Is the Quality of Education in Any Way Related to the Health of the Children in the United States?

Hengameh Hosseini
Penn State University- Harrisburg

This paper tries to demonstrate that children's health is a determinate of their education. In the United States, poor students who are less likely to have health insurance, thus having less access to regular preventive care and timely immunization, are more likely to suffer from disease. This suggests that such students are less likely to receive better education. In general, being more likely to be poor, ethnic and racial minority students have more barriers and less opportunities for being educated. Among these barriers are: often lacking transportation or a social support system, and the likelihood of being healthy.

INTRODUCTION

In the United States, children enter elementary school with many differences in needs, skills, and learning histories. In this environment, in addition to the challenge of meeting the typical needs of a group of young children who are at different developmental and skill levels, American teachers also need to be prepared to work with young children who are at risk of failure in school. It should not be surprising that many children who are considered "at risk" live below what the United States views as the poverty level. The developmental and achievement deficits in children from low socioeconomic backgrounds are significant by kindergarten entry and increase with each additional year of schooling.

Child poverty is not new in the United States. For example, according to the National Poverty Center, in 2010, some 16,401,000 children lived under poverty level in the United States. And, children of poverty are more likely to have unmet needs in their basic foundations of life such as proper food/nutrition, health care, socialization, and stable living environments. No doubt, child poverty is influenced by and results from a number of factors that include political, social, and economic causes.

Notwithstanding the newly passed Affordable Care Act of 2010, impoverished children pose a unique challenge to the health care system. At least before the implementation of the Affordable Care Act, due to a lack of health insurance or inadequate coverage, these children had no access to health care. Consequently, these poor, uninsured children are at greater risk for having their medical needs unmet. When children are inadequately immunized, they cannot gain admission to schools; and when they suffer from acute and chronic illnesses, they cannot attend school regularly to learn effectively. It is obvious that, poor children often lack the various means to achieve and maintain wellness required for being properly. To more effectively address the needs of impoverished children in the educational system, it would seem that a partnership in the form of an interdisciplinary, multi-dimensional, professional team might be a beneficial approach to investigating issues and offering solutions.

Of course, child poverty is not only about income. It is also about inequitable access to services such as education, lack of opportunities, reduced outcomes, and reduced hope and expectations. Thus, an

effective anti-poverty strategy must address educational inequalities, and an effective measure of child poverty should take them into account. Even as far back as 2002, Wagner, Spiker, and Linn indicated that human service providers should be aware of the impact poverty has on the lives of young children, and that the advantages of the programs developed to meet their needs should be maximized. These authors also suggest that schools and communities must seek to find ways to increase resources and improve the manner in which services are delivered to families and children who are poor. The above authors cite Sampson and Groves (1989), who mention that the residents of a community can support the well-being and education of its members when there are strong social ties, resident participation, and links between institutions. In what could be seen as one of the most important statements in regard to the recommendations to address the question posed within this paper, Wagner, Spiker and Linn (2002) state, "This means that schools, health and mental health agencies, recreational centers, businesses, law enforcement agencies, courts, and community organizations need to collaborate to meet the multiple needs of students and families living in poverty" (p. 79).

As school officials struggle with high stakes testing, accountability, and factors that can impact the educational experience of students, socioeconomic status and backgrounds of students is a variable that cannot be ignored. Sadly, the number of children from families whose income falls below the poverty level is increasing.

What the paper has tried to do is to develop a proposal that recommends how to improve the quality of the educational experience for impoverished children which in turn improve their health. This will include the following components: traditional frameworks and barriers; interdisciplinary framework, recommendations, and solutions; traditional frameworks and barriers, which would analyze the improvements of children's education, thus health.

Traditional Educational Frameworks of Education, Health, and Social work, and Child Poverty and Health

The educational framework has a direct relationship to the issue of educating children in poverty, because the formal institution of education (the school system) is often the only source of educational enrichment in children's lives. This is especially true for children in poor families, whose parents don't necessarily have the education to tutor and enrich their children in the home environment. An important goal is to instill a life-long passion for learning in students. It is also hoped that students will be able to adjust to the many changes that will undoubtedly occur during their lifetime. In an effort to provide all children with a positive educational experience, school districts typically develop plans to address this concept in many areas of school life. Programs such as extracurricular and after school activities, as well as sports and clubs help alleviate this problem.

