of ESRD care, North American children with CKD may be at greater risk of the major cause of mortality than those in other regions of the developed world.

There can be no denying that the major global contributor to health care disparities in children is poverty. These reports, however, remind us that in more resource-sufficient regions, wealth is no guarantee of optimal health outcomes.

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Protecting Our Nutrient Safety Net

Food insecurity, part of the complex matrix of poverty and toxic stress, is a significant health risk. Embarrassingly, the US ranks among the highest of the developed countries in the prevalence of food insecurity, with the prevalence of food insecurity higher than Canada, Australia, Germany, France, Denmark, Spain, and the United Kingdom. In 2016, 15.6% of US households with children reported food insecurity; that is, 4.2 million households were unable to provide adequate food for their children.

Although the percentage of US households with children experiencing food insecurity seems to have decreased in recent years, that is an illusion. Food insecurity increased dramatically during the 2008 recession, reaching 23.1% of US households with children in 2010. Even though the slow decline since then is encouraging, we have yet to return to the 2007 level of 15.6%. Indeed, the prevalence of food insecurity has remained relatively constant between 2015 and 2016 and the lack of real improvement in the prevalence of food insecurity over the last 2 decades indicates both its intractable nature and our own neglect of this important healthcare issue.

The article by Lohman et al in this volume of The Journal describes one of the healthcare risks associated with food insecurity. The authors showed that higher levels of food insecurity at age 15 years were associated with a faster rate of body mass index increase over the next 16 years. In females, but not males, body mass index increases correlated with increasing food insecurity over time. Although this study focuses on the impact of food insecurity on obesity, this is only one of several pediatric and adult diseases associated with food insecurity. In children, food insecurity has profound effects on health and development, including (but not limited to) increased cognitive problems, higher levels of anxiety and aggression, and higher risk of hospitalization, anemia, and asthma.

Recently, the American Academy of Pediatrics published a policy statement encouraging providers caring for children to screen for food insecurity at every clinical visit. The validated 2-question food insecurity screen developed by Hager et al is the recommended tool. In many healthcare organizations, these questions are embedded in electronic or paper questionnaires for patients or caregivers. However, increasing screening for food insecurity, although challenging for the busy pediatric healthcare provider, is not the greatest challenge we face.

The greater challenge is what to do when the screen is positive. We have many programs and organizations available to address food insecurity in our patients, including the Supplemental Nutrition Assistance Program (SNAP), the National School Lunch Program, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and food shelves and other safety net programs. Access to these programs can be complex and difficult, and even when referred to appropriate food resources caregivers may fail to follow through—whether from lack of time, lack of transportation, or perhaps, fear of deportation. Further, children from households with marginally nonqualifying incomes find themselves excluded from these governmental programs—and hungry.

SNAP Supplemental Nutrition Assistance Program
WIC Supplemental Nutrition Program for Women, Infants and Children

The authors declare no conflicts of interest.
Our current nutrient safety net has not prevented food insecurity in children, and yet it is under attack. Congress is attempting to reduce or restrict SNAP benefits, which will reduce food support available to children. The initial budget submitted by the Trump Administration in 2017 proposed funding cuts to WIC and more recently they proposed work requirements for WIC. The Trump Administration has proposed that both WIC and SNAP be counted among the public services that, if used, may label a legal immigrant as a “public charge” and reduce the chances of the immigrant or their families being granted permanent status. This threat alone is increasing fear among the immigrant population of using these resources to reduce their children’s hunger. Thus, we dissuade families from taking advantage of public benefits by subtle threat of deportation—and increase illness in children and healthcare expenditures in the US.4

Lohman et al are to be commended for adding to the growing literature associating food insecurity with chronic illness. Yet their concluding statement, “These results argue for preventive measures such as increasing access to food during key developmental periods such as early adolescence” could have been written anytime in the last 4 decades. Childhood hunger, malnutrition, and food insecurity must be addressed as critical issues of individual and population health and healthcare expenditures, not as opportunities for political posturing. Pediatricians, and all providers of healthcare to children, can play a role in translating the data on food insecurity to policymakers to achieve better lifetime health for our country. ■

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The Journal of Pediatrics • www.jpeds.com
Volume 202

Child Poverty: New Opportunities for Pediatricians

When the US Bureau of Labor Statistics announced in May that we had hit the lowest unemployment rate—3.9%—since 2000, few felt a wave of relief. Americans may be employed, but wages are stagnant. A review of workers in the labor market found men entering the market in 1983 had a 10%-19% decrease in median lifetime income compared with those entering in 1967.1 Further, an analysis of Congressional Budget Office data found widening income inequality; since 1979, those in the top 1% have had a 228% increase in their income, whereas the middle 60% and bottom 20% have had a 42% and 69% increase, respectively.2

For the parents of many of our patients, having a job does not feel sufficient when working hard does not equate with being able to pay their bills and feed their children. The microcosm of discontent and hopelessness of low- and even some middle-income parents presenting to our examination rooms is reflected in national political trends of rising populism. Social policy has not kept pace with economic trends. What, if anything, can child health clinicians do to offset the fact that low income and financial stress undermine children’s health and development?

An important and time-honored approach is advocacy to promote policies that increase money or provide resources for families in order to prevent the health and developmental consequences of poverty. Examples include the Earned Income Tax Credit, Supplemental Nutrition Assistance Program, housing subsidies, and health insurance. Although advocacy is important, pediatricians need to go beyond these important but