Child Poverty in the United States Today: Introduction and Executive Summary

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CHILDHOOD POVERTY HAS been a persistent problem in the United States, with approximately 1 in 5 children living below the official federal poverty level (FPL) and almost 1 in 2 who are poor or near poor.[1] Child poverty rates have varied somewhat with economic cycles. In recent decades, implementation of antipoverty measures aimed at families with children has shown some protective benefit, especially during the Great Recession. Nevertheless, children remain the poorest members of our society even in good times, with rates that are unacceptably high for a developed nation. This situation is not an inevitable fact of life. The United States is a nation that knows how to use policies and programs to raise its citizens out of poverty. In 1959, a total of 35% of seniors lived below the official FPL, but today, with programs such as Social Security expansion and Medicare, only 10% of seniors live below the official FPL.[1]

The negative consequences of poverty on child health and well-being are often lifelong, leading to worse health, lower developmental and educational outcomes, increased criminal behavior as adolescents and adults, and ultimately intergenerational cycles of poverty.[2–4] In terms of traditional health outcomes, poor children have increased infant mortality, higher rates of low birth weight and subsequent health and developmental problems, increased frequency and severity of chronic diseases such as asthma, greater food insecurity with poorer nutrition and growth, increased unintentional injury and mortality, poorer oral health, and increased rates of obesity and its complications. In particular, poor children experience greater trauma and have substantially worse behavioral and mental health outcomes. There is also increasing evidence that poverty in childhood creates a significant and lasting health burden in adulthood that is independent of adult-level risk factors.[5]

After a call to action in the 2012 Academic Pediatric Association (APA) presidential address,[6] the APA established a Task Force on Childhood Poverty, bringing together leading pediatricians, social scientists, policy experts, and advocates from across the United States and Canada. Many leaders in the APA, as well as leaders in the American Academy of Pediatrics (AAP), joined this endeavor. In 2013, the AAP adopted poverty and child health as its latest strategic priority, lending its reach to 64,000 pediatricians and its ability to effectively lead policy and advocacy in this effort.

The APA Task Force developed a strategic road map, including a focus on public policy and advocacy, health care delivery, medical education, and research and data.[7] One overarching deliverable was a state-of-the-art compilation on the entire scope of childhood poverty in the United States that would inform the response of pediatricians, educators, advocates and policy makers to this critical issue facing children and our country today. This supplement to *Academic Pediatrics,* published thanks to generous funding from the Robert Wood Johnson Foundation, brings together leading pediatric researchers and child advocates, social scientists, economists, and public health and policy experts from North America and Europe to address the following issues:

- The impact of poverty on the nation's human capital—elucidating how poverty gets under a child's skin.
- The definitions and measurement of poverty (ie, who is poor)—unpacking what poverty means, what is built into the concept of poverty in different measures, and what role government programs play.
- A comparison of the United States to other developed nations internationally, including levels of child poverty and interventions to alleviate and ameliorate child poverty
- Interventions in the United States, inside and outside the health care system, to decrease the level of child poverty and mitigate the effects of poverty on children, defining a position and role for child health professionals as advocates

In this executive summary, we summarize the thoughtful articles from each category and provide some conclusions.

In addition, several commentaries by experts in child poverty provide perspectives on the roots of this problem and strategies to move forward.

CHILD POVERTY: AN ATTACK ON OUR NATION'S HUMAN CAPITAL

Chaudry and Wimer[8] discuss the negative effect of family poverty experienced during childhood on outcomes for children into young adulthood. They focus on impaired physical health, developmental problems, poor educational outcomes, food insecurity, and life-altering events, such as teenage pregnancy and criminal activity. They conclude that improved income causally leads to meaningful improvements in child outcomes. In addition, the authors elucidate the mechanisms by which low family income affects children, especially reduction in resources available to the child (ie, material hardship), compromised family relationships and increased parental stress.

Blair and Raver[9] focus on poverty and early brain and child development. They review the literature regarding the association of poverty with decreased volume and surface area of key brain structures, as well as the role of toxic stress and resultant neuroendocrine disturbances in producing negative behavioral outcomes and ultimately decreasing school readiness and school achievement in poor children. Because parenting is a key mechanism in producing these outcomes, they propose multigenerational antipoverty policies that focus on improving positive parenting through interventions in the home, the community, and pediatric primary care in order to prevent or repair these biological and psychological developmental disturbances. In addition, a focus on the child in the context of high quality preschool is recommended as a policy imperative.

