

Editorial

GLOBAL POVERTY: A CHALLENGE FOR CRITICAL CARE

By Kathleen Dracup, RN, DNSc, and Peter E. Morris, MD



In general, we journal editors are shy and retiring by nature. We are not selected to be editors because of our charisma or leadership skills (no matter what we'd like to believe or what our mothers tell their friends). No, we are selected for the skills we have in working behind the scenes with authors and reviewers to bring the best clinical and scientific articles to publication. We are not in the business of defining our professions. The boundaries of our science are drawn by researchers, not editors.

Recently we made an exception to our usual reticent ways of behaving. A large group of science editors from different professions and countries identified a theme that affects all of our readers in one way or another. Editors representing 224 journals selected the topic of global poverty and human development to highlight in their respective October issues. This is an international collaboration with journals from developed and developing countries.¹ Some journals will dedicate an entire issue to this subject; others will publish a few papers; still others will publish an editorial.

The *American Journal of Critical Care* falls somewhere in between. In this issue we present the theme in our editorial; Futterman and Lemberg² also have selected inequalities in the healthcare system as the topic of the Cardiology Casebook. We wish we could publish more papers on this important theme, but

critical care, by its nature, is technology intensive and does not lend itself to a discussion of global poverty.

Or does it? In reflecting on the topic we realize that there are several issues that affect critical care clinicians every day. The first of these is the impact of poverty on health outcomes in developed countries such as the United States. The second is the quality of healthcare (including critical care) that the United States provides its citizens. The third is the issue of recruiting healthcare personnel from developing countries who seek to better their lives by immigrating to the United States.

Poverty and Health Outcomes

We know that patients with lower socioeconomic status—whether assessed by income, education, or occupation—have poorer morbidity and mortality than do patients with higher status. They die younger and are more likely to have poor clinical outcomes following hospitalization.³ As an example of the latter point, lower income patients hospitalized for treatment of heart failure are more likely to be readmitted to the hospital for recurring heart failure symptoms than are patients with higher income, even after adjustment for other clinical and demographic differences.⁴

The relationship between poverty and health outcomes is obviously complex, but one of the factors that contributes to poor outcomes is a lack of

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adequate treatment for patients once they are diagnosed. Outside the hospital, the poor may not be able to afford medications and therefore skip doses or not fill their prescriptions.⁵ They may delay seeking treatment when they have symptoms.⁶ Once hospitalized, patients with low incomes may receive poorer care than patients with higher income status. For example, patients hospitalized for acute myocardial infarction who are poor are less likely to have percutaneous transluminal coronary angioplasty (PTCA) or surgery to revascularize the myocardium.⁷

The negative impact of poverty on healthcare and clinical outcomes is particularly evident in underrepresented minorities. In one study on racial variations in care for patients hospitalized with community-acquired pneumonia, black patients were significantly less likely (approximately 40% less likely) to receive antibiotics within 8 hours of diagnosis.⁸ Black patients also were more likely to die within 30 days of diagnosis than were those from other racial groups.⁸ In another study, black patients were less likely to receive a cardiac invasive procedure (catheterization, PTCA, coronary artery bypass surgery) than were other racial groups.⁹ The negative impact of race (with its undeniable relationship to lower socioeconomic status) on mortality has been documented by many researchers. Black patients with pulmonary embolism, for example, have a 30% higher risk of dying at 1-month follow-up compared to white patients with the same diagnosis.¹⁰

Therefore, we don't have to look beyond our own borders or even outside the intensive care unit to realize that poverty impacts the optimal health outcomes we are committed to achieving for our patients. Poor patients often receive less quality care in the hospital, have more barriers to recovery, and experience higher morbidity and mortality than do patients with higher incomes.¹¹

About the Authors

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Quality of Healthcare in the United States

