DR. NANCY MIMM

Poverty and Health:

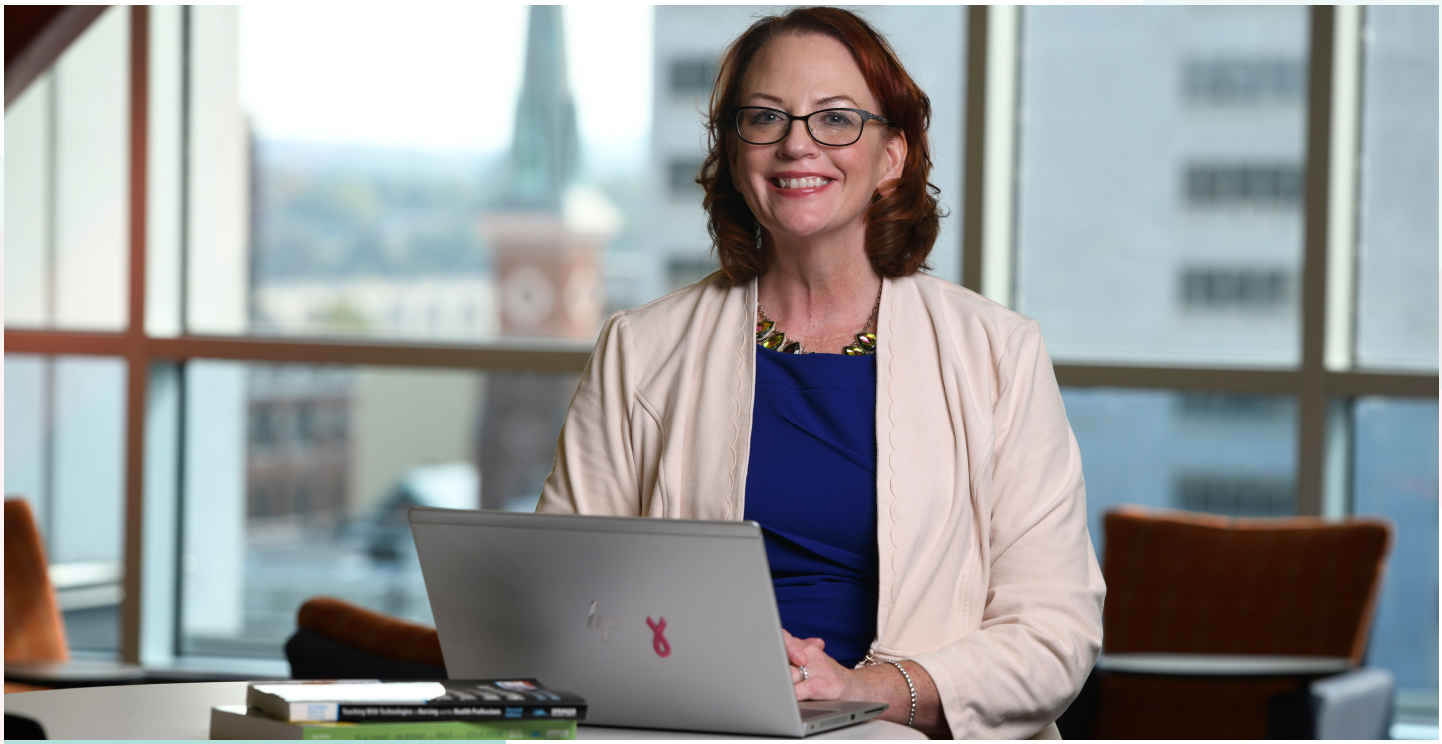
How our Institutions Fail the Most Vulnerable

Dr. Nancy Mimm is an associate professor of nursing at Harrisburg University. She received her doctor of nursing practice from Rutgers University and is board certified in advanced public health. Dr. Mimm's research focuses on population health: for 23 years, she has studied topics including maternal health, prevention of childhood morbidities in disadvantaged communities, and public health policy. She offers her expertise on improving health outcomes in disadvantaged populations.

BY: MEGHANA KRISHNA

Economically disadvantaged communities in the United States have long pointed to shortcomings in the American health system that limit healthcare accessibility and affordability. For years, their concerns have been remedied with ineffective public health, education, and housing policies. Today, a global health crisis has further exposed weaknesses in the healthcare system disproportionately impacting the poor.

The U.S. has one of the largest income-based health disparities in the world: studies show the richest one percent of Americans live, on average, 10 to 15 years longer than the bottom one percent. Environmental stress encourages maladaptive coping mechanisms like smoking and drug use, and poorer communities often lack access to nutritious food and safe recreational areas.



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Dr. Nancy Mimm, an Associate Professor of Nursing at Harrisburg University, studies social determinants of health within economically disadvantaged communities. According to Dr. Mimm, there are a number of structural barriers within and outside the healthcare system that contribute to negative health outcomes in low-income areas.

