

**Still in Peril:
The Continuing Impact of Poverty and Policy
On America's Most Vulnerable Children**



Children's Health Fund

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Still in Peril: The Continuing Impact of Poverty and Policy On America's Most Vulnerable Children

Summary

Compared to other modern political campaigns over the past sixty years, the run-up to the 2012 elections seems particularly devoid of substantive debate on critical issues or real solutions to unmet challenges. One of the most pressing concerns facing the U.S. relates to how we are—or are not—addressing the needs of America's children.

In fact this is an appropriate and compelling moment to assess the overall status of children with respect to trends in poverty, homelessness, food insecurity and selected specific child health challenges that continue to affect the nation's most vulnerable children and their families. While progress has been made (including the passage of the Child Health Insurance Program in 1997 and its reauthorization in 2009 as well as improved immunization rates), rates of child poverty, homelessness and a number of specific health indicators have stagnated or worsened over the past quarter century.

For instance:

- Child poverty rate in the U.S. in 1987 was 21.4%, compared to the current rate of 22%
- Estimated number of homeless children in the U.S. in 1987 was 1 million; currently 1.6 million
- National childhood asthma prevalence was 8.8% in late 1980s, now 13.6% with much higher rates in inner city or homeless populations
- Childhood obesity was at 11.2% of total child populations in 1987; now is at least 18%

During this 25-year span, political control of government at every level has shifted back and forth between the two major parties. And the national economy has also cycled between times of great prosperity and times of dangerously depressed economic indicators, including high unemployment, massive budget deficits and deep recession.

Yet an unfortunate constant, through good times and bad, has been the seemingly intractable childhood poverty levels and an unstable, increasingly porous safety net for children who have

immediate need for food security and accessible medical care. While food and health care are immediate and urgent challenges, permanent solutions to persistent poverty and strategies to implement a rational, affordable health care system remain elusive or highly vulnerable to political and ideological attack.

Sadly, for very disadvantaged children, the ability to succeed in school and life is profoundly affected by unmet health care needs. In the absence of timely access to the right kind of health services, the chances of a hearing or visual deficit going undiagnosed is high. The same is true for an early developmental deficit, environmental exposure to lead, chronic anemia or a host of other conditions that can undermine brain development, cognitive capacity, and the chance of achieving success in school. This is a major concern, much exacerbated by the prevalence of sub-standard schools in the communities where these children live.

If yet another generation of children are lost to the unmet challenges of poverty, poor access to appropriate and timely health care, and an inability to fix our educational system for all children in every community, the next 25-year report from Children's Health Fund will be written when America's global leadership is diminished in ways that are impossible to imagine. Every child that has been cared for by Children's Health Fund programs since 1987—and all those who didn't have such opportunities—is part of the vital fabric of our society. The extent to which they are able to succeed at their full potential will determine the fate of our country in the decades to come.

Children's Health Fund: 25 Years of Health Care for Medically Underserved Children

Throughout the 1980s, stories in the press about the growing crisis of homelessness in New York City became increasingly frequent and more dramatic as the media reported on growing numbers of homeless families and the deplorable conditions of the city's welfare hotels and shelters.

These facilities became the mainstay of a shelter system that was simply unable to accommodate a homeless population that seemed larger and needier with every passing day. What's more, it was clear that homelessness was taking a particularly terrible toll on children.

Intended as a short-term response to an urgent, extreme, and what was then considered to be a "temporary" crisis, pediatrician Irwin Redlener and singer-songwriter Paul Simon created

Children's Health Fund to bring doctors to the doorstep of New York City's homeless shelters and provide badly needed care to the children living in extreme urban squalor. They, along with Karen Redlener, designed and funded a unique, fully-equipped mobile clinic, outfitted it with all the facilities of a conventional pediatrician's office, and started the New York Children's Health Project, the first direct medical care initiative of Children's Health Fund.

Twenty-five years later, Children's Health Fund and its New York City programs continue to play a key role in assuring access to quality care for homeless and other medically underserved children and their families. While conditions in homeless shelters have qualitatively improved, the number of homeless children has dramatically soared. On an average day in 1987 there were nearly 11,000 homeless children in New York City, while there are now almost 18,000. Across America, there are currently at least 1.6 million homeless kids, up from an estimated 1 million in the late 1980s.

Today, after program expansion and replication, Children's Health Fund has gone from the single mobile pediatric clinic serving homeless shelters in New York City in late 1987 to a national fleet of 50 mobile clinics. [1, 2] Working with partners, including major academic medical centers across the country, Children's Health Fund's national network provides high quality health care to some of the nation's most vulnerable populations. The New York Children's Health Project, which remains the Fund's flagship program, now includes four mobile clinics providing medical and dental care at 11 homeless and domestic violence shelters. The remainder of the fleet provides service in 16 other states and the District of Columbia. In addition to its mobile clinics, Children's Health Fund has also established fixed site and school-based clinics in underserved communities with high rates of poverty where access to other sources of medical care is extremely limited. Fixed-site programs in New York City include the South Bronx Health Center, the new Center for Child Health and Resiliency, and a school-based health care program in Harlem.

For 25 years, the doctors and medical professionals who work in these programs have witnessed firsthand the impact of poverty on America's children. In early 1988 when the new mobile pediatric program was barely two months old, Dr. Redlener and his team were already seeing

many young children who were under-immunized and suffering from hearing loss, speech-language delay, asthma, nutrition deficits, and emotional problems. Some children needed specialty care and many required extensive transportation assistance to get it. [3] Those needs are still present and, if anything, more severe in 2012. Through the years, Children's Health Fund expanded and enhanced its scope of care, developing solutions to the access barriers that families living in poverty face and creating a "medical home" for its patients to provide the comprehensive, consistent and high-quality health care that all children need, especially those who are burdened by persistent poverty.

After providing nearly three million health care visits for children in New York City and across the U.S., Children's Health Fund has developed insights that are relevant to understanding the current needs of the nation's most disadvantaged children. These health care services have included diagnosis and management of acute and chronic illness, preventive and health education services, oral health care and extensive management of psychological and behavioral challenges.

It is reasonable to conclude, however, that over the course of this past quarter century of failing to meet the needs of so many very vulnerable children, we have allowed yet another generation to grow up facing adversities and disparities that will deny many the opportunity to reach their full potential. Yes, Children's Health Fund has touched, and likely improved, the lives and life chances for hundreds of thousands of extremely disadvantaged children and families. But too many children did not have access to the Fund's network of pediatric care or other similar programs that seek to provide this same kind of lifeline.

The 1980s: A Decade of Rising Income Inequality and Poverty

In the post-World War II period, the vast income inequality between the wealthiest and poorest segments of the population that had characterized most of the first half of the century began to decline. This trend continued through 1968. The gains for working class and middle class families were lost in the years that followed, and by 1982, the 1947 level of inequality was re-established. By 1985, the fifth year of the Reagan Administration, the after-tax income of the wealthiest 1% of Americans was nearly 100% higher than it had been in 1979, while the income of the lowest 20% of Americans showed a steady decline.

