of the UCLA Center for Health Policy Research, Professor of Public Health in the UCLA School of Public Health, and Principal Investigator for the California Health Interview Survey.

The California Health Interview Survey

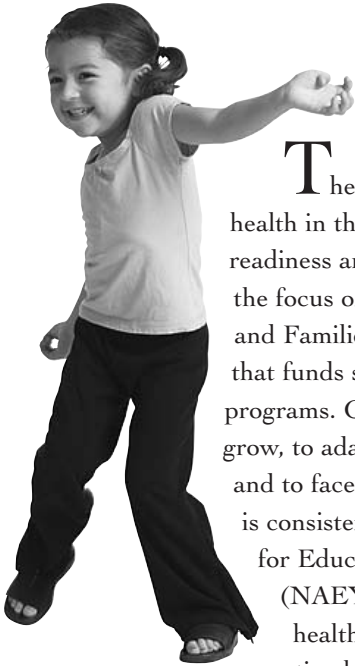


CHIS is a collaboration of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute. Funding for CHIS 2001 has been provided by the California Department of Health Services, the National Cancer Institute, The California Endowment, the California Children and Families Commission, the Centers for Disease Control and Prevention (CDC), and the Indian Health Service. For more information on CHIS please visit www.chis.ucla.edu.

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The importance of early childhood health in the development of school readiness and lifelong learning potential is the focus of the First 5 California Children and Families Commission, an organization that funds state and county early childhood programs. Good health allows children to grow, to adapt to changing environments and to face life's challenges...a view which is consistent with the National Association for Education of Young Children (NAEYC) and their concept that good health is critical to the development of optimal physical, emotional, social and cognitive capacities, and to children's

readiness for school.

First 5 California has launched an ambitious campaign to leverage new resources in the development of more comprehensive and integrated systems of early childhood services. California's recently issued Master Plan for Education also includes a new school-readiness component which calls for statewide strategies to guarantee that children enter school healthy and ready to learn. These strategies—such as daily parent-child reading—can reduce risk factors, as well as enhance “protective” factors for children's development. The 2001 California Health Interview Survey (CHIS 2001) provides information about key measures of health and well being for California's three million children age 0-5 years, and on patterns and disparities in these measures due to family, social and environmental contexts.

The Contribution of CHIS 2001 to Understanding the Health of California's Young Children

The California Health Interview Survey (CHIS 2001) is a ground-breaking survey on the health and well-being of children, adolescents, and adults. The health outcome and family context measures in CHIS 2001 provide important new statewide information that overlap several of First 5's strategic priority areas. This CHIS 2001 report presents indicators of health and well-being as well as measures of children's access to services and the use of early care and education programs (Exhibit 1). The planned administration of CHIS every two years will make it possible to track changes in health indicators over time, and

to add new measures that answer emerging policy and programmatic questions.

This CHIS 2001 report describes health outcomes, health access, health and developmental risks, and health promoting behaviors for young children in California. Many of these are associated with differences in the economic characteristics of the child's family, ethnicity, place of residence and insurance coverage. This report focuses on disparities across population groups and interprets what these disparities mean in relation to a child's health, developmental “trajectory”, and prospects for school readiness. It also highlights gradients in outcomes that are related to levels of income, types of health insurance coverage (e.g. none, public, private), and place of residence (urban to rural). When gradients are observed, it is evident that some systemic factor is causing the disparity.

Key Findings

Disparities in Health Status and Well-Being

The global rating of a child's health, ranging from poor to excellent, gives an important indication of children's overall health and well being. Global measures of health provide an overall assessment of children's health and indicate their capacity to function and develop normally in multiple domains: physical, psychological, social, and emotional.

- ✓ In California, about 75% of children age 0-5 years are described by their parents as having excellent or very good health. This is lower than the national average of 85% of young children in very good or excellent health. Given that children in California represent one in nine children nationally, this difference is substantial.
- ✓ Latino children have lower ratings of overall health status, with only about 60% reported to have excellent or very good health, compared to about 90% of Non-Latino White children. This substantial racial/ethnic disparity in young children's health status begins to disappear only for children at or above 300% of the Federal Poverty Level (FPL).
- ✓ Children in urban and in rural areas of California have poorer health status due to health risks and to poor access to medical care compared to children living in suburban areas.

