2018

Improving Outcomes in Child Poverty and Wellness in Appalachia in the "New Normal" Era: Infusing Empathy into Law

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IMPROVING OUTCOMES IN CHILD POVERTY AND WELLNESS IN APPALACHIA IN THE “NEW NORMAL” ERA: INFUSING EMPATHY INTO LAW

Jill C. Engle*

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I. INTRODUCTION

This Article examines trends in Appalachian child poverty and wellness in the context of the Affordable Care Act (“ACA”). Appalachia is a region with mercurial definitions1 and boundaries,2 which, in its broadest iteration, includes all of West Virginia and spans parts of 12 other states: Maryland, Pennsylvania, New York, Ohio, Kentucky, Virginia, North Carolina, Tennessee, South

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1 See, e.g., ANTHONY HARKINS, HILLBILLY: A CULTURAL HISTORY OF AN AMERICAN ICON 47 (2004) (asserting that at the dawn of the twentieth century, “Appalachia” was “itself less a clearly identifiable locale than a newly constructed cultural space developed by urban northeastern novelists, book publishers, magazine editors and writers, and their middle-class readership . . . .”).

2 See, e.g., LAUREL SHACKELFORD & BILL WEINBERG, OUR APPALACHIA: AN ORAL HISTORY 3 (1977) (explaining that the region known as Central Appalachia includes western North Carolina, southwestern Virginia, and eastern Kentucky but that the borders of Appalachia overall are ill-defined and that the material in their book will likely resonate with those in parts of Georgia, Pennsylvania, and other states in the region).
Carolina, Georgia, Alabama, and Mississippi.\textsuperscript{3} Child poverty has plagued Appalachia for decades.\textsuperscript{4} Nationally, child poverty in rural areas is higher overall than in cities.\textsuperscript{5} A 2017 report by the U.S. Department of Agriculture explained that the rural rate was nearly one-fourth (23.5%), while the urban rate was just over one-fifth (20.5%).\textsuperscript{6} The report also explained that pockets of certain states are classified as "persistent poverty counties," where the poverty rates run long and deep.\textsuperscript{7} Roughly 85% of those counties are in non-metro areas, and a significant swath of them are in Appalachia.\textsuperscript{8} Compounding its vulnerability to widespread poverty is Appalachia's persistently high concentration of child residents.\textsuperscript{9}

This Article will discuss the impact of the Affordable Care Act on poverty and health for Appalachian children. It will also discuss issues of connectivity, because many Appalachians grapple with geographic isolation and its collateral effects. The Affordable Care Act's public health strategies attempt to compensate for isolation as well as poverty, so we must continue to implement those strategies to improve Appalachian child welfare in both health and economics. Part II of this Article will discuss the paradox of poverty, the declining health of Appalachian children, and the association of geographic isolation and its collateral effects. Part III of this Article will then explore the implementation of the Affordable Care Act and public health strategies used as a means to compensate for isolation as well as poverty. Finally, Part IV of this Article will conclude by arguing for implementation of the empathy-based strategies laid out in the Affordable Care Act to improve Appalachian child welfare in both health and economics.

\textsuperscript{3} See Appalachian Region, APPALACHIAN REGIONAL COMMISSION (Oct. 8, 2008), https://www.arc.gov/images/appregion/AppalachianRegionCountiesMap.pdf.


\textsuperscript{6} Id.

\textsuperscript{7} Id.

\textsuperscript{8} Geography of Poverty, U.S. DEP’T AGRIC., https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/geography-of-poverty.aspx (last updated Mar. 1, 2017) (explaining that "[n]onmetro counties with a high incidence of poverty are mainly concentrated in the South. Those with the most severe poverty are found in historically poor areas of the Southeast, including the Mississippi Delta and Appalachia . . . ").

