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저소득 가정 아동의 건강불평등과 건강 복지

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Health Disparity and Health Welfare among Children from Low-Income Families

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Children from low income families are vulnerable to physical problems including obesity, asthma, hypertension and psychological problems including depression, anxiety. This study was done to identify trends in welfare policy for children from low-income families and future direction for solving health disparity problems. Dream Start is a government-sponsored project that offers services for vulnerable children, ages 0 (include pregnant woman) to 12 years and their families. The Korean Government has made an effort to alleviate health disparity through the 'Health Plan' by establishing health objectives. However, in spite of these efforts by the Korean government, health disparity has worsened in Korea. In order to strengthen family function as well as promote growth and development for vulnerable children, experts in child care need to be significantly involved in identifying neglected children in the community.

Key words: Children, Health inequality, Low-income population

Introduction

According to a report from UNICEF (United Nations Children's Fund) approximately a billion children among world's 2.2 billion children may die due to poverty: In short, at least every second child suffers from poverty (Shah, 2010). In Korea in 2009, the percentage of children and adolescents living below the poverty line was 6-9% , moreover, child relative poverty rates, the percentage of children living at a threshold lower than 50% of the median income, was 10-14% (Ministry of Health and Welfare & Seoul National University R & DB Foundation, 2009). Also, according to 'Household survey data 2012' conducted by Statistics Korea, because the widening gap between the rich and the poor has increased since 9 years ago (Lee, 2013), exposure to poverty or having low socioeconomic status in childhood may have also increased. On the other hand, the number of children who are recipients of the national basic livelihood guarantees is only 3% of all children.

Children from low income families are much more susceptible to physical problems including obesity, asthma, hypertension and psychological problems including depression, anxiety than children who live above the poverty line (Chen, Martin, & Matthews, 2006; Hernandez, Montana, & Clarke, 2010). Park, Patton and Kim (2010) reported that adolescents in families in the higher affluence level brush their teeth more frequently and receive preventive dental care and have clustering of health behaviors including eating breakfast and exercising regularly. Oh et al. (2009) also stated that youth with high level family affluence were more likely to do moderate physical activity. Similarly, inequality in children's health has been associated with increased adult cardiovascular disease and adverse health indexes related to higher risk of adult morbidity and mortality. Lynch and Smith (2005) showed that increased car-

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diovascular disease risks after the middle age likely resulted from poor socioeconomic backgrounds in childhood, Khang (2005) also showed that deaths in adults have relevance not only to current health but also socioeconomic status.

Health disparity refer to 'the absence of systematic and potentially remediable differences in one or more aspects of health across populations or population subgroups defined socially, economically, demographically, or geographically', 'Poverty' is the leading factor for health disparity in childhood (Hernandez et al., 2010). In the United States, objectives of the Healthy people 2020 are to 'achieve health equity, eliminate health disparity, and promote good health for citizens in all walks of life', Similarly, objectives of the Healthy plan 2020 in Korea also target 'promotion of health equity', and the government making efforts to reduce health inequalities globally (Ahn et al., 2011). Personally, the health-related costs associated with children from low-income families are in vicious circle between poverty and disease, and nationally, future health expenditure will increase because of health problems of poor people.

Therefore, concern for childhood health disparity and an effort to solve this problem cannot be overlooked anymore. The intention for this study was to identify health matters in welfare policy for children from low-income families and suggest strategies for future directions to solve the health disparity. Domestic after school activity is so far divided into after school programs, community child centers, and after school academies for adolescents.

Health Policy in Korea

Dream Start

Dream Start is a government-sponsored project that offers services for vulnerable social groups such as recipients of basic living supports, low income families, and singe-parent families including children of age 0 (include pregnant woman) to 12 years and their families. The Ministry of Health & Welfare started this project in 2007 based on "We Start". Local government in partnership with private organizations were in operation in 2004 with the purpose of providing inclusive early support services for children in poverty. Sixteen pilot centers were started in 2007, and by 2013, 211 local administrations were participating in an extended operation. Dream Start offered `customized integrated service`, which included an integrated case management system using local sources at early stages for children from low-income families. The ultimate objective was to improve latent capacity to escape poverty. In this way, Dream Start gives an even-handed starting line to vulnerable children from early childhood through national intensive investment. It shares similar qualities to 'Sure Start' in the United Kingdom and 'Head Start' in the United States (Korean Ministry of Health & Welfare, 2009; Lee, 2010). The overall services of Dream Start are shown in Table 1.