EXHIBIT 1 – CHIS 2001 INDICATORS IN FIRST 5 HEALTH AND WELLNESS FOCUS AREAS

CHILD WELL-BEING	ORAL HEALTH
OVERALL HEALTH STATUS	USE OF PREVENTIVE DENTAL SERVICES
PHYSICAL ACTIVITY LIMITATIONS	BARRIERS TO ACCESSING DENTAL CARE
SPECIFIC HEALTH CONDITIONS	PREVENTIVE DENTAL HEALTH BEHAVIOR
ACCESS TO QUALITY HEALTH SERVICES	NUTRITION AND OVERWEIGHT
HEALTH INSURANCE COVERAGE	PREVALENCE OF OVERWEIGHT
UNINSURED CHILDREN ELIGIBLE BUT NOT ENROLLED	DAILY INTAKE OF FRUITS AND VEGETABLES
BARRIERS TO ACCESSING SERVICES	DAILY INTAKE OF SODA
USUAL SOURCE OF CARE	SLEEPING WITH MILK/JUICE IN BABY BOTTLE
CHILDREN WITH SPECIAL HEALTH CARE NEEDS	PHYSICAL ACTIVITY AND FITNESS
ACCESS TO HEALTH CARE	SEDENTARY TIME WATCHING TV/VIDEO GAMES
MANAGEMENT OF ASTHMA	
	SOCIAL AND DEVELOPMENT-PROMOTING ACTIVITIES
ENVIRONMENTAL HEALTH	PARENT-CHILD READING
USE OF SUNSCREEN	FAMILY SOCIAL ACTIVITIES
PARENT IN HOUSEHOLD SMOKES	
PARENT IN HOUSEHOLD DRINKS	EARLY CARE AND EDUCATION
GUNS PRESENT IN OR AROUND THE HOME	CHILD CARE ARRANGEMENTS
	LICENSURE
INJURY/VIOLENCE PREVENTION	SATISFACTION WITH CHILD CARE
INJURIES	ENROLLMENT IN PRESCHOOL
	HEAD START ENROLLMENT AMONG ELIGIBLE CHILDREN
CHILDHOOD IMMUNIZATIONS	
PRESENCE OF IMMUNIZATION RECORD	INCOME ASSISTANCE AND FOOD SECURITY
DIFFICULTIES GETTING IMMUNIZATIONS	WIC, FOOD STAMPS, TANF
RECEIPT OF REMINDER/RECALL	FOOD SECURITY

Disparities in health status are an important indication of differential exposures to health risks and to protective factors as well as indicators of differential access to health care. Children who start life with fair or poor health status may have difficulty regaining full function if developmental delays or disabilities limit opportunities to learn and grow. Racial/ethnic disparities in health status prevent many young children in California from the optimal developmental trajectories that First 5 hopes to help achieve. The burden of poor health status among lower income and Latino

children is especially of concern, given the growing number of low income Latino children in the state of California.

Asthma Prevalence and Impact

Chronic health conditions last for a significant period of time and range from those static conditions that require ongoing medication and treatment, to those conditions such as asthma that can have an episodic and relapsing course. Chronic health conditions can pose significant barriers to a child's physical, cognitive, social and emotional

development. CHIS 2001 provides extensive new information about childhood asthma, the most common health condition affecting young children.

- ✓ About 10.5% of young children age 1-5 years in California have been diagnosed by a doctor as having asthma. Asthma prevalence varies dramatically by race/ethnicity. One out of every five African-American children (20.4%) has been diagnosed as having asthma, compared to 10.4% of Non-Latino White and 9.2% of Latino children.
- ✓ Almost half of African American children with asthma are reported to be symptomatic on a monthly basis, showing that one in ten young African American children in California is regularly affected by asthma.
- ✓ About half (51.5%) of young children diagnosed with asthma are taking medication to control the condition—with little variability by type of health insurance or having a usual source of care—even though many are experiencing symptoms and physical limitations.
- ✓ Nearly one quarter (22.3%) of young children diagnosed with asthma have an asthma-related emergency room visit during the year with a rate of 33.7% for children age 1-2 years, showing that asthma is not well controlled for many young children.

CHIS 2001 information on childhood asthma highlights not only the growing prevalence of asthma in children, but also the extraordinary disparities for African-American children. National data show that only 20-40% of children with asthma receive the recommended medications. The impact of inadequate asthma management can be seen in the symptoms and limitations experienced by young children in California. Changes in asthma prevalence, severity, and access to care are important measures of how well the health care system is responding to the health care needs of young children. This is important not just for monitoring asthma prevalence and care, but also because access and quality of asthma care are potentially important indicators of the access and quality of health care for other less common chronic health conditions.

