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Review

Poverty in childhood and adverse health outcomes in adulthood

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ABSTRACT

The experience of poverty during childhood is a potent predictor of a variety of adverse health outcomes during middle and late adulthood. Children who live in poverty are more likely as adults than their peers to develop and die earlier from a range of diseases. These effects are especially strong for cardiovascular disease and type II diabetes. Most disturbingly, these effects appear in large part to be biologically embedded such that later improved life circumstances have only a modest ameliorative effect. Considering these findings and the relatively high rates of child poverty in nations such as Canada, UK, and USA, those concerned with improving the health of citizens should focus their attention on advocating for public policy that will reduce the incidence of child poverty.

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1. Introduction

The experience of material and social deprivation is strongly related to adverse health outcomes at each period of the lifespan. These effects can be contemporaneous. As examples, children in poor quality housing have greater risk of asthma; adults who experience employment loss have greater risk of depression; isolation during later adulthood increases risk of early mortality. More disturbing, deprivation during childhood serves as a potent predictor of adverse health outcomes during middle and late adulthood. And in many cases, these effects persist regardless of later life circumstances.

A variety of processes are responsible for this. First, children experiencing deprivation due to their social location (e.g., social class, gender, race, etc.,) frequently continue to experience deprivation – and adverse health outcomes – later in life. Second, children experiencing deprivation manifest developmental delays that block access to health protecting resources during adulthood. Third, the experience of deprivation during childhood becomes biologically embedded increasing risk of later adverse health outcomes regardless of later life circumstances [1].

In both developed and developing nations the term childhood poverty describes the experience of material and social deprivation shown to be such a potent predictor of adverse health outcomes. The term "absolute poverty" refers to deprivation so severe as to threaten biological integrity (i.e., lack of shelter, clothing, and food) and is the stuff of child poverty in developing nations, though also present in wealthy developed nations. "Relative poverty" refers to deprivation that does not allow the individual to carry out the usual activities expected within the society (i.e., employment, leisure, and cultural). International consensus identifies individuals or families receiving less than half the median income of the jurisdiction as living in relative poverty. Use of this definition finds childhood poverty rates of 21% in the USA, 15% in Canada, 10% in the UK, 8% in France, and 3% in Denmark [2]. Ample evidence exists to show that children living in relative poverty experience significant threats to health across the lifespan.

The article reviews how child poverty – using the relative poverty definition – leads to adverse health outcomes during adulthood in wealthy developed nations. Such analysis is especially timely. First, there is increasing evidence that exposures to adverse conditions associated with living in poverty are important predictors of a variety of adverse health outcomes during middle and late adulthood. Second, despite this accumulating evidence, there continues to be an inordinate emphasis on modifying behavioural risk factors during adulthood that plays out as "healthy lifestyle choices" approaches to promoting health. Third, public policy decisions in many wealthy developed nations have done little to reduce child poverty rates and in many instances have served to increase them. The goal of this review is to draw attention to the importance of reducing childhood poverty as a means of avoiding adverse health outcomes during middle and later adulthood.

2. Disciplinary perspectives

A variety of literatures inform this review: epidemiology, developmental psychopathology, developmental and physiological psychology, sociology, and political economy.

2.1. Epidemiology

Adverse experiences associated with living in poverty during childhood manifest in illness during adulthood [3]. These associations hold for a remarkable range of adverse physical and mental health outcomes. Longitudinal studies show that in some important instances, these child-acquired experiences increase the risk for adverse health outcomes regardless of later adult circumstances [4].

2.2. Developmental psychopathology

During pregnancy poverty affect the integrity of specific body organs [5]. Later, poverty experiences alter children's bodies to affect emotional regulation, sensory regulation, gross and fine motor skills, generalized brain development, and hypothalamic-pituitary–adrenal function [6]. Greater incidence of infections leads to later adverse health outcomes [7].

2.3. Developmental psychology

Children in poverty do less well in school, develop a weaker sense of control over the environment, and show a greater likelihood of adopting health threatening behaviours, all of which are powerful determinants of health [8]. Poverty experiences disrupt cognitive, affective, and social competencies that reduce future access to economic and social resources that protect health [9].

2.4. Physiological psychology

Ongoing elicitation of the stress reaction – associated with living in poverty – threatens health [10]. Elevated levels of the stress hormones cortisol and adrenaline contribute to endocrine, metabolic, and immune systems problems during adulthood. The elevated presence of these among children affects brain functioning and development [11].

2.5. Sociology

The operation of economic and political systems skew the distributions of influence, power, and resources that create childhood poverty [12]. Societal discourses – or explanations – are developed to justify poverty's presence and the adverse health outcomes during adulthood that result.

2.6. Political economy

In liberal welfare states such as Canada, the UK, and US, governments tend to avoid intervening in the operation of the market economy. The result is skewed distributions of resources that create poverty. This is less so among social democratic (e.g., Norway and Sweden) and conservative (e.g., France and Belgium) welfare states. Reducing child poverty – thereby improving adult health outcomes – requires addressing a range of political and economic issues [13].

3. The evidence

The strong relationship between material and social deprivation and adverse health outcomes has been known since the mid 1800s but an extensive literature is now available of how deprivation during childhood – i.e., child poverty – leads to adverse health outcomes during adulthood.

3.1. All-cause and specific disease mortality

Two studies illustrate typical findings of the effects of childhood deprivation using the proxy of manual occupations in the UK. Davey Smith et al. [14] report that lower socioeconomic position during childhood is significantly related to relative mortality rates among Scottish men even after adjusting for adult socioeconomic position. Men whose parents were in the lowest positions (IV and V, manual

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