As would be expected in this distribution of income and wealth away from the poor and middle class, families with children were hardest hit. Between 1979 and 1983, there was an increase in child poverty from 16% to 22%. Poverty among preschool children (under 6 years old) increased from 18% to 25%. Even though there was a 16% increase in average annual income between 1983 and 1989, there was not a proportional decrease in child poverty. In 1989, 20% of children (22% of children less than six years old) were still living in poverty. [4]

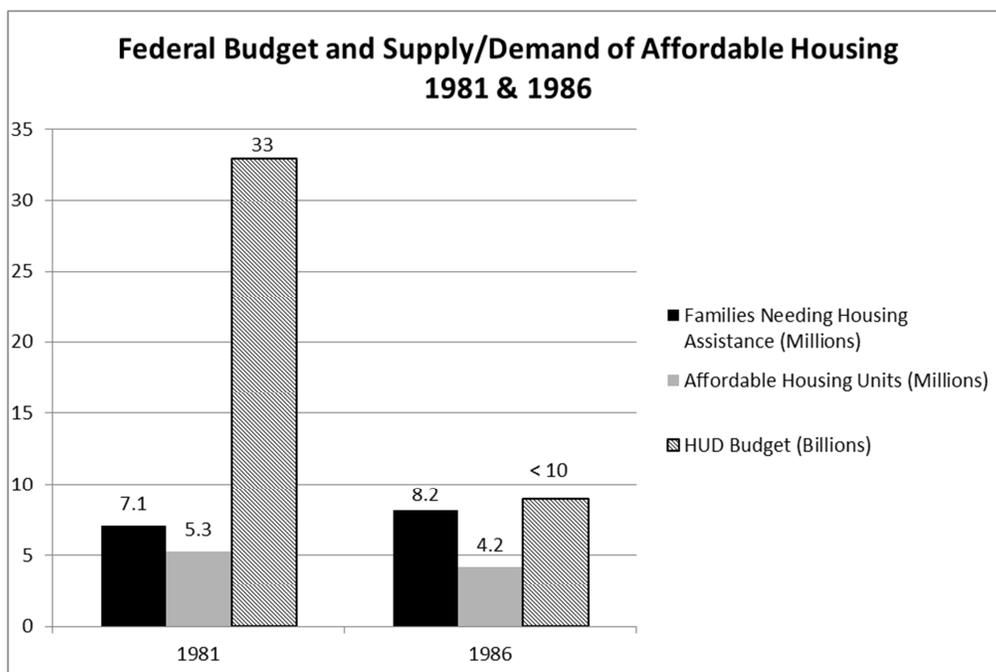
There were significant race-ethnic disparities in income distribution and poverty. The highest poverty rates were found among young children especially in single parent households. The disparities are striking when these poverty rates are contrasted with the total minority population. In 1987 32% of children living in poverty in the U.S. were African-American, comprising 48% of African-American children less than six years old. Similarly, while 21% of poor children in America were Hispanic, they accounted for 42% of all Hispanic young children. By comparison, only 13% of white children less than six years old were poor. Poverty was predominantly concentrated in the inner city (31% child poverty rate) and rural areas (28% child poverty). [5]

Rising income inequality has continued to the present day. By 2007 the top 1% controlled 35% of the nation's wealth while the bottom 90% controlled only 27% of wealth. That year the degree of disparity between the nation's richest and poorest households reached the highest level since the 1920s, before the Great Depression. Most of the disparity was accounted for by the increasing proportion of the nation's wealth controlled by the richest half-percent of households. [6] This increase in income inequality reflected changes in the distribution of earned income and policies between 1980 and 1985 that reduced the progressivity of federal taxation. [7]

The Rise of Family Homelessness

In the 1980s, competition for affordable housing was fierce. Throughout the decade federal funding for the Department of Housing and Urban Development (HUD) was cut while simultaneously the number of families in need of housing assistance increased and the nation's stock of affordable housing units decreased. These trends are shown in the table below for 1980 and 1986, by which time family homelessness had become a crisis. ¹

¹ There are conflicting reports of the HUD budget during the 1980s; however, it is generally accepted that there were



In the 1987 report that compiled these statistics, the United States Conference of Mayors found that demand for low income housing had recently increased by an average of 40% in the 25 large cities surveyed. The average wait for subsidized housing was 18 months and two out of three families in need of public housing or rent subsidies did not get any assistance. [8]

By 1989, 3.5 million poor households (56% of poor renters) spent half or more of their income on housing. About one million poor households were doubled up or otherwise living in overcrowded conditions. [9] Studies at the time found that the principle reason families became homeless was unmanageable housing costs. [10]

The insufficient supply of affordable housing was accompanied by a predictable increase in demand for emergency shelter for homeless families along with a dramatic shift in the demographics of our cities' homeless. For the first time since the Depression, families with children were emerging as the new homeless, with an average 22% annual growth in numbers. In nearly three-fourths of the cities surveyed, families with children – typically single mothers with

very significant cuts during this period.

young children – comprised a majority of homeless people. In New York City, children less than six years old were the largest homeless population.

In New York and elsewhere the real number of families that became homeless during the 1980s is far greater than indicated by any statistical measure of the growth of homelessness. [11] Poor families who lost their own home typically doubled and tripled up in the home of another family. Reversing a 30-year decline, between 1978 and 1983 the number of families doubled up and living in overcrowded conditions increased by 100% to an estimated 2.6 million families. [8] In 1989 the U.S. General Accounting Office (GAO) estimated that there were nearly three times as many children and youth living in doubled up conditions as were counted as homeless. [12] In New York the City Council estimated in 1989 that more than 100,000 families were doubled up (including 35,000 in city housing projects). [13]

There was concern at the time that the undercount of the homeless may have been intentional. A member of the House of Representatives characterized a 1984 report by the federal Department of Housing and Urban Development (HUD) to understate the number of homeless families as “intentionally deceptive.” [14] During Congressional hearings on the Urgent Relief for the Homeless Act (later known as McKinney-Vento), the New York City Human Resources Administration Commissioner suggested that "persons living doubled up with other households, people living in grossly substandard housing, and people living in institutions who lack a place to live upon discharge" should not be counted as homeless. To do so "would greatly expand the number of people eligible for assistance...." [15] In 1992 during the administration of George H.W. Bush, the U.S. Census Bureau was sued for deliberately undercounting the homeless in the 1990 census. These census data were to be used to set federal funding levels for municipalities beginning in 1993, so the undercount was viewed as a means to reduce federal assistance levels and expenditures. [16]

Differences in how to define homelessness is only one of the many complexities that make it difficult to accurately quantify the extent of the problem of homeless families with children. Surveys and research at the time used different methods of counting the homeless, e.g., how many are homeless on one night vs. how many experience periods of homelessness during one

year. [17] Data nonetheless show that by 1990 homeless families with children made up 36% of homeless Americans, and one-fourth of the homeless were children. [18]

The Impact of Homelessness on Children

Health and Development

In 1988, estimates of the number of homeless children in New York City varied but most agreed that it was approximately 11,000. [19, 20] About three-fourths of homeless families were placed in “welfare hotels,” with entire families staying in a single room furnished with a bed, desk and dresser, no kitchen and sometimes only a shared bathroom in the hallway outside the room. Cots or cribs were supplied to accommodate larger families. Only 8% were placed in apartment style shelters with a kitchen and bathroom. [11]

New York City paid about \$1,300 a month per family for rooms at its most notorious welfare hotel, the Hotel Martinique. The Associated Press reported that some rooms had been illegally subdivided to 9 x 12 feet and did not have private bathrooms. [21] Once placed in a welfare hotel, families would typically have to wait up to 18 months for help with rehousing. [22] Some meals were provided, but not for all residents, and use of a hot plate could have resulted in eviction. These conditions predictably had a negative impact on child health and nutrition, and welfare hotels were New York Children’s Health Project’s first service sites.

