Childhood Poverty

Understanding and Preventing the Adverse Impacts of a Most-Prevalent Risk to Pediatric Health and Well-Being

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KEYWORDS

• Poverty • Income • Low-income • Financial assets • Social determinants of health • Life course

KEY POINTS

- Children living in poor households are at greater risk for worse health, less productivity, and harms to well-being far into adulthood and on into subsequent generations.
- Timing and duration of poverty matter for outcomes throughout the life course, especially for education attainment, health, and lifetime productivity.
- Attention must be focused on interventions at the levels of policy advocacy and the pediatric health delivery system on ways to protect the health and well-being of children and families in economic hardship from the dynamic disadvantages and trauma wrought by poverty.
- A framework for the prevention of child poverty and its dangerous consequences for lifelong health and success on a national scale is presented.

INTRODUCTION

Poverty is the most pervasive of risks for America's children. It routinely cuts short children's lives, ravages the health of families, and blights communities to the detriment of society as a whole. However, the hazards of poverty for child health and well-being are preventable. This has been recognized by pediatricians for more than a century. Abraham Jacobi, a founder of modern pediatrics in America, was born into poverty

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and was an outspoken advocate for the needs of low-income orphans. A principle area of advocacy for the American Academy of Pediatrics today continues to be elimination of child poverty and its preventable ills. Although the notion that the harms of poverty are preventable is not new, today, more than ever, pediatricians have the capability to reduce the ills that low-income children suffer. With more than 1 in 5 of the nation's children living in poverty and nearly half of families struggling to make ends meet on a low income, the pediatrician's ability to intervene could not come at a more critical time.

Decades of evidence make clear that the harms of poverty are much more than a matter of unidimensional material and financial shortage but, instead, are an encompassing and unremitting experience of disadvantage, trauma, and disease. Shortage of capital can be expected to lead to significant health harms and functional limitations in a society in which nearly every basic transaction is monetary. The reality that poverty undergirds and entrenches pediatric disease at all levels is more apparent than ever based on new evidence into the direct, indirect, and contextual effects of poverty; the lifelong harms of poverty that compound over sequential sensitive periods of child development; and the knowledge of what works to reduce the prevalence and complications of poverty.

This article reviews this evidence, presents promising programs to prevent harms of poverty, and outlines a comprehensive framework for child poverty prevention, including a vision of the ways pediatricians can protect the health of low-income children through innovation and action.

DEFINING THE EXTENT OF CHILDHOOD POVERTY

About 15 million, or 1 in 5, American children live below the federal poverty line (FPL).[1] Children are the poorest of all age groups in the United States, where the child poverty rate ranks among the very worst in the developed world.[2] Other first-world nations with similar child poverty rates, such as the United Kingdom,[3] have managed to reverse course as a result of concerted public and political leadership. Yet, in the United States the number of poor children has remained persistently high for decades.

As staggering as the nation's child poverty rate is, the standard measure of poverty used, the FPL, actually significantly underestimates the number of families in economic need. The FPL was created in the mid-1960s, when the economic demands on families were far fewer than today. At the time, food costs represented about a third of a family's budget and the pretax income poverty threshold (the FPL) was simply estimated to be the cost of the minimal adequate food intake multiplied by 3 and adjusted for family size. The FPL represented about half of the median household income when it was devised. However, because its calculation has changed little aside from adjustments for inflation, it is now equivalent to less than a third of median income.[4] Without adjustments to reflect the growth in the cost of raising children and the range of expenses facing families, changes in acceptable living standards, and place-based variation in cost of living, the FPL measure is now seen as too simplistic and too low in real dollars. Nevertheless, it continues to be the conventional needs test for myriad program eligibility, simultaneously entrenching its position as the prevailing poverty benchmark and justifying limited access to programs for many low-income families that could benefit.

Alternative poverty measures exist to address the practical and policy limitations of the FPL and delineate the population of poor children (**Fig. 1**). If the poverty line were still set at half of median income, as it was initially intended in the United States and as has become common in most developed nations, 1 in 3 American children would be