

Medicalization of poverty: a call to action for America's healthcare workforce

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ABSTRACT

As a social determinant of health, poverty has been medicalised in such a way that interventions to address it have fallen on the shoulders of healthcare systems and healthcare professionals to reduce health inequities as opposed to creating and investing in a strong social safety net. In our current fee-for-service model of healthcare delivery, the cost of delivering secondary or even tertiary interventions to mitigate the poor health effects of poverty in the clinic is much more costly than preventive measures taken by communities. In addition, this leads to increasing burnout among the healthcare workforce, which may ultimately result in a healthcare worker shortage. To mitigate, physicians and other healthcare workers with power and privilege in communities systematically disenfranchised may take action by being outspoken on the development and implementation of policies known to result in health inequities. Developing strong advocacy skills is essential to being an effective patient advocate in and outside of the exam room.

INTRODUCTION

The earliest reference to the term 'social determinants of health' in the peer-reviewed literature occurs in a publication from 1961 in the *American Journal of Public Health* (and the *Nation's Health*).¹ Here, they are defined as 'being related to (1) the health behaviour of the individual; (2) community organisations and procedures for meeting group health problems and (3) the social structure for planning and providing community medical care'. In the period leading up to its official classification in the US National Library of Medicine in 2014, there were more than 600 articles, using the current definition established by the 2008 WHO, Commission on Social Determinants of Health, stating it as 'the complex, integrated, and overlapping social structures and economic systems in which people are born, grow up, live, work and age.' This present-day definition represents a distinct cultural shift away from the aforementioned viewpoint of poor health as a failing of individual behaviours and inadequate healthcare systems to one that places greater

emphasis on the impact of poorly designed public systems, infrastructures and policies. There is consensus among both medical and public health professionals that less than 10% of health is determined by access to healthcare services.² This understanding has driven several healthcare organisations to develop initiatives and innovative strategies to address the social determinants of health at the point of care and in the community.³⁻⁵ The most notable of which is the integration of social determinants of health screening tools coupled with the coordination of social and behavioural health services to minimise and or alleviate their negative impacts. Though widely adopted, early evaluations of the effectiveness of these screening and referral interventions have demonstrated no reduction in individual poor health outcomes, population disparities, healthcare utilisation or cost.⁶

If less than 10% of health is the result of healthcare, why then is the responsibility of counteracting the effects of poor economic, social and political policies, systems and infrastructures disproportionately placed at the feet of healthcare professionals? The reason, unfortunately, is because of the systematic disinvestment of federal and state programmes created to lift the economically disadvantaged out of poverty and provide a social safety net for the most vulnerable populations. It is the confluence of these complex and integrated scenarios which perpetuate and exacerbate the severity of chronic illnesses which clinicians are expected to alleviate with treatment recommendations developed from a medical model of health that fail to address their patients' abilities within their social context. The ability to purchase prescriptions, engage in daily moderate exercise and consume healthy foods are limited when patients have no car, earn below a living wage, issues of neighbourhood safety or security, or are living in a food desert.



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THE MEDICALIZATION OF POVERTY

'Medicalization' is a term used frequently in the social sciences literature to describe a process by which human conditions and issues become defined, diagnosed and treated as topic of medical study and inquiry. Early references to medicalization emerged in the late 60s and early 70s to describe the criminal behaviours of those suffering from mental illness.⁷ During this period, the process was viewed to be driven primarily due to the 'self-interested manoeuvres of the medical profession' which because of their power, influence and prestige in society were able to shape the moral, cultural and societal view of what was considered good or poor health.⁸ However, in the book, *The Medicalization of Society*, Brandeis Professor Peter Conrad, proposes that medical and pharmaceutical enterprises as well as direct-to-consumer advertising fueled by public worry are the primary drivers of medicalization, not physicians.

