Poverty and Health from the Health System Perspective

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Abstract

Poverty undermines a wide range of human capabilities, possibilities and opportunities. Poverty interacts with health in a myriad of ways, such as being able to attend school, earn a living, and be socially connected, for example, all of which require at least a modicum of good health. The aim of this paper is to explore the complex mutual inter-relationship of poverty and health in terms of place of residence, minority status, socioeconomic status and local and national governments. We also address the implications of this relationship worldwide, and the common and systemic trends and multiplicity of factors it involves. Some solutions and interventions to disrupt the vicious cycle of poverty and poor health are suggested.

MeSH Words: poverty, health status, socioeconomic status, systems thinking, broken windows syndrome, traditional and new poverty, income, infrastructure, visible minority, government policy and political action

Introduction

"To be impoverished is to be an internal alien, to grow up in a culture that is radically different from the one that dominates the society. The poor can be described statistically; they can be analyzed as a group. But they need a novelist as well as a sociologist if we are to see them" [1].

Modern science offers the means and knowledge to aid everyone in making lifestyle decisions. However, if you wish to live a long and healthy life, it is best that you be wealthy. Indeed, try not to be born into poverty; and if you have been, through no fault of your own, you must change your station in life as early as possible.

A logical place to begin a discussion on poverty and health is by asking what is meant by poverty. How do we define and understand what it is to be poor? Poverty is considered essentially an economic concept -- a measure of income or, rather, lack thereof. In 1899, Rowntree [2] defined a poor family as one whose total income was insufficient to cover the basic needs related to the maintenance of physical efficiency. More recently, Pringle and Walsh [3] explored the meaning of poverty in the context of socioeconomic vulnerability. They claimed that "…the terms poverty, deprivation and social exclusion are sometimes used interchangeably as synonyms for one another. However, it is useful to make a conceptual distinction between them. Poverty is generally interpreted as being income-related, deprivation, in contrast, is a more diffuse concept related to the quality of life. Social exclusion tends to refer to the process whereby individuals become deprived…"

By contrast to the fairly consistent view of

poverty over time, the concept of health has undergone a major transformation. Once considered a strictly biological phenomenon of the absence of disease, good health is now defined by the WHO [4] as a state of complete physical, mental and social well-being.

Poverty affects a whole range of human capabilities, possibilities and opportunities, and as such it interacts with health in a myriad of ways. Being able to attend school, earn a living, and be socially connected, for example, all require at least a modicum of good health. The aim of this paper is to explore the complex mutual inter-relationship between poverty and health, the implications of this relationship worldwide, and the common and systemic trends and multiplicity of factors it involves. Some solutions and interventions to disrupt the vicious cycle of poverty and poor health are suggested.

Minorities, neighborhood and socioeconomic status

The most robust finding of social epidemiology studies in the United States is the association between health and poverty. While Thomas and Quinn [5] found that health disparities among populations or sectors are often a result of poverty, the opposite also holds true. Poor health leads to higher medical expenses and reduces the individual's ability to work and earn income, leading to further illness and further poverty, in a downward spiral. Therefore, a holistic approach to reconcile the health-poverty inter-relationship is necessary.

The same authors [5] also noted that a major determinant of poor health, as it relates to socioeconomic status (SES), is belonging to a visible minority. This is best illustrated in the United States by the high mortality and morbidity rates among residentially segregated minorities relative to the white population. Racial and ethnic health disparities are undisputed. However, what often goes unrecognized is the complex cause-effect web of factors of poverty, racism, and political, social and economic environment, which poses an enormous challenge to the quest to provide equal health care access to all.

