The Vicious Cycle of Poverty and Healthcare

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***Abstract*— In this brief, we examine the complex and cyclical relationship between poverty and healthcare. We approach our analysis on both the domestic and international fronts, evaluate past and current policies put in place to break this cycle, and suggest additional interventions to promote healthcare quality and accessibility.**

***Keywords*— poverty, accessibility, healthcare, War on Poverty, ACA, NHS**

I. Executive Summary

The relationship between poverty and healthcare (both in quality and accessibility) has long been a subject of concern. On both the domestic and international fronts, poverty leads to environmental pressure, diminished health literacy, and financial inaccessibility, each of which detrimentally impacts healthcare quality and accessibility. In turn, the subpar healthcare services have a negative impact on economic development of impoverished areas, trapping impoverished communities in a vicious cycle. There have been policies implemented in attempts to break this vicious cycle, such as Medicaid, COBRA, HIPAA, and the ACA. However, more efforts on this front are warranted, especially those targeting quality, accessibility, and acceptability.

II. Overview

Poverty is defined as the state of not having enough money to fulfill basic human needs such as food, clothing, and shelter. Aside from being unable to afford these basic necessities, poverty has many negative implications on individuals' health, including increasing the risk of mental illness and chronic disease, higher mortality, and lower life expectancy. In the United States, poverty thresholds can be calculated by considering a person's age, family composition, and geographical location. According to the Census Bureau, 37.2 million people (11.4% of the population) in the US were living in poverty in 2020.

Socioeconomic status largely determines poverty status through indicators such as the family income level, education level, and occupational status. Oftentimes, poverty is not due to a single cause; rather, it tends to be multi-faceted. Factors like marital status, education, social class, social status, income level, and geographic location can influence a household's risk of poverty. Poverty status also mirrors various racial and ethnic lines and is associated with migrant status and intergenerational patterns. However, when considering the relationship between poverty and community health, the associations are profound.

A. Pointed Summary

- Poverty is a major factor in determining the accessibility and quality of healthcare that people receive.
- Poverty is often due to a variety of factors, such as insufficient education, marital status, migrant status, race, age, and household size.
- Poverty and healthcare are entangled in a vicious cycle—impoverished people find it more difficult to access quality healthcare, and this lack of quality healthcare in turn contributes to more poverty.
- Healthcare disparities in both domestic and international spheres exist along socioeconomic lines and are impacted by environmental and educational factors.
- Several policies, domestic and international, have been implemented to combat poverty and its accompanying exacerbation of health inequities, notably the War on Poverty in the

US and the WHO's Integrated Global Action Plan.

B. Domestic Relevance

Poverty is intertwined with various health risks, including environmental, educational, and economic factors. People living in poverty tend to work in more environmentally dangerous areas. These jobs may carry inherent risks, such as coal miners being more likely to develop lung cancer due to their prolonged exposure to asbestos. Additionally, those living in poverty tend to rely more on the environment to satisfy their basic needs, which makes their living situations more volatile due to potential environmental damage. On the other hand, poverty tends to place more pressure on the immediate environment in ways such as improper waste disposal, resource overexploitation, and habitat destruction. These result in vicious cycles of unsanitary living conditions, low crop yields, and erosion of fertile farming land.

Aside from environmental risk factors, those who endure poverty tend to be less educated. From a healthcare lens, this education gap leads to decreased health literacy. This diminished health literacy impairs individuals' abilities to make informed decisions about their health, including understanding written and oral medical instructions, following prescription and appointment directions, and thoroughly understanding the nuances of the healthcare system enough to navigate it effectively. These impairments directly impact the accessibility of medical services and the quality of healthcare received. For instance, people with low levels of health literacy were less likely to receive preventive screenings or immunizations, which increases the risk of infectious disease propagation. In diabetics, those with lower health literacy tended to be less successful in controlling their glucose levels. In general, low health literacy has also been linked to increased levels of depression and other mental illnesses.

