Mindful
Continuing Education

Poverty Effects on Social Determinants of Health

Introduction

To help better understand health and health outcomes, the U.S. Department of Health and Human Services developed the Healthy People 2030 program, which outlines what are called the Social Determinants of Health. One of the main goals of outlining the Social Determinants of Health was to allow providers to take a deeper dive into both what promotes healthy living and what detracts from healthy living. One of the factors that was identified, and the focus of this training, is poverty.

Poverty is a difficult concept to define because of the broad array of meanings that poverty can hold, from dictionary definitions to societal constructs and more. Per Merriam- Webster (n.d.), poverty is defined as "the state of one who lacks a usual or socially acceptable amount of money or material possessions." Poverty can also be defined in absolute or relative Terms.

Absolute poverty is defined based on fiscal outlines. This means that poverty is defined and measured by the amount of money someone has and whether or not that person has the ability to meet their basic needs. Relative poverty, on the other hand, describes either the lack of monetary resources a person has to engage in activities of daily living or the idea of living at or below an area's standard of living threshold. Relative poverty, unlike absolute poverty, is more fluid and can change based on a person's geographic location (Langford & Keaton, 2022, endPoverty.org, 2023).

So, how does poverty impact the Social Determinants of Health? Poverty is deeply embedded in society through long-standing stigmas and stereotypes. As poverty is so commonly known and socially constructed, it is often overlooked as a major contributor to poor outcomes when assessing the Social Determinants of Health.

In this continuing education series, we will explore each Social Determinant of Health more fully, and we will also explore how poverty plays an important role in either promoting or detracting from health outcomes.

Section 1: Social Determinants of Health

Healthy People 2030 has described 5 categories of health that healthcare providers must attend to when improving the health and wellness of a community. These factors are Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context. Each of the next sections will focus on a particular Social Determinants of Health, and each section will include a description of the goals of Healthy People 2030, the outcomes of measurement, and how poverty impacts those outcomes. The sections will also discuss recommendations for mitigating the negative impacts of poverty by bringing awareness to those impacts and by addressing tools for working with clients experiencing poverty.

Section 2: Economic Stability

Section 2 Activity

Before starting this section, think about the next list of items. On a sheet of paper, or in your mind, answer each question as a yes or a no, and then tally the number of yes answers and the number of no answers.

1. I am employed and can reasonably expect a paycheck that will be about the same amount each time I am paid either weekly, biweekly, or monthly.
2. I spend less than 30% of my income on a home or monthly rent.

3. I have access to health insurance, paid time off, and/or sick leave through my employer.
4. I have enough money to pay for gas to go to and from medical or mental health appointments.

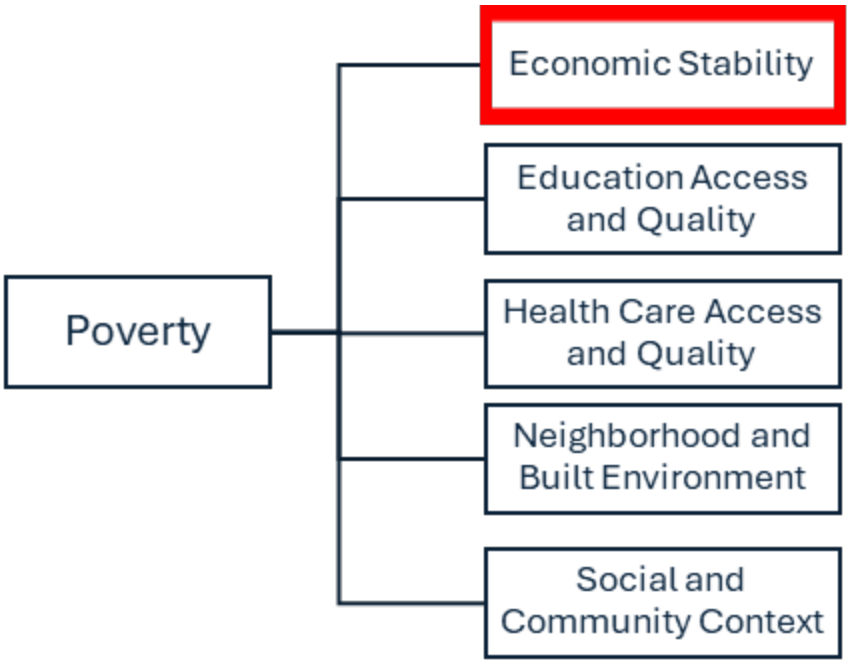
Section 2 Answer

If your answers tended more toward yes than no, then, per the goals of improving economic instability, Healthy People 2030 would deem your status as “improving” or “target met or exceeded.”