Wise[10] reviews the life-course literature to articulate what is known regarding the impact of child poverty on long term health, morbidity and mortality in adulthood. Clinical conditions, such as cardiovascular disease, cancer, mental health, respiratory conditions, and osteoporosis all demonstrate associations with child poverty. Proposed mechanisms for associations or causality include epigenetics, in utero nutrition, environmental contaminants, and chronic or toxic stress with increased inflammation and allostatic load. In addition, adult health behaviors have their antecedents in childhood, and these established health risk behaviors lead to bad health outcomes later in life. It is likely that there is not a singular critical time period in early life for these mechanisms, but that sensitive periods and cumulative exposure and experiences lead to development of adult conditions and behaviors.

WHO IS POOR: THE DEFINITION AND MEASUREMENT OF POVERTY

Short[11] focuses on income-based poverty measures, the most commonly used type of measure in most countries. Basic needs budgets, which sum up necessary goods and services to the point of family self-sufficiency, are different from income-based measures and are also briefly discussed. Analyses of current basic needs budgets demonstrate that our income-based poverty threshold (the FPL) is likely not high enough to meet a self-sufficiency standard, which is generally estimated as closer to 200% of the FPL, with wide variations based on local cost of living.

Three poverty measures are explained in depth by Short and compared: relative poverty measures used internationally, the United States absolute official FPL, and a new supplemental poverty measure (SPM) that has been designed to address some of the criticisms of the official FPL. The 3 measures give different results for child poverty rates, with the relative measure being highest and the SPM being lowest. The SPM includes as income both cash and noncash benefits, such as tax credits and food assistance programs, that are specially designed for families with children. It is therefore the most useful measure to gauge the impact of federal policies on child poverty rates and on helping families meet their basic needs. By all 3 measures, however, children are the poorest age group in our society.

Poverty involves at least 3 types of disadvantage: income poverty, severe material hardship, and adult health problems such as family illness or disability that threaten economic security. Material hardship is related to finances, utilities, food, housing, and medical care, as evidenced by running out of money before the next paycheck, utilities turned off because of lack of payment, food insecurity, moving in with others or moving to a shelter, or foregoing medical services because of lack of money. The longitudinal New York City Poverty Tracker study, described by Neckerman et al[12] in this supplement, captures all 3 dimensions of poverty and creates a broader, more nuanced picture of economic disadvantage than do previous studies. In New York City, more than half of families with children experience at least one type of disadvantage. Although families' material hardship and family health problems are associated with income poverty, these problems extend well into near-poor and even nonpoor families (eg, 55% of poor, 42% of near-poor, and 22% of nonpoor families experience material hardship). Among factors associated with economic disadvantage, low parental education is consistently highly associated with all components.

Wimer et al[13] further explore improvements on the official FPL described by Short.[11] They use the SPM methodology, which uses a core "basket" of goods defined as necessary to survive in contemporary society. This basket includes food, clothing, shelter, and utilities, plus a multiplier (1.2) to account for other necessities. The SPM adds as income cash and near-cash benefits and tax credits, but it also subtracts necessary expenses such as child care and medical out-of-pocket expenses. Wimer et al use this basic methodology but have developed a research tool called the anchored SPM that fixes the poverty threshold in contemporary living standards, allowing historical comparisons and analyses of trends. The anchored SPM shows that child poverty, while still distressingly high, has dropped by a third over the last 50 years, due mainly to government benefits. Without these benefits,

child poverty would have actually increased substantially over the same 50 years. Once again, parent education appears to be the primary buffer against child poverty. The education dividend appears roughly as large today as it did 50 years ago; while 51.9% of children whose parents have less than a high school degree live in poverty, only 4.9% of children whose parents are college graduates are poor.

INTERNATIONAL CHILD POVERTY COMPARED TO UNITED STATES

The question is often asked: how do child poverty and government antipoverty programs in the United States compare to those in other developed countries? Smeeding and Thévenot[14] examine policies to reduce child poverty and support low-income families in a set of selected rich countries from Europe, North America (the United States and Canada), and Australia. In these countries, relative child poverty rates range from 5% in Norway to over 20% in the United States. The child poverty rate in the United States is twice as high as in the United Kingdom, Sweden, or France. The authors point out that the United States is nearly unique in the degree of disparity in poverty rates between single-parent and 2-parent families, which points to specific failures in the US safety net system. The authors also analyze government policies and their impact. Both cash and in-kind public expenditures vary among the rich nations, with some nations relying more heavily on one strategy or the other. Countries with lower total expenditures supporting families, like the United States, have higher child poverty rates. Finally, this study highlights international differences of in-kind expenditures that support parental work such as public-funded child care, which both lowers poverty rates and ameliorates the impact of poverty on children.