It is a fact that impoverished children have less access to quality health care, they are disadvantaged in terms of their educational experiences. Traditionally, providers of health care have been primarily concerned with the physical health of children, but not their access to health care or their insurance needs. Health care providers, as deemed necessary, have referred child consumers and their families to medical specialists. Oftentimes the health care provider must wield their influence or rely on charitable service when helping poor clients secure access to medical specialists. However, the health care providers' hands were often tied by financial powers when it came to actually providing services for uninsured children and families who had no source of income. Health care's response has been to open clinics outside of the school and mandate that children have various immunizations to keep them and others healthy; these clinics, however, have not been school based. The field of health care has perpetuated the disjointed view of children's medical needs as separate from their cognitive development and their ability to function at school.

Additionally, in the social work framework, helping children is the focus of the entire profession. Social workers have the opportunity to interact and directly impact poverty-stricken children and their families. With this framework, social workers began to work on behalf of impoverished children and addressed issues such as poor housing, diseases, and lack of education. Social work was responsible for advocating for various supports for impoverished children including Women, Infants, & Children (WIC),

medical assistance, housing, and other such needs. Social workers were also responsible for assisting those eligible to enroll and receive such benefits. The field championed such initiatives as public works, Head Start programs, clinics, and community centers for children. The framework for the profession allowed social workers to intervene on many levels in an attempt to counteract the deprivation of poverty and its effect on children.

What Are the Barriers to the Above Frameworks?

First, in the education framework, there are barriers that hinder the classroom teacher from effectively working with students. Teachers are continually faced with developing strategies to help them deal with the disruptive behaviors students bring to the classroom. Impoverished children are likely to come into the classroom with disruptive behaviors and undiagnosed learning disabilities and have likely not been properly assessed for educational deficits than those children not coming from a culture of poverty. Impoverished children are more likely to have been moved around through several school districts due to their high mobility and most times do not come into a school district with up-to-date school records and achievement testing. These same impoverished children are likely to be attending to other issues in the day, losing their primary focus on education because there are other important issues on their minds or in their worlds.

Second, in the health care framework many barrier have to do with the perspective of health care practitioners. At first glance, clinical practitioners might think they have very little to do with the educational experience of the children living in poverty, unless of course they happen to be the school or public health nurse, and have direct contact with these children. Those not in a direct role might recognize their responsibility and obligation to meet the health care needs of this vulnerable segment of society, but not immediately see themselves as linked to the child's educational experience. Because they don't always see themselves as having a responsibility or influence, health care practitioners may not immediately see themselves as part of the solution. Unless the health care practitioner is the school nurse, encounters between the impoverished child and the health care practitioner probably occur off of school property and out of the educational context. For many impoverished children who lack access to health care, the health care practitioner is not even part of their world. The only interface between the impoverished child and the health care practitioner may occur in the emergency department during a health care crisis.

Study after study documents the negative effects of poverty on children - on their physical growth, cognitive development, academic achievement, socioeconomic functioning, and productivity later in life. This invisible population, impoverished children, may not have the resources or the voice to access health care. Their parents or guardians may not have the knowledge of health promotion practices, nor a high value on good health. For many families living in poverty, daily survival in securing food, shelter, and safety takes precedence over health and wellness. Children in poverty often suffer physical, mental, and emotional obstacles to learning when their families do not have the resources for or access to adequate health care (Smith, 2003).

Health care practitioners cannot provide care and practice in a vacuum. Treating the impoverished child's symptoms without treating the family, the school, or community is likened to putting a Band-Aid on a gaping wound that requires much more intensive medical attention and skill; without proper care and treatment, the wound will continue to gape and be susceptible to secondary problems. Similarly, without early nurturing and a quality educational experience, many impoverished children grow up into adults without the resources and skills they need to escape poverty. Then, the cycle perpetuates itself.

