PERSPECTIVE

Health Policy Approaches To Population Health: The Limits Of Medicalization

Lack of access to health care is not the fundamental cause of health vulnerability or social disparities in health.

by Paula M. Lantz, Richard L. Lichtenstein, and Harold A. Pollack

ABSTRACT: Because of a strong tendency to "medicalize" health status problems and to assume that their primary solution involves medical care, policymakers often focus on increased financial and geographic access to personal health services in policies aimed at populations that are vulnerable to poor health. This approach has produced real public health gains, but it has neglected key social and economic causes of health vulnerability and disparities. Although access to care is a necessary component of population health, concerted policy action in income security, education, housing, nutrition/food security, and the environment is also critical in efforts to improve health among socially disadvantaged populations. [*Health Affairs* 26, no. 5 (2007): 1253–1257; 10.1377/hlthaff.26.5.1253]

MATERIAL DEPRIVATION, social marginalization, and psychosocial stressors get "under the skin" in many ways that provide a biological basis for health vulnerability.[1] As argued by Alice Furumoto-Dawson and colleagues, negative conditions in early life are especially critical, for these exposures can interact with developmental gene expression and, in turn, can influence adult health through multiple mechanisms and pathways, including hormonal, neurological, and immune system dysfunction.[2] Their paper calls for community-based policy responses that will improve neighborhood social environments for children and that will reduce marginalization, discrimination, and other forms of psychosocial stress over the life course.

Such arguments reinforce a critical yet often neglected lesson for health policymakers: For policy responses to health vulnerability and population health disparities to be effective, they must extend beyond the provision of medical care. In this essay we offer the perspective that U.S. health policy has become too focused on medical care as the primary policy lever. Along with an increasingly medicalized view of population health and health vulnerability has come a policy focus on the narrow issue of improving access to personal health services. The overarching goal of improving health status has become displaced by the more immediate goal of increasing access to health care services. As a result, we have a fragmented and beleaguered health care safety net, and insufficient policy attention is being paid to socioeconomic conditions that give rise to health vulnerability in the first place.

Paula Lantz (plantz@umich.edu) is a professor, Health Management and Policy, at the University of Michigan in Ann Arbor; Richard Lichtenstein is an associate professor there. Harold Pollack is an associate professor in the School of Social Service Administration at the University of Chicago (Illinois).

DOI 10.1377/hlthaff.26.5.1253

Medicalization And Health Policy

A century ago, policy interventions addressing health vulnerability often reflected a broad view of the causes of vulnerability and the conditions that needed to be addressed through public action. The specific etiology of most illnesses and diseases was poorly understood. However, given the large and obvious statistical association between poverty and illness, health status vulnerability was readily seen as a consequence of socioeconomic vulnerability.[3] As a result, public health activities in the late nineteenth and early twentieth centuries focused on "upstream" causes of poor health, including poor sanitation, overcrowded and squalid housing conditions, work-related hazards, food security, and nutrition.[4] Interventions in these realms are believed responsible for sharp mortality declines across age groups in the United States.[5]

"Many policies establish and reinforce a two-tier 'safety-net' system in which vulnerable populations primarily go to separate institutions or providers for their health care."

Concurrent with these public health improvements, a sea change was under way in biomedical science, with an increasing focus on individual causes and manifestations of illness and disease. This increasingly individualized perspective fostered a tendency to medicalize health and illness.[6] Irving Zola defines *medicalization* as the expansion of medicine as an institution and the use of a medical lens to view human processes and behavior.[7] A medicalized perspective tends to define health problems as the result of individual failures of biology, hygiene, and behavior, with the implicit or explicit belief that the primary strategy for addressing these problems is through biomedical treatments delivered to individuals by physicians and other providers.[8]

Multiple economic, social, and political factors fueled the growth and dominance of individualistic, medicalized perspectives regarding public health, although a detailed analysis of this topic is outside of the scope of this essay.[9] Michael Katz argues that individualized accounts of illness and vulnerability strongly resonated with Americans' historic ambivalence toward disadvantaged individuals and groups, with accompanying moral and ideological distinctions between citizens deemed worthy and unworthy of assistance.[10]

As health status and health vulnerability became more medicalized throughout the twentieth century, discourse and decisions regarding policy priorities changed as well. Given an increasingly medicalized view of health vulnerability, public policy became focused on expanding access to individualized medical care.[11] The federal government was providing personal health services to certain populations (such as merchant seamen and Native Americans) before 1900. However, as the problems of vulnerable populations became more medicalized, policies and initiatives focusing on health care access proliferated across populations and across a range of pertinent medical services.