If your answers tended more towards no than yes, then, per the goals of improving economic instability, Healthy People 2030 would deem your status as “little or no detectable change” or “getting worse” (U.S. Department of Human Services, 2024).

Economic Stability

In this section, we will start to explore the first Social Determinant of Health (SDOH), which is called **Economic Stability**.



To understand how poverty impacts Economic Stability, it is important to understand what it means to be economically stable versus to be living in poverty. Let's start with some statistics. "In the United States, 1 in 10 people live in poverty, and many people can't afford things like healthy foods, health care, and housing." (U.S. Department of Human Services, 2024). Additionally, as of 2023, 11.1 percent of the population of the United States was living in poverty. This means that of the roughly 334.2 million people living in the United States in 2023, 36.8 million people were living in poverty (Shrider, 2024). Despite this, the United States continues to be one of the wealthiest countries in the world (Ventura, 2024). So, how do these statistics relate to Healthy People's goal of Economic Stability? Let's make the connection.

Healthy People 2030 has set a goal that states, "Help people earn steady incomes that allow them to meet their health needs." (U.S. Department of Health and Human Services, 2024). If a person is living in poverty, how do they earn a "steady income"? What is a "steady income" that will "allow them to meet their health needs"? Healthy People has also set goals to increase the number of people in the

workforce and thereby improve access to steady income. However, just because someone is in the workforce does not mean that they are always economically stable or that they have access to a steady income.

To understand how someone can be employed yet still be economically unstable or unable to meet their healthcare needs, let's review the definitions of **absolute poverty** and **relative poverty** as they relate to being employed versus underemployed or unemployed. Absolute poverty is poverty based on specific fiscal guidelines, while relative poverty is considered as having a lack of monetary resources that ultimately negatively impacts activities of daily living (endPoverty.org, 2023).

Most clients who consider themselves gainfully employed often live above absolute or relative poverty lines and enjoy access to employer-sponsored benefits such as health insurance plans, paid time off, and paid sick leave for healthcare needs. Clients who are gainfully employed are also likely to have higher levels of **discretionary income**, which can be used for expenses such as transportation to and from appointments. As providers, we need to be careful that we don't assume that just because a client has a job, they are gainfully employed and are able to enjoy the privileges of someone who is gainfully employed.

Clients who are employed but lack a steady income and/or lack employer-sponsored benefits often fall into the category of **underemployed**. A client who is underemployed will not be able to meet their healthcare needs. They may lack a steady income, which means that they may have limited or no discretionary income for things such as gas or transportation to and from appointments and they may not have the ability to access vacation days and childcare to attend appointments. Many families who experience underemployment often struggle with decisions like whether to use gas money to drive to and from work (and not

have gas to go to an appointment) or to use gas money to attend an appointment and miss out on work and earnings.

Clients who are **unemployed** lack both steady income and access to employer-sponsored health benefits. While not all clients who are unemployed are at absolute poverty or experience relative poverty, many clients still face the issue of the cost of healthcare and deciding where they can and need to spend any discretionary income.

As providers, what can we do to start to combat economic instability? First, it is important to know that employment status is on a spectrum. Just because your client is employed does not mean that they earn a steady paycheck. They may not have access to employer-sponsored health insurance, they may not be allowed enough vacation days to care for themselves or others, and they may not have enough month-to-month discretionary income for things like utilities, childcare, and other activities of daily living. Employment should be viewed from the lens of secure employment (little variability in income and access to employer-sponsored health insurance), underemployment (employed, but missing steady income and/or benefits), and unemployed.

Second, as providers, we need to view client engagement (or lack thereof) from a lens of economic stability. Asking ourselves, “Did my client not attend today due to financial constraints?” changes the narrative from a client being **non-compliant**, or refusing to attend visits, to recognize that a client may have wanted to attend the visit, but may not have had the ability to attend (i.e. lacking the financial resources to pay for gas, lacking the ability to take time off of work, or lacking adequate childcare). Understanding where our clients could benefit from financial resources can start to help alleviate the burden of financial and economic instability.

Lastly, as providers, it is important to ensure that any financial assistance programs offered through your agency are accessible. This means ensuring that the thresholds for what constitutes lower income and/or living in poverty are not too high and thus arbitrarily stopping clients from accessing necessary financial support. Also, program titles for financial assistance need to be chosen carefully so as not to continue the shame and stigma of poverty. For example, calling a program “Charity Care” can bring a connotation of shame. Many persons who live in lower income or poverty situations already receive shame from society because society perceives them as “lazy” or “unwilling to work” (Langford & Keaton, 2022). Calling a program “Charity” or some other similar term continues to perpetuate the stigma of poverty and the societal perception that the program recipients are “lazy” or “unwilling to work.”