Through its New York Children’s Health Project, Children’s Health Fund provided care to 2,900 pediatric patients representing over one-fourth of the city’s homeless children. More than half of these patients were preschool age; their mean age was 34.6 months. Consistent with national trends, immunization status was low and nutritional problems high. Controlling for missing immunization records, 47% of children 19 to 35 months old were up-to-date for all vaccinations on their first health care visit, a rate generally comparable to that of other poor and low-income children.² One-fifth of children less than three years old (19.8%) had iron deficiency anemia and

² Data for tracking of national immunization rates was standardized in 1994 through the National Immunization Survey (NIS). The NIS methodology reports up-to-date status for children 19-35 months old rather than at 24 months or preschool entry as had often been done previously. The NIS statistical methodology was changed in 1998 for improved accuracy. See: U.S. Department of Health & Human Services, Centers for Disease Control & Prevention (CDC). U.S. Vaccination Coverage Reported via NIS. Available at: <http://www.cdc.gov/vaccines/stats-surv/nis/default.htm#chart>. Accessed July 24, 2012.

8.7% were diagnosed with underweight. The obesity rate in the homeless population was 14.2% compared to 10.0% nationally (1988 federal household survey data, NHANES). Notably higher was the asthma rate of 14% at a time when the national asthma rate, based on the National Health Interview Survey, was 8.8%.³ [23]

SPOTLIGHT: YOUNG CHILDREN AT THE HOTEL MARTINIQUE

There was a day care center in the ballroom of the Hotel Martinique which provided comprehensive full-day preschool education and child care services. Each day two meals and two snacks were served, and the children had a nap time. In a review of the health and development of 87 three- and four-year-old children who lived at the Hotel Martinique and attended the day care center:

- 52% were not up-to-date for immunizations prior to day care entry;
- 13% had been diagnosed with asthma (which may have been under-reported because of prior poor access to care);
- 4 children had pneumonia while at the Martinique;
- 3 children had been hospitalized for diarrhea and dehydration;
- 2 children were diagnosed with conductive hearing loss secondary to chronic middle ear infections;
- 75% showed signs of emotional disturbance, including severe impulsivity, mood swings, severe separation anxiety, sleep disturbance, and extreme oppositional and manipulative behavior;
- 75% were sufficiently speech and language delayed to be eligible for preschool special education services. [24]

There were multiple reports of health disparities affecting homeless children. The New York City Department of Health found that more than half of homeless preschool-age children had significantly higher rates of under-immunization and high lead levels (which can affect cognitive functioning and school readiness) compared to domiciled poor children. [25] Among school age children, studies done in Boston showed about half had developmental, psychiatric and/or learning problems. [26]

Most children did not have a source of pediatric care and frequently used hospital emergency

³ There is a range of estimates of national pediatric asthma prevalence depending on the methodology used. Based on the 1987 National Medical Expenditure Survey “period” prevalence, a snapshot of prevalence at a specific point in time was 8.8% while lower childhood asthma prevalence rates were also presented, e.g., “treated” prevalence at 4%. [P Lozano, SD Sullivan, DH Smith, KB Weiss. The Economic Burden of Asthma in US Children: Estimates from the National Medical Expenditure Survey. *Journal of Allergy and Clinical Immunology*. 1999; 104(5): 957-963.] Federal asthma prevalence tracking methodology was redesigned and better standardized in 1997.

departments. [27] Nutrition problems were evidenced by high rates of underweight, obesity, and iron deficiency anemia. Adding to the nutrition problems of homeless children was a federal policy that cut food stamp benefits for homeless families. In the new policy, the rental payments made to hotel owners were to be considered as family income, reducing their eligibility for food stamps. Initially this was not enforced; however in 1986 the federal government threatened to cut off all food stamp assistance to states that did not implement this policy. [28]

Education

Homelessness also had a profound impact on progress in school. In 1989, Advocates for Children of New York reported a high percentage of children in homeless shelters had to change the school they attended several times during the year. For example, more than one-fourth of students in the shelter system for six months or less attended three or more schools during that short time period. More than three-fourths had to transfer school at least once, in part because 71% of homeless families had been placed in shelters in boroughs different than their prior borough of residence. [29]

Litigation was required to establish the legal right to public education for homeless children. Many were denied enrollment because, being homeless, they did not have a permanent address. In other instances, children were sheltered in an area other than their prior community of residence, so they did not meet the residency requirement needed to enroll in the new school district. Nationally, 43% of an estimated half million homeless children did not attend school in 1987 primarily because of residency or transportation issues. [30] In New York City homeless children were generally absent from school one or two days a week; some did not attend at all. Long periods of absence, a month or longer, were not uncommon. Because families were often distantly placed from their communities of origin, long bus rides were needed to transport children to school. [31]

The 1987 passage of the McKinney-Vento Act was intended to safeguard the entitlement to a free, appropriate public education for homeless children. [32] Also included in the legislation was transportation at the parents' option to the school that the child had previously attended. [33] In 1989, two years after the law passed, the U.S. Department of Education estimated that one-

third of the nation's school-age homeless children still did not attend school. [34] In 1990, compliance and enforcement of McKinney-Vento remained problematic. The Department of Education had not made adequate funding available to the states and did not effectively monitor compliance. For example, in the nation's capital, District of Columbia school officials had not yet defined who would be considered homeless and eligible under the law, and transportation barriers kept half of homeless children from regularly attending school. [35]

A Disinvestment in Poor Families and Children

Housing was not the only area in which there were significant disinvestments at the federal level. The health sector was also hit hard by federal budget cuts. Among the programs suffering serious budget cuts were the Public Health Service, the National Center for Health Care Technology, and new health research. Medicaid was a particular target. States were afforded more discretion in their administration of Medicaid. Block granting of entitlement programs, which had been previously discussed but not enacted in the Nixon and Ford Administrations, consolidated 21 categorical federally-funded programs into four block grants for preventive health care, mental health, maternal and child health, and primary care services. This ceded control of health care for vulnerable populations to state and local governments, who had to manage these programs with about \$2 billion less in 1983 than had been available in 1981. [36]