Prevalence of Disabilities (Activity Limitations)

Restriction in physical activity is a traditional measure of disability. Disabilities due to health problems can impair a child's ability to learn and to develop other kinds of abilities. These disabilities affect children's participation in daily activities—such as play and going to school and other events—that can affect the development of their relationships with others. Children who are unable to engage in age-appropriate play, or interact with their peers in normal activities, may experience other delays in cognitive, social, or emotional function in addition to the physical limitation. Interruption of age-appropriate activities reduces a young child's chances of being ready for school and succeeding in school. Like disparities in health status, disparities in disabilities reflect a complex set of higher health risks, and lower access to health care.

- ✓ About 3.7% of California children age 0-5 years have a condition that limits normal childhood activities. Disability increases with age and affects nearly 5% of children age five years.

From national studies we know that surveys of parents tend to underestimate the prevalence of disabilities, especially prior to school entry. Upon school entry disabilities become more obvious to parents and teachers alike. Therefore, the CHIS 2001 estimates of disabilities in young children are likely to be conservative.

Getting Children Covered: Health Insurance

Access to health insurance for young children has become a major policy and programmatic initiative statewide in California and a focus area for many First 5 commissions. CHIS 2001 provides the first statewide data on California's potential to close the gap for children who are eligible for health insurance but not enrolled.

- ✓ About 202,000 children under the age of six years are uninsured, representing 6.9% of young children in California. The vast majority of these young uninsured children (77.8%)—about 158,000—appear to be eligible for either Medicaid (Medi-Cal) or Healthy Families.

- ✓ One third (35.8%) of uninsured children did have coverage at some point in the last year, but lost it. This shows the need not just to enroll children in health insurance but to retain them once enrolled.
- ✓ CHIS 2001 provides the first data showing that even insured children experience gaps in coverage during the year. These gaps in coverage are important indicators of children's retention in health insurance, once enrolled. Nearly 20% of young rural children have a gap in coverage during the year with gaps also more frequent among low income and Latino children. These gaps undermine access to the continuity of care that is needed for pediatric guidance and education to be effective for parents of young children.
- ✓ Enrollment is important for health care access. Young children who are eligible for but not enrolled in public insurance have more delayed or missed care than children in either Medi-Cal or Healthy Families.

These new data on health insurance eligibility and enrollment provide important information as California attempts to extend health insurance to more children, and develop policies and programs to fill existing gaps. These findings show that targeted outreach and enrollment are needed, given the large number of children who are uninsured despite being eligible for Healthy Families or Medi-Cal. It also suggests the importance of improving the retention of children who are enrolled. Administrative requirements for periodic eligibility redetermination and monthly premium payments in the Healthy Families program are unraveling much of the effort expended to get young uninsured children enrolled.

Access and Sources of Health Care

While health insurance is a necessary component of access to health care, it is not sufficient to guarantee that children get care when they need it, *and* from a provider with the technical and interpersonal skills to provide high quality care. Indicators of access include whether children receive needed care, where they receive that care, when they receive it relative to need, and how frequently they receive care.

- ✓ About 98% of young children in California have a regular source of health care, a figure that is comparable to national estimates.

- ✓ Latino and rural children are less likely to have a usual source of care. When they do, they are more likely to receive care in community clinics rather than in physician offices.
- ✓ Most parents (97.4%) report that their young child has seen a physician within the last 12 months. Even most uninsured young children (92%) have visited a doctor in the past 12 months.
- ✓ There is a strong income gradient in where young children receive care, with children in higher income families almost twice as likely as children in lower income families to report receiving care in a physician's office.

While most children have access to some form of regular health care, the place where children receive care differs based on where they live, their ethnicity, and income and insurance status. While many community and hospital clinics provide good quality care, many of these institutions function as safety net providers, and their capacity to provide basic services (such as after-hours phone consultation for a child with asthma) can vary with the levels of funding that the provider has. For example, if parents of an asthmatic child cannot reach his or her community clinic doctor when acute exacerbation strikes at night, they are more likely to take the child to the emergency room. Real functional disparities exist in the content and quality of health care that children receive. California has important improvements to make in assuring that young children have equitable access to appropriate providers.

