

Health and Poverty Through the Lens of Economic Class

An invitation to healthcare providers to create new models for better serving people in poverty

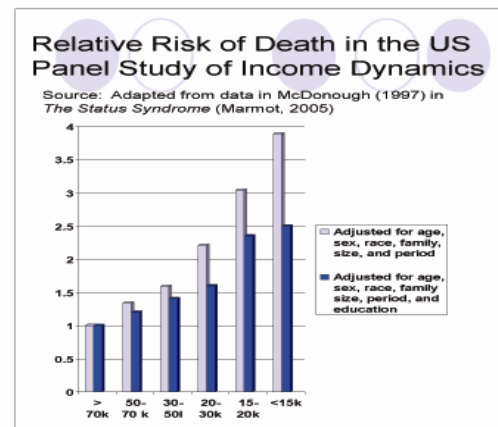
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The United States is not doing well in international rankings of quality-of-life indicators. The OECD (Organization for Economic Co-operation and Development) ranks the U.S. third from the top of 30 nations for the greatest disparity in income ratio between the top and bottom 10% of households, just behind Mexico and Turkey (p. 197, *Measure of America*). The OECD also ranks the U.S. 24th of 24 in Health and Safety indicators. And in the UNICEF Measures of Child Well-Being 2007 REPORT CARD, the U.S. ranked 20th out of 21 countries in child well-being.

The correlation between poverty and ill health is well-established. In his book *Why Zebras Don't Get Ulcers*, Robert Sapolsky describes the socioeconomic status (SES) gradient where there is better health every step up the economic ladder. The wealthier you are, the healthier you are. The corollary also is true. The poorer you are, the sicker you are. Sapolsky finds that the U.S. has the worst SES gradient of the 13 industrialized countries in the study (pp. 301–305). Poverty is associated with increased risk of cardiovascular disease, respiratory disease, ulcers, rheumatoid disorders, psychiatric diseases, and several types of cancer. He says, “For centuries, it’s been true that if you want to increase the odds of living a long and healthy life, don’t be poor” (p. 300).

Given the disproportionate amount of death and early death in poverty, do individuals have access to the people, strategies, and support systems necessary to address the emotional wounds? Unaddressed emotional issues often lead to physical health issues (Myss, 1996).

As you can see from the chart from the work of Marmot (2005) on the right, the poorer you are, the greater the risk of death. It’s based on a study of 8,500 men and women who were followed for 20 years, 1972–91, or until they died. The study showed the risk of dying in relation to average household income in 1993 dollars. The figure shows the risk of death in each group relative to the best-off group, those with an income of \$70,000 or more, who were arbitrarily assigned a risk of dying of 1, then all other groups were compared with them. The graph shows the gradient.



The process of grieving outlined by Kubler-Ross (1969) indicates there are five stages of grief: denial, anger, bargaining, depression, and acceptance. Who helps with this grieving when language is limited, when another death comes before acceptance comes for the previous death, when depression stays and doesn't leave, and when the support systems are thin with limited access to behavioral health professionals?

Furthermore, brain research indicates that external experience can impact the internal chemicals that are manufactured by the brain for processing of information. In resourced households, death is a traumatic. In under-resourced households, death is often an additional unhealed wound.

The purpose of this paper is to identify the complexities found at the intersection of poverty and healthcare using the lens of economic class. Understanding the impact of poverty on individuals and families can lead to a paradigm shift and, ideally, to better outcomes. We are not going to offer solutions but, instead, are going to invite healthcare providers who are attracted to our work to create new models by applying our constructs and tools together with their best practices. The range of potential partners in healthcare is wide. Partners may come from professionals in such health-related areas as prenatal care, infant mortality, immunizations, lead poisoning, dental care, obesity/diabetes, safety/violence, nutrition/diet, addiction, mental illness, and depression. This process has developed new approaches with proven results that improve the lives of people in poverty in other sectors, such as business, criminal justice, education, and community development.

One such champion is Cascade Engineering, a plastics firm in Grand Rapids, Michigan. Fred Keller, the owner and CEO, says, "Our future employees are coming from poverty; we should be good at working with them." To be good at working with someone in poverty, we must understand the impact that poverty has on individuals, families, and communities. This means confronting the myths and misunderstandings about poverty and developing an accurate mental model upon which to build our plans.

In this paper we identify some of the complexities that exist at the intersection of poverty and healthcare that aren't part of the standard lexicon but arise from the findings of *A Framework for Understanding Poverty* (1996, 2005). What follows is not an exhaustive list but enough to illustrate the depth of the work that lies ahead with any healthcare entity that wishes to apply our constructs and use our tools.

Perhaps the best way to present the new information is to stay with Sapolsky who, with Aaron Antonovsky, introduced the concept of social coherence as a barrier to better healthcare for people in poverty. They argue that access—or the lack of access—to healthcare is not the only important variable. According to Antonovsky in *Why Zebras Don't Get Ulcers*, "[T]he poor lack a strong sense of social 'coherence' that contributes significantly to their poor health" (p. 306).

Sapolsky and Antonovsky assert that social coherence can be determined by the answers to the following **five questions**. We'd like to expand on those questions in order to illustrate new insights provided by aha! Process.

