

Children's Health Trajectories in the US and England: Racial and Ethnic Disparities by Family Immigrant Status

Extended Abstract

Introduction. Americans experience significantly worse health than their English counterparts at all ages from birth to old age (Banks et al., 2006; Teitler et al., 2007; Martinson et al., In Press), however it is largely unknown how this country-level health differential translates into country-specific racial and ethnic health disparities. The majority of comparative studies on health in the two countries have focused on the magnitude of SES inequalities in health and the steepness of the gradient in the two countries (Case et al., 2002; Banks et al., 2006; Currie et al., 2007; Case et al., 2008; Avendano et al., 2009). However, we know of only two previous studies comparing racial and ethnic disparities in morbidity in the United States (US) and England, and neither of these focuses on the childhood years. Nazroo et al. (2007) find similarities in adult health disparities between whites and African Americans in the US and between whites and Black Caribbeans in England, though they find no statistical difference in the health of “Caribbean Americans” (immigrants) and whites in the US. Similar levels of racial/ethnic disparities in low birth weight have been documented in both countries in a study examining the rates among whites, blacks, and Hispanics in the US and whites, blacks, and Asians in England (Teitler et al., 2007). This study did not explicitly examine differences by nativity.

Despite a number of social and cultural similarities between the US and England, there are stark differences in the provision of healthcare in the two countries. A recent study has demonstrated that there are no racial/ethnic differences in access to primary care services in England (Nazroo et al., 2009). Yet in the US, we know that compared to non-Hispanic whites, twice as many blacks and three times as many Hispanics are uninsured (US Census, 2009).

There are other social and economic policies in England, such as the Health Visitor Program and extensive and equitable early childhood education, which could reasonably lessen the extent of racial and ethnic disparities in health.

Another major difference between the two countries is the nature of the racial and ethnic populations. For example, blacks in the US are very different from the black population in England, which is predominantly of Caribbean ancestry, followed by those of African ancestry. There is a large black immigrant population in England, so we might expect disparities between blacks and non-Hispanic whites to be larger in the US. Finally, we know that there are different immigration histories in the two countries that could also play a significant role in racial and ethnic disparities. The majority of US immigrants are from Mexico and Latin America followed by China, whereas most UK immigrants are from Pakistan, India, Bangladesh, and the Caribbean. Despite all these differences, Jackson et al. (2009) find similarities in the protective effect of foreign-born status among mother's health behaviors in the two countries.

This study examines the health trajectories of children in the US and England, using longitudinal data, in order to determine the extent of racial and ethnic disparities, and how these disparities develop in the two countries. First, children's health trajectories are systematically examined in order to discern the magnitude of racial and ethnic disparities in each country, and the differences in disparities in these two countries. Second, we explore how these disparities vary by parent's nativity status and the extent of the immigrant advantage in each country.

With respect to the first analysis, we hypothesize that we will find larger racial and ethnic disparities in the US than in England as the children mature, based on differences in health care and social protection systems. For the second analysis, we expect that children born to immigrant parents will be in better health than children with native-born parents in both the US and

England, and that the protective effect of parent's immigrant status will be similar in the two countries based on the literature on mothers' health behaviors (Jackson et al., 2009).

Data and Methods. This study uses the Fragile Families and Child Wellbeing Study (FFS) for the US and the Millennium Cohort Study (MCS) for England. Both datasets are representative of national populations born between 1998 and 2000 (FFS) or in 2000 (MCS), and both have oversamples of minorities. The primary health outcomes of interest are body mass index (BMI) and obesity/overweight, diagnosed asthma and wheezing, and parent's report of child health (5 point scale). The racial and ethnic categories for the US are: Hispanic, non-hispanic black, and non-Hispanic white. For England the categories are: Asian (Pakistani, Bangladeshi, and Indian origin), black (Black Caribbean and Black African), and white. Finally, the immigration status of each of the child's parents is also included in both datasets, as is their country of origin and age at migration. FFS and MCS both have very rich sets of covariates, which is an advantage in this study over previous studies that have used health surveys with only basic sociodemographic controls.

Children are observed at 0, 1, 3, 5, and 9 years in the US and at 9 months, 3, 5, and 7.5 years in England. Growth models are estimated using multilevel modeling in Stata SE 11. We will present trajectories of BMI and obesity/overweight, asthma and wheezing, and parent's report of health by race/ethnicity in each country – allowing for variation by parent's immigrant status and a rich set of sociodemographic controls. All estimates are weighted to account for the complex sampling design in the FFS and MCS.

References

- Avendano M, Glymour MM, Banks J, Mackenbach JP. (2009). Health disadvantage in US adults aged 50 to 74 years: A comparison of the health of rich and poor Americans with that of Europeans. *Am J Public Health* 99:540-548.
- Banks, J., M. Marmot, Z. Oldfield, & J.P. Smith. (2006a). Disease and disadvantage in the United States and England. *Journal of the American Medical Association* 295(17): 2037-2045.
- Case, A., D. Lubotsky, and C. Paxson. (2002). Economic status and health in childhood: The origins of the gradient. *The American Economic Review* 92(5):1308-1334.
- Case, A., D. Lee, & C. Paxson. (2008). The income gradient in children's health: A comment on Currie, Shields, and Wheatley Price. *Journal of Health Economics* 27(3): 801-807.
- Currie, A., M.A. Shields, & S. Wheatley Price. (2007). The child health/family income gradient: Evidence from England. *Journal of Health Economics* 26: 213-232.
- Jackson, M., S. McLanahan, & K. Kiernan. (2009). Mothers' investments in child health in the U.S. and U.K.: A comparative lens on the immigrant paradox. *Fragile Families Working Paper WP09-24-FF*.
- Martinson, M.L., J.O. Teitler, & N.E. Reichman. Health across the life span in the United States and England. *American Journal of Epidemiology*. In press.
- Nazroo, J., J. Jackson, S. Karlsen, & M. Torres. (2007). The black diaspora and health inequalities in the US and England: Does where you go and how you get there make a difference? *Sociology of Health and Illness* 29(6): 811-830.
- Nazroo, J.Y., E. Falaschetti, M. Pierce, & P. Primatesta. (2009). Ethnic inequalities in access to and outcomes of healthcare: Analysis of the Health Survey for England. *J Epidemiol Community Health* 63: 1022-1027.
- Teitler, J.O., N.E. Reichman, L. Nepomnyaschy, & M. Martinson. (2007). A Cross-National Comparison of Racial and Ethnic Disparities in Low Birth Weight in the United States and England. *Pediatrics* 120(5): e1182-e1189.
- U.S. Census Bureau. (2009). Income, poverty, and health insurance coverage in the United States: 2008. Washington DC: United States Census Bureau.