Section 2 Key Words

Absolute Poverty - poverty is defined and measured by the amount of money someone has and whether or not that person has the ability to meet their basic needs (Langford & Keaton, 2022, endPoverty.org, 2023).

Discretionary Income - income that is left over after someone has paid any required weekly or monthly bills or taxes.

Economic Stability - the ability to “earn steady incomes” which will allow for a person or family to access health care and support health related needs (U.S. Census Bureau, 2024).

Non-compliant - a term used to describe a client who makes an active choice to refuse healthcare services, attend appointments, or follow medical recommendations.

Relative Poverty - Relative poverty describes either the lack of monetary resources a person has to engage in activities of daily living or the idea of living at or below an area's standard of living threshold. Relative poverty, unlike absolute poverty, is more fluid and can change based on a person's geographic location (Langford & Keaton, 2022, endPoverty.org, 2023).

Unemployed - being without steady, consistent work.

Underemployed - having employment, but the employment is either sporadic or does not support basic needs such as paid time off or employer-sponsored health insurance.

Section 3: Education Access and Quality

Section 3 Activity

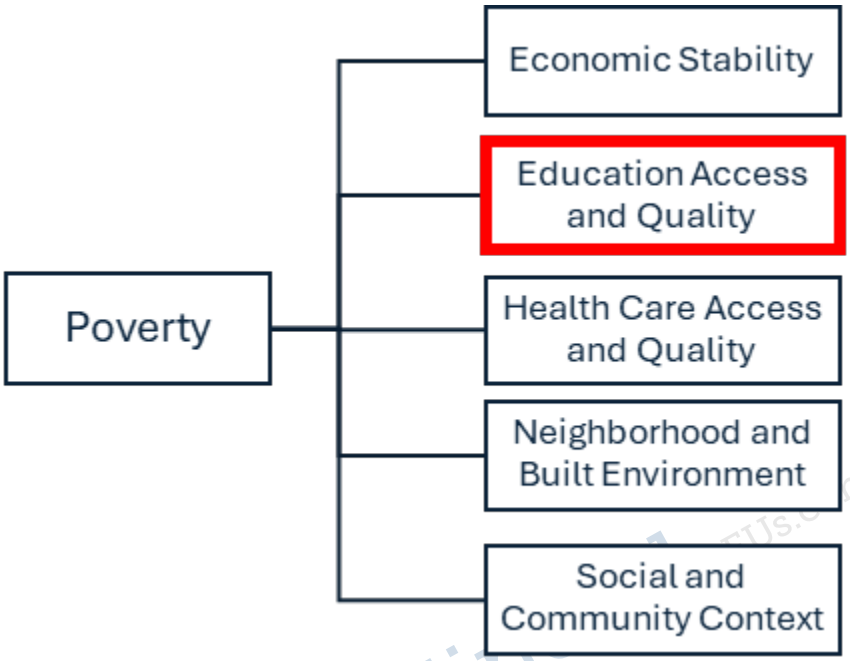
Before starting this section, reflect on your education pathway. If you have earned a bachelor's degree, master's degree, doctoral degree, or have attended post-secondary education and obtained a license, did you feel at any time that your education was unattainable due to literacy issues?

Section 3 Answer

If your answer was no, you likely had a positive educational experience, meaning that you received the skills needed to complete post-secondary education and/or training/licensure pathways.

Education Access and Quality

In this section, we will be focusing on the intersection of **Education Access and Quality**, poverty, and health literacy as it pertains to health outcomes.



The goal of **Education Access and Quality**, as defined by Healthy People 2030, is to "Increase educational opportunities and help children and adolescents do well in school." (U.S. Department of Health and Human Services, 2024). What this means is that, in order to achieve a higher education, children and adolescents need to have access to primary and secondary schools that support their ability to learn to read, write, and understand basic mathematical terms. Students who have these basic skills and can evaluate written word documents, handouts, education sheets, etc. have what is considered **literacy**. **Health literacy** is similar to literacy; however, it has the added skills necessary to "obtain, understand, appraise, and use the information to make decisions and take actions that will have an impact on health status." (Nutbeam & Lloyd, 2021). So, how many adults in the U.S. have health literacy skills? Very, very few.

Let's start with some facts about general literacy levels in adults in the United States. As of 2024, 79% of adults were considered "literate" while 54% of adults were considered literate only at a 6th grade or lower reading level (National Literacy Institute, 2024). Based on this, it should not be a surprise that it is estimated that about 9 out of 10 adults in the United States struggle with health literacy. Remember, this does not mean that 9 out of 10 adults struggle with literacy. It means that health literacy is a much more difficult skill to master, especially when basic literacy skills have not been fully developed (National Library of Medicine, 2024).