Community Child Centers

Domestic after school activities include school-based after school programs, community child centers, and after school academies for adolescents (Leftovers Love Sharing Community & National Youth Policy Institute, 2011). Particularly, community child centers were created for the purpose of community protection for children from low income families by offering space at all times (during the semester and the vacation months, Saturdays, holidays, and during the night) which differed from school programs or after school academies. Community child centers which began as study rooms to help children from low income families to study, have become child welfare institutions through the Child Welfare Act which was enacted in 2004. A recent report on community child centers shows a rapid rise in the number of centers on a nationwide scale -895 centers in 2004, 2,618 centers in 2007, and 4,003 centers by June 30, 2012 (Ministry of Health and Welfare & Headquarters for Community Child Center, 2012). The number of children who use the

Table 1. Service Contents of Dream Start

Domain	Service contents
Physical · health service	Improve physical and mental health development of children from low-income families Support pregnant women from low-income families in need of healthy delivery and childcare support Strengthen parents education for healthy life and family competence (medical examinations and therapeutical intervention)
Cognitive · language service	Improve linguistic cognitive development of children in need Support customized learning to develop children's strengthes Reinforce the capability of parents for parent-children interaction and appropriate educational environment
Emotion· behavior service	Provide emotional development services for improvement of self- esteem and positive mind Promote development of mature social citizenship by providing proper social recognition and understanding Provide children in need and their families with stability, improvements in quality of life and reinforcement of family ties
Family and integrated service	Provide an integrated children and family care service that includes one-to-one home visiting by professional case managers, reinforcement of self-esteem for parents and nurturing skill support

community child centers has also shown a consistent rise - 23,347 users in 2004 to 107,171 users in the first half of 2012. Among community child center users, 34.8% were children from low-income families an especially high rate. Other users included children of immigrant families, 29.0%, children of recipients of national basic livelihood guarantees, 23.3%, and children of families living above the poverty line, 13.0%. Services provided by community child centers are shown in Table 2.

Table 2. Service Contents of Community Child Centers

Domain	Service contents
1. Basic program	
Protection program	Child protection from poverty and neglect, daily-life guidance, provision of school lunch, sanitary guidance
Educational program	School readiness for children, homework guidance, special tutoring in learning for under achieving children, arts and physical education, reading guidance
Culture program	Cultural experiences, field trips, camps, community activities, play activities, encouragement in special ability aptitude
Welfare program (emotional support)	Children's psychology, emotional support and counseling, parent and family counseling, emotional stability and promotion of healthy physical development
Community connection	Human and material resource connections in the community
2. Specialized program	
Holiday program	Providing culture programs or field studies for children who need care on weekends or holidays
Strengthening family programs	Promoting nurturing and communication skills, parents programs and self-help groups, classes for family and development, classes for parenting improvement, affiliation with local residents and mentoring
Night protection program	Providing care at night for children who need services

Foreign Health Welfare Policy

Many advanced countries have implemented 'Start programs' which supported children in poverty. 'Start' referred to an effort to give every child the best start in life by helping them to overcome poverty. Also, Start supplies a community network, and works in close collaboration between private and government organizations to provide vulnerable children with the fair opportunities that most children enjoy in health, welfare, and education. Representative Start programs in the United States, the United Kingdom, Canada, and Australia are displayed in Table 3. Below are details of 'Head Start' in the United States and 'Sure Start' in the United Kingdom.

Head Start in the United States

Head Start was designed by the United States Department of Health and Human Services to offer education, health, nutrition, society and parent involvement services to low-income children and their families. Head Start is a comprehensive developmental program for low-income

