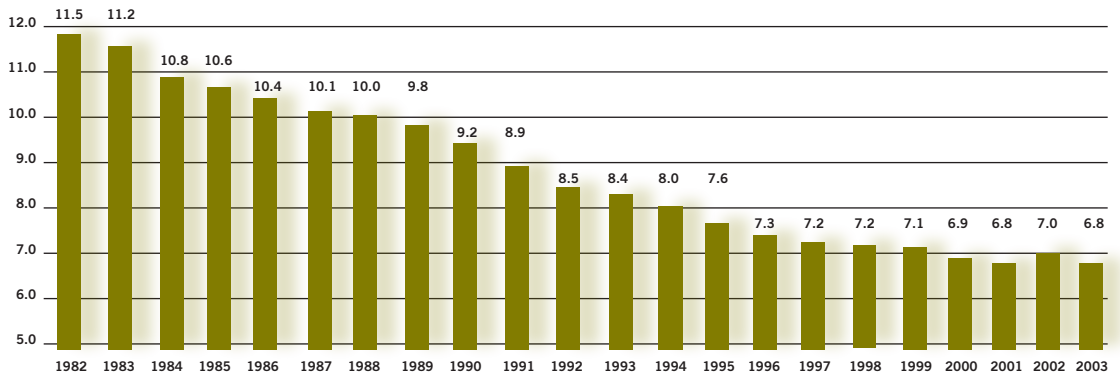
Children & Youth

The United States has witnessed enormous improvements in children's health over the past several decades. Both childhood mortality and infectious disease rates have decreased. Rates of infant mortality, the most common indicator of child health, have dropped dramatically since 1982 (Figure 1).

Despite these successes, the prevalence of chronic health problems such as obesity, mental illness, and asthma, is on the rise (Wise 2004). Over the past two decades, the rate of children with asthma has doubled, from 3 percent in 1981 to 6 percent in 2004 (Child Trends 2006). Over the past three decades, rates of obesity have doubled for preschool children and adolescents and have more than tripled for children aged 6 to 11 (IOM 2005). Despite the gains in infant mortality, the U.S. ranks behind many nations in this measure, including the European Union, Japan, New Zealand, the Czech Republic, and Cuba (CIA Worldbook 2006).

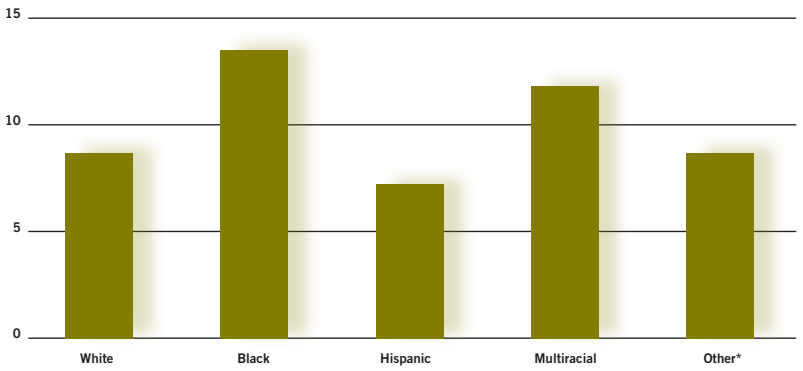
It is of great concern to many that these diseases and disorders are not equally distributed across the population, with some groups of children suffering more than others (Figure 2) (IOM 2004). For example, infant mortality among African Americans in 2000 occurred at a rate of 14.1 deaths per 1,000 live births, more than twice the national average of 6.9 deaths per 1,000 live births (Minino et al. 2002). African-American children are almost twice as likely to have asthma as white children (Child Trends 2006). While obesity is prevalent among all groups of children and youth, Hispanic, African-American, and Native American children are disproportionately affected (IOM 2005). Racial and ethnic minorities also experience lower rates of health insurance coverage and higher rates of poverty, making accessing appropriate health care even more difficult. Children have been the poorest age group in the U.S. since the 1980s (Wise 2004). In 2004, approximately 18 percent of all children in the

Figure 1. Infant Mortality Rates in the U.S., 1982–2003 (per 100,000 live births)



Mathews, T.J. and Marian F. MacDorman, "Infant Mortality Statistics from the 2003 Period Linked Birth/Infant Death Data Set" *National Vital Statistics Report* (54)16: 1-5, May 2006; Minino, Arialdi M., Elizabeth Arias, Kenneth D. Kochanek, Sherry L. Murphy, Betty L. Smith, "Deaths: Final Data for 2000" *National Vital Statistics Report* (50)15: 11-13, 2002.