Mansour and Curran[15] focus on the efforts in the United Kingdom to systematically attack the problem of high child poverty rates starting in the late 1990s. The British prime minister pledged to halve child poverty in a decade and eradicate it within a generation. The government then set targets and dedicated resources in the form of income supplements, employment, child care, and education support. While the United States uses primarily means-tested benefits and benefits that require work, the United Kingdom additionally invests in universal supports for children. As a result of these initiatives, absolute child poverty levels nearly halved by the end of the first decade of the United Kingdom war on child poverty. Subsequent changes in government leadership and an austerity response to the Great Recession have slowed progress and resulted in a different approach, focusing more on the drivers of poverty than on poverty level targets. The UK child poverty reduction effort, now spanning 15 years and significant changes in government, offers us a useful comparison model, as well as important policy lessons, as we in the United States consider ways to better address child poverty in this country.

CHILD POVERTY INTERVENTIONS IN THE UNITED STATES

What is the United States presently doing to reduce child poverty and ameliorate the impact of poverty on child health and well-being? Furthermore, what additional policies and programs would be important? In this section of the supplement, a number of authors address these questions.

Racine[16] describes health care system strategies to compensate for the increased morbidity seen in poor children. First, expansion of Medicaid and establishment and strengthening of the Children's Health Insurance Program (CHIP) have helped to give low-income children better access to health care. Barriers related to access to Medicaid-accepting practices or a paucity of physicians to serve the rural poor are an additional challenge. Second, practice-level changes in delivery systems, such as the patient-centered medical home, team-based care, and extending management into the community, have tried to address the needs of poor children in a more comprehensive, holistic way. Third, the federal government and state Medicaid programs have been experimenting with a number of recent models focusing on payment reform, concentrating efforts on high-risk populations, and intensive case management. Fourth, screening for social determinants of health and referral to community resources has begun in pediatric practices. This study also highlights the limits to what can be achieved within the health care system alone to attenuate health consequences of child poverty. Advocacy for public policies such as minimum wage, tax credits, family leave, home visiting programs, and universal preschool becomes an increasingly important responsibility for pediatricians and other health care providers.

Sherman et al[17] address government programs that provide cash and near-cash benefits and review the evidence regarding their impact. They point out that tax credits for working families have been shown not only to decrease child poverty but to lead to higher birth weight, better school outcomes, and increased employment in adulthood. Likewise, the Supplemental Nutrition Assistance Program (SNAP, or food stamps) has been shown to have similar positive impacts. It is likely that these programs work by reducing family stress due to financial difficulties and preventing neuroendocrine and biochemical changes that affect long-term child outcomes. The policy implication is clear: safety net programs really work, and we need to reject funding cuts to these programs and instead work toward increased funding.

Wherry et al[18] address the role of public health insurance in reducing child poverty. Public health insurance, including CHIP and Medicaid for children and Medicaid for parents through the Affordable Care Act (ACA), has offered significant financial benefits to families. These benefits have included reduced out-of-pocket medical expenses, increased financial stability, and improved material well-being. Child poverty in measures like the SPM can be decreased when out-of-pocket medical expenses are reduced. Receipt of public health insurance

connects families to other safety net programs such as SNAP and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which also reduce poverty rates. Furthermore, exposure to public health insurance during childhood has long-lasting effects for both health and economic outcomes in adulthood. The risk of losing public insurance programs such as CHIP that require cyclical reauthorization or limiting Medicaid expansion poses a perpetual threat to children and families in poverty.

Minkovitz et al[19] describe the Federal Home Visiting Program. They highlight the evidence for the effectiveness of the program for low-income families, and they identify ways to promote coordination between medical homes and home visiting. Home visiting programs, funded through the ACA of 2010 and refunded through the Medicare Access and CHIP Reauthorization Act of 2015, have demonstrated effectiveness in improving family economic self-sufficiency; birth outcomes; maternal health; child health, development, and school readiness; and positive parenting practices. Programs work through direct interventions with parents as well as connecting parents to community resources. Coordination between medical homes and home visiting programs is a work in progress, with less than 40% of home visiting programs reporting regular communication with pediatric providers. Ongoing research, evaluation, and quality improvement will further enhance home visiting impact on childhood poverty.

The innovative use of pediatric primary care visits in the first 5 years of life for the promotion of positive parenting to prevent adverse child developmental outcomes is reviewed by Cates et al.[20] The authors describe interventions that involve primary prevention, secondary prevention, and a combination of the two. They stress the characteristics of these interventions—low cost, delivered during the frequent visits in early childhood, and dependent on both strong relationships with pediatric providers and robust public health insurance—and discuss the evidence for effectiveness. Examples of these programs include Reach Out and Read, the Video Interaction Project, Incredible Years, and Healthy Steps. The authors also discuss the challenges of scaling programs to reach the largest number of children, as well as integration with programs in other sectors relevant to children such as home visiting, preschool, and public libraries.