So how does poverty impact literacy and, more specifically, health literacy? Poverty affects an education system's ability both to retain students and to increase student attendance. Students experiencing **truancy** in schools are often also facing issues such as homelessness, lack of food, lack of basic survival needs, systemic discrimination, community violence, isolation, invisibility, and many other factors (Cookson, 2020). These factors, either individually or combined, create significant barriers for students to regularly attend school and for the school systems to support student attendance, retention, and ultimately achievement.

Returning to the topic of literacy, if a student who is living in poverty is not able to attend school, then their education will start to suffer. They will have infrequent access to the educational tools that are needed to deepen their skills in reading, writing, and interpreting information that is presented in either verbal or written form. If a student does not have access to basic literacy skills, it will be nearly impossible for them to be able to understand healthcare or mental health care related materials.

What can we do as providers to understand and combat health literacy? First, do not assume that what you have written down, or put into a patient or client

handout, is sufficient for informed consent. **Informed consent** is defined as a right by the patient "to receive information and ask questions about recommended treatments" so that they can make a decision based on benefits and risks. Informed consent is reached through supportive communication between a provider and a client (American Medical Association, n.d.). It is imperative that a provider engage in a skill called teach back. **Teach back** means asking the client to verbalize, in their own way, their understanding of what they have been told. This is the first step toward ensuring informed consent. Next, do not assume that your client will remember everything that you have said. Clients who experience poor health literacy may feel overwhelmed and stressed and thus have a lack of ability to remember or comprehend complex instructions. Finally, ensure that the client has the time and space to ask questions. In client care settings, many times clients are rushed out of the door and are expected to be able to just read what has been given to them. Since many adults read at a lower than 6th-grade level, it is inappropriate to assume that time for questions is not needed or necessary.

Section 3 Key Words

Education Access and Quality - A Healthy People 2030 goal is to "Increase educational opportunities and help children and adolescents do well in school." (U.S. Department of Health and Human Services, 2024).

Health Literacy - the ability for a client to "obtain, understand, appraise, and use information to make decisions and take actions that will have an impact on health status" (Nutbeam & Lloyd, 2021)

Informed Consent - an ethical and legal standard that a client demonstrates an understanding of the benefits and consequences of any medical or mental health decision.

Literacy - the ability to evaluate the written word.

Teach Back - an exercise where a provider asks a client to tell them what they heard and understand about their care. The goal of teach back is to ensure that a client has achieved informed consent and understands what is being asked of them.

Truancy - when a child misses several classes or days of school and these absences may or may not be excused.

Section 4: Health Care Access and Quality

Section 4 Activity

Reflect on the following question:

When I don't feel well and need to see a doctor, I go to _____.

Section 4 Answer

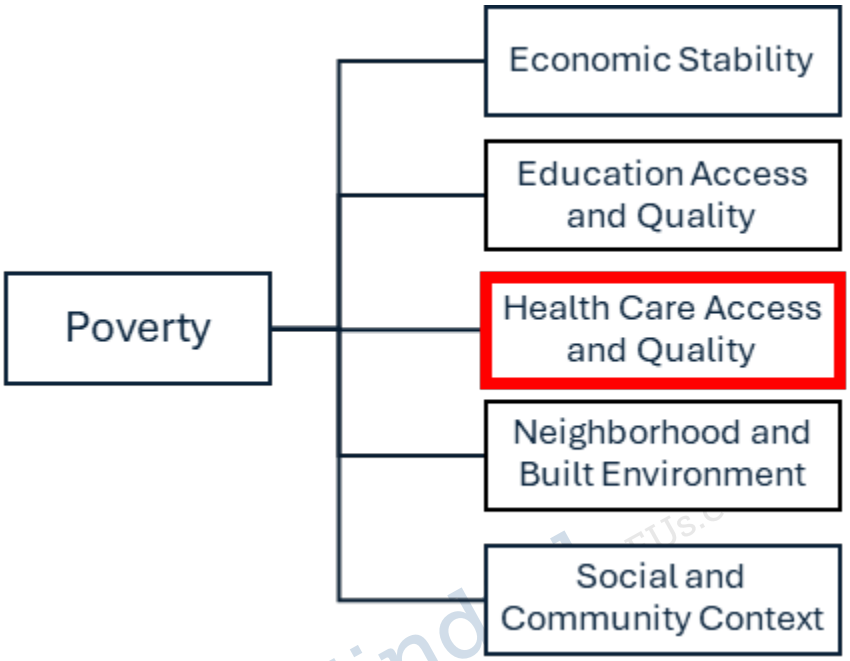
If your answer included:

- My primary care doctor
- My local clinic
- My local urgent care

Then you are living with health care access and quality. In this section, we will review why many of our patients, especially those living in low-income or poverty, miss preventative care visits and often utilize services like the emergency room.