At the start of the 1980s, the health status of low-income children was notably worse than that for middle- and upper-income children, and they had experienced more days with activity limitations. [37] By 1985, the number of Americans without health insurance had increased 25% since 1971. Children comprised 40% of the nation's poor, and two-thirds did not have Medicaid coverage. Those with Medicaid generally got care at federally qualified health centers; however, 1982 budget cuts forced the closing of 250 of these safety net health facilities, which had been the major source of care for more than one million people. More than one million children lost supplementary nutrition programs due to budget cuts to programs like WIC. The direct impact of federal health care spending cuts was disproportionately borne by pregnant women and young children in poverty. Despite difficulties obtaining data, partly due to federal budget cuts to the agencies that tracked health indicators, in 1985 it was reported in the *New England Journal of Medicine* [38] that since 1981:

- Fewer pregnant women received prenatal care, and those who had recently lost insurance were also least likely to get timely prenatal care;
- There was a significant increase in anemia among pregnant women;
- There was a notable increase in low birth weight deliveries;
- Improvements in national infant mortality rates slowed;
- Hospitalizations for failure to thrive and for diarrhea and dehydration increased;
- Childhood anemia rates increased;
- There were increases in young children with elevated lead levels and with clinical lead poisoning;
- In 1984, there was an increased incidence of measles for the first time since 1963, a sign that children were not receiving vaccinations as part of preventive care. Studies at the time showed a direct association between federal funding cuts and increased incidence of measles.

By 1988 and the end of the second Reagan term, an estimated two million children were using hospital emergency rooms as their usual source of pediatric care nationwide. Most likely to do so were minority children in single parent households regardless of whether they had Medicaid or were uninsured. [39] Children living in poverty who had asthma were four times more likely than higher-income children with asthma to use a hospital emergency room for sick care. [40]

In New York City, young children had high rates of lead exposure. Available data reflect only children with high blood lead levels; 61% of those identified with lead exposure had lead levels from 25 and 34. Lead levels as low as five are now considered to be a potential harm to the child. Most of the exposed children were less than two years old. Lead exposure for young children is associated with higher risk of significant developmental delay. [41, 42]

The 1990s: Declaring an End to Homelessness?

In December 1988 the city closed the Hotel Martinique and two other large welfare hotels. Families, many of whom had been homeless three years or longer were rapidly rehoused during the last three months of 1988, mostly to newly renovated city owned buildings. [43] The reasons for this policy shift were not entirely clear. One theory at the time, as reported in the *New York*

Times, was that “the scourge of homelessness....acting as a magnet for drug dealing and street crime” interfered with real estate development in Herald Square. [44] Another theory was that New York City officials wanted to avoid assuming a higher proportion of the cost of sheltering homeless families because of a policy shift proposed by the Reagan Administration which would reclassify homelessness as a short-term emergency and limit the federal share to three months of shelter cost. [45]

Throughout this period there had been a shelter option for families, far worse than welfare hotels, called congregate shelters. These typically were armories with huge open spaces and hundreds of cots lined up side by side. Homeless families with children were intermingled with homeless single adults. While families were not supposed to be placed in these shelters for more than three weeks, many stayed longer. It was typical for a homeless family to have spent several days sleeping in a city office (“Emergency Assistance Unit”) then weeks in a congregate shelter and years in a welfare hotel. The congregate shelters were also slated to be closed by 1990. [46]

It did not take long, however, for the number of homeless families to rebound and soon exceed the levels seen in the 1980s. By 1993 there were a record number of 5,600 homeless families with more than 12,000 children in New York City shelters on any given night. Because of insufficient shelter availability and delays in rehousing families in available city owned apartments, up to 175 families slept in city offices each night.

With the closure of the welfare hotels and congregate shelters, shelter conditions were much improved for families placed in city transitional housing. Most shelter facilities were apartment style with multiple bedrooms and a bathroom and kitchen. The quality of housing offered to homeless families, however, was substandard and often proved unacceptable, with gas leaks, malfunctioning plumbing, structural damage, etc. Without subsidies, rents often became unaffordable and families were evicted. [47] These are among the reasons why a new problem in homelessness emerged: recidivism, families rotating in and out of the shelter system. [48, 49] This was reflected in studies of homeless compared to domiciled poor children that found the differences in their functioning to be narrowing, especially with regard to academic and behavioral functioning. [50] Similar trends held for preschool aged children. Homeless young

children experienced greater levels of stress than did their housed counterparts (residential instability, violence exposure, etc.). While this was reflected in somewhat greater levels of problem behaviors, homeless children were not found to have a higher prevalence of emotional and behavioral problems consistent with a psychiatric diagnosis. A major factor in whether the child showed signs of emotional disturbance was how well his or her mother coped with stressful life events. [51] Homeless children continued to have worse health status, however, reflecting problems associated with substandard housing and shelter placement, including poor nutrition and restricted access to health care. A 1993 study found homeless children to have higher rates of iron deficiency anemia and under-immunization, with only 30% of homeless children up-to-date for their vaccinations. [52] These studies illustrate the extent to which periods of homelessness had become an integral part of the experience of being poor for many families.

Following the closure of the welfare hotels and congregate shelters, many families were rehoused in communities without adequate services, including health care. Follow-up with rehoused NYCHP patients in the Bronx revealed that most no longer had adequate access to health care. A 1990 CHF study found that children had to wait several months for a health care appointment in their inner city communities. Community Service Society found in their study of 248 primary care doctors in these neighborhoods that only six provided minimally acceptable hours of operation, coverage, and hospital affiliation—that is, were accessible to patients for timely health care services. [53] Health budget cuts continued into the early 1990s and began to erode a critical component of the health care safety net, community health centers. Public health services in low-income neighborhoods had to be cut, including school nurses. [54]

In response to these problems and to maintain continuity of care, Children's Health Fund sent a mobile clinic to a central location in the Bronx where families had been relocated. This evolved into a new bricks-and-mortar community health center, the South Bronx Health Center for Children and Families, which opened in 1993.

While many factors were involved, continuing economic problems associated with fewer non-skilled employment opportunities, low and stagnant wages and increasing housing costs were most prominent. Homelessness continued to grow through the 1990s despite the otherwise

prosperous economy. It was estimated that between 900,000 and 1.4 million children were homeless annually in the U.S. An estimated 10% of poor people, with single parents and children most vulnerable, were at imminent risk of homelessness each year. [55]

Overall income distribution trends in the decade of the 1990s, however, were positive. The benefits of economic growth from 1990-2000 were more equitably distributed across the U.S. population than was the case from 1979-1989. These gains, which especially benefitted poor and low-income populations (African-Americans, single mothers and their families), were most pronounced during the Clinton Administration from 1993-2000, and the magnitude of improvement in income equality was similar to that seen in the decades immediately after World War II. [56]

SPOTLIGHT: SHELTER CONDITIONS IN THE 1990s

In 2000, CHF surveyed family shelter administrators around the country for the federal Health Resources and Services Administration, Bureau of Primary Health Care (N=259 respondents) to explore nutrition practices and shelter living conditions. These are key findings:

- Nationally, families had an average length of stay between five and eight months;
- Only 71% of shelters accepted all children regardless of age. For families with children outside the acceptable age range (especially adolescent males), families had to split up in order for mothers and their younger children to get shelter;
- Families had their own kitchen in only one shelter in four (24%);
- 60% of shelters did not allow families to store food in their shelter room;
- Some shelters had a communal kitchen shared by up to 10 families;
- 20% of shelters provided neither kitchen facilities nor meals;
- One-third of shelters did not provide assistance to families with rehousing; and
- Only one-third provided access to health care services.