Third, there are even barriers in the social work framework. Most children living in poverty are of school age and can be found in public schools. Because education is mandated until a child reaches the age of 16, the school becomes a logical system to which social workers turn in order to reach impoverished children. Social workers have been major players in society's piecemealed response to children living in poverty. Although social workers most often practice independently, they frequently are members of multidisciplinary teams comprised of other mental health professionals or substance abuse counselors.

Component Two and Suggestions

The foundation for this interdisciplinary framework has its basis in the practice of the individual disciplines' linear traditional responses. All three disciplines have had limited practice in working outside of their own traditional experiences with other disciplines. When there have been contacts with other disciplines, it has been for reasons to assess discipline responsibility or to refer for other resources.

Our aim as an interdisciplinary team is to provide connections and direction toward new innovative solutions. Vygotsky believed development and learning took place at the same time. He was not interested in identifying stages, yet he was not opposed to them. The socialism of Marx and Engles was the foundation to Vygotsky's social learning and development theories. He emphasized social interaction between children and adults, peers, and their cultural world. Vygotsky (1978) felt that social activities shaped the mind, and that society shares the knowledge so all are enlightened by the brightest. Shared knowledge and ideas lead to the education and learning experienced by the whole society. Vygotsky related that human behavior could not be understood independently of society. Active learning was key through the encouragement and guidance of the child's teacher, who could be an adult or an older child. According to Vygotsky, the child should be challenged to question things and to work with other children in problem solving. He believed in Hengel's dialectical changes, the analysis, criticism and exposition of ideas, and argumentative logic.

People at or below the poverty level must have a very deterministic view of life. They must feel they do not really have free choices. It is the pressures of life that determine how they make decisions the way they do. People at poverty level are not really free agents to choose a course of action; they are simply the fulcrum point of competing pressures.

Hopefully the ideas presented in our reframing will allow for such a community to evolve. Gladwell also mentions that to facilitate a contagious movement, many small movements need to occur first. The Theory of Tipping Points is that those who are successful in creating social epidemics do not just do what they think is right, they deliberately test their intuitions.

In defining the problem of the lack of quality educational experiences for impoverished children, we as professionals must make an effort to define a solution. As a team of interdisciplinary professionals we have reflected on our respective codes of ethics to provide direction for the creating of a solution. If one were to ignore the problem, one would be refuting the principles of beneficence and justice as upheld in many professional codes of ethics in the caring professions. Moral responsibility provides the impetus to action and utilization of available resources. In this case, it will be the community as a focal point in the promotion of education throughout the lifespan and the facilitation of the collaboration of specific systems in this endeavor.

The Affordable Care Act and Its Implications on the Topic of Educating Poor Children

In March of 2010, President Barack Obama signed the Affordable Care Act into law, a multi-faceted plan to improve healthcare for all Americans over a span of five years. This new addition to healthcare has important influences on poor children's healthcare. For example, in 2013, actions will be put into place to put additional funding towards poor children's healthcare programs, such as CHIP (Children's Health Insurance Program). This will help to fill in the gaps or deficits left for children not eligible for Medicaid. Programs such as CHIP insure children who are ineligible or not enrolled in other health coverage. Specifically, CHIP insures children until the age of 19, who are from families that have a household income of less than $46,100 (CHIP 2012). The insurance provided helps pay for check-ups/wellness visits, emergency care, dental, vision, and other crucial parts of healthcare for growing children.

Another example of the improvements to impoverished children's healthcare is the 2014 plan to increase access to Medicaid. Specifically, households who earn below 133% of the poverty level will become eligible for Medicaid. The federal government plans to initially fund this increase in individuals being covered 100%, and after three years (a transitional period) has passed, that funding will decrease by 10%. This plan of action directly helps children living in households who are at or near the poverty level get the healthcare they desperately need.