Duncan et al[21] focus on school reform from preschool to high school. The authors discuss the changes in the labor market and the increasing income gap between high- and low-income families that act as drivers of the worse educational and economic outcomes seen in poor children. They review preschool education interventions (such as model programs started in the 1960s and 1970s, Head Start, and pre-K) that focus on preparing children to learn in K-12 education. The article then reviews existing K-12 school reform strategies—including investing more money, introducing more accountability, and putting in place new governance structures such as charter schools—and shows why each of these strategies has often proven insufficient in isolation. The authors then present case studies of more successful reform models in pre-K, elementary, and middle school as well as in high school. These successful interventions focus directly on improving teaching and promoting learning, incorporating sensible accountability systems, and having high academic standards, all leading to raising the achievement of low-income children.

The role of neighborhood, or place, in perpetuating child poverty and place-based neighborhood revitalization to improve opportunities in areas of concentrated poverty are elucidated by Sandel et al[22] in this supplement. The authors briefly discuss mobility assistance programs to move low-income children to higher-opportunity neighborhoods, but they primarily focus on 3 case studies of neighborhood-level interventions. They describe the Child Opportunity Index, a tool that integrates multiple indicators of child-relevant neighborhood opportunities and risks in 3 domains: education, health and environmental, and social and economic. The Child Opportunity Index can be used to track change over time and to understand the impact of interventions. They point out the importance of community engagement; multifaceted solutions; the merging of multiple funding streams from cities, philanthropy, and anchor institutions; and the importance of building equity of opportunity and enhancing collective efficacy of community residents. Case studies illustrate interventions that focus on affordable and safe housing, toxic waste removal, early childhood development, school-based programs, and workforce development as examples of multifaceted interventions to improve communities.

Fierman et al[23] highlight the ongoing work of the Health Care Delivery Subcommittee of the APA Task Force on Child Poverty, focusing on pediatric practice redesign to identify poverty-related social determinants of health and to provide interventions to address them. The authors compare available tools for screening for social determinants and describe various strategies for linking families to community-based resources addressing their needs. They also discuss well-established and developing embedded programs, such as Health Leads, the Medical-Legal Partnership, and Reach Out and Read. Opportunities for partnership with home visiting programs in the community, as well as the challenges of reimbursement for these types of practice redesign activities, are also addressed.

What is the role of pediatricians as change agents to reduce child poverty and lead system change to improve the lives of children in the United States? How can we educate pediatricians in training to create the next generation of pediatrician-advocates? Plax et al[24] address this important issue by focusing on the powerful tools that pediatricians can already bring to bear. The authors present 3 examples of pediatrician–community partnerships to make a difference for children in Ferguson (Missouri), Denver (Colorado), and Rochester (New York). Finally, they describe the Community Pediatrics Training Initiative at the AAP, a national program to develop pediatric faculty and train pediatric residents to use these tools and to engage with community partners to make a difference.

Finally, preparing for future involvement of pediatricians in the critical issue of child poverty,

Chamberlain et al[25] describe the work of the Child Poverty Education Subcommittee of the APA Task Force on Childhood Poverty to develop a curriculum on child poverty for teachers and learners across the medical education continuum. Over a 2-year period, educators, pediatricians, trainees, and public health professionals from across the United States and Canada met to develop a curriculum that could be implemented in undergraduate and graduate medical education. Four core domains were identified: the epidemiology of child poverty, poverty-related social determinants of health, the pathophysiology of the effects of poverty, and leadership and action to reduce and prevent poverty's health effects. Future activities include implementation, evaluation, and dissemination of the curriculum, as well as adapting it to the issues specific to local communities.

CONCLUSION

The intent of this supplement to *Academic Pediatrics* is to summarize our knowledge of the impact of poverty on children, of the present state of policies and interventions to alleviate and ameliorate child poverty in the United States and in the developed world, and of future directions for policy. We hope that this synthesis will empower pediatricians and other pediatric health providers, local and national leaders who are striving to improve the lives and outcomes of children and families, and policy makers and change agents to use their agency and activism to address this critical issue. Underlying this agenda are: 1) a belief that social justice demands both a robust safety net and universal opportunity for social mobility; 2) an acceptance of a broad definition of health that goes beyond well-being and focuses on the accumulation of human capital; 3) a recognition that social determinants of health impact and outweigh traditional health care for most children, and that health care must radically transform in response; and 4) a desire to eliminate, now and for the generations that follow, the health inequities that divide us. Pediatricians are in a unique position to help poor children, both directly in their practices and as trusted advocates for children in the public arena. They must work with leaders in education, social service programs, government, and business—virtually every sector of society that collectively has a strong stake in addressing the problem of child poverty. For whom are these children not our children? And for whom is the time to engage not now?

To quote Frederick Douglass, "It is easier to build strong children than it is to repair broken men."

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