In recent years, medicalization has evolved to now include more common life events such as birth and death, as well as conditions; obesity, menopause and erectile dysfunction.^{9 10} Although not yet described in the literature as such, poverty, another common life event, has also become medicalised. How? First, it's been redefined as the 'social determinants of health'. Within primary care, the consistent definition of the 'social determinants of health' among family medicine, paediatric and internal medicine specialties is that they are non-medical factors, such as income, education and housing, which if deemed substandard, can lead to poorer health outcomes. Second, the 'social determinants of health' (a.k.a. poverty) can be diagnosed in the clinical setting. A 2017 systematic review of interventions to identify or 'diagnose' the social determinants of health in the clinical setting found 37 programmes which included some variation of a protocol to screen patients for risk associated with poor housing, unemployment, violence, food insecurity or abuse.⁶ These identified risk factors are also associated with a billing code from the International Statistical Classification of Diseases and Related Health Problems (ICD-10) list for which physicians can receive payment. Poverty is coded as Z59.5 for Extreme and Z59.6 for low income.¹¹

Lastly, poverty is medicalised by offering a physician-facilitated non-clinical treatment option, which may include a warm hand-off to behavioural health and or social service staff colocated in the clinic or a referral to a community based organisation or service. Unfortunately, for those practicing in fee-for-service healthcare models, a reimbursement strategy has yet to incorporate how to compensate physicians appropriately for providing these non-clinical services in a way that also adjust for quality of care and outcomes.¹² In the era of evidence-based medicine, how then do we train medical professionals to effectively prevent and treat poverty?

EVIDENCE VERSUS ART

Teachers of evidence-based medicine define three core skills physicians must have to apply it in practice: the ability to integrate information based on research into the clinical setting, a recognition that simply understanding the course of a disease is insufficient in the practice and requires the methodological and statistical skills necessary to discern the quality of medical studies.¹³ Treatment of poverty does not lend itself well to the application of evidence-based medicine in clinical practice for three reasons. First, the evidence describing the appropriate treatment is still emerging as noted previously. Second, there is no standard pathophysiology for poverty as it manifests itself as a multitude of complex comorbidities (diabetes, hypertension, obesity, etc) with variable root causes. Lastly, the methodological approaches identified as being most appropriate to evaluate interventions in this area are largely qualitative, not quantitative, which do not lend themselves easily to systematic review.^{14 15}

One unexpected, yet potentially beneficial aspect of forcing the responsibility of addressing poverty into the healthcare sector is that it creates a cultural shift within the physician workforce that reverts to a time when the practice of medicine was considered more of an art and less about the rigorous application of a one size fits all set of standards and processes. A 2001 study evaluating the application of evidence-based medicine into clinical practice conducted interviews with paediatric residents to get their perspective.¹³ In it, one physician states the following: 'A lot of medicine is dealing with social, psychological, emotional stuff that impacts the physical and there is not much literature about that. That is not something you can read about; that is something you have to learn and do.'

This type of on-the-job learning can and does lead to significant knowledge gaps among the healthcare workforce in part because physician encounters with the social determinants of health are likely determined primarily by geographical location, type of practice and patient population. A physician practising concierge medicine in the northeast is likely to have few practice experiences with the social determinants of health than one employed by a federally qualified health centre in the south. Thankfully, medical education has recognised this knowledge gap and has developed accreditation standards for residency training programmes, which incorporate experiential learning on the social determinants of health.^{16 17} This didactic evolution of the medical education continuum will ultimately result in the creation of a next-generation workforce of physicians with a thorough understanding of the impact, causes and solutions to the social determinants of health, but at what cost.

EFFECT ON THE WORKFORCE

Medical specialties are actively engaged in the dissemination and implementation of resources supporting the integration of social determinants of health into clinical

practice and didactic medical education. Proponents of this work recognise that primary care physicians provide a continuity of care for their patients across the lifespan, enabling them to actively engage with the communities they serve and use their power and influence to bridge gaps, build capacity and advocate on behalf of their patients. However, it is the view of some that this strategy adds new responsibilities which expand the physician's scope of practice and many will become overworked, stressed, frustrated and discouraged by their inability to make a real impact. For this reason, an unintended and potentially catastrophic effect of integrating these non-clinical components into medical education, training and practice may lead to an increased rate of physician burn-out.