\textsuperscript{9} See PAUL SALSTROM, APPALACHIA'S PATH TO DEPENDENCY: RETHINKING A REGION'S ECONOMIC HISTORY 1730–1940, at 60–61 (1994) (describing the commonality of large Appalachian families who worked on farms and in coal mines during the period 1880–1930).
II. APPALACHIA: A PARADOX OF POVERTY AND DECLINING HEALTH

Economic deprivation in Appalachia has been a problem for decades, prior to the 2008 Recession or even the Depression of the 1920s. Economic deprivation in Appalachia has been a problem for decades, prior to the 2008 Recession or even the Depression of the 1920s. Appalachian poverty was well-documented throughout the 20th century, often in contrast with urban poverty with divisive racial undertones. Remarkably, one of the largest population movements in U.S. history took place from the 1940s to the 1970s, as Appalachians of all races fled that depressed region for the North and West. Those movers included recent immigrants from Eastern Europe, Italy, and Hungary, who, alongside many African-Americans, formed a new cultural identity in urban-Appalachian enclaves of cities like Detroit and Cincinnati. For those remaining in Appalachia, poverty is color-blind, affecting the whitest of West Virginians alongside a dramatically disaffected minority population. For example, black Appalachians are more likely to experience poverty than their white counterparts, particularly in Southern Appalachia and its neighboring regions in the Deep South.

The complexities of our national consciousness regarding Appalachia have persisted. President Kennedy relied on it to frame his 1960 primary election campaign message of reducing human suffering, although his post-election

10 See id. at 111 (explaining that “since at least the 1920s, Appalachia has suffered from region-wide economic liabilities that cry out for planned solutions”).

11 HARKINS, supra note 1, at 8, 43 (explaining that “[d]uring the War on Poverty of the 1960s, images of impoverished and exploited white Appalachians ... provided ‘cover’ for liberal politicians promoting government aid programs primarily designed to benefit urban nonwhites” and that “[t]he construction of a class of ‘mountain whites’ and the significant growth of settlement schools and missionary programs in the Appalachian region gave many reformers the chance ‘to turn with a clear conscience away from blacks to aid Appalachia’ and its citizens, who, unlike African Americans and southern ‘poor whites,’ had the cultural and racial qualities to rise out of their impoverished and benighted state”).

12 See id. at 175 (explaining that “[t]he migration of over three million southern Appalachians in the three decades after the start of World War II—part of the much larger southern diaspora of at least eleven million people, black and white, who relocated to the North and West in the years between 1910 and 1970—is one of the largest population movements in American history”).


14 Ed Pilkington, A Journey Through a Land of Extreme Poverty: Welcome to America, GUARDIAN (Dec. 15, 2017), https://www.theguardian.com/society/2017/dec/15/americ6-extreme-poverty-un-special-rapporteur (noting that “numerically a majority of all those living in poverty nationwide—27 million people—are white. In West Virginia in particular, white families have a lot to feel sore about. Mechanization and the decline of coal mining have decimated the state, leading to high unemployment and stagnant wages.”).

15 See Baird, supra note 13.

16 Pilkington, supra note 14 (explaining that African-Americans comprise 23% of those living in poverty in the U.S. but only 13% of our total population).
poverty reduction programs (within and outside Appalachia) were limited. In the 1970s, denigration of the War on Poverty increased and our attention to Appalachian welfare decreased. Over the next 30 years, however, Appalachian scholarship and activism developed in sort of backlash, galvanizing efforts to recognize and attack the economic disadvantage continuing to plague Appalachia. The cultural consequences of the War on Poverty and other post-Vietnam sociopolitical changes are complicated in the states, towns, and hollows that comprise Appalachia. Research shows the coal industry, once lionized as the business that would transform the region, has cultivated economic and health marginalization to epic proportions. In West Virginia, for example, average wages are lower than they were in 1979, and a free medical clinic in the capital city treats 21,000 people who work but cannot afford health care.

A. Child Poverty and Poor Health in Appalachia

Child poverty in Appalachia follows the pattern of overall Appalachian poverty, which is marked by higher rates than the rest of the U.S. and its persistence over time. The links between poverty and poor health for Appalachian children are as basic as the poor nutrition that flows from food insecurity. The parents of these children are earning significantly lower wages