Figure 2. Children Affected by Asthma, by Race and Ethnicity (percentage)



*Includes Asian or Pacific Islander and American Indian or Alaska native children.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, *The National Survey of Children's Health 2003* (Rockville, MD: 2005).

United States lived in poverty. Over the last five years, child poverty has risen substantially, increasing by 12 percent (Koball and Douglas-Hall 2006).

Certain aspects of childhood make children's health needs different from those of adults. Illness, injury, or difficult family and social circumstances can seriously harm a child's physical and emotional development. Many complex challenges facing children—including family substance abuse, neighborhood violence, and learning problems—cannot be adequately addressed by traditional medical services and require more comprehensive care. And children are almost totally dependent on adults to identify and react to their health needs, to arrange and consent to care, and to follow treatment guidelines. For these reasons, health promotion, disease prevention, and coordinated care strategies are essential to children's health care (Halfon et al. 1996).

There are both short- and long-term consequences of poor childhood health. Healthy children are more ready and able to learn, and are more likely to become healthy adults who can contribute to society. Children who are in poor health face disadvantages that often persist throughout their lives. Unhealthy children face higher rates of failure in school, often leading to additional societal expenditures for special education, mental health, and juvenile justice. Unhealthy children also often become unhealthy adults, with research showing that many adult health conditions and disparities have their roots in childhood. For this reason, poor childhood health is linked with lower rates of productivity later in life, with the result of increased rates of social dependency among individuals and diminished economic performance for the nation as a whole (Halfon 2005).

Over the past several decades, the federal government has implemented several popular and far-reaching programs to improve access to health services for the nation's low-income children and youth. For example, in 1981, the Maternal and Child Health Services Block Grant (Title V) recognized the critical issues

facing children with special health care needs (Children with Special Needs), facilitating the development of family-focused, community-based systems of care. A decade later, in 1991, the Health Resources and Services Administration (HRSA) began the Healthy Start initiative to reduce infant mortality. Introduced as a five-year demonstration program, community-based systems were tasked with reducing the infant mortality rate by 50 percent as well as improving the health and well-being of women, infants, children and their families. Originally, 15 demonstration programs were funded for a five-year period, including 13 urban and 2 rural programs. In 2002, HRSA funded 96 Healthy Start programs. Required elements of the program include a focus on reducing infant mortality, inclusion of the local community in planning, assessment of local needs, public education, a package of innovative health and social services for pregnant women and for infants, and an evaluation of the initiative.

Medicaid is the single largest health insurance program for children. In 2003, over 25 million children were enrolled in Medicaid. While children account for nearly half of all Medicaid enrollees, they account for only 19 percent of total program spending (Kaiser Commission on Medicaid and the Uninsured 2004). Medicaid has boosted the overall health of children through increased primary care utilization, decreased mortality and hospitalization rates, improved school readiness, and controlled health care costs.

The key component of Medicaid coverage for children is the mandatory Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. EPSDT includes a vast range of benefits, including screening; immunizations; health education; and vision, dental, and hearing services. States are required by law to provide EPSDT services to eligible children whether or not the state Medicaid plan provides the services to the rest of the Medicaid population. In 1989, EPSDT was expanded to benefit children with special health care needs.

The creation of the State Children's Health Insurance Program (SCHIP) in 1997 expanded children's public health insurance coverage. SCHIP provides health coverage to low-income children who live in families with income or assets above Medicaid eligibility levels, yet whose parents cannot afford to purchase private insurance. When SCHIP was established, the federal government committed $48 billion over 10 years to support the state-administered program. Each state receives an annual allotment of this funding, at a match rate higher than that for the Medicaid program.

SCHIP has resulted in major improvements in children's access and coverage. Under SCHIP, states have worked to improve enrollment and retention processes and have used many different outreach strategies. Declines in the number of uninsured children have been associated with the growth in SCHIP enrollment, and the program has been shown to reach the low-income children it was designed to target. SCHIP coverage has been found to diminish unmet need, boost preventive care, raise the probability of having a usual source of care, lessen parents' stress and financial barriers, and improve children's access to oral health care. Medicaid has also increased enrollment of children by adopting many of the novel enrollment and retention procedures used in SCHIP (GIH 2006). Some argue that this progress is at risk, however, since states have only a few ways of cutting Medicaid and SCHIP costs, most of which transfer the burden to patients and their families (GIH 2006).

