

| [About NextGen](#) | [NextGen Alerts](#) | [Submissions](#)

[Current Issue](#)

[Pathways Through Medicine](#)

[Advice to the Next Generation](#)

[Special Series](#)

[Letters and Comments](#)

[Past Issues](#)

[Other Resources](#)



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Unlinking Poverty and Poor Health

A NextGen [Free-Standing Perspective](#) Article
by Eva Luo

With the Presidential Election of 2008 less than a year away, healthcare reform is in the air. Presidential candidates and state governors alike are trumpeting their plans and solutions for better healthcare in the United States. Most of these plans promise to provide universal access to healthcare, directly addressing the 45 million Americans who are uninsured. [1] Are these plans potent enough cure the US healthcare system?

Common cases at Boston Medical Center's Pediatrics Department point to a different set of pressing problems in the US healthcare system. Picture this. A six-year-old boy who suffered from uncontrolled asthma arrives at the Boston Medical Center for care. Despite receiving daily oral doses of corticosteroids, a common asthma prevention medication, he was absent from school once or twice every six weeks. As a result, his mom was forced to miss work in order to take care of him and bring him to the hospital. Dr. Barry Zuckerman, Chief of Pediatrics at Boston Medical Center, often uses this example to illustrate an overlooked problem in the US healthcare debate. This young boy, through state subsidized health insurance has access to healthcare and is receiving quality healthcare at Boston Medical Center, yet his asthma is still a major disruption in his life.

On a visit to the young boy's home, the visiting nurse discovered asthma triggers: mold due to a leaky water pipe and wall-to-wall carpeting harboring dust mites. Thus, each step of improvement the young boy tried to make was inevitably countered by his poor living conditions. As Dr. Zuckerman reiterates, "I can provide the most updated form of medical care for low income families, but they

would still get sick.” Upon discovery of the asthma triggers in the young boy’s house, negotiations with the landlord led to replacing the leaky pipe, cleaning up the mold, and removing the carpet. Within six weeks, the young boy had stopped corticosteroid asthma treatment and was attending school regularly.

As one of the most modernized countries in the world with arguably the most advanced medical technology, the United States still boasts the highest infant mortality rate and lowest life expectancy rate for residents older than the age of 60 when compared with almost two dozen industrialized nations worldwide. [2] Professor Mary Ruggie, Adjunct Professor of Public Policy at Harvard University John F. Kennedy School of Government, sums up these observations not as statements of poor health, but as “indicators of the high level of poverty” in the US.

The effect of poverty on health is very well documented. Social factors such as unsanitary living conditions, crowding, malnourishment, and homelessness are still widespread problems in the US and continue to contribute to poor health, especially children’s health. Living in substandard housing and being forced to make a decision between food and heat, contribute to many physical and mental developmental problems that carry on into adulthood. Low-income children not only are at higher risk for exposure to these factors, but also face greater difficulties when managing and controlling resulting medical conditions. If a family is suffering from any of the above psychosocial factors, keeping up with treatment regimens are relegated as secondary concerns often until the medical illnesses become insurmountable. Dr. Zuckerman explains, “I can treat a child with antibiotics for an ear infection, but if the child is living in a house where the heat is being shut off constantly or his family is being evicted, giving medicine kind of pales.”

Dr. Zuckerman’s frustration is common among physicians. Rebecca Onie, co-founder of Project HEALTH recounts, “Physicians are frustrated because the clinical interventions that they can do in 18 minutes are not enough to change the health of their patients.” Onie further explained, “There are professional guidelines that formalize the role of doctors to address the psychosocial needs of families proactively. But, the healthcare system practices a ‘don’t ask don’t tell’ policy. In some cases, doctors will take \$20 out of their wallet and hand it to patients. Doctors don’t ask because they can’t do anything about the psychosocial needs of their patients.”

Rebecca Onie believes that since the hospital is the site where healthcare is delivered, it is also an “opportunity to improve the health of kids and families.” More importantly, Onie views the healthcare system’s “don’t ask don’t tell” policy as an infrastructure problem. In a powerful analogy, Onie explains that physicians would not prescribe patients medication unless there was a pharmacy for patients to go to. Likewise, psychosocial difficulties never arise in the 18 minutes of patient-doctor interaction because the physicians are unaware of the resources available to help their patients. To specifically address this infrastructure problem, Onie co-founded Project HEALTH along with Dr. Zuckerman in 1996.