17 HARKINS, supra note 1, at 185.
18 Id. at 202.
20 See, e.g., Theresa L. Burris, Appalachian Cultural Consequences from the War on Poverty, AM. PSYCHOLOGICAL ASS’N (Jan. 2014), http://www.apa.org/pi/ces/resources/indicator/2014/01/consequences.aspx (stating that “[f]or well over a century now, central Appalachia has been ruled by absentee landowners only interested in making the highest profit available from natural resource extraction, primarily coal . . . . As a result of these mono-economies, most central Appalachians have been dependent upon and at the mercy of that one industry, an industry that has a legacy of exploiting both land and people.”).
21 See Pilkington, supra note 14, at 11, 13 (noting that “[t]he transfer of jobs from the mines and steel mills to Walmart has led to male workers earning on average $3.50 an hour less today than they did in 1979” and that “[d]octors at Health Right, a volunteer-based medical center in Charleston that treats 21,000 low-income working people free of charge, presented [a recently-visitng United Nations human rights] monitor with a photograph of one of its dentistry clients”).
22 UNIV. OF WIS. APPLIED POPULATION LAB., RECENT TRENDS IN POVERTY IN THE APPALACHIAN REGION 28 (2000) [hereinafter APPLIED POPULATION LAB.], http://www.arc.gov/assets/research_reports/RecentTrendsinPovertyintheAppalachianRegion.pdf (explaining that “the absolute level of child poverty was slightly higher in Appalachian counties than in non-Appalachian counties [from 1989–93]” (emphasis omitted)).
than their counterparts in other regions of the U.S.\textsuperscript{24} Attorney and congressional candidate Betsy Rader described her childhood in Newark, Ohio, as steeped in poverty, with her “family liv[ing] on $6,000 per year” and plotting together “with pen and paper to help find a way for us to live on that amount.”\textsuperscript{25}

The vulnerability of Appalachian children to poverty’s negative consequences is acute, not least because they suffer poverty as infants and toddlers in higher numbers than their counterparts nationwide.\textsuperscript{26} Geographic isolation also plays a part: roughly half the women giving birth in rural Appalachia must travel out of their home area, an indicator of reduced access to health care.\textsuperscript{27} More importantly, rates of low birth weight and infant mortality well exceed the national average in rural Appalachia.\textsuperscript{28} Columbia University economist Janet Currie, who studies Appalachian child poverty and health, argues that “if fetal health was poorer in rural Appalachia than elsewhere over the past 50 years (as seems likely), it is not surprising to observe that many Appalachians remain poor and subject to higher death rates years later.”\textsuperscript{29} Diabetes and heart disease rates in central Appalachia are also dramatically higher than in the rest of the U.S.\textsuperscript{30}

\textsuperscript{24} See Appalachian Poverty, FAHE, https://fahe.org/appalachian-poverty/ (last visited Mar. 29, 2018) (explaining that “[i]n 2014, the per capita income of the Appalachian region of Kentucky was only $30,308 while the entire U.S. was at $46,049. The number for the region taken as a whole comes out to $37,260, which is only 80.9% of the U.S. per capita income.”).


\textsuperscript{26} See APPLIED POPULATION LAB., supra note 22, at 39 (stating that “considerable research has shown that poverty can be particularly detrimental to the development of very young children. Poverty rates for children ages 0–4 years were, and continue to be, considerably higher than for children ages 5–17 years both nationally and in Appalachia. This gap was even wider for Appalachian counties than for the remainder of the U.S., with 27.3 percent of children ages 0–4 in poverty, compared to 19.5 percent for children ages 5–17 in 1995”).

\textsuperscript{27} See JANET CURRIE, UNIV. OF KY. CTR FOR POVERTY RESEARCH, SOCIOECONOMIC STATUS, CHILD HEALTH, AND FUTURE OUTCOMES: LESSONS FOR APPALACHIA 12 (2009) (noting that “it is striking how many women in rural Appalachia must travel out of county to give birth, roughly 50%”).

\textsuperscript{28} Id. at 11, 14.

\textsuperscript{29} Id. at 19–20.

\textsuperscript{30} See Left Out of Health Debate, Appalachian Poor Seek Free Care, ASSOCIATED PRESS (Sept. 12, 2017, 9:18 AM), https://wtop.com/virginia/2017/09/appalachian-poor-left-out-of-health-debate-seek-free-care/slide/1/ (stating that “[p]eople in central Appalachia are 41 percent more likely to get diabetes and 42 percent more likely to die of heart disease than the rest of the nation, according to a study released in August by the Appalachian Regional Commission and other groups.”).
A 2017 report by the U.S. Department of Health and Human Services found the same disparities between Appalachia and the rest of the county in infant mortality and life expectancy. The researchers concluded that health policy interventions such as smoking reduction, anti-obesity measures, and improved access to health care have the potential to reduce health disparities between Appalachia and the rest of the country [and that] reducing inequalities in the underlying social determinants of health—for example, by . . . reducing poverty . . . are equally important policy goals for reducing the health gap between Appalachia and the rest of the nation.