Schools can play an important role in the provision of health care services. The concept of school-based health centers (SBHCs) began in the late 1960s with pediatrician-formed school clinics in cities such as Dallas, Minneapolis, and Cambridge, Massachusetts (Morone et al. 2001). The programs usually provide comprehensive services and employ a variety of health professionals, including nurse practitioners, mental health care providers, nutritionists, and part-time physicians. Some programs provide laboratory tests and dental care. Initially, these centers were a lightning rod for controversy, particularly because of concerns about the distribution of contraceptives, but eventually gained widespread support. In 1994, HRSA launched a grant program, Healthy Schools, Healthy Communities, to support the development and operation of school-based health centers that provide preventive and comprehensive primary health care services to children at risk for poor health outcomes and other medically underserved populations. In other communities, students are served by school-linked services involving collaboration between schools, health

care providers, and social service agencies. Typically, school personnel provide students with referrals to services that are provided on or near school grounds.

Neuroscience as a discipline exploded during the second half of the 20th century, creating new knowledge about how children develop and what they need to succeed. Contrary to earlier thinking, brain development is now known to continue throughout adolescence and is not completed until early adulthood. Assisted by new imaging technologies, researchers have found that early adolescents experience a second surge in brain growth and change (Giedd et al. 1999). Growth in gray matter—the thinking part of the brain—during early adolescence may present a second window of opportunity for the acquisition of skills and abilities. There is also emerging evidence that adolescent brains process information differently than adults, which may help explain some characteristics of adolescent behavior. For example, one study found that young teens process emotional information in an area of the brain that mediates fear and other gut reactions, whereas older teens and adults process the same information in the frontal lobe, which handles tasks like planning and reasoning (National Institute of Mental Health 2001). Adolescents may also be more likely to respond to interpersonal interactions in an impulsive and emotional way, rather than by thinking through an appropriate response. Finally, there is evidence that adolescent brains are more susceptible than those of adults to short-term impairment and long-term damage from alcohol and tobacco, and potentially from other drugs as well (GIH 2002).

This new information is driving new approaches to adolescent health. Positive youth development is not a specific program, but rather an approach to structuring services, systems, and supports for youth so that young people develop the skills and competencies they need to thrive and enter adulthood ready to face the numerous challenges of adult life. Grounded in the concept of resiliency, positive youth development seeks to help youth overcome or deal with negative conditions in their environments. The Minneapolis-based Search Institute identified 40 developmental assets that young people need to grow up to be healthy, caring, and responsible, including family support, safety, positive peer influences, school engagement, honesty, and self-esteem (GIH 2002). Positive youth development approaches seek to take advantage of opportunities presented by the various stages of adolescent development to influence behaviors, attitudes, and self-esteem (GIH 2002). Successful approaches have been linked to improved health outcomes, such as decreased teen pregnancy rates, lower rates of substance use, and fewer psychosocial problems. Overall, the U.S. teen pregnancy rate dropped 30 percent from 1991 to 2002 (Guttmacher Institute 2006).

Philanthropic Efforts

Grantmakers have devoted significant resources to children's health over the past 25 years. Total foundation giving for children and youth reached a record $3.2 billion in 2004 (Foundation Center 2006).

Early Childhood

Programs that promote early and continuous prenatal care have been helpful in reducing the rates of preterm births, leading to lower rates of infant mortality. Home visitation programs, for example, are designed to help provide families with the skills they need to care for a new child. These programs are also proven to contribute to the healthy development of young children.

Robert Wood Johnson Foundation (RWJF) began the Nurse Home Visiting Program, now called the Nurse-Family Partnership, to help improve health outcomes for children born into disadvantaged families. The program began in 1978, built on research by then graduate student David Olds (Alper 2002). His theory was that poor, first-time parents often lack the necessary skills and supports that are the foundation of good parenting. Through the program, Olds set out to help women understand the influence of their behavior on the behavior of their children. Nurses, who received thorough training on maternal and infant development, visit women at various stages of pregnancy and through the child's second birthday to assist and coach the new family. Long-term research proved the positive effects—fewer runaways, less frequent use of tobacco and alcohol—of the program on children through adolescence. Research has shown that these programs have other positive effects as well: decreases in maternal smoking, increased spacing between pregnancies, and increased birthweight. The results were so convincing that RWJF continued funding the program, as did other funders,

Total foundation giving for children and youth reached a record $3.2 billion in 2004.

including The Commonwealth Fund, The David and Lucile Packard Foundation, The Pew Charitable Trusts, and The Colorado Trust. Today, the Nurse Family Partnership serves over 20,000 families in 22 states, with the hope that the program will be replicated in other areas (Nurse-Family Partnership 2006).