The patient-physician relationship, particularly in rural and poor urban communities, is, in many ways, more strained than ever. Disadvantaged patients, including those from low-income households and minority groups as well as the uninsured, disproportionately report receiving sub-par care from health employees. A 2016 Health Affairs research initiative examined patient interactions with the healthcare system: researchers were surprised to find it was treatment from healthcare workers — not prescription costs or the bureaucracy and lack of transparency in the system — that concerned patients the most.

Patients reported treatment bordering on a lack of respect and outright contempt, providing anecdotes of healthcare professionals who disregarded their symptoms, avoided eye contact, and even expressed disgust during examinations. 2017 data released in California revealed the top quality of care complaint by Medi-Cal recipients was “poor provider/staff attitude.” Many recipients of Medi-Cal are non-English speaking immigrants and struggle to communicate with their physicians. Some felt doctors patronized them, equating a lack of English skills with a lack of intelligence.

Several participants in the Health Affairs study felt their physicians were motivated more by money than by a desire to help their patients. Their suspicions aren’t unfounded — a 2016 ProPublica analysis uncovered a strong correlation between the amount of money a physician receives from the pharmaceutical industry and the rate at which he or she prescribes brand-name drugs. In 2015, nearly half (48%) of all physicians in the U.S received some form of industry payment, amounting to a $2.4 billion total. Though drug kickbacks are illegal, payments between physicians and pharma companies are not tightly regulated. Payments do not, of course, equate to bribery — however, the analysis suggests pharma companies use monetary compensation as a strategy to raise their bottom lines, and patients are justified in their concerns.

A deeply rooted mistrust of the healthcare system combined with a lack of community and social support in disadvantaged communities means ailing individuals often don’t seek out the help they need until it’s too late. Patients who lack faith in their doctors are less likely to comply

with treatment orders and schedule timely follow-ups, further corroding the patient-physician relationship and fueling a cycle of deteriorating outcomes. Bridging the trust gap is critical, and it's not easy — healthcare providers often aren't aware of their own biases, and the system can work against the best interests of physicians and patients, says Dr. Mimm.

Building trust requires repeated, meaningful interaction. Experts point to the administrative burden on physicians as a factor limiting face-to-face time with patients and contributing to lower morale. The National Institute of Health analyzed inefficiencies in healthcare administration and found doctors, on average, spend nearly 9 hours a week on administrative tasks. This is largely due to shifts in healthcare policy over past decades: the implementation of electronic health records and a rise in large-practice employment have contributed to more bureaucracy and paperwork. More efficient administrative software, possibly enhanced by machine learning, is critical to improving patient-physician relationships.

More importantly, the healthcare system disincentivizes physicians from working in rural and low-income urban areas, where the sickest people live. The profit margins from treating privately insured patients are typically much higher than those from government insurance. Altruistically motivated doctors who forgo larger profits to work in low-income areas face a number of challenges: they often work in understaffed clinics lacking critical resources like counseling, therapy, and aid to communicate effectively with non-English speaking individuals.

The most fundamental way to transform the patient experience in poorer communities is by recruiting more healthcare providers who reflect the demographics of their communities. Healthcare workers with an intricate knowledge of the unique challenges faced by disadvantaged patients can more easily establish trust, open communication, and cultural competence, notes Dr. Mimm, citing affirmative action as an important means of recruitment. Transforming the demographics of the healthcare system is, however, a challenging, long-term undertaking, requiring sweeping changes to the pre-college education system.

Healthcare policy reform is critical — ultimately, however, the healthcare system can only do so much. Without adequate housing, education, and transportation infrastructure in place, improving public health will continue to be an uphill battle as poverty forces individuals to prioritize day-to-day needs over long-term health.

According to Dr. Mimm, institutions like churches and schools play a critical role in public health and have a moral obligation to help create a healthy environment. Churches and other religious organizations strengthen the social fabric of communities by giving members a sense of belonging and help combat loneliness. Faith-based organizations are integral to the social welfare system and can provide critical support without the bureaucratic barriers of government welfare.

Schools can help prevent the development and progression of childhood morbidities. Instituting mental health counselors who are trained to recognize and treat signs of poverty-induced trauma, for example, can greatly benefit students. The needs of students in poverty are unique — students from more secure backgrounds often arrive at school primed to learn, while disadvantaged students may need additional emotional support and remedial education to perform optimally.

Improving health outcomes in low-income communities requires a holistic approach, stresses Dr. Mimm — it's crucial to push for reform across every social institution, in addition to the healthcare system, to create real change.

"Most people cannot steer their own health outcomes — the whole community needs to stand behind them," Dr. Mimm says.

> "We need to stop thinking about just treating the patient. In reality, we need to treat their surroundings, including their family and their entire community. That's the only way we can improve the future of public health."