Health Care Access and Quality

In this section, we will be focusing on how poverty drives health care decision-making as it pertains to **Health Care Access and Quality**.



Did you know that in 2022, individuals and families living in poverty were 2.5 times more likely to use an emergency room visit as a medical visit (Udalova et. al., 2022)? You may wonder why low income families would use an ER visit when primary care visits are an established service in most communities. Here's why.

Healthy People 2030 has set a goal for Health Care Access and Quality that states, "Increase access to comprehensive, high-quality health care services." (U.S. Department of Health, 2024). This is a broad goal encompassing many issues, such as lack of quality health care services, lack of quality insurance plans, and even lack of health care screenings. For the purposes of this training, we are going to focus on the accessibility of providers due to the availability of care services.

Individuals and families that are living in low-income households have a multitude of barriers that prevent them from accessing routine or preventative health care

screenings and visits. One of the main barriers, besides insurance coverage, is access to a medical or mental health clinic. When thinking about the accessibility of medical or mental health providers, it is important to discuss two topics: timing of clinic appointments and location of clinic appointments.

Let's start with the timing of clinic appointments. Primary care visits often fall outside of after-hours care, meaning that visits are mainly available between the hours of 8 am and 5 pm Monday through Friday (O'Malley et. al. 2012) and often not on holidays. This becomes a barrier to accessing preventable care services for many low-income persons because low-income persons are forced to choose between competing demands such as attending a primary care visit and attending work (Chapman et. al., 2022). Missing work often leads to a loss of money, and it can even lead to a loss of employment. When choosing between attending a primary care visit and attending work, this can make attending work a higher priority for many low-income persons. This then leads to the use of an emergency room as it is a medical service that is available 24/7. It may not be the right level of care, but it is the most readily available type of care. By changing the availability of primary care appointments to include options between 5 pm and 8 am and options on the weekends and holidays, would likely increase the ability of low-income persons to schedule and attend primary care visits.

The second main barrier to accessibility of primary care visits is transportation (Witting, 2023; Centers for Disease Control, 2024). A major bias in the health care system is the belief that clients have access to a form of transportation, whether it is a vehicle, bus, train, or other mass transit system. This bias includes many misconceptions including that the primary care office will have appointments during transportation hours, that the primary care office is within an accessible distance of a bus, train, or other mass transit stop, and that parking for personal cars is available, is within accessible distance of the clinic, and is free.

So, how do providers start to combat these issues? First, let's discuss transportation. We will discuss transportation first because the first barrier to getting to a primary care visit is transportation. You can set evening hours, weekend hours, or holiday hours, but if those hours do not align with mass transportation systems, then clients will still face barriers getting to clinic visits. It is important as a provider to be aware of the environment around your clinic. Where are the bus stops or train stops? Are they within an accessible distance of walking or using a wheelchair? If the answer to these is no, providers can advocate with their mass transit authority to add a bus stop or to find another way to increase accessibility to the clinic.

If there is a mass transit stop near the clinic, review transit schedules. When is there a bus or a train stopping at the station? Does mass transit run after hours or have a weekend schedule? Based on that information, have a discussion with clients or community members who are lower income to see if clients would be better able to attend visits if hours were available during those times. Similarly, be aware of parking in and around your building. Does your clinic have parking that is free and an adequate size to allow for multiple visitors? If parking lots are nearby, but have an associated cost to them, low-income clients may not be able to afford parking. Offering support such as parking vouchers for free parking or working with a parking venue to offer discounted parking for low-income clients will help to remove a monetary barrier and increase the likelihood of attending care visits. By asking the questions and being informed of the barriers low-income individuals face when seeking health care, providers can greatly impact preventative or routine health care needs.

Section 4 Key Words

After-Hours Care - Clinic appointments that are available between the hours of 5 pm and 8 am Monday through Friday and on weekends and holidays (O'Malley et. al. 2012)

Competing Demands - Competing demands exist when a client is forced to make a choice between two important needs in their life. A common example of this is the need to work to generate income and the need to care for a sick child who is home from school. Clients also have competing needs when choosing between work and family caregiving and taking time to go to clinic appointments.