Over the past three decades, the Nurse-Family Partnership has evolved based on theory and research. One of the challenges Olds identified was that some home visiting programs do not work well because of poor implementation. To be effective, programs must invest not only in developing curricula but also in training nurses and implementing the program in the community. In one state, Olds and his colleagues worked to assure appropriate implementation by developing an Internet-based information system to improve monitoring efforts of local programs.

The Commonwealth Fund has also devoted significant resources to early childhood development. In 1994, the fund supported the creation of Healthy Steps, a national initiative focused on improving the quality of preventive health care for children and toddlers with an emphasis on fostering a close relationship between parents and providers. In a pediatric or family practice, a Healthy Steps team includes a specialist, such as a social worker or nurse, with child development training. The whole-child, whole-family model is designed to provide comprehensive services to children as well as support the parents and caregivers in the process of child-rearing. In 1995, the program developed 24 original sites, with funding from local and national foundations such as The Boston Foundation, The Dorothy Rider Pool Health Care Trust, W.K. Kellogg Foundation, and the Kansas Health Foundation. In 2003,RWJF became the lead national funder, and by 2005, the number of Healthy Steps sites grew to 43.

In 1999, The Commonwealth Fund launched the Assuring Better Child Health and Development (ABCD) initiative to strengthen the capacity of the health care system to support the early development of children from low-income families. The focus of the program is to help states improve the delivery of early childhood development services to children through their Medicaid programs. The four participating Medicaid programs—North Carolina, Utah, Vermont, and Washington—learned lessons that can be replicated in other states, including the importance of interagency collaboration, strategies for reimbursement and financing, and the significance of improving referral services. In January 2004, the fund launched the second phase, ABCD II, to help states promote the healthy mental development of low-income children under age five.

School-based health centers are an important provider of health services to school-aged children. The Health Foundation of Greater Cincinnati has worked extensively in this area, funding planning and development, SBHC start-up projects in schools, evaluation of SBHCs in the greater Cincinnati area, collection of data about the effectiveness of SBHCs across the nation, and the dissemination of evaluation results to help generate and retain community support. As part of its ongoing commitment, the foundation established the Center for the Promotion of Lifelong Health, now known as the Child Policy Research Center. The original grant's intention was to conduct a three-year study of the impact of school-linked health services provided in elementary schools. The outcomes evaluated in the project include school connectedness, school absences, emergency department utilization, and referrals to off-site services. The process evaluation examined characteristics of school-linked health service users, the number of student encounters, reasons for visits, chronic illnesses of students, and parental satisfaction with services. Data collected for children with asthma suggested that school-linked programs have significant effects on the quality of care a child receives.

School-based health centers are an important provider of health services to school-aged children.

The foundation also commissioned a study to determine the effectiveness of funded SBHCs. Part of the study evaluated how SBHCs affect students' health status, use of healthcare services, and school attendance. Another component looked at how the health care costs for students enrolled in Medicaid before and after the centers opened. The studies revealed, by the end of the evaluation period, that SBHC users had higher health status ratings and achieved those levels without significant increase in health care costs. Specifically, the evaluation found that every dollar spent on operating costs generated about $2 in social benefits.

Disparities

The Blue Cross Blue Shield of Minnesota Foundation, through its Growing Up Healthy in Minnesota initiative, made grants to nine organizations around the state to improve access to and use of preventive medical and dental services for children and teens. Focused particularly on the needs of immigrant communities and communities of color, the $1.4 million initiative aims ultimately to improve the health of Minnesotans at highest risk for lifelong health disparities. Grantees included organizations providing direct health and dental care, education and referral services, and curriculum development and training groups. In two years, the program reached an estimated 17,500 people, approximately 6,000 of whom were children of color. Through Growing Up Healthy, grantees formed collaborations with community agencies serving immigrant groups or communities of color. Health and dental care providers strengthened their cultural competence by working with bicultural or bilingual community health workers. Grantee organizations also helped change

dental policy through advocacy work, integrated a wellness and fitness approach into a local public school system, and worked with faith leaders to change cultural norms regarding preventive health (Decker, Gerrard and Owen 2005). Using lessons learned from the initiative, the foundation developed Growing Up Healthy: Kids and Communities, a program that focuses on supporting culturally appropriate and community-based partnerships to improve the social determinants of children's health.