Project HEALTH is a non-profit organization that seeks to break the link between poverty and poor health by mobilizing college students to provide public health interventions in urban hospitals and communities. More specifically, college students act as the pharmacy that physicians need to address these psychosocial issues. If doctors feel their patients need assistance obtaining housing, have food insecurities, or can benefit from utilities discount programs, doctors can now refer patients to Project HEALTH volunteers who work with patients to obtain those resources. The organization began as a small group of volunteers working at a desk outside the pediatrics department of Boston Medical Center and has now expanded to sites in New York, Providence, Chicago, Baltimore, and

Washington D.C. Project HEALTH has also increased the diversity of programs offered to include mentoring programs for urban youth managing chronic diseases in addition to the hospital based programs. With the presence of Project HEALTH volunteers in the hospital and the community, physicians are now empowered to include a “psychosocial screening” when treating patients.

In the long run, Rebecca Onie hopes that Project HEALTH will spur future changes in the healthcare system. As Onie explains, “The college students recruited to be Project HEALTH volunteers are likely to be leaders. We put them in healthcare settings that serve low-income patients. With the existence of these Project HEALTH programs, physicians are empowered to ask and be proactive about psychosocial factors. Referrals to the Project HEALTH programs will eventually become routine. As Project HEALTH becomes integrated into the hospitals, we will be able to reach new doctors, who through ‘viral marketing’ will become champions of the new infrastructure that Project HEALTH programs provide. In the end, we would have catalyzed a new generation of leaders who will continue to change the healthcare system.” Onie’s “Theory of Change” resonates with Professor Ruggie’s idea of humanizing medicine, “The healthcare system is not an island on its own. Insurance, access to healthcare, and social conditions all go together and cannot be separated.”

Voters in America have deemed healthcare as one of the top domestic issues in the coming Presidential election [3]. While most agree that the proposed plans of increasing access to care are a significant step forward, we still have a long way to go. Summarizing a recent report by The Boston Foundation entitled, “The Boston Paradox: Lots of Health Care, Not Enough Health,” Rebecca Onie explains, “in the city of Boston, there is abundant healthcare, but health disparities and health outcomes are still really troubling. The healthcare system was not built to address the psychosocial needs or social antecedents to health. While gains in healthcare are expected to improve, this will not translate in improved outcomes for underprivileged populations.” Dr. Zuckerman adds that the links between poverty and poor health are well established globally, “in Africa we focus on children in poverty in great detail, but this is not the case across town. I really think that we need to reduce the impact of poverty and marginalization, reduce the financial barriers to healthcare and particularly language and cultural barriers. We see overall improvement for a lot of diseases, but also increased disparities based on race and income.”

Looking to the future, improvements in healthcare are slowly being made. Professor Ruggie is greatly impressed with how medical education is changing, “emphasis on patient-doctor relationships, more women in medicine, incorporation of complementary and alternative medicine, and students interested in inequalities in healthcare show that there are lots of new changes.” Dr. Zuckerman adds, “There are a variety of vehicles [in medicine], working in a laboratory in a white coat, performing technological procedures, or having the spirit of working in the community. Science is only one part of medical training and the other is related to social justice. We need an integrated approach towards healthcare. We need teachers and lawyers. We need to move beyond healthcare and health policy to improve the health of people. We know this globally in Africa and now we need to apply this to the US.” The work towards a cure for the ills of the US healthcare system will require a combined effort to address the issues of access, quality, and poverty. Dr. Zuckerman states that his interest in this sort of program development stemmed from his “ability to try to be a better doctor by going beyond traditional medicine.” Similarly, as members of a civil society we are all responsible for taking the challenge of stepping beyond the limits of traditional roles to ensure quality health for all.

Eva Luo is a writer for the Next Generation and a member of the Harvard Class of 2008.

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[» Back to Current Issue](#)

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