CHF also surveyed 130 providers of health care for homeless families and found that:

- 46% reported concern about high rates of iron deficiency anemia;
- High rates of obesity were a ubiquitous concern;
- 70% reported that families could not afford enough food to get through the month [57]

Child Health and Homelessness in the 1990s

The rate of uninsured children in the U.S. increased from 20.9% in 1977 to 30.8% in 1987, and one consequence was under-immunization. A national measles epidemic erupted between 1989 and 1991 with 55,251 cases, 11,251 hospitalizations, and 136 deaths. New York City had the highest number of measles cases of any locale: 3,148 cases with 1,109 hospitalizations and 24

deaths. This increasing incidence of measles was related to under-immunization of preschool-aged children; by 1991 the immunization rate in New York City had fallen to 40%. Preschool immunization rates were low at the time because children too often caught up on immunizations when they entered kindergarten to meet regulatory requirements for school entry. [58-60] The Children's Defense Fund found similar increases in incidence of other vaccine-preventable diseases, mumps and whooping cough, and nationally there were at least 100,000 preventable cases of these illnesses during this period. [61, 62]

In 1991 the National Commission on Children expressed strong concern about children in poor health and limited access to care because of, among other reasons, the low immunization rate. Lack of health insurance had increased through the 1980s as did child poverty and the proportion of children in single parent households (17% in 1977, 25% in 1987). Children raised by a single parent were especially unlikely to be covered by employer-provided family health insurance. More low income families with employer-provided coverage were paying out-of-pocket contributions, and the high cost of these contributions affected the family's ability to maintain continuous coverage. One-fourth of children who were uninsured for all or part of a year did not have a usual source of pediatric care, and children with interruptions in their health coverage were less likely to have a usual source of health care than continuously uninsured children. [63] Not having a regular source of health care is associated with delayed treatment for illnesses, inadequate management of chronic conditions such as asthma, and not receiving preventive care including immunizations.

Public Health Insurance Expansion and Improved Child Health

Important gains were made in the health of poor and low income children later in the decade, notably through the 1997 expansion of Medicaid coverage and passage of federal legislation to assist states in providing child health insurance programs. Medicaid expansions prior to the CHIP legislation led to a reduction of uninsured children from 30.8% in 1987 to 23% in 1996. [64] The State Child Health Insurance Program (SCHIP, now known as CHIP) was included in the Balanced Budget Act of 1997 as part of the Social Security Act (Title XXI). Through this law, states may target low-income families who are over the income threshold for Medicaid eligibility and unable to afford to purchase commercial insurance on the open market. Cost

sharing (monthly premium plus deductibles, co-payments, etc.) is permitted but may not exceed 5% of the family's income, and no cost-sharing may be applied to preventive health care services. A formula is built into the law to determine the percentage of total cost to the states that will be covered by the federal government. States may also determine the scope of their benefit package, and typically SCHIP coverage was less inclusive than Medicaid (e.g., may or may not include vision and hearing services, dental care, mental health services). [65] Between 1997 and 2001, 3.5 million children gained health insurance through SCHIP. Medicaid coverage also expanded through better outreach to eligible populations and reduction of administrative barriers to enrollment. This increase in public insurance coverage of children was critical: Private insurance coverage of low-income children fell from 47% to 42% while Medicaid and SCHIP enrollment grew from 28% to 36% of children. Overall, the uninsured child rate declined from 20% in 1997 to 16% in 2001. [66, 67]

Most of the children enrolled in SCHIP were in families with annual incomes at or below 150% of the federal poverty level (\$24,990 for a family of four in 1998). Nearly half were in households headed by a single parent. [68] Children were more likely after SCHIP enrollment to have a usual source of pediatric care, and more likely to receive preventive health care and continuity of health care services. [69] Children with chronic health conditions especially benefitted from insurance expansion. Children with asthma experienced fewer acute asthma attacks and significantly better asthma control including access to medication. [70, 71] Improved asthma control in primary care is associated with decreased hospital emergency department utilization, which is more costly than primary care and often results in less satisfactory treatment. [72] Subsequent studies found that disenrollment from Medicaid and SCHIP was associated with reduced health care visits, less receipt of preventive health care services, and less access to prescription medications when needed. [73]

SPOTLIGHT: A DECADE OF CHANGE IN THE HEALTH OF HOMELESS CHILDREN

In 2001 CHF compared the health status of homeless children served by its New York Children's Health Project in 1988 to 1998 and found:

- A significant improvement in being up-to-date for immunization, 47% in 1988 compared to 79% in 1998
- A significant decline in iron deficiency anemia (19.8% vs. 10.3%)
- Improvement in prevalence of underweight (8.7% vs. 7.4%)
- Significant increase in prevalence of obesity (8.7% vs. 14.2%); and
- Significant increase in asthma prevalence (14% to 30%).

The 2000s: Losing Ground Following a Great Recession

By 2000, there was a decrease in poverty in all regions of the country. The child poverty rate showed the steepest decline, falling to 16.2% in 2000, the lowest rate since 1979. [74] With the gains made by CHIP coverage for 3.8 million children, the uninsured child rate fell to 18.6% by 2002. [64] The good news did not last long. More Americans fell into poverty each year from 2001 to 2003. The child poverty rate increased to 17.6% in 2003. Median household income declined by \$1,500 annually. With more than 700,000 children newly poor, nearly 13 million U.S. children lived in households with income at or below the federal poverty level (\$18,810 for a family of 4 in 2003). The proportion with employer-provided health insurance fell to its lowest point in the past 10 years, and 1.4 million people lost coverage. [75]

Things got still worse following the great recession that began in 2007. Children's Health Fund worked with CBS News to conduct a national survey of parents to determine the impact of the recession on children. Key findings are summarized in the chart below. [76]

Children and the Recession: Children and Families with Income Less Than \$30,000 / Year	
82%	of parents said the recession was affecting them personally
78%	of parents said they were experiencing financial stress
63%	of parents said it had become harder to afford utilities
62%	of parents said it had become harder to afford groceries
50%	of parents reported behavior changes in their child which they attributed to the recession
46%	of parents said it had become harder to afford medical bills
44%	of parents said it had become harder to manage housing costs
39%	applied for public insurance (Medicaid or CHIP) for the first time in the preceding 6 months
32%	of households had an adult who lost a job
23%	of parents skipped a well child visit (check-up) for their child
22%	of parents skipped a dental visit for their child
20%	of parents skipped a visit with a pediatric specialist for their child
11%	of parents reduced use of prescription medications

According to the federal Department of Housing and Urban Development (HUD), there was a 9% increase in the number of homeless families in the year following the recession, with more than a half million homeless families in 2009. Homelessness ceased to be primarily an urban problem; the greatest increases were in suburban and rural communities. Families with children were most likely to experience homelessness as an impact of the recession. [77]

Free clinics were an important element of the health care safety net for children and families who lost employment and health care access during the recession. In April 2009, working with a local hospital partner, CHF provided a weekend long free clinic in a city particularly hard hit by the recession, Detroit. A snapshot of the children seen for medical and/or dental care on mobile clinics that weekend is in the following text box.