Teenage Years

The preteen period, between the ages 9 and 13, is an important time of a child's development. The Lucile Packard Foundation for Children's Health has focused on promoting the behavioral and emotional health of this often overlooked group. The foundation has devoted significant resources to organizations in the San Mateo and Santa Clara counties in California for a variety of programs, including an after-school program for preteen girls to build social and behavioral skills, child abuse prevention programs, and other youth development activities. An evaluation of the foundation's grants in this area found that balancing school- and community-based programs makes sense for reaching the greatest number of preteens. Successful programs target specific subgroups of youth and provide supportive relationships for youth.

In 1997, The Colorado Trust launched Assets for Colorado Youth (ACY), a six-year, $10 million statewide effort based on the positive youth development model. Built on the Search Institute's 40 developmental assets, ACY originally provided grants to youth-serving agencies and community groups across Colorado and eventually evolved into an independent 501(c)3 organization.

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OMNI Institute's extensive evaluation of the program yielded several results. First, the evaluators identified that the asset-building approach is different from other youth development programs. By connecting social change to everyday actions, grantee staff were more aware of the opportunities they had to shape youth. Second, asset building promotes self-awareness, relationship building, and empowerment. Finally, while difficult to prove the effort was indeed effective, the evaluators indicated that asset building caused grantee staff to be more aware of the potential of young people, which helped shape future programming. Organizations, as a result, were forced to examine their networks and realign if necessary to improve services (OMNI Institute 2003).

In response to alarmingly high rates of teenage pregnancy statewide, The California Wellness Foundation launched its 10-year, $60 million Teen Pregnancy Prevention initiative in 1995. The foundation's board was concerned with the consequences associated with teen pregnancy, such as low birthweight babies and lower educational attainment for teen mothers. Because of the complexity of the issue, the board recognized the need for a long-term commitment of resources. After examining literature on the issue, it was decided that a key component of the program would be focusing on the role of adults to prevent teen pregnancy. Over 10 years, the foundation has supported a variety of organizations, such as research institutes, education and policy advocacy programs, and community-based direct service agencies. Through work with grantees, the initiative has succeeded in filling gaps in knowledge about teenage pregnancy, in informing policymakers of strategies to prevent teenage pregnancy, in building the capacity of the state's adolescent health service providers, and, as hoped, in helping to reduce the state's teenage pregnancy rate. Since the initiative's conclusion, the foundation has continued to support teen pregnancy prevention programs. For instance, in 2005, the foundation awarded a three-year, $225,000 grant to a new rural health clinic to provide access to contraceptive and reproductive health services to teens. Funding was also provided to convene a youth advisory council to help direct teenage pregnancy prevention services and programming. Eventually, the clinic will expand its services to operate as a primary care facility, offering a broad range of preventive health services for teens.

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Fast Facts

Health Indicators

At least 24 countries, including Japan, Cuba, and the Czech Republic, rank better than the U.S. on infant mortality (Starfield 2004).

The rate of low birthweight babies has increased from 6.8 percent in 1980 to 8.1 percent in 2004 (Federal Interagency Forum on Child and Family Statistics 2006).

In 2004, 83 percent of children ages 19 to 35 months had received the recommended combined series of vaccines, compared with 76 percent in 1996 (Federal Interagency Forum on Child and Family Statistics 2006).

Dental caries (tooth decay) is the single most common chronic childhood disease (HHS 2003).

In 2004, 18 percent of children were overweight (Federal Interagency Forum on Child and Family Statistics 2006).

The rate of children with asthma doubled, from 3 percent in 1981 to 6 percent in 2004 (Child Trends 2006).

Overall, the U.S. teen pregnancy rate dropped 30 percent from 1991 to 2002 (Guttmacher Institute 2006).

The rate of teen smoking decreased from 36 percent in 1997 to 29 percent in 2001 (CDC 2002).

Injuries, including homicide, suicide, and accidents, account for three of four deaths among adolescents ages 15 to 19 (Federal Interagency Forum on Child and Family Statistics 2006).