In this highly developed country with its thousands of intensive care beds, we'd like to believe that Americans receive the best healthcare in the world. Most of us do not suffer this particular delusion, but for those who might still cling to it the Commonwealth Fund has once again set us straight. In its latest report,¹² it ranked the United States last or next-to-last compared with 5 other developed nations—Australia, Canada, Germany, New Zealand, and the United Kingdom—on most measures of performance, including quality of care and access to it. In a comparison with 8 other countries, the United States ranked last in years of potential life lost to circulatory diseases, respiratory diseases, and diabetes and had the second highest death rate from asthma, bronchitis, and emphysema. We ranked last among 23 nations in infant mortality rates, but first in obesity.¹²

Most of the poor showing of the United States on quality of healthcare indicators can be traced to the inequities in our system described previously. Given the large number of uninsured and underinsured in this country—a number that increases every year—we have the greatest disparity in the world in the quality of care given to the very rich and the very poor. However, there are other problems that contribute to our poor results. The Commonwealth Fund report noted that we lagged years behind other developed countries in adopting electronic medical records, which means that the staff at most hospitals are still struggling with illegible physicians' orders that can lead to innumerable errors and sometimes avoidable deaths.¹² The lack of electronic records in healthcare (eg, in hospitals, outpatient settings, home care agencies) makes it harder to coordinate care and to follow standard clinical guidelines in practice, and this difficulty applies to all patients, even those not burdened by poverty or racial prejudice.

Recruiting Nurses From Other Countries

Global poverty affects immigration. For centuries, individuals and families have emigrated from homelands that offered little in the way of financial security or opportunity to come to the United States to start new lives. The nursing shortage has provided opportunities for migrants, many of them trained as nurses or physicians in their own countries, to come legally

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to the United States as nurses. This is a movement supported by the American Hospital Association because of this country's severe nursing shortage, but it is not without controversy. Critics point to the corrosive effect of attracting nurses to the United States from the Philippines, India, China, and Africa on the healthcare systems of those countries. According to the *New York Times*, "The exodus of nurses from poor to rich countries has strained health systems in the developing world, which are already facing severe shortages of their own. Many African countries have begun to demand compensation for the training and loss of nurses and doctors who move away."^{13(pA1)} The shortage of educated healthcare workers in developing countries is an ongoing challenge, particularly in those countries with high numbers of AIDS patients, and the exodus of well-trained professionals adds an enormous burden to an already burdened system.

Despite the ethical controversy, the temptation to "fix" our nursing shortage by recruiting individuals who already are educated as nurses or physicians in other countries continues in hospitals across the United States. It is not a trend that we see ending any time soon. Poverty is its stimulus.

The Problem Is Clear, Solutions Are Not

The intent behind science editors throughout the world publishing papers on global poverty simultaneously is to raise awareness, encourage research into poverty and human development, and stimulate solutions. In the specific case of the health sciences, the intent is to focus on the negative role poverty plays in health and clinical outcomes. But this is not a new theme, and prolonged repetition of this kind of rhetoric can lead to a sense of helplessness. Isn't global poverty too big a problem to solve? What can any one nurse or physician (or pharmacist or respiratory therapist) do about it? Won't all this talk lead to a giant case of compassion fatigue in which all the caregivers agree that it is a terrible problem to be poor and sick and then simply go back to the bedside to hang another IV or tweak a ventilator setting?

Coming up with solutions that address the problem of poverty in the short term is the hard part. Reducing the dire effects of poverty on health will require system-wide changes in this country. Part of the solution may be universal access to healthcare for all patients, no matter what their income, occupation, or education. Part of the solution may have to evolve at the local level. Each healthcare provider, each intensive

care unit, and each hospital can develop unique solutions that are appropriate for the individual setting. A solution may be based in securing industry support for free equipment for a poor patient at discharge, or it may mean attending to health literacy and translating a patient education pamphlet into a lower reading level. It may mean questioning a decision of a team for an uninsured patient when it appears that the plan is not appropriately aggressive, or it may mean volunteering in a clinic or a country where poverty is endemic and resources are scarce or nonexistent. The problem is clear. The solutions are for us to determine.

The statements and opinions contained in this editorial are solely those of the coeditors.

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None reported.

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