Relative Child Poverty, Income Inequality, Wealth, and Health

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ABUNDANT EVIDENCE NOW SUGGESTS THAT LIVING IN relative poverty and exposure to relative income inequality, especially in childhood, may have a detrimental influence on health and well-being during childhood and across the life course. This Commentary discusses the importance of relative poverty in childhood and the implications of income inequality for population health.

Child relative poverty (ie, children living in a household with relative income poverty) appears to be a potentially important indicator for children's health. Relative income poverty is commonly defined as having equivalized household income of less than 50% of the national median.[1] Equivalization is calculated by dividing household income by an indicator of household composition or need, for example, the square root of the number of individuals living in the household.[2] Child relative poverty is strongly related to overall income inequality as measured by the Gini coefficient, which reflects inequalities in the distribution of income and wealth for the population of a nation; a lower Gini coefficient suggests more equal income or wealth distribution, whereas a high Gini coefficient reflects more unequal distribution of income and wealth.[3] For instance, the United States has both the highest national wealth and the highest Gini coefficient.[3] Thus, in the United States, as with many of the world's richest countries, there is little or no association between national wealth and the levels of income inequality evident within those nations.

Given that relative poverty is defined in terms of deviation from country-specific median income, there is no a priori reason to expect an association between relative poverty and national wealth. Two factors appear to be particularly relevant to understanding the variation in relative poverty.[1,2] First, clear international differences in income inequality (and the consequent risk of exposure to relative poverty) result from levels of participation in and the operation of labor markets. Second, redistributive income policies (the combined effects of progressive direct taxation and provision of welfare benefits) play a key role in attenuating market-driven inequalities and thereby in determining rates of child relative poverty and income inequality experienced by the population.

For instance, a recent Organisation for Economic Cooperation and Development study reported that child relative poverty rates in 2000 calculated without taking into account any effects due to taxation and benefits were more than 25% in the United Kingdom, France, Australia, New Zealand, and the United States.[2] However, the effects of redistributive income policies varied markedly across these countries, reducing actual child relative poverty rates by more than 70% in France (from 28% to 7%) by more than 50% in Australia (from 27% to 15%), by more than 40% in the United Kingdom (from 29% to 16%) and New Zealand (from 29% to 15%), and by just 18% in the United States (from 27% to 22%).[2]

Relative child poverty appears to be associated with health and, in particular, the health of nations. For example, international or interstate variation in rates of income inequality or child relative poverty have been associated with higher rates of adverse health outcomes[1,4-11] including the following: poorer overall child well-being, infant mortality, low birth weight, not having polio immunizations, child mortality due to unintentional injuries, juvenile homicide, low educational attainment, dropping out of school, nonparticipation in higher education, aspiring to low-skilled work, poorer peer relations, having been bullied, teenage birth rate, physical inactivity, childhood obesity, not eating breakfast, feeling lonely, and mental health problems.[5] Moreover, across nations with wide ranges of per capita income and poverty levels, there appears to be an ecologic association between child relative poverty rates and mortality rates for children younger than 5 years (FIGURE). Similarly, exposure to relative poverty or having a low socioeconomic position in childhood has been associated with increased adult morbidity and mortality resulting from (among other causes): stomach, liver, and lung cancer; diabetes; coronary heart disease; stroke; respiratory diseases; nervous system conditions; diseases of the digestive system; alcoholic cirrhosis; unintentional injuries; and homicide.[9,10]

It is therefore not surprising that increasing attention is being paid to reducing child relative poverty (or ameliorating the effects of child relative poverty) as a central component of attempts to improve the health of nations and reduce health inequalities between and within nations.[4,11] Indeed, there exists a sound evidence base regarding the de-

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Figure. Relationship Between Relative Child Poverty and Under Age 5 Mortality in High-Income OECD Countries
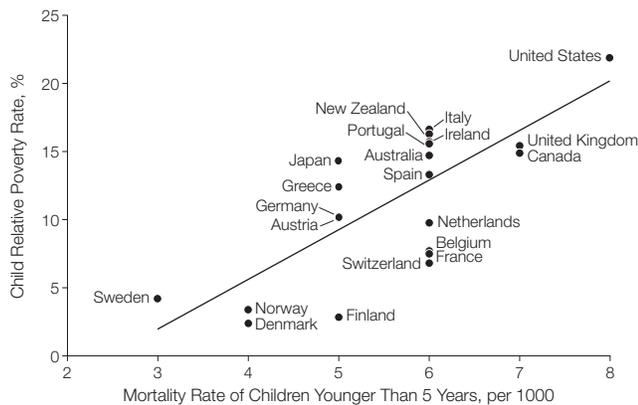
Child relative poverty rates were extracted from data reported in the 2005 United Nations Children's Fund (UNICEF) report on child poverty in the world's rich countries.[12] Child relative poverty was defined as having equivalized household income (equivalized by dividing total household income by the square root of the number of individuals living in the household) of less than 50% of the national median. Mortality rates of children younger than 5 years for the same period covered by the poverty estimates were extracted from data reported in the 2003 UNICEF report on the *State of the World's Children*.[13] Data are presented for all high-income Organisation for Economic and Co-operative Development (OECD) countries for which data were available in the 2 reports. Linear regression was used to estimate and plot the linear trend between relative child poverty and mortality rates of children younger than 5 years ($r^2 = 0.56$; relative child poverty = $-0.09 + 0.04 \times$ mortality in children younger than 5 years).

terminants of child relative poverty and many examples of successful approaches to reducing child relative poverty.[4,12,14] Addressing these issues is not merely a matter for health professionals and health policy but centrally con-

cerns the willingness of the electorate in democracies to tolerate the existence of inequality and its effects.

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Describing Physician Language Fluency
Deconstructing Medical Spanish

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LANGUAGE BARRIERS ARE INCREASINGLY IMPORTANT IN US health care. Limited English proficiency is associated with poorer health care processes and outcomes.[1] Disparities in care for patients with limited English proficiency persist even when socioeconomic and insurance status are considered, suggesting that language and culture also play an important role.[2] Accumulating research shows that having a language-concordant physician is associated with improved quality and outcomes.[3-5] Using professional interpreters can also lead to better care for patients with limited English proficiency,[6] but physicians and medical trainees underuse professional interpreters, fre-

quently substituting their own limited spoken Spanish during clinical encounters.[7]

Because many physicians who provide language-concordant care are not native speakers of Spanish, studies are needed to help understand the degree of fluency a clinician needs to provide high-quality, language-concordant communication. In addition, a more basic problem is the lack of consistency in describing and assessing physicians' linguistic

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