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# INTRODUCTION

## The Medicalization of Poverty

*Lois Shepherd and Robin Fretwell Wilson*

**I**t is well documented that a number of diseases are strongly linked to poverty, and poverty strongly predicts health status. Diseases like diabetes, asthma, and cancer are not only borne of poverty, but they presage future poverty — they are chronic, disabling, and expensive. By the time one reaches an advanced age, the economic, social, and environmental conditions into which a person is conceived, born, reared, educated, eats, sleeps, lives, works, and receives health and social care have had a life-time cumulative effect. For those who are poor, the toll is heavy.

A second aspect of poverty is less well-explored and the subject of this symposium. We have medicalized poverty. Poverty shows up at the emergency room door, in the school nurse's office, and at the addiction clinic. We spend inordinate amounts of money and other resources to address healthcare needs brought on by poverty instead of providing for the tangible needs of the poor before illness results — a phenomenon we call the Medicalization of Poverty. We treat the symptom, not the problem. Rather than adequately address poor housing conditions and prenatal care, we offer inhalers and NICUs. This approach comes at both a financial and a human cost. How can we do better?

In November 2017, in a two-day conference in Champaign, Illinois, experts and scholars gathered to examine the connection between poverty, disease burden, and healthcare expenditures and to explore creative approaches for improving the life chances of

the most disadvantaged among us. The collection of papers in this Symposium is one sustaining outcome of that conference.

These short articles cover a wide range of topics relating to poverty — housing, income, marital status, family caregiving, reproductive choices, rural and urban poverty, black, white, and Hispanic poverty, gun violence, opioid misuse, living in housing plagued by mold, literacy, data collection, and more. In addition to sharing a keen appreciation for how poverty presages poor health, contributors explore important questions about the connection between the medicalization of poverty and the roles of health policies, health systems, and healthcare providers. In particular, how do federal, state, and local laws and policies fail to address or even contribute to the problem of poor health outcomes for people with low incomes? How might they be redesigned to do better?

This collection of papers includes a gamut of perspectives. Many find fault with medical solutions to poverty's ills — rejecting continued reliance on (and further expansion of) health policies and practices that apply band-aids to the root causes of health-endangering poverty. While recognizing that poverty shows up at the clinic in the form of ill health, some contributors urge, to more or lesser degrees, that society stops trying to address poverty through the provision of healthcare or through services offered by health providers. Such attempts are too little, too late, too expensive, too ineffectual, too injurious to the dignity and autonomy of people who are poor.

The new approaches offered are varied. For scholar and former state legislator David Orentlicher, in order to improve the health of low-income individuals, poverty should be addressed directly, outside of health policies, through income supports and other

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measures.<sup>1</sup> He offers the example of an experimental 1970s program that guaranteed income security in a small rural city in Manitoba. William Sage also supports a more direct approach. He compares the current medicalization of poverty to the continuing criminalization of poverty. Neither approach works nor, he explains, represents the best the way to respect and care for people. Sage urges society to “disconnect relief of poverty from medical care as much as possible” and instead “invest in unadorned benefits for the poor.”<sup>2</sup> David Hyman also rejects a role for healthcare dollars to solve the problems of the poor. What the history of the financing and delivery of healthcare shows us is that what may start out as a movement with good intentions quickly turns “into a business and then a racket.”<sup>3</sup>

A very different tack is taken by other authors in this volume, who write about leveraging current health system practices or health system policies to address poverty or its health effects. Incrementalism and reform may be the answer here. Given relatively enduring political support for certain health policies and the current infrastructure of existing programs, should they be reformed or expanded to address the needs of the poor? Cameron Webb and Dayna Matthew advocate a “medicalization of risk factors,” wherein clinical encounters are seen “as an opportune setting in which to identify and coordinate” ways to address poverty-driven needs. This approach — which Webb and Matthew demonstrate through the example of substandard housing — has three advantages: it more accurately acknowledges the risk factors for ill health; it motivates clinical providers to build alliances with social service providers who can work to address those risk factors; and it makes the “business case” for financing comprehensive interventions to improve health.<sup>4</sup>

Mary Crossley also addresses housing from a perspective that capitalizes on existing programs. She asks whether we should expand Medicaid — which already provides for some housing through its bundled benefit of nursing home care — to address the needs for shelter of homeless Medicaid recipients. She argues, in fact, that justice requires doing so if we are to treat similarly situated persons alike.<sup>5</sup>