"Does a person have a sense of being linked to the mainstream of society, of being in the dominant subculture ...?"

While people in poverty may strive to be part of the mainstream, they find out that they aren't when they encounter the healthcare system. As described in Sapolsky's book, people in poverty are often

treated with disrespect or even contempt when they seek help. It's as if they aren't quite American enough to qualify for respectful treatment.

Most of the institutions of the land are run on middle-class rules and norms. Members of the middle class often normalize their societal experience and, assuming that everyone shares their mindset, design programs, policies, and procedures accordingly. Of course, not everyone experiences life in the U.S. the same way; the greater the disparity in income and wealth, the greater the differences in the societal experience. Professionals are familiar with diversity trainings designed to help them better understand their patients from various racial, ethnic, and cultural backgrounds. What they usually lack is an understanding of the impact of poverty and economic class.

In addition, the power that goes along with running and being able to navigate the systems is often invisible to those in the middle class. But people who have little power or influence, who may not have the ability to navigate the systems smoothly (and who might not even have the power to stop bad things from happening to them) are hyper-vigilant about who has power and who doesn't. When individuals with little power are disrespected by those with power, their only option to maintain self-respect is to leave, to separate themselves from the person who has disrespected them. People will tend to avoid institutions where they have been treated badly.

Organizations that have applied aha! Process constructs successfully base their work on relationships of mutual respect. Many healthcare organizations are trying to get their patients and the public to change the way they think and behave when in fact their own thinking and behavior are often bigger issues. To paraphrase Dr. James Comer, a well-known author in the education field, virtually no significant learning or change takes place without a relationship of mutual respect.

“Can a person perceive society’s messages as information, rather than as noise? In this regard, the poor education that typically accompanies poverty biases toward the latter.”

There's no doubt that healthcare professionals have important health messages for us. But countless healthcare and social work professionals who have attended our seminars have told us that when they are pitching their messages they have seen the eyes of people from poverty glaze over. It's as if the presenter had suddenly been transformed into Charlie Brown's teacher (in "Peanuts"): "Waa waa waa."

This has to do with the registers of language that we learn to use in our homes. The world of work, school, and healthcare operates according to formal register, which calls for specific word choice, a big vocabulary, proper grammar and syntax, and the use of language to negotiate and explore different points of view. Some people in poverty are raised with casual register, which means a relatively small vocabulary and a reliance on reading non-verbals and the social context. People who have only casual register tend to be masters of reading body language and

social nuance. Densely written material and lecturing in the formal register turns words into “noise” for those in poverty.

Organizations that have applied aha! Process constructs develop strategies for communicating information that doesn't rely on formal register alone and, when time allows, will teach formal register to their consumers, clients, or patients.

“Has a person been able to develop an ideal set of coping responses for dealing with society's challenges?”

Poverty is a societal challenge. When the price of both gasoline and milk went to four dollars a gallon, many of the working poor were working for just two gallons an hour (Shipler). Poverty today is an unstable, unpredictable, vulnerable environment where you don't know what will break down next. The breakdown of a car leads to a negative chain reaction of events: You're late to work; you can't pick up your kids; and you spend the day solving those three concrete, immediate problems. People in poverty are problem solvers. They use reactive skills to fix problems on the fly. They use their relationships to fix problems. It isn't triple A that helps you with your car, it's Uncle Ray. The more people you have to help you get by, the better.

Poverty, as a societal challenge, isn't just about the choices of the poor. Research shows that there are three other causes: the lack of human and social capital in the community, exploitation of people in poverty, and political/economic structures. These are all societal challenges.

In addition to poverty as a challenge, people in poverty experience other common challenges: disabilities, discrimination, and crime, to name just three.

It's important that we have an accurate mental model of what poverty is like; without it our plans, programs, policies, and procedures will be based on faulty information.

aha! Process has tools to help people in poverty examine the impact of poverty on themselves and their community. Out of this learning experience people often develop new coping strategies and problem-solving skills that allow them to break out of the cycle of dealing with the same concrete problems over and over again. Organizations and communities that use aha! Process constructs also develop ways to provide long-term support for people who are making the transition out of poverty.

“Does a person have the resources to carry out plans?”

Before going to this step we would insert another question: “Does the individual use planning strategies?”

As already noted, people in poverty are problem solvers; but living in an unstable environment requires instant fixes and reactive skills that usually don't involve planning. In poverty, people are afraid for today; they live in the tyranny of the moment with a time horizon of one day to two weeks. A common expression is "I can't see past next week."

By comparison, a middle-class environment is generally stable. Most middle-class people aren't afraid for today because their resources—insurance, money to pay for repairs or childcare, and social connections—help them smooth out rough edges. The stability they enjoy gives them a future orientation that, coupled with a driving force of achievement, makes them natural planners.

Middle-class planners and program designers may have normalized their planning skills, not recognizing that the "tyranny of the moment" is a key feature of life in poverty and that people in poverty may use reactive skills more than planning skills.