B. Child Poverty in the U.S.: A Paradox of Deprivation Within Wealth

Our country has grown richer by staggering proportions since its inception, and our government adopted social safety nets when we tottered on the brink of economic collapse. Certainly our children are better off economically as a result of both forces. The percentage of U.S. children living in poverty is lower than ever, with U.S. Census Bureau data showing the rate as 18% overall, despite a spike in the wake of the 2008 Recession. In 2017, the non-partisan Center on Budget and Policy Priorities ("CBPP") analyzed the child poverty decline using the federal Supplemental Poverty Measure ("SPM"), which puts the actual rate at 15.6%. The CBPP attributed the decline to government programs like the Supplemental Nutrition Assistance Program ("SNAP") and the Child Tax Credit. Child poverty has fallen sharply since the

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32 Id. at 1431.

33 See JESSICA L. SEMEGA ET AL., INCOME AND POVERTY IN THE UNITED STATES: 2016, at 12 (2017) (stating that child poverty was 18% in 2016); see also ISAAC SHAPIRO & DANilo TRISI, CTR. ON BUDGET & POL’Y PRIORITIES, CHILD POVERTY FALLS TO RECORD LOW, COMPREHENSIVE MEASURE SHOWS STRONGER GOVERNMENT POLICIES ACCOUNT FOR LONG-TERM IMPROVEMENT (2017), https://www.cbpp.org/sites/default/files/atoms/files/10-5-17pov.pdf (explaining the Census data that showed it was 18%); Latest Census Figures on Child Poverty Merit a “Thumbs Up,” but There’s More to Come, NAT’L CTR. FOR CHILD. POVERTY (Sept. 14, 2017), http://nccpblog.tumblr.com/post/165331376052/latest-census-figures-on-child-poverty-merit-a (explaining the use of the Supplemental Poverty Measure to aggregate the child poverty data and reach the 15.6% rate).

34 See SHAPIRO & TRISI, supra note 33, at 1 (stating that the child poverty rate was 15.6% by using the “Supplemental Poverty Measure” analysis, a more comprehensive tool than the government’s raw data).

35 Id.
dawn of such programs in the 1960s, yet the United States sustains an embarrassingly high child poverty rate as compared to other wealthy nations. A doctor who has volunteered at free Appalachian medical clinics since 1999 anecdotally characterized the region’s residents as “sicker here than in Central America,” blaming the declining economy and poor health.

A 2017 special report by the United Nations Special Rapporteur on Extreme Poverty and Human Rights castigated the United States’ failure to harness our “power [and] technology . . . to address the situation in which 40 million people continue to live in poverty.” Our national failure to reduce poverty does not reflect ignorance of its health impact: robust data shows that children living in poverty in the U.S. are unhealthier than U.S. children who are not poor. The inverse is also true—improving child health reduces child poverty. Importantly, the CBPP 2017 report stressed the Affordable Care Act’s critical role in reducing child poverty, as well as similar health care programs like the Children’s Health Insurance Program (“CHIP”) and Medicaid expansion. A 2006 Indiana report on its statewide child health initiative noted that children without health insurance face increased risks of gaps in care, and that a child’s family’s inability to pay is a significant barrier to accessing health care. The 2017 congressional attempts to sunset the national Children’s Health

See id. (explaining that the child poverty rate in 1967 was 28.4%).

Philip Alston, Extreme Poverty in America: Read the UN Special Monitor’s Report, GUARDIAN (Dec. 15, 2017), https://www.theguardian.com/world/2017/dec/15/extreme-poverty-america-un-special-monitor-report (stating in its introduction that “U.S. child poverty rates are the highest amongst the six richest countries—Canada, the United Kingdom, Ireland, Sweden and Norway”).


See David Wood, Effect of Child and Family Poverty on Child Health in the United States, 112 PEDIATRICS 707, 709 (2003) (explaining that “[n]umerous studies have demonstrated that poverty is associated with higher rates of poor health and chronic health conditions in children”).