Of course, problems of poverty are rarely contained to healthcare needs alone, but spill over to other needs, which sometimes have a legal dimension. Authors from the Solomon Center for Health Law and Policy at Yale Law School describe how medical-legal partnerships — legal professionals embedded in the healthcare setting — can prevent or lessen the ill health effects of poverty through a preventative legal approach. In these partnerships, an attorney provides

legal screening and consultations on site, addressing those social determinants of poverty that might have a legal component — such as landlord-tenant issues or access to public benefits.<sup>6</sup>

Adapting or building onto existing structures in this way in order to take care of broader needs seems almost matter-of-course for health professionals. James Leonard, President and CEO of The Carle Foundation, believes we are in the midst of a re-visioning and retooling of hospitals and healthcare systems to address population health in addition to acute care needs.<sup>7</sup> Part of this response may be driven by the ethical commitments of medical professionals: When people show up at your doorstep, you take care of them. For Danny Becker, a primary care physician caring for low-income patients in chronic pain, many of whom have become addicted to opioids, it starts with listening.<sup>8</sup>

While doctors listen one-on-one to patients, health systems may be uniquely positioned to listen to groups and communities. The new requirement for non-profit hospitals to conduct community health needs assessments, discussed in Carolyn Pointer and colleagues’ article, provides a structure for that listening post.<sup>9</sup> Bringing the right people from the community to the table — and giving them leadership roles — bridges health system and community, allowing for more effective collaboration. Craig Konnoth wants to leverage health systems’ data collection abilities even further — both to offer benefit to the individual patient and to guide social policy. Knowing when patients are low income can help health systems anticipate challenges patients might have in filling prescriptions or finding transportation to attend follow-up visits; this knowledge can also help providers link patients to social services organizations. And if enough data can be gathered and analyzed together, we can compare the effectiveness of social interventions — where should we put our money, in cancer research or in cash assistance to individuals?<sup>10</sup>

Marissa Levine, former commissioner for the Virginia Department of Health, aptly describes the tensions here, knowing how to mine and navigate and yet move beyond our current medical approach. Yes, healthcare systems are “the one place where the very disparate populations of people come and are seen one-on-one by providers. As the entry point, the medical system presents an opportunity for change.” But, she cautions, “the change needed must happen beyond the walls of medicine and healthcare.”<sup>11</sup>

Other authors in this volume examine policies that are at a remove from healthcare delivery but that nevertheless contribute to the problems of poverty and poor health. Richard Kaplan explains that current

limitations on public financing of family caregiving contributes to the intergenerational transmission of poverty.<sup>12</sup> Robin Wilson documents how the problems of tying health insurance coverage to marital status fails to reflect the full diversity of America's families, unfairly disadvantaging co-resident or financially interdependent adults, and sometimes their children.<sup>13</sup> She explores whether "employee plus one coverage" might be expanded to protect non-marital families from the financial devastation of uncovered medical expenses. Kaplan and Wilson's approaches, like many of the authors' in this volume (e.g., Crossley, Sage), are grounded in both utilitarian and justice concerns.

A final theme permeates this volume: the lived experience of the poor with both preventable illness and the doctors and other medical professionals on

and social aspects of living with low income and associated low literacy that can result in alienation and poor health choices.<sup>16</sup> They urge a "bottom up" approach for improving the healthcare experience for low income people. That approach — starting with the felt needs of the very people lawmakers and policymakers hope to help — is the linchpin to good policy. Governor Tommy Thompson shares lessons from both his experience reforming Wisconsin's welfare program and the creation of Medicare Part D while the Secretary of Health and Human Services to stress that bipartisan solutions are possible, especially when the approaches "draw on the wisdom of the real people affected."<sup>17</sup>

In the United States healthcare system and the ethical standards that embody it, respect for patient autonomy, for patient choice, reigns supreme — in the-

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which the poor must depend because they are sick or need help. Here, race, gender, geography, and low-literacy have pronounced effects. Ruby Mendenhall's work interviewing low-income Black mothers reveals the perils of living in city neighborhoods with high levels of violence and toxic mold, the imminently preventable health problems mothers and their children experience, and the resiliency of many people living in the hidden margins of society.<sup>14</sup>