Place and health are intimately linked, given that goods and services, exposure to hazards and the availability of opportunities are all spatially distributed. Therefore, alongside such factors as age, race, personal income level and education, living in a poor area lowers one's life expectancy [6]. There is increasing empirical evidence of the effects of the neighborhood SES on a wide range of health outcomes, including rates of chronic disease, psychological and psychiatric disorders, poor health-related behaviors, and mortality risk [8]. The level of affluence of the neighborhood determines the level of health available to its residents. Some researchers emphasized the structural characteristics of the environment, such as concentration of affluence, residential stability, ethnic heterogeneity, social support and sociability and collective efficacy in promoting good health, ensuring access to health resources, and drawing health resources to the community [6]. Other mediators include the physical features of the environment shared by the local residents, the services available to support people in their daily lives, the sociocultural features of the neighborhood, and the reputation of the neighborhood [7]. Accordingly, the flight of the middle class from inner-city communities in the last decades has led to a decline in the viability of local organizations and institutions, including churches, schools, and voluntary organizations and in the community's capacity to maintain informal social controls. The resulting overall drop in neighborhood SES and services leads, in turn, to the formation of health-compromising subcultures that support and tolerate risky behaviors and detachment from conventional values and norms.

The income distribution of the neighborhood also plays a role: people who live in high income-inequality areas are at a higher risk of mortality than people who live in low income-inequality areas. The effects of income inequality on health reflect a combination of negative exposures and lack of resources held by individuals, along with systematic underinvestment across a wide range of human, physical, health and social infrastructures.

Age and social isolation

According to Santana [8], most research ignores the dynamics of low income and persistent poverty and the cumulative effect of low income during the life span on health. These authors distinguished between "traditional" poverty and "new" poverty. Poverty is present in all countries

of the European Union, even the most prosperous. Traditionally, poverty was mainly associated with aging and the isolation of individuals from social networks and, thereby, from the consumption of essential goods and services. These factors tended to stabilize and decrease over time, as more countries increased social support services and invested more in combating stigmas and improving education. The new poverty emerged as a consequence of changes in the labor market as well as demographic and social changes, such as increased life expectancy and increased immigration of ethnic minorities. Santana [8] claims that in disadvantaged groups, equal access to health care does not depend exclusively on the existence of the services, but also on economic, social and temporal factors.

Underlying social and physical factors

Although there is strong evidence pointing to a link between SES and mortality, disparities in SES are not necessarily a direct cause of disparities in health and vice versa [9]. The finding that differences in SES cut across many different health processes, each with a distinct pathogenesis, suggests that there may be some underlying causative factor. Candidates include lack of adequate and appropriate nutrition, poor availability/accessibility of sources of good nutrition at lower SES levels, and decreased physical activity dictated by the physical environment; all of these have been found to be predictive of or major contributors to a wide range of negative health outcomes. The dominant concept today is that individual knowledge, attitudes and skills determine health behaviors. Nevertheless, the conditions in which we live are, in large, partly responsible for longevity and health. This factor, together with social segregation and isolation, further complicates the outcomes of health status and the ability and willingness to seek and engage in health-focused activities.

Role of government: poverty and health as a social evil

Gupta and Kumar [10] explored the role of government in the poverty-health association. They based their work on earlier findings that poverty is a major determinant of ill health; community structure and functioning play an important role in disease; individual disease and community disturbances and poverty have a mutually dependent relationship; and health status is strongly determined by socioeconomic status. They noted that according to numerous studies, most of the causes of death in developed countries occur at a higher rate in lower socioeconomic- status groups. In developing countries, the leading causes of death include, but are not limited to, cardio respiratory illnesses, bowel and other forms of digestive cancers, self-inflicted injuries, diabetes, and communicable diseases such as HIV/AIDS. Most of these can be traced to states of under nutrition, substance abuse, occupational hazards and adverse environmental conditions, such as the unavailability of clean water, clean air and adequate sewage and sanitary systems. Gupta and Kumar [10] stressed the decisive role of the political milieu and governance failure on the health of the population, which has hardly been investigated and warrants further vigorous consideration. They maintain that democracy may have an indirect positive impact on health by affecting socioeconomic position. The medical benefits of democratic systems are well recognized, although democracy is not a prerequisite for good health. In third world countries, there is often a rampant disregard of universal civil and political rights, particularly in certain sectors of the population (women, children, the illiterate), who are more likely to be disadvantaged and economically dependent and therefore at higher risk of poor health and increased morbidity and mortality. Besides fighting poverty per se, increasing individual capabilities and literacy levels in societies suffering from material deprivation will empower populations to reduce health inequalities.