Demography

Children under age 18 represented 25 percent of the population in 2004, down from a peak of 36 percent at the end of the baby boom in 1964. The number of children is projected to increase to 80 million and represent 24 percent of the population in 2020 (Federal Interagency Forum on Child and Family Statistics 2006).

In the U.S., 13 percent of children have at least one special health care need (Association of Maternal and Child Health Programs 2005).

Thirteen million children live in poverty. This number has increased 10 percent to 12 percent over the past five years (Brookings Center on Children and Families 2006).

In 2004, 16.1 per 1,000 infants and toddlers were victims of abuse or neglect (Urban Institute 2006).

Access to Health Care

Twelve percent of all children are uninsured; 20 percent of children in low-income families are uninsured (Kaiser Commision on Medicaid and the Unisured 2005).

In 2004, 29 percent of uninsured children had no usual source of health care (Federal Interagency Forum on Child and Family Statistics 2006).

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Recommended Reading

Begley, Sharon, and Ruby P. Hearn, "Children's Health Initiatives," in Stephen L. Isaacs and James R. Knickman, eds., *To Improve Health and Health Care 2001: The Robert Wood Johnson Foundation Anthology* (San Francisco, CA: Jossey-Bass, 2001).

This essay examines the wide range of approaches employed by the foundation to improve the health of all children. The authors demonstrate how the foundation shifted its strategies in response to social and political changes and offer suggestions about how to improve children's health based on over 25 years of experience.

Brodeur, Paul, "School-Based Health Clinics," in Stephen L. Isaacs and James R. Knickman, eds., *To Improve Health and Health Care 2000: The Robert Wood Johnson Foundation Anthology* (San Francisco, CA: Jossey-Bass, 1999).

Robert Wood Johnson Foundation has been involved in school-based health for over 25 years. This essay describes the foundation's work in establishing some of the first school-based health clinics in the nation as well as examines how to sustain the projects in the long term.

Federal Interagency Forum on Child and Family Statistics, *America's Children in Brief: Key National Indicators of Well-Being, 2006* (Washington, DC: U.S. Government Printing Office, 2006).

Since 1997, the Federal Interagency Forum on Child and Family Statistics has published this annual report that includes detailed information on the well-being of children and families. The forum updates all data on its Web site (http://childstats.gov), and the report provides indicators such as teen birth rates, percentage of children living in poverty, and percentage of overweight children.

Grantmakers In Health, "Adolescence to Adulthood: Crossing the Threshold," Issue Focus, *GIH Bulletin*, November 6, 2006.

The period between adolescence and adulthood is a time of great transition. This article outlines major health-related issues for transition-age youth and highlights some important work that foundations have been pursuing.

Grantmakers In Health, *In Harm's Way: Aiding Children Exposed to Trauma* (Washington, DC: 2005).

Every year, thousands of children nationwide experience trauma as a result of exposure to violence, abuse, natural disasters, severe illness or injury, loss of loved ones due to violence or accident, or forced relocation. This Issue Brief focuses on the needs of children exposed to trauma, strategies for early identification and intervention, and ensuring the provision of timely and appropriate services to them and their caregivers.

Grantmakers In Health, *More Coverage, Better Care: Improving Children's Access to Health Services* (Washington, DC: 2006).

This Issue Brief covers how the current health care system succeeds and fails for children, emerging policy developments, what grantmakers are currently doing to promote children's access to health services, and lessons learned to help guide future work.

Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Washington, DC: National Academy Press, 2000).

This report reviews the science of early childhood brain development. The report recommends that new investments in children's health take advantage of the research on early childhood development to improve existing policies aimed at raising and educating young children.

Lawrence, Steven, Lauren LeRoy, and Anne L. Schwartz, *Foundation Funding for Children's Health: An Overview of Recent Trends* (New York, NY: Foundation Center, 2005).

This detailed examination of U.S. foundation health giving that specifically benefits children and youth studies funding trends from 1999 through 2003. The report breaks out giving by priority area, geographic region, and type of support.

Wise, Paul H., "The Transformation of Child Health in the United States," *Health Affairs* 23(5): 9-25, 2004.

This *Health Affairs* article outlines trends in children's health, with a specific look at the social disparities that persist. The author provides a thorough examination of the child health system—what works, what is broken and explains the implications for both practice and policy.