The experiences of people living in urban poverty and rural poverty sometimes differ, as do the challenges and potential solutions for addressing the health problems that result. As Elizabeth Weeks Leonard points out, "lack of reliable public and private transportation, poor Internet connectivity, lack of employment (and, accordingly, lack of health insurance coverage) further impair access to care in rural areas....Access to mental health and substance abuse treatment is especially challenging."<sup>15</sup>

Add to both urban and rural challenges the low literacy that often comes with low-income. While recognizing that people living in low-income communities sometimes experience "socially-rich" environments, Madhu Viswanathan and colleagues from the Subsistence Marketplaces Initiative at the University of Illinois explicate the thinking, feeling, behavioral,

and social aspects of living with low income and associated low literacy that can result in alienation and poor health choices.<sup>16</sup> They urge a "bottom up" approach for improving the healthcare experience for low income people. That approach — starting with the felt needs of the very people lawmakers and policymakers hope to help — is the linchpin to good policy. Governor Tommy Thompson shares lessons from both his experience reforming Wisconsin's welfare program and the creation of Medicare Part D while the Secretary of Health and Human Services to stress that bipartisan solutions are possible, especially when the approaches "draw on the wisdom of the real people affected."<sup>17</sup>

For the poor, choices are often illusory. Michelle Oberman writes about what she has learned by listening to patients at a pregnancy crisis center. We imagine poor women to have more reproductive choices than they do. Motherhood is costly. "Poverty drives rates of unintended pregnancies," she notes, "and then circumscribes women's responses to those pregnancies."<sup>18</sup> As Lois Shepherd and Hilary Turner point out, when women do seek abortion, for whatever reason, politically-motivated abortion restrictions — for examples, laws that unnecessarily require physicians to have admitting privileges at hospitals or force a mandatory early ultrasound — fall disproportionately on poor women.<sup>19</sup> Abortion is a medical procedure, no doubt; Shepherd and Turner argue, though, that for poor women especially it is over-medicalized and that medicine has been corrupted for political ends. The cost is to poor women's health, safety, autonomy, and dignity.

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We hope this Symposium will continue to spur efforts to understand and address the problems of poverty that manifest in ill health and disease.

#### Note

The authors have no conflicts to declare.

#### References

1. D. Orentlicher, "Healthcare, Health, and Income," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 567-572.
2. W. M. Sage and J. E. Laurin, "If You Would Not Criminalize Poverty, Do Not Medicalize It," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 573-581.
3. D. Hyman, "The Medicalization of Poverty: A Dose of Theory," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 582-587.
4. C. Webb and D. Matthew, "Housing: A Case for The Medicalization of Poverty," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 588-594.
5. M. Crossley, "Bundling Justice: Medicaid's Support for Housing," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 595-601.
6. E. Benfer et al., "Medical-Legal Partnership: Lessons from Five Diverse MLPs in New Haven, Connecticut," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 602-609.
7. J. C. Leonard, "Reflections on Evolving Understandings of the Role of Healthcare Providers," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 680-681.
8. D. Becker, "The Addicts on Main Street," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 610-614.
9. C. Pointer et al., "The Role of Community Health Needs Assessments in Medicalizing Poverty," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 615-621.
10. C. Konnoth, "Data Collection, EHRs, and Poverty Determinations," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 622-628.
11. M. Levine, "Intentionally Designing Communities for Health and Well-Being: A Vision for Today," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 685-690.
12. R. Kaplan, "Reflections on Evolving Understandings of the Role of Healthcare Providers," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 629-635.
13. R. Fretwell Wilson, "Moving Beyond Marriage: Healthcare and the Social Safety Net for Families," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 636-643.
14. R. Mendenhall, "The Medicalization of Poverty in the Lives of Low-Income Black Mothers and Children," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 644-650.
15. E. Weeks, "Medicalization of Rural Poverty: Challenges for Access," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 680-681.
16. M. Viswanathan et al., "A Bottom-Up Approach to Understanding Low-Income Patients: Implications for Health-Related Policy," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 658-664.
17. T. Thompson, "Reflections on Bipartisan Solutions to Addressing Poverty," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 682-684.
18. M. Oberman, "Motherhood, Abortion, and the Medicalization of Poverty," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 665-671.
19. L. Shepherd and H.D. Turner, "The Over-Medicalization and Corrupted Medicalization of Abortion and its Effect on Women Living in Poverty," *Journal of Law, Medicine & Ethics* 46, no. 3 (2018): 672-679.