Systems thinking in the study of poverty and health

According to Leischow and Milstein [12], conventional forms of problem framing, action planning and evaluation often exclude or ignore features of dynamic complexity. The systems thinking approach offers a context for understanding complicated interactive systems. By applying such concepts as multimindedness, inertia and multidimensionality, we can better understand how such systems are organized, how they behave over time, and how they can be better managed in an ever-changing environment. Thus, systems thinking is well

suited to address the dynamics of health care systems and health care issues of capabilities and capacity, in addition to the multiple factors that play a role in the mutual reinforcement of disease and disease risk. Using systems thinking we can obtain a more realistic epidemiologic picture and a better in-depth understanding of the implications of management and other policies on the intricacies of the poverty-health connection at all levels of society [11]. It is well recognized that the solution to health care problems requires that we transcend boundaries and that individuals, organizations and nations communicate more effectively [13]. As long as there are dynamically complex health issues in search of answers, a systems thinking approach will have an important place in interpreting them.

Recommendations for the future

Complex problems require complex solutions. Eliminating disparities in health on both the local and global scale is an intricate procedure. Although it is very difficult to pinpoint all the conditions that affect the relationship between poverty and health, some major ones that need to be grappled with are childhood malnutrition, social exclusion, disadvantaged physical environment, substance abuse and mental disorders. Policymakers should strive to develop social structures that enable better access to health care services, especially to primary care, promote means to improve health, and manage problems that lead to poor health. The use and availability of services should be based on need and not personal wealth. Adequate infrastructures, improved education, employment opportunities, economic stability and social connectedness must be primary considerations in urban planning. Mitigating socioeconomic inequalities in health should be part of all future policy programs [8].

More robust data are required for the evaluation of existing health care services and systems. Future research is warranted to explore, for example, why aggregated education is good for individual health and why certain social resources at the neighborhood level are more powerful determinants of health than the availability of health-enhancing services. The manner in which social resources mediate the impact of neighborhood affluence and other neighborhood social and structural contexts warrants in-depth research. On the global level, Gupta and Kumar [10] suggested that both poor and wealthy countries redirect their interests in war, corruption and political infighting to devote more concerted efforts at countering the challenges of poverty and health.

More specifically, it is the author's opinion that to mitigate, control, and even eliminate the mutual effects of poverty and ill health, it is first necessary to address the issues that lead to poverty. This would involve, on the one hand, a participatory approach to encourage individuals, families and communities to define their problems in order to seek appropriate solutions, and on the other hand, programs to promote advocacy and partnership among health care providers across the various disciplines and health and government sectors. Interest groups should be established to lobby for equity in health care and social services toward a universal level of good health that permits individuals and communities to lead socially and economically meaningful and productive lives. Authorities should be encouraged to invest in health and social policies that target poor populations and enhance the health of the people and the community.

Conclusions

The World Bank estimates that there are approximately 1.5 billion extremely poor people in the world. The impact of poverty extends far beyond material concerns; the most grievous fallout is the opportunities lost to develop essential human capabilities. Poverty drains people's energy, reduces their dignity and creates a sense of powerlessness and loss of control over one's life. It contributes to illiteracy, malnutrition, environmental risks and lack of choices, which in turn lead to poor health. Health is a vital asset for the poor. Without it, the person's potential to escape from the yoke of poverty is diminished, due to lost time, labor, income and health care costs [14].

The application of systems thinking can help authorities to build a more realistic picture of poverty-health inter-connectedness and its underlying factors and to formulate creative solutions. It provides an excellent platform for examining strategies to improve health and health outcomes on the individual, local and global levels.

Policy makers have the obligation to seek innovative means to stop the cycle of poverty and ill health. This requires a paradigm shift that will mobilize all nations to collaborate and take responsibility for the ailments of the poor by equalizing the distribution of social resources and recognizing the right of all individuals to good health and opportunities.

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