What Can Be Done

It was important that this solution involve several key components. All community groups would be called upon to develop a solution and key community leaders need to be a part of the planning. The solution should be an interdisciplinary/multidimensional approach that facilitates interactive partnerships and finds ways to utilize existing resources. It was also essential to implement specific activities rather than use a scattered approach and to address ways to obtain funding.

From the perspective of a social worker, the solution involves being an agent of change. The first task of this change must be evident in the social worker's willingness to lead and at time follow when working in groups. The center of power will be shared among the group members and all team players must be willing to wrestle with this shared power and acknowledge when shifts occur. This may be a new challenge for some. The team members individually need to frame and reframe control among the team members throughout this new approach of working with others. The team members are fully aware of the need to work cooperatively so that new solutions are found to improve the quality of education for children trapped within the culture of poverty. The goal of the team's work is to reduce the stigma found within the culture of poverty and to provide families and children with newfound opportunities. The team is the agent of change charged with the task of applying the strategic plan and coming up with new solutions involving connections between and among the cohort of the multidisciplinary team. This cohort has the responsibility to add many other new members onto the skeleton crew by inviting any and all players to join and create a new vision for reduction of the stigma.

The original multidisciplinary team will look to other individuals and organizations for help in the goal. This idea, borrowed from the field of social work, is to empower potential partners in the community to improve students' opportunities, connections, and to encourage their educational success. The result of this in-depth consideration was the idea of a small pilot program to be initiated within a community. Once the pilot program has become a permanent fixture within the community, its scope could be enlarged to work with additional issues. This process would provide a never-ending strategy that over the years would foster interactive partnerships that would evolve as community needs change.

The process also allows for a never-ending strategy that over the years would allow for the program to evolve as community needs change. Once the recruitment process is completed, the school district officials would hold a seminar to present information to those community members who indicate they wish to be involved. The seminar would include the results of research highlighting the impact poverty has on student achievement, the number of students within the school district who fall within lower socioeconomic status levels. Student achievement as reflected through standardized test results, and examples of how services, resources and conditions within the community impact impoverished children. At the end of the seminar, school district officials would ask community members of the various community groups to join with them in offering more support to families whose income falls within poverty levels in an effort to impact the quality of the educational experience for children often.

The Advisory Board, in following the Strategic Plan Model, would develop a vision, mission, objectives, values, strategies, goals, and programs. The vision for the project should be practical and should project at least three years into the future. The mission statement is followed by objectives or the needs and/or wants that exist for the medium and long term. The values that guide how these objectives will be realized is also a key aspect as the strategies or the rules and guidelines by which the mission and objectives may be realized are established. Goals are developed in such a way that they are time-based, measurable, and attainable. Programs are the elements that actually allow for the goals to be achieved.

It is very likely the proposed plan would be two-fold in its approach. The plan would seek to include strategies to make the community members aware of the issue of poverty and its effect on quality educational experiences. The board would also need to coordinate the services that are already in place in the community and develop strategies for how they can be more effective, reach the people who would benefit from them, and encourage their involvement in these programs that already exist.

As the Advisory Board begins its work, a needs assessment would be conducted to determine the current status of the strengths, weaknesses, and threats in regards to community support of families representing lower socioeconomic status.

The problem of educational experience for poor children would be reframed to include personal health and wellness. Just as free or reduced lunches are accepted for hungry children at school, health care and wellness promotion for all would be accepted as the norm. In addition, partnerships with institutions of higher learning such as schools of nursing or medical and dental schools would enable a venue for onsite delivery of care. Many university nursing programs have Wellness Centers, where experienced faculty and graduate nurse practitioner students provide direct health care services and education. This would help meet the primary care needs of children with chronic health problems as asthma, diabetes, or obesity as well as serve as a clinical setting for health professional education. Similar arrangements can be made to help address the mental health and dental needs of students.

In conclusion, providing healthcare and other vital resources to impoverished children will allow them to obtain the education they need to better themselves and end the cycle of poverty. By implementing the aforementioned plan, the government can assist in this much needed change to our society. The Affordable Care Act is a step in the right direction, but much more funding and attention is needed to make a permanent positive change. By giving the poor children a hand, we can help our country on the road to success.

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