A. International Relevance

On the global stage, the disparities in poverty and healthcare are magnified. People in lower-income, third-world countries tend to have less access to healthcare, lower quality of healthcare, and generally less healthy living conditions. There is little mystery as to why poor people in low-income countries suffer from high rates of illness, particularly infectious diseases and malnutrition: a lack of food, unclean water, poor sanitation and shelter, failure to address environments that lead to high infectious agent exposure, and a lack of appropriate medical care. Similarly, there is a significant amount of understanding about the causes of noncommunicable diseases, which account for the majority of disease burden for persons at the bottom of the social gradient in middle and high-income nations.

However, health disparities exist between demographic groupings in all countries. Access to personal health care services is ubiquitous in industrialized Organization for Economic Cooperation for Development (OECD) nations, although health disparities have been linked to income and other socioeconomic factors. Improved health among the urban population in emerging countries, on the other hand, has been linked to improved health care knowledge and services rather than higher wealth.

The World Health Organization's Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea emphasizes the importance of prevention. In 2017, poor water and sanitation were the #1 and second leading risk factors for diarrhoeal disease death worldwide. These dangers make it easier for infectious organisms that cause diarrhoea to spread, such as rotavirus and Vibrio cholerae. They're also associated with the spread of NTDs, as well as negative consequences like stunting, wasting, and being underweight. Low access to adequate water and sanitation has also been related to broader societal effects such as decreased school attendance (especially for girls who are menstruating), lost economic output, and undue time spent gathering water on women.

B. Tried Policy

President Lyndon B. Johnson's War on Poverty, launched more than 50 years ago, had a significant impact on expanding the health-care safety net and facilitating community participation in the leadership of larger health-care organizations,

leaving behind programs like Head Start and AmeriCorps, as well as community health centers. Poverty rates in the United States fell to their lowest level since complete data began in 1958 in the decade after the 1964 introduction of the war on poverty: from 17.3 percent in the year the Economic Opportunity Act was introduced to 11.1 percent in 1973. Since then, they've remained between 11 and 15.2 percent.

The Consolidated Omnibus Budget Reconciliation Act of 1985 was enacted by the United States Congress on a reconciliation basis and signed by President Ronald Reagan. It mandates, among other things, an insurance program that allows some employees to keep their health insurance coverage after they leave their jobs. The National Health Service is the umbrella phrase for the United Kingdom's publicly funded healthcare systems. They have been sponsored by public taxation since 1948. The NHS was established with the purpose of providing healthcare to all people, regardless of their financial circumstances. Everyone in the UK is entitled to NHS services, and EU citizens with a valid European Health Insurance Card can also access the NHS.

III. Policy Problem

A. Stakeholders

Individuals and families rely heavily on health insurance to manage financial risk. Families with even one uninsured member face embarrassment, anxiety, and the risk of financial ruin. Uninsured families are more likely than insured families to have significant out-of-pocket health-care costs, although spending less overall (excluding premiums). Uninsured people who are hospitalized face a slew of financial problems over the next four years, including a reduction in credit availability and a much higher risk of bankruptcy.

Individuals and families have greater disposable cash to spend on products and services as a result of the personal economic effects. This additional spending has a "multiplier effect," since greater corporate revenues are passed on to suppliers and employees, who then use them. The multiplier effect of Medicaid expansion is estimated to be between 1.5 and 2 times the amount of new federal Medicaid spending, according to one study.

Health-related productivity losses are expected to cost the United States $260 billion annually. Workdays missed due to illness, workers' inability to concentrate due to their own or a family member's health condition, and reduced labor force participation among persons whose health state prevents them from working all contribute to these productivity losses.

B. Risks of Indifference

The lower quality and accessibility of healthcare for impoverished communities manifests itself in unexpected ways throughout society. Globally, prenatal healthcare is one example: poor women tend to access prenatal care less frequently than wealthy women because of the financial inaccessibility and lack of health literacy on this issue. The combination of the lack of affordability and understanding about reaching out leads to poor women suffering worse birthing outcomes than their wealthier counterparts. These impacts percolate to their children: internationally, children born to women with five or more years of primary school education have a 40% higher survival rate than those born to women with no education.

Domestically, a vicious cycle also exists in relation to health insurance and Medicaid. Lower-income people are more likely to be uninsured and rely solely on Medicaid services, leading them to seek care less often. Being uninsured also leads to limited care coverage for the low-income people, which forces them to grapple with issues of greater magnitude that otherwise would not manifest. These issues involve being unable to access the healthcare system and not being presented with adequate treatment options during a healthcare emergency.