SPOTLIGHT: CHILDREN AT A CHF FREE CLINIC IN DETROIT, 2009

Average age of children seen (N=238): 7 years.

Of the children seen for medical care:

- Half did not have a usual source of pediatric care
- 44% had not had a check-up in the past 12 months
- 22% were overweight or obese and 3% underweight
- 17% had asthma
- 64% of children under 36 months old were not up-to-date for immunizations

Of the children seen for dental care:

- 38% had at least one cavity
 - 43% of children these had multiple cavities (average, 3.2)

Two significant features of child health in the decade were the increasing prevalence of asthma, and the dramatic increase in pediatric obesity. There were several changes in the way that the federal government tracked asthma prevalence since 1987, so accurate long-term trend data are not readily available. Data after 1997 frequently reflect “lifetime” asthma prevalence, defined as whether a child had ever been diagnosed with asthma by a doctor or other health professional. Lifetime asthma prevalence increased from 11.4% of children in 1997 to 12.5% in 2005. [78]

Lifetime asthma prevalence of homeless and other poor children is dramatically higher. During 1998-1999, a CHF asthma surveillance study found that 26.9% children entering the New York City shelter system had been previously diagnosed with asthma and another 12.9% had current asthma symptoms but had not been diagnosed, for a record-high asthma prevalence of 39.8%. [79] Continued surveillance showed this rate to decline and level off at 30.3% for the period 2001-2003. [80] When CHF repeated its chart review of homeless NYCHP patients seen in 2004, the asthma rate was 31.5%. [81] Similarly high asthma prevalence was reported in multiple inner city communities including Harlem, a community of origin for families entering the homeless system. [82, 83] The national lifetime asthma prevalence rate for 2005 was 12.7%, indicating both health disparities and the degree to which vulnerable populations are under-represented in the federal household surveys from which national prevalence rates are generally derived. [84]

Also notable through the decade was a steep increase in prevalence of obesity. The obesity rate for children and youth 6-19 years increased from 5.5% in 1976-1980 to 21.6% in 2007-2008.⁴ There were significant racial-ethnic and socio-economic disparities with higher rates among poor and minority children. [85] In a 2006 CHF study (N=395) presented at the annual research meeting of Academy Health, the obesity rate for homeless 6-19 year old patients of the NYCHP was 30.5%. There were no significant differences in obesity rate or in mean body mass index (BMI) value between this homeless population and same-aged low-income housed patients at the South Bronx Health Center. This underscores the impact of poverty on child health regardless of its specific manifestations such as homelessness.

High rates of developmental and psychiatric disorders were found in the homeless population, all of which are predicted to seriously compromise school performance and academic achievement. These are summarized by age in the text box below. [81]

SNAPSHOT: BEHAVIORAL HEALTH OF HOMELESS CHILDREN, 2004

- Children 12 months-19 years old:
 - 30% were diagnosed with a developmental or psychiatric disorder
 - 34% had been exposed to domestic violence
- 19% of infants and toddlers (1-35 months old) were found eligible for Early Intervention Program services (at least moderate level of developmental delay) compared to NYC-wide rate of 8%
- 41% of 3 and 4 year olds were found eligible for preschool special education services
- 34% of 5 to 11 year olds were diagnosed with a learning disability or psychiatric disorder
- 24% of 12 to 19 year olds were diagnosed with a psychiatric disorder-

During this decade CHF focused on specialty care needs of its vulnerable populations. In a review of referral trends of NYCHP patients, it emerged that nearly one homeless pediatric patient in four, 23% required at least one specialty appointment, far above typical pediatric referral rates. Keeping these important health care appointments at distant hospital sites was

⁴ There was a change in the methodology to determine pediatric obesity in 2000, when the CDC introduced new Body Mass Index (BMI) growth charts to replace the previously recommended weight-for-stature charts in use since 1997. While the trend towards increased prevalence of pediatric obesity over time is generally accepted, details are not directly comparable prior to the introduction of BMI methodology (obesity as BMI at or above the 95th percentile). See: WH Dietz & U MC Bellizzi. Introduction: The Use of Body Mass Index to Assess Obesity in Children. American Journal of Clinical Nutrition. 1999; 70(Suppl): 123S-125S; and CDC.CDC Growth Charts: United States. Available at: <http://www.cdc.gov/growthcharts/background.htm>. Accessed July 24, 2012.

extremely problematic for many homeless families. By implementing a comprehensive initiative to support specialty care access that included transportation services, CHF increased adherence with these crucial health appointments from 7% to 61%. [86] This experience underscored the importance of transportation as a potential barrier to health care access.

The Current Situation

The impact of the recession of 2007 continues to affect America's children. The national child poverty rate has risen consistently, increasing four points in four years, from 18% to 22% (2007 to 2010). In several states and the District of Columbia, child poverty is 30% or greater. [87]

What seemed like a short-term crisis of homelessness in families especially with young children has turned out to be an intractable problem, one which has expanded from primarily urban to include the nation's suburban and rural communities. In 2008 there were more than 1.5 million children homeless in the U.S. each year, considerably more than in the prior decade. Homeless children are twice as likely to experience hunger and food insecurity as other poor children and twice as likely to have serious school problems such as suspension, grade retention, and drop out, with fewer than 25% graduating high school. [88]

Following passage of the McKinney-Vento Act it seemed to be settled law that homeless children are entitled to a free, appropriate public education; however, that has been challenged again. In a 2000 study by the National Law Center on Poverty and Homelessness it was found that more than three-fourths of homeless families reported transportation to school as a problem, 38% reported residency requirements as a barrier, and half had trouble getting a copy of their child's birth certificate as required for school enrollment. [89] Four years later in 2004, a class action lawsuit was filed in Suffolk County, New York to again establish that being homeless does not require a child to lose his or her right to an education. [90] In 2007, a similar suit was brought by the American Civil Liberties Union in Hawaii. [91, 92] These lawsuits were necessary decades after federal legislation ensuring the education rights of homeless children was passed. The New York City Education Department, an epicenter of urban homelessness in the 1980s, revised its Chancellor's Regulations for the education of homeless children "to comply with the language of the McKinney-Vento Act" in June, 2009. [93]

The continuation of family homelessness is all but assured by the current economic climate. In 1987, at the Congressional hearings for the “Urgent Relief for the Homeless Act” which became enacted as McKinney-Vento, then Boston Mayor Flynn argued that housing costs were moving the American dream out of reach for too many families. He cited a Harvard-MIT study that found the poor typically pay nearly half of their income for rent. [15a] Despite the strong recommendation in 2003 of a special panel in New York City exploring ways to prevent family homelessness that highlighted the impact of high rents and limited rental subsidies, the disparity between income and affordability of housing had widened. [94] A June 2012 report from the Community Service Society of New York found that poor and low-income families that do not have the benefit of rent subsidies paid 49% of their income for rent, leaving on average \$4.40 per family member per day for everything else including food. [95]