Table 3. Start Programs in Other Countries

	Purpose	Participants	Content	Present condition
Head Start (U.S)	A federal program to break the vicious circle of poverty caused by differential educational opportunities in early life	For children between the ages of three and five years old and their families (Early Head Start: from early pregnancy until the child is two years of age)	To provide comprehensive education, health, nutrition, and parent involvement services to low-income children and their families	Launched in 1965, so far, more than 18 thousand Head Start Centers have participated
Sure Start (United Kingdom)	A government-initiated program to give every child the best start in life	Initial: children ages birth to four years of age Extended to include children up to fourteen years of age (disabled children, up to sixteen)	Integrated services for young children and their families based on community infrastructures in order to improve quality of nurturing services	Launched in 1997, as of 2010, more than 3,500 Sure Start Centers have participated
Fair Start (Thunder Bay, Canada)	"As the years before five last the rest of their lives", all children starting school to be provided the opportunity to reach their full developmental potential	For children between eighteen months to school age	Service of free screening including speech and language develop ment, fine and gross motor skills, and social development and self-help skills	Launched in 1996, so far the 'Fair Start committee' is compromised of 7 community groups (3 councils for schools, 3 medical institutes, 1 nonprofit organization)
Best Start (Australia)	Support the role that families and communities play in giving pre-school children the best environment and experience to encourage them in health, education, and development for all	For children from early pregnancy until the child is eight years of age and their families	To provide long-term high-quality programs for children, parents, and community by cooperating with appropriate branches of the government	Launched in 2001, so far, extended to include 26 centers

Figure 1. Head start home page. http://eclkc.ohs.acf.hhs.gov/hslc.

children which offers a qualified regular education in early childhood (Figure 1).

The program is expected to have a "positive impact" on children's experiences through the preschool years. Therefore, the overall educational purpose is to enhance children's potential capacity in cognitive, social, emotional, and physical development, and to establish an environment to develop social competences (Nelson et al., 2011).

Sure Start in the United Kingdom

Sure Start is to improve outcomes for children and their families from low-income areas, and has a particular focus on the most disadvantaged children. Thus the children get ready (Start) for life and school surely (Sure), no matter what their background or family circumstances. Sure Start constructs infrastructure for all child nurturing systems and offers educational programs which would be inaccessible to children from low-income families. It is also a program for a better life by supporting nurturing environments for working parents. Namely, Sure Start's aim is to improve social and emotional development, health promotion, learning ability and the capability of parents (Laura & Tony, 2012).

Conclusion

Even though the Korean Government have made efforts to alleviate health disparity through 'Health plan 2020' by establishing health objectives, a few prioritized health concerns and efforts to resolve them still need attention (Kim, Jeon, & Seo, 2011). To date, while decreasing birth-rates have led to a decrease in the childhood population, the family system is faced with the greater challenges of an increasing number of children who live in single-parent families or grandparents' families due to an increasing number of divorces. With such challenges, more children are likely to be exposed to material, psychological and mental crisis from poverty, aberration, and diseases.

The intention of this article is primarily to suggest future directions in health matters, particularly in welfare policies for children in order that they can live in a healthy environment and develop as a healthy citizens.

First, health welfare policy requires an expanded budget. The domestic welfare budget has been concentrated in the welfare budget for elders thus, a recent report found that Korea ranked second lowest among 35 OECD member countries in child its welfare spending, which was just 0.8% of GDP, one-third of the OECD average of 2.3% (Yu & Lee, 2013). Every dollar spent to help a pre-school child to thrive can result in the far-reaching benefit of $17 over the following four decades (Irwin, Siddiqi, & Hertzman, 2007). Thus, experts on health/welfare and policy makers should realize the importance of health matters in welfare policy as well as strive to extend the budget.

Moreover, in Korea there are currently two domestic welfare policies: One is the Welfare and Community Child Centers of the Ministry of Health. Community Child Centers which began as study rooms to help

vulnerable children in their learning and have become a child welfare institution through the Child Welfare Act (2004). The other is Dream Start launched in 2007 based on Head Start in the United States and Sure Start in the United Kingdom. As mentioned above, however, the programs provided by Dream Start and Community Child Centers overlap considerably in content. Also, as 10-14% of children live in relative poverty below the 50% median family income (Ministry of Health and Welfare & Seoul National University R & DB Foundation, 2009), universal and preventive policy need to be promoted. Therefore, the government should encourage the utilization of linked resources by relevant government ministries rather than overlapping content in which the targetted child may already have experienced such projects. Further, the government should make an effort to construct a system of mutual cooperation for children from low-income families.

Finally, the crises threatening healthy growth and development can be divided into familial crisis and individual crisis; familial crisis includes poverty, family dissolution and abuse, individual crisis includes school under achievement, drinking, acting out, and crime. These crises are related and complicated. The urgent issue is to provide professional services for endangered children in oder to promote healthy growth and development and strengthen family function. Particularly for vulnerable populations, experts in child health care should be involved in a significant way to identify neglected children in community, and when identified to help focus on family environment to resolve the problems.

Conflict of Interest

No potential conflict of interest relevant to this article was reported.

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