Poverty in America: How Public Health Practice Can Make a Difference

Health inequities linked to poverty remain entrenched in certain subgroups in the United States, despite public health efforts to the contrary.

My experiences in working with the poor in Nepal and Pakistan informed my later approach to addressing health and poverty in the Appalachians of eastern Tennessee. Three aspects of this approach include enhancing community power through participation in local decisionmaking about health, educating students within the actual context of poverty, and increasing local opportunity by employing people from the communities of concern to serve as a means to reach those communities.

Empowerment, education, and opportunity can serve as ways to ameliorate poverty and may serve to modulate the persistent underlying conditions that create and sustain poverty. (*Am J Public Health.* 2008;98:1570–1572. doi:10.2105/AJPH.2007.127787)

| Paul Campbell Erwin, MD, MPH

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time

—T.S. Eliot, "Little Gidding"

THE IMAGE IS SEARED INTO my memory: a young girl, 5 or 6 years old, swinging silently outside the mobile home, her dress thin, her eyes all-knowing. The yard is a steep hillside tucked out of sight from other dwellings, a fold of the Appalachians that protects and hides, comforts and shields, like a rumpled quilt. We approach the front door, which stands open like a rotten mouth, at once violent and mute. Inside there is only a bare mattress on the floor and scattered empty food cans. We are here on a home visit, following up on family tragedies: a teenaged boy who has shot and killed his mother's lover; the mother herself accused of child abuse and neglect, of forcing her son to perform oral sex on her ("But she only made me do it when she was drunk," he says). The little girl watches us come and go, bemused at the parade, at the ennui of the retreat of the cars into the dim, gray, agonized woods.

Now, some 15 years later, I try to imagine her life since then. I try to imagine how the cycle of poverty, ill health, low educational attainment, and social diminution has likely been perpetuated and reinforced, producing another generation who will experience health inequities that have become so familiar as to no longer be noticed. Why? Why, in this land of great wealth and opportunity, do we continue to find population subgroups who suffer so disproportionately? It is written that "the poor shall never cease out of the land" (Deuteronomy 15:11). Is it the poor's fate to perpetuate poverty? Do those of us who are not poor perpetuate it for them?

Such questions took me from the north Alabama foothills of the Appalachians to Nepal and Pakistan, working with John Bryant, MD, former dean of the School of Public Health at Columbia University. Bryant's influential book, *Health and the Developing World*, opened my eyes to a world that had been right in front of me in Alabama, if only different by degree and language.[1] In Karachi, Pakistan, Bryant was instrumental in helping to develop new medical and nursing schools at Aga Khan University, so that future doctors and nurses could receive a high-quality education that would enable them to address Pakistan's health care problems. The students at Aga Khan learned Swan-Ganz catheters and oral rehydration therapy, fetal monitoring, and childhood nutrition surveillance. Equally important, however, was *where* the teaching and learning occurred; for Bryant's Department of Community Health Sciences, it was in the *katchi abadis*, the squatter settlements of Karachi.

In these settlements, in which virtually everyone was at risk of poor health outcomes, we questioned why some households experienced repeated child deaths, yet others did not. Was death just a random event? When I posed this question to Richard Levins, PhD, who was then director of the Human Ecology Program at the Harvard School of Public Health, he responded,

> The larger system of which your households are a part creates the poverty field within which vulnerability is higher than outside, and small stressors or weaknesses of homeostasis can have devastating effects. While it is important to look at household-to-household variation in homeostasis within poverty, the question of how that poverty is created and how it might be ameliorated would have to be addressed. Otherwise, we could end up blaming the victims for not being perfect shoppers or better educated or more strongly plugged into the neighborhood or kin support systems (written communication, October 1989).

This is the human ecology perspective on health that René Dubos elucidated in his book *Mirage of Health*.[2] My interest in addressing public health challenges by empowering communities, and in teaching and learning in the classroom of the community as a means to understanding illness in areas of profound deprivation, took root in Nepal, began to grow in Pakistan, and achieved fruition in my return to the United States to work with the Tennessee Department of Health in 1990.

And so, in a sense, I have returned to the place of my initial exploration—the southern Appalachians—and am knowing it for the first time. My work for

the Tennessee Department of Health takes place in a region of profound contrasts: Oak Ridge National Laboratories and one of the highest per capita rates of PhDs in the nation, located in a county with lower high school graduation rates than the US average; multimillion-dollar lakefront homes in areas with poverty rates more than twice the overall US rate; and the nation's most-visited national park—the Great Smoky Mountains—surrounded by descendants of those forced out of the Smokies, who struggle to pay property taxes inflated by the commercialization surrounding the park. How, in this setting, have we tried to understand and address poverty, particularly as both a cause and a result of ill health? What can public health do to improve the health of those in poverty? I will provide three possible approaches, all based in the real world of public health practice in east Tennessee.

ENHANCING COMMUNITY POWER

Ten years ago in Tennessee, regional and local health departments initiated a process of community-based health assessment and planning through local volunteer groups called county health councils (CHCs). Staff from the health departments facilitated the assessment process, but it was the community that determined the priorities among the health issues identified. In Scott County, where county rates of cardiovascular disease and lung cancer mortality greatly exceeded the overall state rates, the CHC made dental health their number one priority. Dental health? This is how they framed it: there is not a single dental provider for low-income children in the entire county, and that is unacceptable. If children are in school and in pain from rotting and decaying teeth, they cannot concentrate on their schoolwork. If they cannot concentrate, they will be more likely to fail and ultimately to drop out. If they drop out, they will not be able to get good-paying jobs, and they will not have access to health insurance, and *their* children will sit in class with rotten teeth as well.