Gaps in Dental Care Coverage and Use of Services

Because dental caries are one of the most frequent as well as debilitating and untreated chronic health conditions in children, access to dental care is an important indicator of access to health care. Other studies suggest that access to and use of dental care is a good indicator of access to other preventive and health-promoting services in a community. While the 1993-1994 California Oral Health Needs Assessment evaluated tooth decay in children enrolled in preschool, CHIS 2001 provides the first statewide information on dental care coverage and use of services.

- ✓ Just over half of children age 2-5 years have ever seen a dentist. About 40% of children age 3-4 years and 14% of children age five have never seen a dentist. Few young children have had a visit within the last six months, including only 58% of children age five years.
- ✓ While only 6.8% of young children lack health insurance, about 24% of children age 2-5 years (478,000) have no dental insurance. Fewer children with Medi-Cal (79.6%) than private insurance (85.6%) have dental insurance, and some parents of Healthy Families' enrollees do not know that their child has dental insurance. Almost no children lacking dental insurance are using free community or public dental programs.
- ✓ Private insurance does not assure better access. Initiation of dental care is very low for privately insured children as well as those in Medi-Cal and Healthy Families.
- ✓ About 6.2% of young children are sleeping with a bottle at night, which greatly increases their risk of dental problems, as well as ear infections, and should be addressed through education from pediatric providers as well as information campaigns.
- ✓ In California, most children age 2-5 years (86.1%) receive the recommended daily intake of fruit (at least two servings of fruit and/or 100% fruit juice).¹ Although California is a leading source of vegetables for the nation, few young children (17.7%) in California receive the daily-recommended servings of vegetables (at least three servings).
- ✓ While two-thirds (66.6%) of young children have the daily recommended intake of milk, soda begins to substitute for milk once children reach three years of age, with milk intake declining and soda intake increasing.
- ✓ About a quarter of preschoolers consume soda on a daily basis. Daily consumption of soda has a strong income gradient, with twice as many children in families below the FPL as above the 300% FPL drinking soda at age two (25% vs. 10%). Nearly half (46%) of children below the FPL drink soda compared to 22% of children above 300% of the FPL, of those age 5 years.
- ✓ Rates of television watching that exceed American Academy of Pediatrics (AAP) recommendations place young California children at risk for excessive sedentary activity, which is associated with overweight and later obesity. Two-thirds of preschoolers watch at least two hours of television on weekdays. More than one-third exceed AAP recommended limits on media exposure, watching more than two hours daily.

Improving the dental health of California's young children will require a broad range of interventions including better home health behaviors, greater availability of affordable dental insurance, more information and education about how to receive dental coverage, and how to access available services. Improving access to appropriate dental care for children requires overcoming barriers that include low payment rates for children's dental care and a shortage of well-trained pediatric dental providers, particularly in underserved communities, who are willing and able to take on low-income patients.

Nutritional Intake, Soda Consumption, and Sedentary Activity

Nutritional measures do more than assess the intake of nutrients that affect long term health outcomes. These measures also show the intake of foods that have little or negative nutritional value—such as soda—and may contribute to adverse health outcomes such as obesity, adult onset diabetes mellitus, and other child and adult health conditions.

Many children are not receiving the recommended nutritional intake that is associated with good health outcomes. Moreover, many young children are consuming useless and potentially harmful calories, including nearly half of children age five in households below the federal poverty level. The combination of children drinking soda with poor access and utilization of dental services indicates high risk for tooth decay as well as overweight. Given income gradients and disparities in health eating habits, it is important that public programs and health care providers serving low income families take up the charge of improving nutritional status and behaviors. Programs such as Women, Infants and Children (WIC) are an obvious starting point for educational interventions, especially since the majority of low-income

¹ U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000

families participate in WIC. Culturally appropriate guidance in the pediatric office is also needed.

Young Children's Learning and Social Environment

An increasing body of research literature suggests that children's social environments can have a significant influence on their social and emotional development and learning. Measures of how often families participate in shared reading activities indicate whether a child is getting language and cognitive stimulation on a regular basis. Reading is also a measure of how well families are able to organize their routines and to control their child's social environment. Reading is important for early literacy, as well as for parent-child relationships, by promoting quality time between the parent and child. Yet barriers such as time, parental and caregiver literacy, and parent knowledge of when and how to initiate and sustain family reading time can create disparities in young children's access to this important school readiness enhancing activity.

