

Peering down the vortex

Poverty and human health

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It is difficult to write objectively about poverty. Yet, it does behoove us to examine its morbidity and mortality, its challenge to public health, and its demands on our strained health care system.

Poverty hangs like a lifeless albatross around the neck of our economy: its direct costs in the “welfare” system are easier to see than the lost purchasing power and lack of productivity of a vast pool of untapped manpower. We marvel at the recent increase in the number of homeless people and mendicants on our streets while more and more luxury cars, in the hands of overpaid chief executive officers and professional athletes, drive by.

Poverty simply means surviving below the subsistence level in a community. Where that poverty line falls is arguable,^{1,2} because our income spectrum is a continuum, lacking convenient boundaries between social classes. Finnie³ defines low income as less than half the median income of the population and finds that poverty is not a static phenomenon: people move in and out of poverty, and there are different types of poverty.

Types of poverty, with a model

My model for the dynamics of poverty is the vortex or whirlpool, into whose slower periphery people are drawn, then can spiral inward and downward into a throat and a funnel from which there is no escape. The newly or acutely poor who have suffered job loss, marriage and family breakdown, bereavement, injury, or illness,³ are swept into the periphery of the vortex. The longer they cycle there, the more likely they will be drawn down into the throat of chronic poverty.³ The acutely poor I have known are stressed and dysphoric, at risk for psychophysiological illness, depression, and malnutrition.⁴⁻⁶ They challenge physicians to help maintain

their health and morale toward their expeditious return to productive living.

In chronic poverty, continuing unemployment,^{5,6} living in the inner city,⁷ single parenthood,⁴ homelessness,⁸ and membership in the aboriginal community⁹ all contribute to ill health and premature death. The chronically poor I have known are generally cheerful in adversity and perhaps too accepting of their lot. Some have turned to the “opiates” of junk food, cigarettes, street drugs, spendthrift purchasing, taxi fares, and lottery tickets. Some show great resourcefulness in “working the system.” A few, with courage and tenacity, escape from poverty or see to it that their children do.

Caregivers need to think of poverty as an etiological diagnosis. They can offer health maintenance and education, assist families in coping, facilitate child development, and so minimize the ill effects and maximize the chances of escape.

Chronic poverty afflicts dwellers in rural areas as well as urban slums. It includes the working poor, who eke out a bare living from intermittent or poorly paying jobs, “workfare,” even begging. All are victims of the chronic unemployment that we have “enjoyed” since the 1970s. Child poverty has been steadily increasing.¹⁰ Parliament’s unanimous resolution in 1988, to eradicate child poverty by the end of the century, has been nearly stillborn. The genteel poverty of middle-class widows has nearly disappeared from our culture (personal communication from Corbett B, freelance writer, Kingston, Ont, June 2003).

What I will term “transgenerational poverty” probably corresponds to Finnie’s “hard core”³ as the quintessence of chronic poverty. Young people with few or no skills start families, then squander their meagre resources and neglect or actively abuse their children. Abused, malnourished, or drugged (often single) mothers are at

increased risk of low birth weight babies and fetal alcohol syndrome. Children lacking proper nutrition and intellectual stimulation grow up with improperly developed brains,¹¹ and, going to school cold, hungry, and sleepy, will learn and develop even less effectively.¹¹ Adolescents succumb to cigarettes, alcohol, and street drugs, and drop out of school, ending up functionally illiterate or even delinquent. Emerging adults are likely to lack even more social, vocational, marital, and parenting skills, and controls over aggression.¹² Thus, an intractable poverty culture cycles around and downward in the funnel of the vortex, its members often erroneously mocked as “genetically inferior.”

For caregivers, there are two caveats. First, our traditional ethic of serving patients individually, privately, and confidentially, risks isolating patients from their families and thus impairing family solidarity, a precious commodity and an antidote to poverty. Family physicians need to help whole families. Second, our methods of treating disease and lessening disability fail to deal with the etiological factor of poverty itself. Still, all interventions by good health care professionals act as a cumulative interruption of the vicious spiral of chronic poverty.

Human health and life expectancy in poverty

We have known for years¹³⁻¹⁷ that the affluent enjoy the healthiest and longest lives; the poor endure the shortest and unhealthiest, despite heavy use of the health care system; and the middle class fall between these positions.

Recently, we have learned that citizens of nations with smaller income spreads and higher employment rates have longer life expectancies and lower health care costs. An arresting recent example is Japan, where income disparity has been relatively modest, relatively full employment has prevailed, health care costs have been lower than in the West, and life expectancy has outstripped the rest of the world.^{14,15} Full employment and reduction of income disparity might be the most cost-effective prophylactic for the health and economic problems associated with poverty.¹⁵

Are there remedies for poverty?

Poverty can be attacked, both in its “macro” and “micro” dimensions (“thinking globally, acting locally”), in a hugely concerted public health approach: public education, public awareness, public pressure, political will, and ways and means carried out by a mixture of non-governmental and government agencies. It is easier to point out how to foster income disparity and unemployment than how to reverse them. For example, several Canadian governments have made it their top priority to cut taxes. The result: benefits for the already affluent and layoffs, increased unemployment, and weakened social supports for the less affluent. National fiscal policies appear to have fostered unemployment and poverty in “defence” against inflation. Full employment is a wholly necessary condition for closing the income gap and for returning productivity and purchasing power to a stagnating echelon of society.

Such large issues might be intimidating, though the task of public health is just such large-scale remediation and prevention. Lest such “macro” issues dismay us, we can be cheered by what has been achieved by “micro” interventions. Physicians and their colleagues are not offering mere “Band-Aids” or opiates, but intervening into the vicious spiral of poverty. They are helping people to be healthier, to function better as families, to break out of the throat of the vortex, to halt or reverse the descent into the funnel of transgenerational poverty.

The chronically poor will require a rehabilitation of their poverty culture over several generations. Here concerted community programs come into play: income supports, food programs, social housing, supplemental nutrition and intellectual stimulation programs for children, educational upgrading and social and job skills training for adolescents and adults, family counseling, and good prenatal and perinatal care. Caregivers can take direct part in such programs as well as give their support to them. Though our present public health resources are thinned and strained,^{18,19} it was to them that we must ultimately look for leadership, and we must give them the strength, resources, and authority for the task.



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