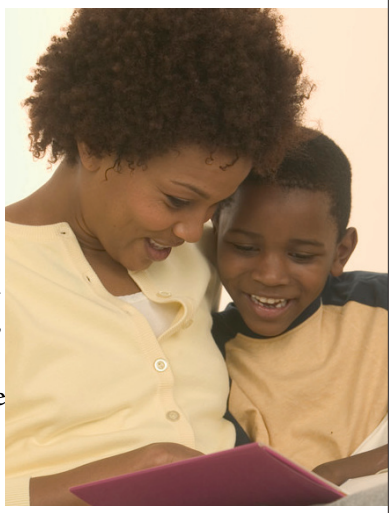
INFORMATION SHEET

Understanding Poverty in Minnesota

Increasing the cultural competence of health care providers serving diverse populations

In order to provide equitable and effective health care, clinicians need to be able to function effectively within the context of the cultural beliefs, behaviors, and needs of consumers and their communities. When serving patients from minority and other underserved populations, health care providers are encouraged to consider the impact of the social and economic factors that already may have put the patient at a health disadvantage.

In 2010, 46 million people in the U.S. were living in poverty. At 15 percent, the official poverty rate was the highest rate since 1993—yet 7 percent lower than in 1959 when the poverty rate was first recorded. [1]



The United Nations and the World Bank define poverty as the denial of choices and opportunities—not having enough money to feed and clothe a family or acquire basic goods and services necessary to survive with dignity. Poverty is not having access to clean water and sanitation, health care, or education, and not having a job to earn a living or having land to grow food. Poverty has immediate and far-reaching consequences. It puts people in a position that makes them vulnerable to disease, violence, and death. It excludes individuals and communities, denying them a voice in the policies and decisions that shape their lives, making them powerless and without the capacity to improve their lives. [2]

In Minnesota, the poverty rate is 11 percent, with more than one in 10 residents living in poverty. The poverty rate for children is higher, at 14 percent. Although Minnesota's overall poverty rate is below the national average, its poverty rate for people of color is higher—26 percent compared with 8 percent for non-Hispanic whites. At 22 percent, Minnesota has the highest poverty rate in the nation among Asian American children, and the fifth highest rate among African American children, at 47 percent. According to the website *Welcome to a Minnesota Without Poverty*, one fourth of Minnesota's population is defined as "near poor" (people living with incomes less than 200 percent of the poverty threshold), and 9,000 people in Minnesota are homeless.

The federally-defined 2012 poverty threshold for a family of four living in Minnesota is $23,050; for a family of three with one adult and two children, $18,530; and for an individual, $11,344. Studies suggest that doubling the poverty threshold would be needed to adequately cover basic needs, such as food, clothing, transportation, and child care. Minnesota receives funds from the federal government to help pay for basic needs,

Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

Stratis Health works with the health care community as a quality improvement expert, educational consultant, convenor, facilitator, and data resource.

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and families can earn up to 115 percent of the poverty guideline and still receive public assistance. [3]

Geography of Poverty

The majority of people in the U.S. and throughout the world live in urban settings, where historically poverty has been concentrated. However, over the last 20 years, across Minnesota and the U.S., poverty has been spreading from the cities to the older, blue collar suburbs. In Minnesota, more than 197,000 people living in the suburbs live below the poverty line—in communities such as Brooklyn Center, Brooklyn Park, Crystal, east Bloomington, Maplewood, and Richfield. Since the last census, Brooklyn Center's poverty rate rose from 7.4 to 14.1 percent and Maplewood's poverty rate rose from 4.8 to 11.4 percent. Brooklyn Center has the highest number of mortgage foreclosures in the state.[4]

Poverty is also prevalent in certain rural areas across the state. In Mahnomen County, 20.5 percent of residents live below the poverty line, followed closely by Beltrami, Blue Earth, Lake of the Woods, and Nobel counties. Ethnicity factors into poverty found in some counties. In Mahnomen County, where one in three residents is Native American, the median income was $38,400. This figure can be compared with the largely white counties of Carver, Scott, and Washington, where the median household income over the past five years has been higher than $78,000. [5,6]

Geography, Poverty, and Health Outcomes

Where we live plays a critical role in shaping our wealth or poverty—and in impacting our health outcomes. As far back as 1776, economist Adam Smith proposed that physical geography and climate of a region can shape its economic success. For example, almost all countries located in temperate zones, such as countries in North America and Western Europe, and coastal regions with access to sea trade have high-income economies. Nations in tropical zones have higher rates of infectious diseases and deaths, which has a direct effect on economic productivity and life expectancy.

At the local level, the geography of poverty is played out in lack of access to economical choices of food, shelter, health care, education, and other basic needs that affect how well people survive and thrive in a community. For example, in lower income neighborhoods, people often lack access to healthy, nutritional foods and basic services. Instead, they have tobacco and liquor stores, fast food restaurants, and convenience stores, which often charge higher prices because the proprietors know that residents lack the resources to go outside the immediate community to shop for better prices.