Health Care Access and Quality - Healthy People 2030's goal is to "Increase access to comprehensive, high-quality health care services." (U.S. Department of Health, 2024)

Section 5: Neighborhood and Built Environment

Section 5 Activity

Please look up the answer to the following question:

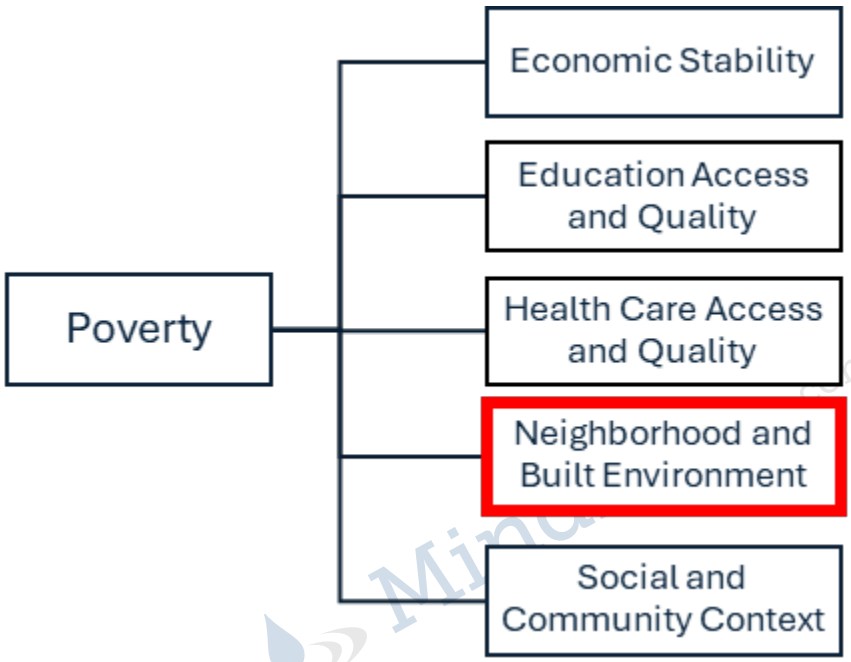
- What part of the body means little mouse in Latin?

Section 5 Answer

If you immediately went to your smart device's internet browser or your computer's internet browser, you live with internet security. Many persons in poverty live with internet insecurity, which is a major barrier to healthcare access.

Neighborhood and Built Environment

In this section, we will explore Healthy People 2030's goals for improving Neighborhood and Built Environment. We will also discuss how conditions of poverty impact a person's ability to access and receive health care services, such as mental health services or chemical health care services.



Healthy People 2030 has set a goal for **Neighborhood and Built Environment** that states, "Create neighborhoods and environments that promote health and safety." (U.S. Department of Health, 2024). This is a broad goal encompassing many issues, such as air quality ratings, violence, and internet availability. For the purposes of this training, we are going to focus on internet availability and how internet availability can impact the accessibility of providers via telehealth.

Telehealth is defined as "the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, health administration, and public health." (Office for the Advancement of Telehealth, 2024). Telehealth was available as a service prior to

the COVID-19 pandemic; however, the use of telehealth skyrocketed with the pandemic shutdowns. To date, telehealth continues to be a positive resource for health care access and health equity because it provides accessible health care to those who could not otherwise get healthcare. An additional positive for telehealth is that it offers cost savings to provider groups (Shaver, 2022). Despite the positive advancements in telehealth and telemedicine capabilities, there continue to be barriers to accessing telehealth services. The main barriers to accessing telehealth services include lack of stable power sources, lack of internet access or a stable internet connection, lack of a device that has internet capability that can support an online telehealth appointment, and lack of a private area in which to conduct a healthcare appointment.

Poverty has been a major contributor to creating and sustaining barriers to telehealth accessibility. Here's how. First, let's discuss access to a power source that is needed both to power the internet and to charge electronic devices for telehealth use. **Energy insecurity** due to poverty or low-income status is defined as "the inability to adequately meet basic household energy needs" (Hernández, 2023). As of 2020, about 27% of households, or roughly 34 million U.S. households were described as being energy insecure (U.S. Energy Information Administration, 2022). While energy insecurity can come from events like natural disasters, poverty continues to be a driving force in prolonged energy insecurity (Hernández, 2023). It is important to remember that even though power is considered a basic need for safety, many households go without power or electricity for periods of time.

Next, poverty has an impact on the ability to own or even access a stable internet connection that affords a person the privacy and confidentiality needed to participate in telehealth. While it is estimated that about 72% of households have "both fixed and mobile Internet connections," we cannot assume that every client we meet will fall into that 72% (Goldberg, 2024). If someone is experiencing a lack

of internet access due to financial constraints, there are resources such as libraries, community centers, coffee shops, and other establishments that offer free Wi-Fi access (Holslin & Schafer, 2024) as well as internet providers who offer discounts on internet service fees (NAMI MN, 2024). The difficulty with many of these locations is that the internet connection is often not secure, and the free Wi-Fi is often located in a wide open space. This becomes a barrier to someone wanting privacy to receive healthcare and support because they are not able to find a safe and secure place where they can receive care, or access a secure connection that is needed to receive care.