The American Academy of Family Physicians defines physician burnout as 'a syndrome characterised by a loss of enthusiasm for work (emotional exhaustion), feeling of cynicism (depersonalisation) and a low sense of personal accomplishment' and at present is reported by nearly half of all physicians.¹⁸ A 2012 study of primary care physicians in the USA estimated that more than half (53%) of physicians age 50 years and older and a third of those ages 35–49 may leave their practices within 5 years due to 'dissatisfaction with tasks that do not require medical expertise' and are not compensated under the fee-for-service healthcare model.¹⁹ Hence, a potential unintended consequences of physicians embracing the diagnosis and treatment of poverty as the social determinants of health may lead to increasing the current physician shortage.

A PATH TO DEMEDICALIZATION

Despite a lack of consensus among the physician workforce regarding the appropriateness of adding diagnosis and treatment protocols to address the social determinants of health to their scope of practice, most should agree that poverty must be demedicalised and no longer the responsibility of the US healthcare system. Failure to do so could lead to a detrimental shortage of primary care providers, resulting in reduced access to care for many, regardless of socioeconomic status. Under the current administration, there is no indication that the USA will now or in the future follow the example of other developed nations and shift much of spending allocations from healthcare to social services. Unless of course there is an alarming call to action by physicians, insurers, policy makers and the public to do so.

Literature from the early years of medicalization theory also includes references to a demedicalization strategy, from which several steps have been suggested.⁸ First the declassification of conditions as illness. The ICD-10 codes for poverty were first introduced in 2016 to compensate physicians for diagnosing this risk in their patient populations. An area of potential research should be to conduct cost-effectiveness research to compare the cost of poverty prevention (tax reform, employment programmes,

etc) to the cost of poverty as a medical expenditure to educate legislators, elected officials and others to support increased funding of federal and local poverty reduction programmes.

A second strategy to demedicalise poverty is to increase physician awareness of implicit biases towards the poor. Frequently, physicians tend to place the blame for poor health on the uneducated and or lackadaisical decisions of the economically disenfranchised. These perceptions lead them to believe that patients experiencing poverty are uninterested in acting on the information given to them regarding their conditions (diabetes, hypertension, obesity, etc) or unmotivated to improve their impoverished circumstances through either higher education or job training. Acknowledgement of these biases may contribute to a balanced distribution of power within the patient–physician relationship, shifting it from paternalistic to that of an ally.

Lastly, there exist a role for patients and patient advocacy groups to demedicalise poverty as the responsibility of the government and not the healthcare system. Grass-roots advocacy, with the support of physicians, can create momentum for the development and implementation of policies, programmes, systems and infrastructure which create communities that support optimal and equitable health outcomes. Physicians can spark this momentum by engaging with their patients one on one as well as lending their voice to movements that advocate for social justice issues, such as universal healthcare, living wages, affordable housing and education.

CONCLUSION

Poverty has become medicalised by the healthcare system because of its redefining as 'social determinants of health' and disinvestment from the federal government of social programmes that support the economically disadvantaged. As a result, physicians are being asked to do more with less; less time, less staff, less training and less resources, to compensate for the inaction of federal and state governments. This will undoubtedly lead to burnout resulting in a shortage of the number of physicians in primary care to adequately support healthcare access for all, despite socioeconomic status. The primary care workforce, which includes providers, researchers, educators and patients can push back, by demonstrating the increased cost of addressing poverty in healthcare as compared with investment in preventive social services, limit misperceptions of poor patients and act as advocates on their behalf, in the clinic and in the community.

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