Poverty and Child Health: Can Pediatricians do anything to Help?

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CME Disclosure

Dr. Renee R. Jenkins has no financial disclosures relevant to this presentation and will not discuss off label use and/or investigational use of a commercial product.
Presentation Objectives

At the completion of the presentation, the audience will be able to:

1. Recognize poverty and child health as a one of the child health priorities on the agenda for children of the American Academy of Pediatrics for 2013-14.

2. List 3 adverse child health outcomes associated with child poverty.

3. Choose at least one strategy that the participant will adopt to reduce the negative impact of poverty on the child health.
Presentation Outline

• Why have child health and poverty as an AAP agenda pillar?
• What do we know about poverty and child health outcomes?
• What are some of the effective interventions?
• Review the UK experience in their focus on reducing child poverty
• Report on the progress of the AAP Workgroup and others on addressing child health and poverty
AAP Agenda for Children 2013-2014
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Poverty and Child Health

Children, Adolescents and Media

Epigenetics

Early Brain and Child Development

Access

Quality

Finance

Health Equity

Medical Home

Profession of Pediatrics

Planning
Implementing
Integrating
Determinants of Health

- Genetic predisposition
- Behavioral patterns
- Environmental exposures
- Social circumstances
- Health care

Proportions
“Actual Causes” of Premature Mortality

- Genetic 30%
- Social 15%
- Environment 5%
- Health care 10%
- Behavior 40%

Social Determinants of Health

- Neighborhood and Built Environment
- Health and Healthcare
- Social and Community Context
- Education
- Economic Stability

SDOH
Race, age, education and household type affect likelihood of being poor

Percent in poverty, by characteristic, Minnesota, 2008-2010

Source: U.S. Census Bureau, 2008-2010 American Community Survey.
About 71,000 children in poverty do not have a parent working

Children in poverty in MN by parents’ work status, 2009-2011

- 74,900 Children with one or both parents working full-time (35+ hours)
- 44,200 Children with one or both parents working part-time (20-34 hours), neither full-time
- 71,100 Children with neither parent working full- or part-time

Source: IPUMS microdata version of the U.S. Census Bureau, 2009-2011 American Community Survey. Tabulations my MN State Demographic Center.
Children are disproportionately affected
Nearly 600,000 Minnesotans lived in poverty in 2011-2012

- About 59,000 young children (under 5)
- About 125,000 school-age children (5-17)
- About 360,000 working-age people (18-64)
- About 55,000 seniors (65+)

Source: U.S. Census Bureau, 2012 American Community Survey.
Official poverty by age groups in Minnesota

Source: MNCompass.org
% Poverty by Age
Living Below the Federal Poverty Level 2010

US Census Bureau
Why Address Poverty Now?

- Poverty affects all aspects of health and development
  - Mortality in many chronic conditions
  - Prevalence and severity of most conditions

- Poverty persists – but we can do something about it

- Strong foundation of community pediatrics offers platform to address poverty
  - Thousands of practice innovations
  - Pediatricians around country/world working for change
Health Consequences of Poverty

- Increased infant mortality
- Low birth weight, subsequent problems
- Chronic diseases: asthma, obesity, MH, development
- Food insecurity, poorer nutrition and growth
- Less access to quality health care
- Increased accidental injury, mortality
- Higher exposure to toxic stress

Poverty and Well-Being

- Poorer educational outcomes
  - Low academic achievement, higher HS dropout
- Less positive social, emotional development
- More problem behaviors
  - Early unprotected sex with increased teen pregnancy
  - Drug and alcohol abuse
  - Increased criminal behavior as adolescents and adults
  - More likely to be poor as adults
Economic Case for Ending Childhood Poverty

- Reduces productivity and economic output by about 1.3% of GDP
- Raises the costs of crime by 1.3% of GDP
- Raises health expenditures and reduces the value of health by 1.2% of GDP
- Total cost of childhood poverty is 3.8% of GDP or $500 billion per year
- Context: Estimated Federal Deficit 2014 is 4.3% of GDP

What have national policies done to address poverty?
LBJ declares war on poverty in 1964
War on Poverty Programs

- **Office of Economic Opportunity** was the agency responsible for administering most of the War on Poverty programs created during Johnson's Administration, including:
  - Job Corps, Head Start, Legal Services, and the Food Stamps Program for example
In March 1999, Prime Minister Tony Blair declared war on childhood poverty:
- “Our historic aim will be for ours to be the first generation to end child poverty.”

Gordon Brown, then Chancellor and later Prime minister, set a further target of cutting child poverty by half in 10 years.

Over the next decade Blair & Brown committed considerable resources to attaining this goal:
- “One Percent for the Kids”: An additional 1% of GDP invested in children and families to decrease childhood poverty.
UK’s War on Childhood Poverty: What did they do?

1. Parental leave and work rules
2. Universal preschool for three and four year olds
3. Preschool for disadvantaged 2-year olds
4. Available high quality child care

5. Home visiting and other services for poorest areas
6. Interventions in primary and secondary schools

2. New quasi-universal child tax credit not based on working which is much greater for low income families
3. Tax credits and benefits all paid regularly throughout the year to mother
4. More benefits for younger children
Absolute Child Poverty Rates: United States and United Kingdom

Some Interventions Show Promise
High/Scope Perry Preschool Program: Major Findings at 40

- 7 to 10% per year rate of return
  - Higher than post-World War II stock market (5.8% -- before the 2008 meltdown)
- 7 to 12X Benefit/Cost Ratio

Heckman et al: Rate of return for High/Scope Perry Preschool Program. 2009
Home Visiting Programs
Parent-Child Home Program

Percent First Graders Passing Cognitive Skills Assessment

Interventions in Pediatric Primary Care

Reach Out and Read

Advance in Language (months) in 2-5 yr-olds

- Receptive
- Expressive

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ROR Reaches 4 million children per year:
- ¼ of all poor children!