Finally, poverty impacts the ability of individuals to afford a computer or other smart device that has the internet capabilities to assist with a telehealth connection. While some financial assistance programs exist to support access to computers and smart phones, not all adults in the United States can afford a private computer or private device if they do not qualify for financial aid or if financial aid does not exist where they live. So, it is not necessarily accurate to assume that all adults have some kind of access to an electronic device with an internet connection.

What can providers do? How do we make telehealth more accessible? The first step is to assess for **digital equity** and energy insecurity. Digital equity means that your client has access to a power source, a stable internet connection in a secure place, and a smart device or computer that can run a telehealth visit. Before signing a client up for telehealth, ensure the client has the necessary components to participate in telehealth. If a client is lacking accessibility, ensure that the resources given to aid in accessing telehealth, such as where to find free Wi-Fi, offer the security and confidentiality needed to fully participate in telehealth. Another recommended step is to evaluate policies regarding missed telehealth appointments. Many policies around “no show” visits penalize a client by charging them monetarily or by reducing the number of remaining available visits. These

penalties often occur before the provider has had a conversation with the client to understand the reason for the missed visit. To be more inclusive, telehealth policies may need to be expanded to allow for a discussion with the client about barriers that contribute to missed visits, such as energy insecurity or digital inequity. Assuming a client no-showed and ndoes ot follow up with that client to understand the situation better is not an equitable service.

Section 5 Key Words

Digital Equity - an environment where clients have access to free or reduced cost internet to assist with improving health care outcomes.

Energy security - a descriptor for persons who have the ability to pay monthly for energy and do not risk losing power, heating, cooling, etc. due to their inability to pay the monthly bill.

Neighborhood and Built Environment - Healthy People 2030's goal is to: "Create neighborhoods and environments that promote health and safety." (U.S. Department of Health, 2024)"

Telehealth - a health care service that is provided electronically through the use of a computer or smart device. Health care is provided in an online meeting room through the use of the internet.

Section 6: Social and Community Context

Section 6 Activity

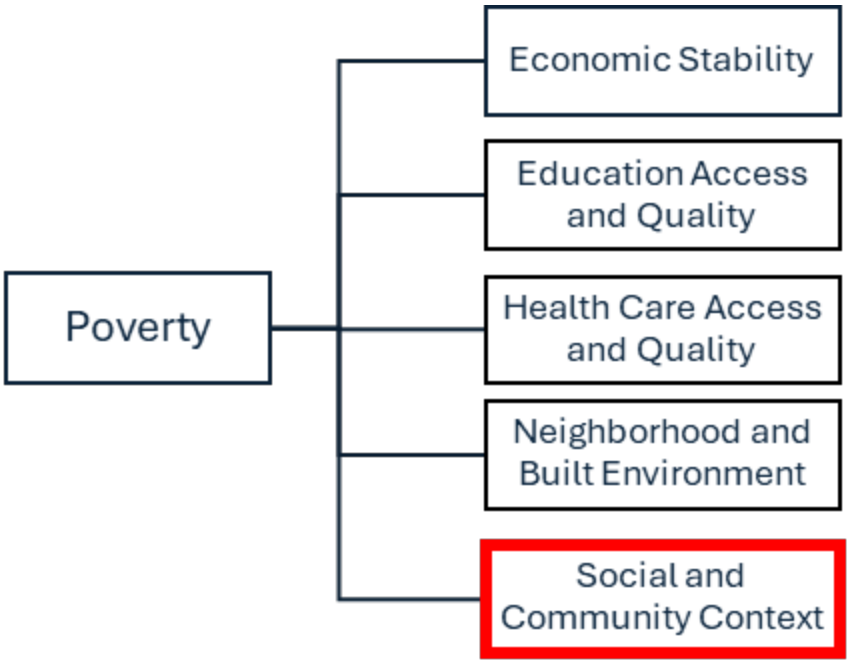
Reflect on this question: when I go to my doctor, I am treated like a person and, most of the time, I feel like they have listened to me and understand what I am asking.

Section 6 Answer

If you thought that the above statement was mostly true and applicable to you, you enjoy the privilege of a positive healthcare relationship. Many persons experiencing low income or poverty do not enjoy a positive healthcare relationship or experience.