Not only is this a clear path to continued and perhaps increased family homelessness, it also suggests that more children will experience hunger and more families food insecurity, just as was the case at the supposed height of the homeless crisis in the late 1980s. In 2011, the Centers for Disease Control and Prevention (CDC) reported that more than 5% of the nation’s housing units are classified as inadequate, with significant structural problems that affect use of the kitchen, plumbing, and/or heating. Most likely to live in inadequate housing are low-income families, 8.5% for those with annual incomes of under \$25,000 compared to 2.4% with incomes of \$75,000 or higher. Inadequate housing is associated with higher rates of acute and chronic illness and of developmental delay in children. [96]

Inadequate housing also contributes to homelessness. There was a 40% increase in the number of homeless families in New York City in 2008 compared to 2007. Increases as high as 58% in Louisville, Kentucky were noted in 16 of 22 cities surveyed by the U.S. Conference of Mayors. [97] In a 2008 survey 28% of school districts reported a 25% or greater increase in the number of homeless students. [98] In June 2012 the Coalition for the Homeless reported that the number of homeless families in New York City reached a new high, with more than 17,000 children in family shelters on any given night in 2011. [99] The number of homeless children increased to more than 18,000 barely two months later. This rapid increase in the city’s homeless population necessitated the opening of nine new shelters, three of which were opened on an emergency

basis. [100]

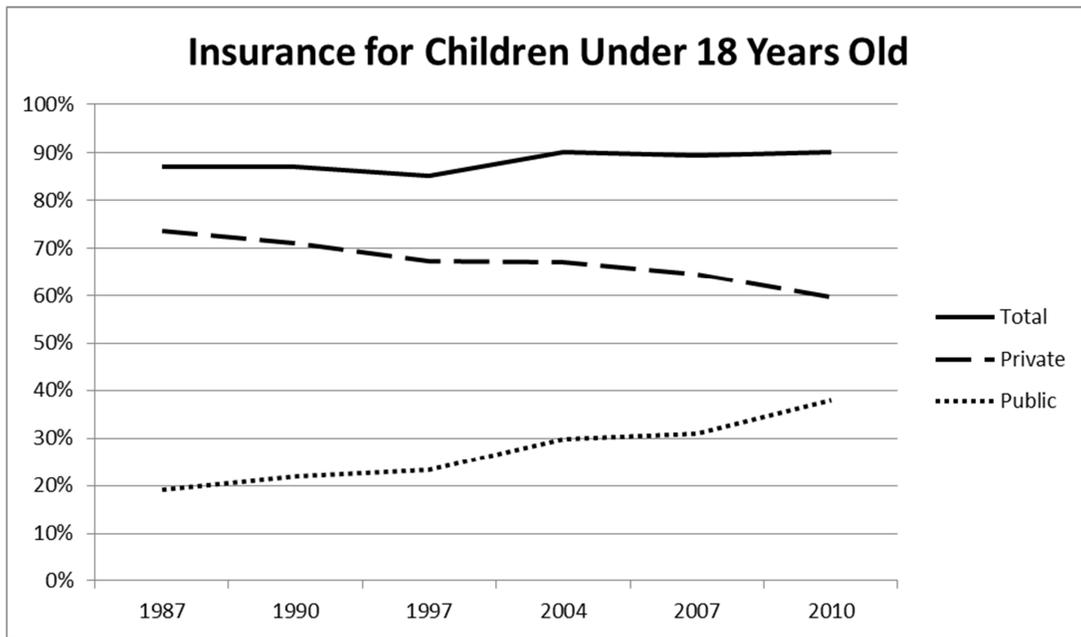
More families are now at risk of homelessness than ever, with a dramatic increase in people living in doubled up housing (estimated at 6 million in 2009). Each year 10% of doubled up people or families become homeless at some time during a year. [101] As has consistently been the case, there is a fairly wide range of estimates for the number of homeless children in the U.S. The federal Education Department reported that by the end of the 2010-2011 school year, including children in doubled up housing there were more than one million homeless students in U.S. schools, up from nearly 800,000 during the 2007-2008 school year. About two-thirds of homeless children in schools are doubled up, with more than 300,000 school-aged children living in shelters. [102, 55] This figure does not include infants and young children, so in this estimate the number of sheltered homeless children is likely to be at least 600,000. [103] A still higher estimate comes from the National Center on Family Homelessness. Each night more than 1.6 million children in this country are living in a family that does not have a home of their own—100,000 more than estimated in the previous year's report. [104]

The number of children experiencing hunger and food insecurity has been increasing as well. By mid-2011 there was a 62% increase in food stamp recipients since the start of the recession, with more than 46 million Americans enrolled in this supplemental nutrition program. The majority of families receiving food stamps were single mothers with young children. Food insecurity grew among families with young children, from 17% of families in 2007 to 22% in 2010. [105] A study from Share Our Strength found that nationally 48% of teachers in rural and urban elementary and middle schools identified children coming to school hungry as a serious problem in 2010, and 63% said that the problem has worsened since 2009. [106]

The consequences of food insecurity and hunger on children can be serious. When experienced for only a brief period by young children, food insecurity may be associated with iron deficiency anemia and cognitive delay. Food insecurity increases the risk of developmental delay for young children and of academic underachievement or failure for children in elementary school. [107-109] For older children, food insecurity is often associated with school problems (academic deficits and behavior problems). [110] Food insecurity is also associated with maternal

depression in families with young children. Maternal depression is associated with increased risk of developmental delay and behavioral problems. [111]

There have been gains made in some areas of child health such as health insurance coverage and receipt of preventive care including immunization, and the prevalence of some health problems has leveled off (asthma, obesity). Health disparities, the gap between the health and well-being of poor and minority children compared to their more affluent counterparts, remain. The most frequently used indicator of barriers to child health care access is lack of health insurance. This is generally defined as not having health insurance coverage for twelve consecutive months and is a limited way to estimate the real number of children who cannot get timely access to services when they need them. In 2007, for example, there were nine million children counted as uninsured, but another 11.5 million children were without health insurance at some point during the course of the year. These children were especially unlikely to have a usual source of pediatric care for preventive services and timely treatment of illness. Another 3.2 million children did not have transportation needed to get to a health care site regardless of their health insurance status. Many lived in areas where there were too few health care providers and limited public transit resources. The total number of children without adequate access to care was 23.7 million, more than double the number of children considered to be uninsured. [112] Trends in child health insurance coverage are presented in the chart below.



[Source: U.S. Census Bureau]

Health professional shortages—an insufficient supply of health professionals for the population of an area—have a devastating impact on access to health care nationwide. It is estimated that nearly 60 million people in the U.S. live in an area without enough health care providers. That represents 19.1% of the nation’s population. These shortages leave an estimated 35 million people medically underserved (11.4% of the population). There are wide variations among the states, with 31.5% of Mississippians considered underserved, as are 27% in Louisiana and 26.9% in the District of Columbia. By contrast less than 10% of the population is underserved in 22 states. [113] Health professional shortages and maldistribution of health care resources contribute to the protracted health disparities of the past several decades.