- ✓ Fewer than half of parents (43%) read to their child daily. About 9% of children age 0-5 years are not read to in a given week by anyone in the household. Only one-third of children age 3-4 years in households below the 200% FPL are read to daily, compared to two-thirds in households above the 300% FPL.
- ✓ While reading to children increases as children grow from infancy into toddlerhood, rates of reading do not increase for two, three, and four year old children in households below the 300% FPL, creating substantial disparities based on income and parental education.
- ✓ Parents of most young children (68.4%) say they spend time with friends or relatives at least once per week. Lower income families and non-U.S. born parents are more socially isolated.

Many young children are not getting the reading exposure they need for appropriate language and literacy development. Reading should be an organized daily activity for young children. Large disparities in reading frequency by race/ethnicity, maternal education, and income are leaving California's most vulnerable children at a considerable disadvantage for school readiness.

While many families may be parenting in social environments with supportive family connections, many families have low social support. The large number of families who are recent immigrants to California might benefit from programs and services that provide family and community social connections. Family support is a major programmatic and policy focus of California's First 5, and it will be important to monitor social support and family connections to the community as the First 5 California program development continues.

Early Care and Education

An increasing proportion of young California children spend at least part of their day in a child care arrangement. Child care thus plays an important role in the early care and education experiences to which young children are exposed.

- ✓ While most parents are satisfied with the quality of their child's care arrangements, a substantial number (19.8%) are not completely satisfied, or not at all satisfied.
- ✓ Many preschool-age children are not in preschool. The rate of preschool participation is slightly higher for children age four years (at 31.8%) than for children age three years (at 18.4%).
- ✓ There are large racial/ethnic differences in preschool attendance among preschool age children. Only 13.8% of Latino children age 3-4 years are enrolled in nursery school or preschool, compared to one-third of Asian and Non-Latino White children, 40.2% of American Indian/Alaska Native children, and 44.4% of African-American children.
- ✓ Among preschool age children, those not in preschool have lower health status as well as less exposure at home to daily reading than children in preschool do. The trend toward higher rates of disability among children in preschool also suggests that as the First 5 universal preschool initiative advances, children and parents with substantial need for support and education will begin to participate.

CHIS 2001 illustrates the preschool attendance gap in California. Many preschool age children spend no time in structured preschool settings. The poorer health of children not yet enrolled in preschool shows that the First 5 universal preschool initiative should anticipate above average needs among newly participating children.

Summary

These new data on health outcomes, health access, health and developmental risks, and health promoting behaviors show that many young children could be healthier, have better access to health services, and be receiving health promotion and preventive services that would provide them with a much greater likelihood of succeeding in school and in life. Many children in California are not receiving the early childhood services they need, such as dental care or the development-promoting activities in the home, for instance reading. While the quality of health care was not directly measured in CHIS 2001, there are many indicators in the data presented that the quality of access and the quality of services available to many children reflect social, economic and ethnic disparities. Improving access to and the quality of health care is a priority for young children, given the impact of physical, oral, developmental, and emotional health for school readiness. Attention needs to be placed on targeted outreach and enrolling eligible children in Medi-Cal and Healthy Families; assuring that enrolled children retain their coverage; and improving the quality of health, developmental and dental health services that are available and provided.

The California Health Interview Survey

This report presents information about children age 0-5 years (under six) based on the CHIS 2001 random-digit dial (RDD) sample which included interviews in more than 55,000 randomly selected households drawn from every county in California. CHIS 2001 is the largest health survey ever conducted in any state and one of the largest in the nation. In each household, one adult was randomly selected for interview (the “sample adult”). In households with children, CHIS 2001 also interviewed one adolescent age 12-17 (the “sample adolescent”) and obtained information for one child under age 12 (the “sample child”)

by interviewing the adult who is most knowledgeable about the child. The RDD survey began at the end of November 2000 and was completed in October 2001.

CHIS 2001 covers a broad range of public health concerns, including health status and conditions, health-related behaviors, health insurance coverage, and access to health care services. To make CHIS 2001 more inclusive and to capture the rich diversity of the California population, the questionnaires were translated and interviews were conducted in six languages: English, Spanish, Chinese (both Mandarin and Cantonese dialects), Vietnamese, Korean, and Khmer (Cambodian). Questionnaires were also reviewed by expert teams to ensure that question wording was culturally appropriate for a variety of population groups. In addition, special community outreach campaigns were conducted in appropriate languages targeting communities of color to encourage the participation of populations that often have low participation rates in surveys.

CHIS 2001 is a collaboration of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute. (For more information on CHIS 2001, visit www.chis.ucla.edu.)