Social and Community Context

In this section, we will explore the goal that Healthy People 2030 has set for Social and Community Context, which states, “Increase social and community support” (U.S. Department of Health, 2024). This overarching goal seeks to improve health care delivery by improving the social and community contexts in which people live. One aspect of the goal includes access to equitable health care that is free from bias and stigma.



The health care system, be it for physical health care or mental health care, is riddled with bias, stigma, and stereotypes. This section will discuss how bias, stigma, and stereotypes related to conditions of poverty can impact the client-provider relationship. We will begin by exploring the commonly held biases and stigmas against those living in poverty.

To understand bias and stigma, it is important to define these terms. **Bias** is defined as "a thought or action that discriminates or disproportionately favors one person or group of people over another" (Penn State, n.d.). **Stigma** is defined as the labeling of difference and then engaging in behaviors that continue to perpetuate that difference. Often, stigma is a negative label ascribed to another person, and thus behaviors towards that person or thoughts about that person also follow a negative process (Link & Phelan, 2001).

Common biases and stigmas that impact those who are low-income or living in poverty are that they don't want to work, they are lazy, or they are unmotivated (Just Harvest, 2015; Choi et al., 2021). Another common bias is that all poor people share these characteristics (Choi et. al., 2021). Because providers engage in

these biases, clients experiencing **non-attendance** due to financial barriers may be labeled as **non-compliant**. Providers often do not do a deeper exploration into non-attending clients because the belief is that if the client just worked harder, they wouldn't be missing appointments. (Chapman, 2022). This attitude assumes that the client is choosing to be non-attending rather than recognizing that a client may be forced to make a difficult decision between two competing priorities such as missing work (and potentially losing their job) and caring for their health. If providers continue to generally label all non-attending clients as non-compliant, we miss the important distinction between choosing not to follow medical advice and not being able to follow medical advice (for example, attending a medical appointment) due to a system barrier or social barrier.

So, how can we, as providers, make a difference? First, it is important for us to fully examine our biases and our beliefs about those individuals who are living in poverty. It is also important that we understand poverty from both an individual/ family systems lens as well as from a community systems lens. To start the process, Choi et. al. (2021) offers this insight: "Individualize, don't generalize." Individualizing each client or family system's circumstances can help us as providers better understand the multifaceted nature of poverty. For some individuals and families, the major barrier to getting to appointments may be a lack of transportation. For others, the major barrier may be the lack of power, the lack of a stable internet connection, or the lack of insurance due to underemployment or unemployment. Understanding the wide variety of scenarios that can exist will help you create a person-centered care plan that focuses on the client as a unique person who is experiencing poverty.

Next, to address systemic challenges, Choi et. al. (2021) recommends engaging in "**Systems knowledge**," which means having a better understanding of the systems that continue to perpetuate poverty and that can have a negative impact on health care equity and health care access. Because providers continue to say that

the system is broken and that “it is what it is,” poverty and the consequences of poverty continue to impact our clients negatively. By taking a different stance and identifying opportunities for how your clinic can affect change, you can help the system start to heal through targeted interventions. For example, understanding your clinic’s policies and language about how to treat clients who are experiencing poverty is a start. Finding appropriate resources that are accessible and helping a client navigate step-by-step through those resources are other ways you can take action in your own clinic. Once you take that first step and make a choice to make a change, you are advocating for healing in the system that is broken. This ultimately leads to you having the power to help make change at the systemic level.

Section 6 Key Words

Bias - “a thought or action that discriminates or disproportionately favors one person or group of people over another” (Penn State, n.d.)

Non-attendance - when a client is unable to attend an appointment due to a conflict or a barrier that they are experiencing.

Non-compliance - when a client makes a decision not to follow medical recommendations.

Stigma - the labeling of difference and then engaging in behaviors that continue to perpetuate that difference. Often, stigma is a negative label ascribed to another person, and thus behaviors towards that person or thoughts about that person also follow a negative process (Link & Phelan, 2001).

Social and Community Context - a goal created by Healthy People 2030 that states, “Increase social and community support.” (U.S. Department of Health, 2024).

Systems knowledge - having a better understanding of the systems that continue to perpetuate poverty, which can have a negative impact on health care equity and access.

Section 7: Conclusion

To summarize what we have learned today, our clients may be living in either absolute poverty (fiscal poverty) or relative poverty (poverty that impacts activities of daily living). These types of poverty are some of the main reasons that clients have poor access to health care services. As providers, it is incumbent upon us to ask about poverty and discuss potentially valuable resources during the assessment and throughout the course of treatment. This will help to ensure that clients have equitable access to healthcare. It is also important to keep an open mind as to what clients are and are not able to do due to poverty. Without having an open mind and without asking supportive questions, many clients today and in the future will continue to receive inequitable health care service delivery.

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