See SHAPIRO & TRISI, supra note 33 (explaining that “[t]his progress on child poverty has been accompanied by striking progress in children’s health coverage: in each of the past two years, roughly 95 percent of all U.S. children have had health insurance, the highest percentage ever recorded. This compares to 86 percent of children having coverage in 1997, and likely significantly lower coverage in the decades prior to that (a consistent time series before 1997 is not available). The coverage gains reflect expansions of Medicaid over recent decades, creation of the Children’s Health Insurance Program in 1997, and the Affordable Care Act’s coverage expansions. In short, child poverty is now at an all-time low while children’s health coverage is at an all-time high.”).
Insurance Program ("CHIP") and the repeal of the ACA’s individual mandate prompted television personality Jimmy Kimmel to bring his infant son on camera as he pled for lawmakers to save the program, tearfully saying: "Parents of children with cancer, diabetes and heart problems are about to get letters saying their coverage could be cut off next month. Merry Christmas, right? This is literally a life-and-death program for American kids." Attorney and CNN Commentator Dean Obeidallah contextualized Kimmel’s plea as

laying out the cold hard truth of why Republicans in Congress have not acted yet to help the children who rely on CHIP... saving over $300 billion to help pay for their massive tax cuts... for corporations and the wealthy that will add over a trillion dollars to the deficit but [repealing authorization for] the $15 billion or so to help children in need.

Lawmakers are pressured to be fiscally responsible, but their empathy for human suffering should preclude corporate savings when it comes to health law decisions.

C. Public Health and Poverty Reduction: Wellness and the Role of Empathy

Community wellness, and the political will to cultivate it, are the foundations of public health. A public health approach can best serve the children of Appalachia, where isolation and deprivation pose unique challenges. Community collaboration can bridge the gaps in access and information by brainstorming strategies for co-located child services, such as

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45 Id.


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school health clinics.\textsuperscript{48} For example, the Partnerships Program for Early Childhood Mental Health and Project Launch combat Appalachian child poverty by engaging early childhood service providers with a "trauma-reduction" approach in Southeastern Ohio schools.\textsuperscript{49} The trauma-reduction approach uses resilience-building principles like relationship-building and compassion.\textsuperscript{50} Ohio University researchers studying these two programs concluded that "traumatic events and regional stressors related to poverty impact not only the resilient capacities of individuals, but also the ability of the entire community to foster health and resiliency among all its members."\textsuperscript{51} Fostering connection between community members also proved an effective health intervention strategy in a rural Appalachian after-school program, where teens mentored elementary students on nutrition to combat childhood obesity.\textsuperscript{52}

Utilizing cutting-edge data about public health, wellness, and empathy can help Appalachian community leaders cultivate lasting changes to the economic, physical, and mental health of their children.\textsuperscript{53} Governing to maximize public health is necessarily proactive, and includes legal oversight as well as empathic measures like fostering community partnerships.\textsuperscript{54} The ACA is a legislative lifeline for rural communities, given its capability to increase access to basic health services and specialties like dentistry and mental health.\textsuperscript{55}

\textsuperscript{48} Id. at 10 (explaining that "[i]n rural settings, nontraditional providers and cross-disciplinary approaches may be key. School health clinics, for example, may be more important in rural than urban settings; successful program elements should be identified and disseminated").


\textsuperscript{50} Id. at 196–97 (describing the intended outcome of increased resilience and the programmatic "focus on relationship building by embedding mental health within schools" and helping teachings to "shift responses to challenging child behaviors from a punitive approach to one of compassion").

\textsuperscript{51} Id. at 199.


\textsuperscript{55} Probst et al., supra note 47, at 9 (arguing that "the Affordable Care Act may serve to make medical, dental, rehabilitative, mental or behavioral health practice economically feasible in more rural communities").
III. ACA EFFORTS AND IMPACT

Section III.A will discuss the purposes behind the ACA and the strategies used as a wellness initiative. Part III.B will explore the impacts of the ACA in Appalachia.