Healthcare organizations, on the other hand, base much of their work with clients and patients on the use of plans. It's a tool for moving people through a change process, a way to organize and monitor changes in thinking and behavior. According to informal surveys we conduct during our workshops, healthcare professionals tell us that people in poverty are in contact with three to nine community organizations a year. Every one of those organizations requires a plan.

Organizations and communities that use aha! Process constructs have strategies to help professionals and people in poverty address this problem. It's possible to live in the tyranny of the moment, to be solving concrete problems all day, and still make a choice to move to the abstract in one's thinking and planning.

Returning to Sapolsky/Antonovsky, "Does a person have the resources to carry out plans?"

Framework defines poverty as the extent to which a person does without resources. Those resources include financial, mental, emotional, physical, social, spiritual, role models, and knowledge of the hidden rules of class. Given the unstable world of poverty, a person may start life with fewer resources or may lose resources over time and end up in poverty. Living in the tyranny of the moment and in persistent and concentrated poverty makes it difficult to build resources, but that is exactly what is needed to get out of poverty.

To carry out plans it helps if one has the resources to:

- Purchase the goods and services to stabilize the environment (financial)
- Think in the abstract, to keep oriented to the future, even while being forced to deal with daily concrete problems (mental)
- Use positive self-talk and maintain the determination to stay with the plan even when exhausted (emotional)
- Stay well and have the stamina to keep moving even when beset by depression (physical)

- Get the emotional, physical, and financial support of others while the plan slowly evolves (social)
- Access an inner strength, a high power, and/or a spiritual fellowship that provides motivation and sustaining strength in hard times (spiritual)
- Get help and guidance from a mentor, sponsor, or guide (role models)
- Navigate new experiences and settings with confidence (knowledge of hidden rules of class)

In a society normalized to stability and planning, these things appear automatic. Assuming that others live the same societal experience leads to poor program designs. Organizations and communities that use aha! Process constructs are intentional about building resources.

“Does a person get meaningful feedback from society; do their messages make a difference?”

When we have normalized the middle-class world, we plan for people in poverty; we talk about them, for them, and to them, but not with them. This goes back to our mental model of people in poverty. If we think they are needy, deficient, diseased, and not to be trusted—and base our planning on that mindset—our outcomes will seldom be good. If, on the other hand, we recognize that people in poverty are problem solvers and we engage them in finding solutions, we’ll generally get better outcomes. We need to bring people from all classes to the planning and decision-making table.

To their credit, some organizations do include people in poverty on advisory boards and sometimes even on governing boards. We have found, however, that typically people in poverty don’t feel comfortable in those settings. And it’s no wonder, given that they may not know the hidden rules of the organization or the board room.

The hidden rules of class arise from the environments in which people live; they are about belonging. When people in middle class and poverty have a common language—the lens of economic class—they can use their knowledge of the hidden rules to make relationships of mutual respect and to resolve conflicts. With knowledge of the hidden rules, people in poverty and people in middle class and wealth can more readily come together to solve problems.

Organizations and communities that use aha! Process constructs bring people from all classes, races, sectors, and political persuasions to the table to plan programs and develop strategies. People in poverty have information that is vital to the success of the endeavors, and they can take an active part in doing the work.

Conclusion

We trust that this brief look at social coherence through the lens of economic class hints at the size and complexity of the barriers that healthcare organizations must address if they are going to achieve better

outcomes with patients and clients from poverty. Those who have attended our workshops, read our books, and utilized our tools—and now own the constructs themselves—may be in a position to apply our work in new ways.

We recognize that early adapters, not the innovators, are the principal agents of change. aha! Process has the tools to help individuals, organizations, and communities move from theory to practice. We seek to work with organizations that are financially and emotionally healthy and well-led—and where the CEO can get things done and has the full backing of the board. Healthy organizations can shift paradigms more easily than those in distress. Together we would like to achieve proven results that can evolve into high-impact strategies that others can adopt.

Bibliography

Burd-Sharps, S., Lewis, K., & Martins, E. B. (2008). *The measure of America: American human development report, 2008–2009: a joint publication of the Social Science Research Council*. New York, NY: Columbia University Press.

DeVol, P. E., Payne, R. K., & Dreussi Smith, T. (2006). *Bridges out of poverty: strategies for professionals and communities* (4th ed.). Highlands, TX: aha! Process.

Kubler-Ross, E. (1969, 1997). *On death and dying*. New York, NY: Simon & Schuster.

Marmot, M. G. (2005). *The status syndrome: how social standing affects our health and longevity*. New York, NY: Henry Holt & Company, LLC, Publishers.

Myss, C. (1996). *Anatomy of the spirit: the seven stages of power and healing*. New York, NY: Three Rivers Press.

Payne, R. K. (2006). *A framework for understanding poverty* (5th ed.). Highlands, TX: aha! Process.

Payne, R. K. (2008). *Under-resourced learners: 8 strategies to boost student achievement*. Highlands, TX: aha! Process.

Sapolsky, R. M. (1998). *Why zebras don't get ulcers*. New York, NY: W. H. Freeman & Co.

www.unicef.org/media/files/ChildPovertyReport.pdf. Child poverty in perspective: an overview of child well-being in rich countries (2007). (accessed November 2007).