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An Antipoverty Agenda for Public Health: Background and Recommendations

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The debate on health care reform in the United States, which culminated in the passage of the Patient Protection and Affordable Care Act[1] and the Health Care and Education Reconciliation Act[2] and the signing of associated public laws[3,4] in 2010, initiated a national discussion that is ongoing.[5] Critiques and countercritiques of this legislation are ever present across the political spectrum.[6] Because the new administration has broached the possibility of repeal and replacement, the discussion shows no sign of abating. This debate is often misrepresented as being about public health reform[7]; however, although the legislation has important public health implications—notably, provision of insurance coverage to uninsured Americans—it was not explicitly written as a public health law,[8] and its public health impact may be dampened by not having addressed social-structural determinants of population-health disparities.[9] Indeed, it may be a stretch to refer to this national discussion as a debate on health care reform; medical care expenditure reimbursement reform may be more accurate. The subject matter centers on medical care—its organization, delivery, and financing—with scant attention paid to the mission of the public health sector.

What would true public health reform look like? First, it would focus on determinants of population-health disparities, especially those that are rooted in inequities and injustices resulting from social structure and policy. This perspective is consistent with the primary-preventive, communitarian, and social-justice orientations of public health.[10] Second, it would prioritize factors responsible for the greatest morbidity, mortality, and underutilization of preventive care. Of the causes of widespread and enduring population-health disparities, social conditions,[11] especially poverty, are the most fundamental. The social, economic, political, and environmental dimensions and sequelae of inadequate material resources are acknowledged as among the greatest contributors to the ill health of populations, in the United States and globally, by the Centers for Disease Control and Prevention,[12] National Institutes of Health,[13] World Health Organization,[14] and US Public Health Service.[15] Accordingly, a renewed emphasis on antipoverty efforts is advocated here as a focal point of a national public health agenda.

Background

The US Department of Commerce defines poverty based on thresholds of annual "total money income" for family units.[16] Incomes below a given threshold identify a family unit and each constituent member as living in poverty. These thresholds signify a lack of material resources to meet basic needs.

Poverty, social-class disparities, and poor social conditions are the world's most pervasive public health problems.[17-19] They are salient and consistent determinants of population-health status, according to various measures, and are thus responsible for an enormous toll in health-related suffering. Poverty is assessed in various ways. For epidemiologists, assessing poverty involves mathematical modeling of, controlling for, or stratifying by social-class standing, usually operationalized as socioeconomic status,[20] whose calculation typically incorporates measures of personal or household income alongside markers of educational attainment and occupational status.[21] The impact of socioeconomic status on population-health outcomes has been recognized at least since the reports of William Farr in the United Kingdom in the 19th century.[22] Social-class disparities are present in morbidity, mortality, and disability in terms of physical and mental health.[23] On average, people in poverty are in worse health than those with sufficient material resources. This disparity manifests ecologically as well: economic development (eg, per capita gross domestic product) and population health (eg, life expectancy at birth) are positively associated across nations.[24] Poorer nations, on the whole, are less healthy nations.

How does poverty influence population health? One way to answer this question is by examining the mediators of a poverty-health association. Think of these mediators as

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sequelae of poverty that, in turn, are associated with population-health disparities, conceived of as poorer population-wide health status or higher rates of disease or death. The health-affecting consequences of poverty are legion: socioeconomic deprivation, social immobility, elevated risk of family and community dysfunction, poor nutrition, inadequate education leading to poor health-behavior choices, socioecologic stress and social instability, racism and disempowerment, limited access to preventive health care and medical care, unhealthy physical environment, poor shelter and living conditions, dangerous occupational exposures, lack of supportive personal and community resources, and lack of discretionary income.[25,26] Astute readers could likely add to this list.

Note how many of these mediators are or can be politically driven, defined as mostly communal exposures or statuses that manifest intentionally or unintentionally because of policies of federal, state, or local governments or agencies. Personal decision making may come into play but is not the exclusive means by which poverty emerges in communities or by which it exerts pathologic effects on population rates of health and illness. As Paul Farmer passionately details, there are population-health consequences of government social policies, for better or worse, even when policies are not explicitly directed at health.[27] These policies may constrain people's behavior such that unhealthy decisions are reinforced. The cause of observed health disparities thus may lie in unjust or ill-advised policies rather than in individual people exhibiting free choice. Consequently, disparities in population health are not best, or ethically, solved solely through targeting people engaging in such behaviors but in efforts to remediate injustices or inequities.[28]

Traditions of social, epidemiologic, and other population-health research have established an inverse association between social class or socioeconomic status and rates of disease, disability, and death overall and due to cause-specific outcomes.[29] This observation is a hallmark of public health research.[30] Poverty is associated with a greater risk of chronic degenerative[31] and acute and chronic infectious[32] diseases; it mitigates access to preventive health services[33] and medical care[34]; and it causes and interacts with other social dysfunctions that themselves heighten population-health risk and are associated with deficits in subjective well-being.[35] People in poverty live shorter lives,[36] suffer a greater disease burden,[37] experience more symptomatology and pain,[38] endure greater disability,[39] have higher rates of depression,[40] lose more work days,[41] and receive less and worse medical care[42] than those with sufficient material resources. This problem is national and global; it affects US citizens and new immigrants; and it touches lives regardless of age, sex, race/ethnicity, religion, family structure, household characteristics, or other sociodemographic and geographic categories.[43] Moreover, it is not adequately addressed by a public health agenda that continues to overemphasize modification of discrete lifestyle behaviors and statuses that are shaped and reinforced by social-class disparities and the burden of poverty. Such an agenda, for example, informs the listed priorities of the original National Prevention Strategy report from 2011: smoking, drinking, diet, exercise, and sexual behavior make the cut but not the sorts of social-structural issues that historically have informed the mission of the public health field.[44]