The 2011 National Health Disparities Report [114] shows that despite progress during the past decades:

- Minority children are more likely to use the hospital emergency room for asthma care, although, as has been demonstrated in a 2007 CHF study, this can be prevented through effective management in primary care (including for homeless children seen on a mobile clinic). [115]
- Poor and minority children and adults are less likely than others to receive preventive health services. Looking at income, for example, preventive care is routinely received by

68% of poor people compared to 76% of middle income and 80% of upper income people.

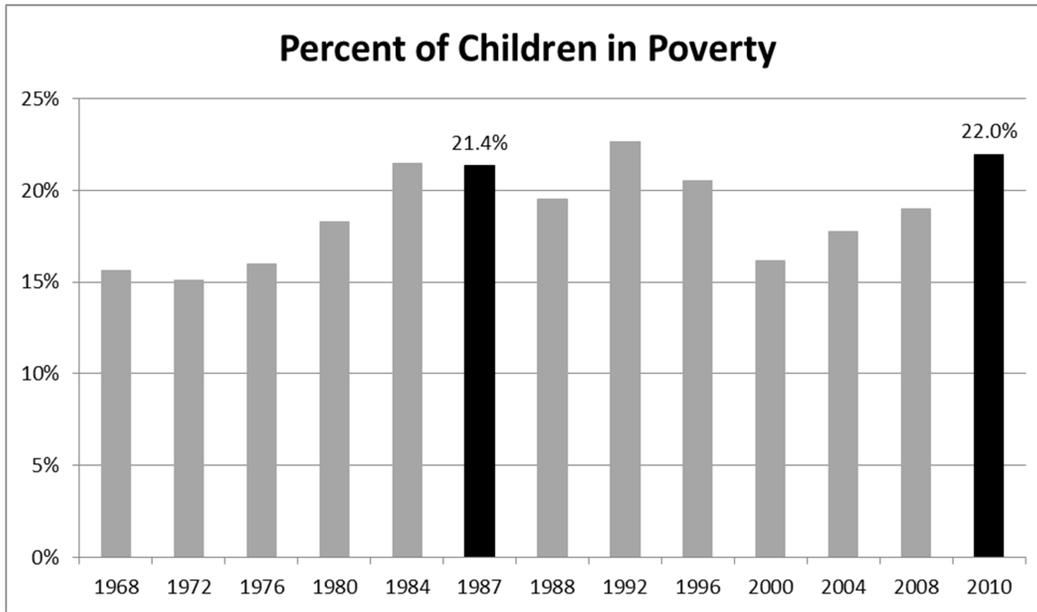
- Poor and minority children including those with Medicaid coverage are less likely to see a dentist for preventive care and to have untreated oral health problems. Again focusing on income, approximately 35% of poor children 2-17 years old have a dental visit each year compared to 50% of middle income and 65% of upper income children.
- People living in poverty are less likely to receive treatment for mental illness. This is especially problematic in rural communities where provider shortages and geographic isolation undermine access to care. There are significant race-ethnic disparities. An estimated 70% of whites with depression receive mental health treatment compared to 50%-55% for African-Americans and Hispanics.

These disparities are likely to persist given the consistent increase in income inequality detailed by the Congressional Budget Office. While their data do not fully reflect the impact of the recession, this much is clear: in the nearly three decades from 1979 to 2007, the after-tax income for the richest 1% of households (99th percentile) has increased by 275% while growth for those at middle income (21st-80th percentile) was less than 40%. For the bottom 20% of households (1st-20th percentile) after-tax income grew by 18% (only 6.5% of the rate of increase experienced by those in the highest income range). These income disparities are so enormous that between 2005 and 2007, the top 20% accumulated more income than did the bottom 80%. [116]

Somewhat more recent data are available from the U.S. Congress Joint Economic Committee. Between 1980 and 2008, the 1% richest households increased their share of the nation's wealth from 10% to 21%, with especially steep increases for the top 0.1% (annual incomes of \$1.7 million and higher). While income inequality was reduced somewhat due to economic losses during the recession, this reversed as the economic recovery began. The middle class did not rebound to their income levels of 2001, and many families moved from the middle class into poverty. [117] The U.S. Census Bureau reports that in 2010 the lowest quintile of household earners (1st – 20th percentile) accounted for 3.3% of overall household income while the top quintile (81st – 100th percentile) controlled about half of the nation's wealth, 50.2%. [118]

While these continuing income trends do not bode well for the health and well-being of children and families in poverty, there are many provisions of the Affordable Care Act of 2010, now found constitutional by the U.S. Supreme Court that may help vulnerable populations over time. The law funds community-based prevention programs and contributes to the better integration of primary care services with public health departments. Provisions of the law will help build health professional workforce and address long-standing maldistribution of health resources that has especially hurt the nation's rural communities. Included in the law is \$11 billion in funding to expand community health centers, improving the safety net for vulnerable populations and making primary care more available to those who will continue to be uninsured. This should contribute to cost savings associated with reduced preventable use of hospital emergency departments. Additional funding to the National Health Service Corps will further contribute to improving health infrastructure in medically underserved areas, both urban and rural. Reforms in the way health care is delivered including an emphasis on prevention and wellness, and improved coordination of care in the medical home model and in Accountable Care Organizations are expected to bring down overall health care costs over time, which should allow for further improvements in the health care delivery system. [119-122] Implementation of the Affordable Care Act should strengthen access and quality of health care services for vulnerable children and families, a safety net seriously challenged by the recession. [123]

In perhaps the most troubling aspects of this retrospective review, the conditions that preceded the "crisis" of family homelessness in the 1980s are present now. Housing shortages and unaffordable rents that consume half or more of a family's income and compromise ability to purchase food mirror the circumstances of 25 years ago. The percentage of children living in poverty continues to rise since the recession, as is shown in the table below.



[Source: U.S. Census Bureau]

Many of the policies that had such a devastating impact in the 1980s are again being advocated by political leaders. The proposed change in Medicaid funding to a federal block to the states would eliminate the flexibility that allowed Medicaid to act as a safety-net to keep children insured after they lost employer-provided family insurance during the recession. A major gain for children through the Affordable Care Act is public insurance expansion (Medicaid, CHIP) to cover an additional five million children. Repealing the Affordable Care Act would deprive these children of health insurance. It would also result in less funding for health care safety net programs like federally qualified health centers at a time when demand for their services is increasing, and would undermine efforts to increase the supply of primary care providers to keep pace with increasing demand for services. Proposed cuts to domestic programs run so deep that they would literally take food (food stamps, supplemental nutrition programs like WIC, and school breakfast and lunch) away from children facing hunger each day. We have seen the impact of these policies in the 1980s: More homeless families, higher rates of iron deficiency anemia and other nutritional problems that may compromise development and readiness to learn, measles epidemics affecting children unable to get vaccinated, and higher health care costs to provide care to children in hospital emergency departments because they cannot get routine health care when they need it. This experience should inform our public policy decisions over the next 25 years.

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