

## Child Poverty and the Health Care System



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### ABSTRACT

The persistence of child poverty in the United States and the pervasive health consequences it engenders present unique challenges to the health care system. Human capital theory and empirical observation suggest that the increased disease burden experienced by poor children originates from social conditions that provide suboptimal educational, nutritional, environmental, and parental inputs to good health. Faced with the resultant excess rates of pediatric morbidity, the US health care system has developed a variety of compensatory strategies. In the first instance, Medicaid, the federal–state governmental finance system designed to assure health insurance coverage for poor children, has increased its eligibility thresholds and expanded its benefits to allow greater access to health services for this vulnerable population. A second arm of response involves a gradual reengineering of health care delivery at the practice level, including the dissemination of patient-centered medical homes, the use of team-based approaches to care, and the expansion of care management beyond the practice to reach

deep into the community. Third is a series of recent experiments involving the federal government and state Medicaid programs that includes payment reforms of various kinds, enhanced reporting, concentration on high-risk populations, and intensive case management. Fourth, pediatric practices have begun to make use of specific tools that permit the identification and referral of children facing social stresses arising from poverty. Finally, constituencies within the health care system participate in enhanced advocacy efforts to raise awareness of poverty as a distinct threat to child health and to press for public policy responses such as minimum wage increases, expansion of tax credits, paid family leave, universal preschool education, and other priorities focused on child poverty.

**KEYWORDS:** children; health care systems; health economics; poverty

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THE CONVENTIONAL ROLE of the US health care system is to identify, ameliorate, and, whenever possible, prevent the pathological conditions that present to it. This system is also the final common pathway through which the physically and mentally suffering of society pass in search of succor and relief. What appears at the threshold of the health care system, however, has antecedents with deep roots in a variety of other social structures—factors such as income, wealth, education, housing, nutrition, and air quality, as well as other features of the context in which individuals grow and develop.<sup>1</sup>

In a market economy, individual or household income determines access to the collection of health-determining resources mentioned above. We can consequently observe a clear inverse relationship between income and disease: the more income available to an individual or family in general, the lower the burden of disease suffered by that individual or family. From a causal standpoint, that association is partly bidirectional. Children with chronic illness may impede parental earning capacity if one or both parents are required to curtail their wage earning to care for the child, but more commonly, parents in poorer families find

that their ability to afford the inputs to raising healthy children is beyond their means.<sup>2</sup> Whatever the causal direction linking income to health status in children, the health care system is frequently called on to confront the consequences of this relationship. In this regard, poverty has a particularly salient impact on the focus of the health care system, its financing, and the effectiveness of its undertakings.

What must also be acknowledged is that the population of children living in poverty, like any population of children, is not homogeneous. Particularly in a country as culturally and regionally diverse as the United States, many groups of children with meager material resources benefit from family structures, broad adult support networks, and traditional cultural norms that foster resilience in the face of resource deprivation, resulting in successful outcomes.<sup>2,3</sup>

### THE NEXUS OF POVERTY, PUBLIC POLICY, AND HEALTH CARE SYSTEMS

#### THE ORIGINS OF HEALTH

There is a substantial theoretical and empirical basis to acknowledge that good health owes less to the receipt of

what the health care system provides than it does to a variety of more influential social factors.<sup>4</sup> The human capital literature,<sup>5</sup> and Grossman's<sup>6</sup> seminal work in particular, conceptualizes healthy time as an outcome produced by combining a variety of inputs including education, nutrition, housing, exercise, and the avoidance of risky behaviors. Medical care services may constitute part of that production function, but the marginal impact of health care services relative to many other factors is small.

Because so many of the inputs into the health production function consist of goods and services purchased in the market, the allocative decisions that individuals make in deciding which elements to access is of signal importance to the outcomes they achieve. The choices available to individuals or families, however, are constrained by their budgets, so that below a critical threshold poverty predictably engenders limited health outcomes, as can be observed in empirical studies of the relationship between health and income.<sup>7,8</sup> Partly this poverty effect is the simple result of not being able to afford to purchase the inputs to healthy time, and partly this effect stems from the impact that economic uncertainty exerts on an individual's capacity to make well-reasoned allocative decisions with the resources available.<sup>9</sup>

### POVERTY DYNAMICS

If being poor conditions suboptimal health outcomes, then the income available to families as modified by governmental tax and transfer policies is the most relevant measure to take into account when considering the influence on health status. The official poverty measure that is used to calculate the percentage of children living below the poverty threshold, for example, tends to overstate the poverty level among children because it does not take into account transfers from such important government programs such as the Earned Income Tax Credit, the Supplemental Nutrition Assistance Program, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and public housing supports.<sup>10</sup> Using the supplemental poverty measure, the actual poverty rate for children in 2014, for example, would have been 16.7% rather than 21.5%, suggesting that governmental programs included in the supplemental measure were responsible for keeping over 3 million US children out of poverty.<sup>11</sup>

Although this is laudable, it is far from what is achievable through the application of these mechanisms, as the experience in England<sup>12</sup> and continental Europe illustrates. In a modern European context, where health care, early child care, sick leave, education, and retirement are financed through tax and transfer policies, the posttax income distribution experienced by the populations of those states is far different than what is experienced in the United States even if the pretax income distributions are not that dissimilar.<sup>13</sup>

Compared with its European counterparts, the United States underinvests in the foundational elements for good health in its pediatric population, then turns to the medical

system when this underinvestment results in elevated levels of disease and disability and asks this system to manage the problem. The health care system in this context is being asked to pay a promissory note that has come due on child health outcomes using the means at its disposal. In response, it has generated a series of attempts to remediate the effects of the relative underinvestment in child health on the part of other sectors in the society.

## RESPONSE OF HEALTH CARE SYSTEM TO CHILDHOOD POVERTY AND ITS HEALTH EFFECTS

### ADDRESSING COVERAGE

The first response to the challenge of caring for poor children with suboptimal health status was to use federal and state government financing to expand the ability of these children to gain access to the services the health care system has to provide. The history of this expansion parallels the evolution of Medicaid and the Children's Health Insurance Program (CHIP).<sup>14</sup> Before 1965 and the enactment of Medicaid as Title XIX of the Social Security Act, poor children received medical services as part of arrangements linked to the welfare programs established as part of the original Social Security Act. Title V of the original Social Security Act of 1935 allowed states to use federal funds targeting public health programs for children and those with special health care needs. In addition, public assistance provisions of the original act enabled states to provide families with dependent children who received cash welfare payments as part of the Aid for Families with Dependent Children (AFDC) program funds to cover the costs of medical care.

The link between receipt of AFDC or welfare payments to eligibility for health insurance coverage began to be weakened with the enactment of the Medicaid program in 1965. Two years after its enactment, states were permitted to cover children not based solely on receipt of AFDC funds but based on family income. Subsequent amendments to the program changed the income eligibility threshold for pregnant women and infants to permit coverage up to 133% of the federal poverty level, and ultimately to 100% of the federal poverty level for older children as well.<sup>15</sup> On a voluntary basis, states could provide even more generous coverage. In 1997, in order to provide similar coverage for children from families whose income exceeded the Medicaid thresholds but did not permit them to afford commercial coverage, Congress enacted CHIP, targeted at children from families with incomes up to 200% of the federal poverty level.<sup>16</sup> Many states took advantage of provisions in the legislation to provide coverage to families with even higher incomes. The principal category of children whose access to coverage is still quite varied, depending on their state of residence, is children of undocumented immigrants. Federal funds for Medicaid and CHIP are available to legally present immigrant children who must, with some exceptions, wait 5 years before such coverage comes into effect. States,

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