A. The ACA: A Federal Poverty Reduction and Wellness Initiative

The ACA included child poverty reduction as one of its goals. The specific human impacts of the ACA are difficult to quantify, but a 2016 federal government report explained that overall, spending on health care in the United States rose somewhat in the ACA’s first few years but leveled off in 2016.\textsuperscript{56} Evaluating the ACA’s impact on child poverty and wellness will help us legally respond in ways that maximize positive outcomes. Helpful research exists on the related topics of health, poverty, and human connection. For example, data shows that programs for young children that enhance their social and emotional skills lead to better lifelong health outcomes, both mentally and physically.\textsuperscript{57} The inverse principle—poor health is caused by poor connections—is supported, for example, by a 2006 New Zealand study, which showed that socially isolated children had significantly higher rates of cardiovascular disease and other poor health outcomes as adults.\textsuperscript{58} Unsurprisingly, the socially isolated New Zealand children also had higher rates of economic deprivation.\textsuperscript{59} U.S. researchers found in 2008 that child poverty was associated with poor health outcomes, resulting


\textsuperscript{57} See PENN STATE, IMPROVING SOCIAL EMOTIONAL SKILLS IN CHILDHOOD ENHANCES LONG-TERM WELL-BEING AND ECONOMIC OUTCOMES 6 (2017), http://prevention.psu.edu/uploads/files/RWJF.EconomicBrief-Final.pdf (explaining that "strong social emotional skills support healthy functioning and help people avoid problems. Those with good SE skills can better manage their own emotions, manage potential conflicts in relationships with others, and in general, have the self-control needed to avoid problems and bad habits. SE skills involve several competencies which are vital throughout life. Most mental health problems first emerge in childhood and adolescence, so there can be substantial economic consequences if those problems persist into adulthood. Problems that emerge early and cascade into negative spirals will lead to costs related to physical and mental health issues, substance abuse, need for additional school services, and delinquency and crime. Those who struggle with SE skills may fall behind in school, which can have longer-term academic and social implications if not addressed. Certain studies have focused on the long-term links between early SE skills and likelihood of future problems").


\textsuperscript{59} Id.
in higher costs to the federal GDP (gross domestic product). Furthermore, a 2013 study found the 2008 financial crisis ushered in a decline in children’s health worldwide, and that children’s health is better in countries with strong social welfare programs. The ACA was one of the largest social welfare and public health advancements in United States history. Perhaps its greatest value is its specificity about implementing public health principles like disease prevention and community strengthening to advance health outcomes.

B. The ACA’s Impact in Appalachia

For many communities in Appalachia, public health measures like the ACA can be a fulcrum to pull the citizenry as a healthier group, and thus entire communities, out of poverty. While not a panacea, and markedly less potent than many health advocates had lobbied for, it has undoubtedly reduced human suffering for those millions of individuals who now have health care. To preserve our capability to thrive, the United States should approach public health as a human rights issue, recognizing our human connectedness. This approach

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61 Luis Rajmil et al, Impact of the 2008 Economic and Financial Crisis on Child Health: A Systematic Review, 11 INT’L J. ENVTL. RES. & PUB. HEALTH 6528, 6528 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4078594/ (explaining that “the economic crisis has harmed children’s health, and disproportionately affected the most vulnerable groups” and that “previous experience, such as the crisis in the Nordic countries in the early 90s, suggested that no impact or a minimum impact on children’s health occurred in Nordic countries given the protective effect of a highly developed welfare state and additional specific measure of child protection maintained during that crisis”).
64 See Gabriel, supra note 38 (explaining that 29 million Americans remain uninsured).
65 See ALICIA ELY YAMIN, POWER, SUFFERING, AND THE STRUGGLE FOR DIGNITY: HUMAN RIGHTS FRAMEWORKS FOR HEALTH AND WHY THEY MATTER 32 (2016) (arguing for a human rights-based approach to health care, and quoting former South African Constitutional Court Justice Albie Sachs who said that “[h]ealth care rights by their very nature have to be considered not only in a traditional legal context structured around the ideas of human autonomy but in a new analytical framework based on the notion of human interdependence. A healthy life depends on social interdependence: the quality of air, water, and sanitation which the state maintains for the public good; the quality of one’s caring relationships, which are highly correlated to health; as well as the quality of health care and support furnished officially by medical institutions.”).
encompasses not just the "health" aspect of health care, but the "care" aspect as well—the emotional impact of medical services.66