CHC members understood the importance of preventive health care, and they endorsed the long-term goal of reduced decay through better oral hygiene, attention to fluoridation, and reducing the consumption of refined sugars. "It's hard, though," they said, "for a family to hear such messages over the cries of children who have disease and decay now." The CHC's focus on dental health raised awareness of the issue and enabled them to find funding for their goals, including a local philanthropic organization with roots in the community. The result was the construction of what is now one of the finest pediatric dental facilities in the state, complete with a telemedicine link to dental faculty at the University of Tennessee. "Now that our children are no longer in pain," CHC members now say, "we can better hear the longer-term messages of prevention."

It is in this context that empowerment, as both process and goal, can be realized: a shift in the balance of power (which occurs during the process) and an increase in control over the individual's, family's, and community's quality-of-life determinants (which constitute the goal).[3] This kind of empowerment is not a paternalistic giving of power, but rather an unveiling of the power that is there. Now that the CHC has succeeded in addressing an issue that was important to it, the CHC has greater capacity to begin addressing larger concerns related to heart disease and lung cancer. They owned the problem, and they solved it, and they will be there to sustain the community's commitment to the health and well-being of their citizens.

EDUCATION

Although it is critically important to expand educational opportunities within communities that experience high levels of poverty, the emphasis here is on a different hinge point: teaching the not-so-poor about poverty by taking them into contexts in which poverty exists. It means engaging students and faculty in the community, in the households in which health either happens or doesn't happen. Those communities become the classroom, the people our teachers. Understanding the vicious cycles of poverty is more likely when the stench of poverty is about you, when the sights and sounds you experience are those experienced by the poor on a daily basis.

In east Tennessee, the Regional Health Office of the Tennessee Department of Health has partnered for several years with faculty from the MPH program at the University of Tennessee, taking students into the field as a part of their health planning curriculum.[4,5] It is in the field that students get to experience firsthand what might and might not work, how what is learned in the classroom can be applied to real-world problems and challenges, how the realities of working on "community time"—with all the messiness of day-to-day challenges of transportation, child care, and work—can conflict with the ordered arrangement of addressing problems in the classroom. Such involvement should not be limited to schools or programs in public health. Students in economics can learn something about poverty and economic growth and development; students in literature can learn where the great local storytellers come from; students in environmental sciences can learn why the locals might support strip mining. This is not about service, the third leg of the academy's traditional three-legged stool; rather, it is a paradigm shift for the other two legs of teaching and research. We are changing *where* the teaching takes place, and *with whom* and *for whom* the research is conducted: in the community and for the community.

INDIVIDUAL OPPORTUNITY

Empowerment and education become linked in public health practice through the community health worker model that is used in many places around the world. In this model, people from the communities of concern are employed as a means to reach those communities. When we work with breastfeeding peer counselors and lay outreach workers to improve early entry into well-child care, we are far more successful in reaching those in greatest need, because we are working with their peers, who help us understand more about their lives. The opportunity is twofold: not only are we able to reach those in need, but the lay workers are able to accumulate experience in the workforce, have gainful employment, and learn new problem-solving skills. The marker of success of the lay

outreach worker model is a high turnover rate, when lay workers leave their part-time lay-worker jobs to take full-time jobs doing something they never dreamed they could do. Opportunity unfolds into openness, which is why the earlier quote from Deuteronomy continues thus: "Therefore I command thee, saying, thou shalt open thine hand unto thy brother, to thy poor, and to thy needy, in thy land."

Empowerment, education, and opportunity: 3 ways for public health to address the health care needs of those in poverty. But what of the underlying structural forces through which poverty is created and sustained: the families who were moved off their generations-old subsistence farms to make way for Oak Ridge; the Smokies now bordered with casinos and shopping outlets and comedy clubs that teach us to laugh at our barefoot-and-overalls image; and the even older image of the Cherokee who first knew this as a living place, whose tears yet linger on the long, high trails? In a follow-up letter 20 years after his first letter to me, Levins added,

> The local history of greed and conflict should not be lost. One priest whose name I forgot said (roughly), 'When I minister to the poor, they call me a saint. When I ask why they are poor, they call me a communist'" (written communication, March 2007).

Public health engagement may ameliorate the health of poor people, because it may serve to modulate these structural forces. The sought-after "end of all our exploring" is to see that such modulation can change the manifestations of the human condition in such a way that ultimately changes the conditions themselves, showing us a way out of the dim, gray, agonized woods.

Am I sick because I am poor, or am I poor because I am sick? It is both; it should be neither. ■

About the Author

At the time of the writing of this commentary, the author was with the Tennessee Department of Health, Knoxville.

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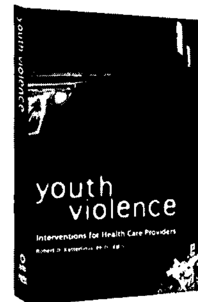
Youth Violence

Interventions for Health Care Providers

Robert D. Ketterlinus, PhD, Editor



This book addresses theory, current research and operational guidance on ways hospitals, especially Emergency Departments (EDs), might respond to intentional violence involving youth. The book includes reviews of current research and practice relevant to healthcare providers, especially ED providers in urban areas. The theoretical and operational components of ED-based prevention interventions, specific examples of program operations and outcomes and directions for further research and program development are included in the text.

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