Perhaps this exclusion is not due to oversight but simply to expediency. Why raise issues that may give the appearance of being overly politicized, in a progressive or liberal direction, during a time in which purse strings are held by conservative legislative bodies? Yet such conciliation may be unnecessary and is a missed opportunity. An agenda prioritizing antipoverty efforts would seem to transcend political ideology: initiatives, programs, white papers, and conferences have appeared across the spectrum of beltway think tanks. Notwithstanding competing political worldviews and economic policies, poverty has been identified as a substantial risk for poorer well-being by the liberal Brookings Institution,[45] the conservative Heritage Foundation,[46] the libertarian CATO Institute,[47] and the progressive Center for American Progress.[48] To use a medical metaphor, although different treatments are prescribed, the diagnosis is the same: the significance of poverty status for population health.

Recommendations

To be effective, a national public health strategy should emphasize solutions at the upstream (eg, government policy), midstream (eg, voluntary institutions), and downstream (eg, individual behavior) levels of intervention.[49] Former US Surgeon General David Satcher[50] and others share this opinion, but too often public health occurs either exclusively far downstream, via programs focused solely on modifying discrete lifestyle behaviors, or exclusively far upstream, via florid national policy recommendations mandating top-down regulatory bodies. The midstream domain is typically overlooked, and outreach to potential institutional allies in redressing community- and population-wide health inequalities is neglected. Moreover, midstream intervention serves as a functional bridge linking social and health policy with the behavior and lives of people. A comprehensive antipoverty agenda for public health should address each level of intervention but especially not neglect the midstream.

The following recommendations focus on these levels of intervention. Each recommendation has characteristically midstream features, engaging what has been termed the civil-society sector—a concept that in contemporary American context refers to voluntary institutions that mediate between the individual and family unit and the government.[51]

First, Congress and the President should commit to strengthen infrastructure and redouble preparedness efforts. The upstream reference here is not just to public health infrastructure but also to social infrastructure, including policies providing assistance to communities and people with population-health disparities rooted in disinvestment of social capital.[52] This recommendation does not necessarily

imply a particular political-economic program, such as big-government liberalism, top-down central planning, laissez-faire enterprise zones, or locally directed community development. As noted, an antipoverty agenda for public health speaks to themes consistently emphasized in reports and policy statements issued by institutions representing multiple constituencies and should resonate with Americans regardless of political perspective. For the new administration, for example, an antipoverty initiative for public health would seem to map onto themes such as economic opportunity, workforce development and job training, and reform of the incentive structure of assistance programs for low-income and vulnerable people.[53]

Second, legislation and executive action should work to promote collaboration between the civil-society and government sectors—federal, regional, state, and local, as well as global. This midstream approach would entail government partnerships with businesses, trade associations, foundations, philanthropies and charities, community and neighborhood organizations, co-ops, consumer and activist groups, labor unions, and fraternal and sororal lodges and clubs. Each entity can partner with the others and with government agencies to identify and address challenges presented by poverty, including through strategies of economic development and through mitigating poverty's health-affecting sequelae. Such "cross-sector partnerships" have been successful in addressing health and equity issues.[54]

Third, special efforts should be made to establish partnerships between the faith-based and public-health sectors. Midstream and downstream partnerships involving religious organizations and individual congregations[55] have a long history and have been multifaceted,[56] entailing efforts in disease prevention, health promotion, primary care, health policy advocacy, and other areas of public health and preventive medicine.[57,58] The White House Office of Faith-based and Neighborhood Partnerships was established, in part, to facilitate collaboration between the faith-based and public sectors, but programs and interventions targeting population-health disparities received only modest attention from the office during the previous 2 administrations.[59] It is too soon to tell whether such efforts will be sustained or expanded in the new administration. At the time of this writing, there is uncertainty about the new leadership of the office, the membership of its President's Advisory Council, and indeed whether the office will be retained. It is recommended that a member of the council serve as a de facto liaison between the faith-based and public-health sectors, including the Office of the Surgeon General (OSG),[60] to encourage and facilitate working relationships between faith-based organizations and public- and private-sector public health agencies and institutions.

Implementing these modest recommendations would no doubt necessitate "a broad-gauged approach"[61] involving many people and institutions working in tandem. But the third recommendation would not require new executive or legislative action and would expand current efforts. Advocacy for an antipoverty agenda should be a priority of the US Public Health Service, including the resources and bully pulpit of OSG. Each Surgeon General has taken on a special issue for advocacy, such as smoking, immunization, AIDS, and childhood obesity—all of which are worthy causes. One would hope that the next Surgeon General places his or her focus, and the weight of OSG's resources, on advocating for public- and private-sector partnerships to address the structural determinants of population health, especially poverty. The closest to articulating this point among recent Surgeons General was Dr. Satcher in his ongoing advocacy of initiatives targeting population-health disparities.[62]

Eliminating poverty is obviously not something that can be accomplished by the US Public Health Service or the OSG alone, nor is this task part of either's charge. But promoting awareness of the link between poverty and population health is a worthy focus for the OSG, in keeping with its statutory charge to advise the executive branch on matters of public health priority. There is no bigger priority for our nation's health than advocating for poverty reduction. Bringing public, and presidential, attention to the implications of poverty for population health can elevate awareness of this critical issue to a point where thoughtful action becomes a national priority.

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