C. Nonpartisan Reasoning

Besides Medicaid and COBRA, the US government has passed several other policies in attempts to address the impact of economic insufficiency on healthcare access. One example is the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which had several provisions to improve the leverage that working people had on

their healthcare access. With the passage of HIPAA, pregnancy could no longer count as a preexisting condition that could lead to denial of health coverage by employers. HIPAA also enabled workers to retain their health benefits after losing or changing jobs. Finally, HIPAA prohibited employer-based insurance plans from charging higher premiums for employees based on the presence of preexisting conditions or genetic predispositions.

One of the most sweeping healthcare reform legislations—the Patient Protection and Affordable Care Act (ACA), or Obamacare—passed in 2010. There were several provisions of the ACA, such as expanding health insurance coverage through individual health insurance exchanges and employer-provided plans. The ACA also provided subsidies and tax credits to individual consumers based on income levels and number of dependents, expanded Medicaid services for low-income childless adults, and expanded the list of minimum health coverage requirements by private insurers. Upon implementation of the ACA, the number of uninsured individuals in the US declined by 18.8%, and Medicaid enrollment increased by 9.5%.

IV. Policy Options

Given the dire need for action on the front of improving healthcare in impoverished regions, researchers and policymakers have been striving for more high-impact, effective policies implemented in innovative ways. Research conducted by Peters et al. from the Johns Hopkins Bloomberg School of Public Health suggest a multi-faceted approach incorporating quality, geographic accessibility, availability, financial accessibility, and acceptability of services to reduce disparities in healthcare access and quality. These approaches involve engaging stakeholders from government, nongovernmental, and commercial organizations to assist impoverished communities, in methods like the use of health equity funds, conditional cash transfers, and coproduction and regulation of health services. Improving geographic accessibility would entail the improvement of transportation infrastructure, such as good roads to ensure distribution of medical supplies and drugs, timely emergency referrals, and health worker supervision. It also entails the expansion of remote health services like telehealth that make communication between patients and physicians more convenient.

Improving availability of healthcare services entails tackling the problems of limited working hours of healthcare professionals, long wait times, lack of drug stocks in clinics, and absentee health workers. These issues often lead people's reliance on unprofessionally trained healthcare providers and shopkeepers who may not have the patient's best interest in mind. Tackling this issue would require allocation of resources to build higher-quality and accessible clinics.

Financial accessibility has been a very pervasive threat to healthcare access and quality. Even in countries that guarantee universal healthcare, the issue of healthcare affordability is a nuanced one. Oftentimes, challenges like scarcity of public financing, the low salaries of healthcare workers, limited public control over drug and healthcare prices affect impoverished communities with the greatest impact. Policy suggestions on this front to tackle financial inaccessibility include reducing user fees, which has been associated with improved accountability and involvement of communities, subsidies for outpatient care, specific disease programs, hospital insurance, and services targeted towards assisting the chronically poor. However, a definite, effective solution has yet to be proposed on this front.

Finally, the issue of acceptability of services presents itself most prominently in developing countries like Bangladesh, Burkina Faso, and India. Patients' perceptions of the quality and effectiveness of medical care can clash with prevailing cultural norms, which can lead to distrust of new medical technology in preference for traditional medicine delivered by shopkeepers or village doctors. Gender and socioeconomic inequities exacerbate these acceptability issues, as women and the poor tend to be less satisfied by the health services offered compared to men and the wealthy. Adding into consideration the availability and social acceptability of village doctors, impoverished people tend to develop closer relationships with them. Tackling the mindset and cultural differences prevalent, especially in lower-middle income

countries, is crucial to breaking the vicious cycle of poverty and healthcare.

V. Conclusions

Although healthcare is a necessary component of a satisfactory quality of life, it is unfortunately all too stratified along economic lines. Those living in poverty often do not have access to high quality healthcare and sometimes healthcare outright. A variety of factors contribute to these inequities, such as insurance coverage, health literacy, geographic and financial accessibility, cultural differences, among others. Policies like the ACA, COBRA, and NHS have been implemented to improve healthcare quality and access, but sustained efforts are required to break this vicious cycle.

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