In a 2008 nutritional study, Rand Health described how neighborhood economic conditions impacted the health and socioeconomic status of residents in disadvantaged neighborhoods. Researchers related the amount of fruits and vegetables they consumed to the resulting prevalence of obesity in disadvantaged neighborhoods. Obesity is increasing faster among black and Hispanic populations than among whites. Black and Hispanic people often live in neighborhoods with fewer transportation and low-priced food options.[7]

A Culture of Poverty

In an effort to understand the persistence of poverty in the U.S., anthropologist Oscar Lewis, in 1959 originated the social theory of the "culture of poverty," offering more than 70 characteristics of families in which children are "socialized into behaviors and attitudes that perpetuate their inability to escape the underclass." He determined that people living in a culture of poverty feel inferior, unworthy, powerless, and dependent. They feel that they do not belong—"as though they were aliens in their own country." They know only their own problems, neighborhood, local conditions, and way of life. Economists describe a culture of poverty as a set of factors or events (e.g., illness, divorce, death of the head of household, etc.) that initiate poverty, and will continue unless there is outside intervention. The poor remain poor because they adapt to poverty and do not have the financial capacity, education, or connections to escape the cycle of poverty. [8]

Author Ruby Payne elaborates on the culture-of-poverty theory by describing families in "generational poverty" who have lived in poverty for at least two to three generations and have formed their own culture with different values, habits, and lifestyles than middle class families. For example, families in generational poverty believe in fate because they feel they don't have a choice in what happens to them: "being proactive, setting goals and planning ahead are not a part of generational poverty…(families) often don't have the tools to organize their lives. . . It's difficult to think about planning for a future when you and your family are hungry today." [9]

As documented in the 1965 Moynihan Report, the culture-of-poverty concept strongly informed U.S. public policy makers and politicians in implementing Lyndon Johnson's War on Poverty during the 1960s. Since that time, however,

sociologists have argued that data do not support the culture-of-poverty concept. (Goode and Eames, 1996)

Social Determinants of Health

Social inequities and discriminatory beliefs that create poverty are shaped by overarching policy choices, such as distribution of money, power, and resources at global, national, and local levels. According to the World Health Organization (WHO), social determinants of health are mostly responsible for health inequities. Social determinants of health are the social and economic conditions in which people are born, grow, live, work, and age, including factors such as low income, food insecurity, and living in crowded housing—all factors associated with poor health and adverse health outcomes. WHO and the U.S. Centers for Disease Control and Prevention are developing more effective policies, systems, and programs that promise to improve health by improving daily living conditions. These programs are aimed at investing in child development and providing the poor with access to quality housing, clean water, and sanitation, as well as fair employment, improved working conditions and policies that ensure secure work, a living wage, gender equity, and the economic contribution of housework, care work, and voluntary work. [10]

More equitable policies and systems that improve daily living and working conditions, as well as provide opportunities for fair employment and reasonable compensation can have far-reaching impact on the health and well-being of the poor.

Sources:

1. *2010 U.S. Census, http://www.census.gov/2010census/, viewed September 10, 2012*
2. *World Health Organization, http://www.who.int/topics/poverty/en/, viewed October 4, 2010*
3. *A Minnesota Without Poverty, http://www.mnwithoutpoverty.org/, viewed September 10, 2012*
4. *Minnpost, Poverty Moves to the Suburbs: http://www.minnpost.com/data/2011/10/poverty-moves-suburbs, viewed September 10, 2012*
5. *U.S. Census Bureau, American Community Survey, http://www.census.gov/acs/www/, viewed September 10, 2012*
6. *Minnpost map contrasting poverty in rural and urban areas: http://www.minnpost.com/politics-policy/2010/12/census-data-vividly-illustrate-minnesotas-rural-urban-divide, viewed September 10, 2012*
7. *Do Neighborhood Economic Conditions Influence the Consumption of Fruits and Vegetables?, Rand Corporation, http://www.rand.org/pubs/research_briefs/RB9375.html, October 4, 2010*
8. *Lewis, Oscar (1969). "Culture of Poverty". In Moynihan, Daniel P. On Understanding Poverty: Perspectives from the Social Sciences. New York: Basic Books. pp. 187–220*
9. *A Framework for Understanding Poverty, Ruby K. Payne, PhD*
10. *World Health Organization, http://www.who.int/social_determinants/en/, viewed September 10, 2012*

Stratis Health has a long record of success in reducing health disparities among communities of color and underserved populations. Our efforts to reduce health disparities include increasing the cultural competence and effectiveness of providers serving culturally diverse populations, improving health literacy in the community, and working with specific populations on targeted clinical conditions.

Culture is essential in assessing a person's health and well-being. Understanding a patient's practice of cultural norms can allow providers to quickly build rapport and ensure effective patient-provider communication. Efforts to reduce health disparities must be holistic, addressing the physical, emotional, and spiritual health of individuals and families. Also important is making connections with community members and recognizing conditions in the community.

Get to know your patients on an individual level. Not all patients from diverse populations conform to commonly known culture-specific behaviors, beliefs, and actions. Generalizations in this material may not apply to your patients.

WWW.CULTURECARECONNECTION.ORG

Culture Care Connection is an online learning and resource center dedicated to supporting Minnesota's health care organizations in their ongoing efforts to provide culturally competent care. Funding to support Culture Care Connection has been provided by UCare.

Contact us for assistance with your quality improvement and patient safety needs related to reducing health care disparities.

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