The ACA has been attacked by conservative politicians since its inception, but has weathered numerous congressional and presidential attempts to repeal it.67 The welfare of the residents of Appalachia is at risk if the ACA were to be repealed. The Appalachian health clinic volunteer doctor quoted above in Section II.B explained it like this: "We all know when we take 32 million people out of the system"—an allusion to a Congressional Budget Office analysis of how many would lose coverage under one Republican plan—"that these people [his clinic’s patients] will be the first to go," he told The New York Times in July 2017, during the heated congressional debate over Republican attempts to repeal the ACA.68

The ACA’s precise impacts in Appalachia are difficult to measure, given the size of the both the legislation and the region.69 To some extent, its success has been dependent on whether state governments accepted or rejected the ACA’s option to expand Medicaid coverage for their residents.70 West Virginia, for example, opted for Medicaid expansion when the ACA passed, resulting in coverage for thousands more people in McDowell County, which has the


67 See Ed Pilkington, Why the UN Is Investigating Extreme Poverty ... in America, the World’s Richest Nation, GUARDIAN (Dec. 1, 2017), https://www.theguardian.com/world/2017/dec/01/un-extreme-poverty-america-special-rapporteur (explaining that “[Trump] has tried, so far unsuccessfully, to abolish the Affordable Care Act in a move that would deprive millions of low-income families of healthcare insurance”).

68 Gabriel, supra note 38.

69 See Jayne O’Donnell et al., Health Care’s Appalachian Spring: Obamacare Comes to an Old Battlefield in the War on Poverty, USA TODAY (Apr. 24, 2014), https://www.usatoday.com/story/news/nation/2014/04/24/obamacare-kentucky-floyd-county/8108687/ (characterizing the ACA as “a work in progress” but finding that it “touches lives across [the Kentucky] county” profiled in the article).

70 See Left Out of Health Debate, supra note 30 (noting that “Virginia was among 19 states that chose not to expand Medicaid as part of the Affordable Care Act. Many states cited the cost, even though Washington pledged to pick up nearly the entire expense. An expansion in Virginia would have covered an additional 400,000 people. ‘A lot of people, when the Affordable Care Act was first enacted and went into effect, had the mistaken belief that it was going to help the very poor people, particularly in Appalachia and other parts of Virginia,’ [area lobbyist August] Wallmeyer said. ‘And it’s just not true.’ Wallmeyer said the clinic [profiled in the article] doesn’t see as many patients as it once did from Kentucky, a state that expanded Medicaid under the ACA”).
nation’s shortest life expectancy. The ACA’s subsidies have also reduced the number of uninsured West Virginians, at a fraction of the costs they would have faced without it—even with the market adjustment resulting from the poor health of their statewide “pool.” Structurally, the ACA has improved Appalachia’s health delivery systems, a critical aspect of public health.

The congressional and presidential attempts to repeal the ACA are a rejection of the empathic poverty-reduction methods the ACA is cultivating for Appalachian children long-term. The ACA’s attention to community-based health care bolsters the sustainability of its effects. Looking to the community for solutions is critical to implementing public health strategies in Appalachia, particularly given its long history with well-intended but misplaced fixes from outsiders.

IV. INFUSING EMPATHY INTO LAW TO MAXIMIZE APPALACHIAN CHILD HEALTH AND WELFARE

To fully implement the ACA’s public health principles, the government should more aggressively subsidize and regulate the delivery of care. Adding economic and qualitative value to the caretaking professions, for example, would cultivate positive outcomes for child wellness and financial stability. Consider the child care field, where workers are notoriously underpaid and the quality of


72 See Vann R. Newkirk II, Simply Repealing Obamacare Will Hurt the White Working Class, ATLANTIC (Nov. 22, 2016), https://www.theatlantic.com/politics/archive/2016/11/trump-healthcare-plan-working-class-whites/508325/ (explaining that “West Virginia, which has been wracked by public-health problems, pollution, and has the most per-capita drug deaths in the country, has had to embrace Obamacare’s Medicaid expansion and subsidies in order to provide affordable healthcare for all those coal miners, other low-income workers, and their extraordinary rates of disease and disability. While premiums for exchange plans have increased by double digits across the state, that largely reflects the cost of covering such a sick pool of rural enrollees, and most people in the state will never see those increases because of subsidies.”).

73 See id. (explaining that “[i]n the ‘coal-miner country’ of Appalachia, the Affordable Care Act has been vital in shoring up collapsing rural-health systems that have become overburdened with the mounting health problems of their constituents”).

