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,