- Increased parent-child interactions, vocalizations
- Improved child cognitive, language, and social-emotional development
- Reduced delay, with *50% reduction in need for Early Intervention*


Work Group Aspirational Goals

- Build pediatricians’ competence, confidence to address needs of children in poverty
- Address poverty through policy, advocacy, education research, practice, partnerships
- Partner with families to help them thrive and support child development
- Assure every child ready for school/every school ready for child
Goals of Poverty and Child Health Leadership Work Group

1. Clinical Practice/Health System Transformation
2. Child Health Outcomes
3. Messaging/Communications
4. Community Engagement and Partnership
5. Advocacy/Policy
Clinical Practice and Health Care Systems Transformation

Goal: Support pediatricians to address poverty within their practices and engage parents in the effort.

Objectives

- Build pediatricians’ knowledge, skills and confidence to address the needs of children and families in poverty.
- Disseminate tested screening tools for practices to identify unmet basic needs such as food insecurity.
- Identify and disseminate effective strategies and tools for practices to make referrals to relevant community services.
- Develop learning collaboratives or train the trainer approaches to enhance spread of best practices.
- Promote training of residents and medical students in the social determinants of health.
Clinical Practice and Health Care Systems Transformation

**Goal:** Support pediatricians to address poverty within their practices and engage parents in the effort.

*Objectives*

- Support pediatricians to engage parents and families in problem solving and maximize the resources that are available to support their children.

- Partner with relevant AAP groups to provide parents with information and tools to optimize parenting skills and build child and family resilience.

- Identify and advocate for health care delivery system and payment models that focus on improving population health outcomes.
Goal: Support pediatricians, researchers, and other stakeholders to translate research evidence about the impacts of poverty on child health into solutions.

Objectives:

- Monitor and disseminate data and trends about the number of children in low-income and poor households and associated health and life course outcomes.

- Develop and promote recommendations for practice improvements that address the health impacts of child poverty.
Goal: Raise awareness about the impact of poverty on child health and development and the strategies that work to mitigate the health effects of poverty.

Objectives:

- Develop a compelling rationale for poverty as a health priority and communicate it to internal and external stakeholders.
- Identify messages to communicate effective strategies to reduce poverty and its impact on child health and well-being.
Community Engagement and Partnership

**Goal:** Support pediatricians to identify and collaborate with community partners to address the health impacts of child poverty, and improve population health through program, policy and infrastructure changes.

**Objectives:**

- Encourage pediatricians to collaborate with diverse community partners to develop and coordinate services.
- Support pediatricians to effectively represent the child health voice on key community coalitions with legislators and regulators, and across key sectors.
- Promote partnerships with schools and educational partners to support the academic needs of underserved children.
Policy and Advocacy

Goal: Advocate for policy strategies at the federal, state, and local level that help lift families out of poverty and ameliorate the impact of poverty on child health.

Objective:

Advance policies that help reduce the number of children living in poverty including those that:

- Ensure access to continuous quality health insurance coverage
- Support family income (e.g. Earned Income Tax Credit, Child Care Tax Credit)
- Protect critical safety net programs (e.g. SNAP, school nutrition programs)
- Sustain and increase access to affordable housing
- Expand paid maternity and family leave
- Create employment opportunities
- Increase wages to a living wage
Policy and Advocacy

**Goal:** Advocate for policy strategies at the federal, state, and local level that help lift families out of poverty and ameliorate the impact of poverty on child health.

**Objective:**

Advance policy strategies that help ameliorate the impact of poverty on child health and well-being such as those that:

- Increase access to affordable fresh food in underserved communities
- Increase access to high quality pre-school programs and other early childhood supports (e.g. Home Visiting programs)
- Focus on the built environment to help create safe recreational areas for children living in poverty
- Promote community development strategies that improve access to resources and opportunities in all communities
Policy and Advocacy

Goal: Advocate for policies at the national, state, and local levels that help lift families out of poverty and that ameliorate the impact of poverty on the health of children.

Objective:

- Provide education and support for pediatricians to engage in advocacy on non-medical poverty related issues such as income and tax policy, and community development.
BHAP – Big Hairy Audacious Problem
Workgroup Partners

- Within larger pediatric community:
  - APA, APPD, APS, AMSPDC, NAPNAP
- Pediatric and family medicine trainees
- Parent and family organizations
- Business
- Education
- Public health
- Faith-based organizations
- Media outlets
Next Steps

Workgroup will continue to meet to:

1. Prioritize and sequence goals and objectives
2. Develop strategies for priorities
3. Identify resource needs
4. Identify lead groups within the AAP including *members in practice* for each strategy
AAP Resources

- Poverty and Child Health Strategic Priority News and Information
  - www.aap.org/poverty

- Poverty and Child Health State Advocacy Resources
  - www.aap.org/stateadvocacy

For more information:

Contact the Council on Community Pediatrics at: cocp@aap.org
Can Pediatricians do anything to help reduce the negative impact of poverty and child health?

- YES they can!!

- Acknowledge the facts about child poverty in your own community, including existent disparities

- Determine if there are any potential practice changes that you can make

- Work with community agencies directly or through your state chapter

- Advocate, advocate, advocate!!!

- Give your input into the work of the AAP as YOUR organization moves forward to change the lives of poor children and their families
Thank You for Contributions to the Presentation

- AAP Staff: Camille Watson and Judy Dolins
- APA Leadership: Benard Dreyer
- Minnesota AAP: Melissa DeBilizan
“It is easier to build strong children than to repair broken men.”

Frederick Douglass
American Abolitionist
1818-1895