74 See Burris, supra note 20 (explaining that those “wishing to make a positive difference in central Appalachia must avoid a ‘missionary mentality,’ namely that superiority position of ‘we know what’s best for you and how to fix your region’... participatory action research and community-based research are some of the more sensitive and respectful approaches.”).

75 See Mary Becker, Care and Feminists, 14 Wis. WOMEN’S L.J. 57, 61 (2002) (arguing that “[w]e need to elevate care to [a core] level of importance for the basic reason that it is essential to human health and balanced development”).
child care among facilities is unpredictable. This amounts to a societal marginalization of empathic acts such as love and care, which is a deep political failure, according to feminist legal theorists. Joan Tronto, for example, says the urgency and imminence of high-dependency caring acts, such as infant and child supervision, removes key constituents—the caregivers and the children receiving the care—from public engagement. The resulting inequity of voice and representation weakens democracy by situating the burden and the benefit of decision-making with those removed from the caretaking arena. Political decision-makers have historically viewed democracy based on its impact on rational, public, adult citizens—devoid of the empathic connections necessary to social justice. Analyses of injustices, then, are limited to outcomes that negatively impact those rational, autonomous, adult actors, leaving behind not only the young and vulnerable, but also their adult caregivers.

These theories are borne out by persistently high poverty rates for single mothers and their children and the chronically low wages of child care workers. Straightforward solutions are ripe: state and local governments can, for example, improve pay standards for child care providers without federal intervention. States already oversee the child care profession with regulations, such as licensing, and many states provide child care directly or offer subsidies. States can use their regulatory prowess to normalize higher child care quality (of which wages are a key component).


79 Id.; see also Pamela Laufer-Ukeles, Selective Recognition of Gender Difference in the Law: Revaluing the Caretaker Role, 31 HARV. J. L. & GENDER 1, 31 (2008) (arguing that “society should revalue caretaking in order to eliminate the burden that domesticity is placing on society’s caretakers. Caretaking should be deemed an action that creates real value in society and be dignified as such.”).

80 MARTHA ALBERTSON FINEMAN, THE AUTONOMY MYTH 41 (2004) (explaining that “[t]he notion that it is an individual choice to assume responsibility for dependency work and the burden it entails allows us to ignore arguments about our general responsibilities . . . . We ignore the fact that choice occurs within the constraints of social conditions, including history and tradition.”).

81 Id.

82 Paquette, supra note 76.
An extensive study for the Appalachian Research Council in 2012 recommended incentives for health care workers to come to the region and technological advancements to bridge gaps in access to care.\textsuperscript{83} Research also shows that increased levels of empathy in health care workers are associated with positive health outcomes for their patients.\textsuperscript{84} Not surprisingly, empathy is even linked to diagnostic accuracy.\textsuperscript{85} Empathy for care workers, though, is something of a double-edged sword, for if it is not managed carefully, it can become a bottomless emotional pit resulting in compassion fatigue.\textsuperscript{86} Care workers, therefore, should be incentivized to cultivate healthy levels of empathy, including sound emotional boundaries, to maximize their resilience and effectiveness.\textsuperscript{87} This is one example of how care delivery can be regulated to comport with the ACA’s public health principles. Recognizing empathy for both care givers and receivers is an inextricable aspect of successful public health delivery. In Appalachia, particularly, success—improved health and economic outcomes for children—should be non-negotiable. Our governmental, social, and economic systems have failed this region’s children for generations. The ACA is a legal reform that can reverse the trends of poor health and economics for Appalachian children, positioning the next generation as a healthier, wealthier, body of citizens.

\textsuperscript{83} Nancy M. Lane et al., Appalachian Reg’l Comm’n, Health Care Costs and Access Disparities in Appalachia xxii (2012), www.arc.gov/assets/research_reports/healthcarecostsandaccessdisparitiesinappalachia.pdf (stating that “encouragement of broadband communications to rural areas will also help with the technology needed to support contemporary health care delivery, thus expand resource access. Finally, encouragement of expanded roles for entry workers in health care labor force will be similarly beneficial.”).


\textsuperscript{86} Kelley Raab, Mindfulness, Self-Compassion, and Empathy Among Health Care Professionals: A Review of the Literature, 20 J. Health Care Chaplaincy 95, 97 (2014).

\textsuperscript{87} Id. at 97–98.