Given this policy emphasis on medical care, a piecemeal, categorical, and separatist approach to providing health care services to vulnerable populations emerged. Throughout the twentieth century, the making and buying of health care services through government policy created facilities, systems, providers, financing arrangements, and bureaucracies that exist outside the mainstream health care delivery system and operate specifically for vulnerable populations. Examples abound, including community and migrant health centers, Title X family planning clinics, local public health clinics, Medicaid managed care, Medicaid expansions for pregnant women, the National Breast and Cervical Cancer Early Detection Program, and the State Children's Health Insurance Program (SCHIP).

The Limits Of Medicalized Policy Responses

Current public policy responses to health vulnerability focus primarily (although not ex-

clusively) on the procurement of medical care services, with a reduction in access barriers proffered as the central benchmark for success. Although policies that address financial and geographic barriers to health care bring important services to populations in need, many such policies establish and reinforce a two-tier "safety-net" system in which vulnerable populations primarily go to separate institutions or providers for their health care.

These separate programs are viewed as necessary as a result of the dominant system's failure to provide adequate access for those who are marginalized and vulnerable. These programs, however, are not well funded, and the services provided are neither adequately paid for nor completely covered.[12] This leaves safety-net providers and programs plagued by financial pressures and often unable to deliver high-quality medical care to the populations they serve.[13]

"The genuine benefits of improved medical technology and personal health services heighten the temptation to place too many policy eggs in the health care access basket."

A second, less noticed consequence of medicalized perspectives is a conflation between health status disparities and health care disparities. Medicalization encourages the view that one can solve socioeconomic and racial/ethnic health status disparities through initiatives and policies that reduce disparities in health care access, use, and quality. This conflation, for example, can be seen in some aspects of the Health Disparities Research Plan of the National Institutes of Health (NIH) and also in the National Action Agenda of the Department of Health and Human Services (HHS) Office of Minority Health.[14]

In turn, when health vulnerability and disparities are medicalized, health care access becomes overvalued and overemphasized as the most promising policy path. It is also an easier path, politically, than are fundamental social and economic reforms. The result is our current situation, in which an estimated 95 percent of U.S. health services spending goes toward direct medical services, and only 5 percent is invested in population or community approaches for prevention and health status improvement.[15]

Medicalized framing of health vulnerability can be an effective strategy to defend policy benefits/transfers to the disadvantaged by sidestepping social and political debates over the deservingness or worthiness of vulnerable populations. The Supplemental Security Income and Social Security Disability Insurance programs are examples of how a medicalized approach to complex social problems can bring valuable income support and other benefits to people living with disabilities.[16] Similarly, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act provides housing and social services that extend beyond the domain of medical care to people living with HIV and AIDS. In addition, Medicaid provides a funding umbrella under which many states finance expanded services and social supports that extend beyond medical treatment and care. Nonetheless, these types of social services and interventions tend to become available only after a person is diagnosed as sick or disabled, and they focus on individuals and families rather than on the social and economic conditions of communities that are the fundamental drivers of poor health over the life course.

Concluding Comments

Increasing recognition is being given to the social and nonmedical determinants of health, with an emphasis on the need to address upstream causes of health vulnerability and social disparities in health.[17] The Acheson Report regarding health inequalities in the United Kingdom concluded that policy action must "address all of the layers of influence on health (e.g., social, environmental, economic, etc.), as well as ensuring that access to and use of health care services improves among those who have previously been underserved."[18] The

report advanced thirty-nine specific recommendations that promote policy in five general areas: (1) breaking the cycle of health inequalities by addressing poverty (especially among families with children) and investing in early childhood development programs and in education interventions to close attainment gaps; (2) addressing social gradients in modifiable health risk behavior (such as smoking, obesity, and physical risk taking); (3) improving access to and use of public services and facilities, including social services, primary health services, and transportation; (4) strengthening disadvantaged and marginalized communities by investing in neighborhood renewal, housing, safety, the physical environment, and educational and employment opportunities; and (5) focusing attention on extremely vulnerable groups, such as the homeless, the mentally ill, and their families.[19]

Building on the Acheson Report, Al Tarlov promotes an "intervention framework" to improve population health that includes five broad objectives: (1) improve child development; (2) strengthen community cohesion; (3) increase opportunities for self-fulfillment; (4) increase socioeconomic well-being; and (5) modulate hierarchical structuring. Interventions in these areas require participation on the part of multiple sectors, including public policy, private-sector investment and action, and community programs.[20]

David Kindig has repeatedly warned against falling "into the medical model trap of thinking that all health improvement comes from individual medical care interventions."[21] The genuine benefits of improved medical technology and personal health services heighten the temptation to place too many policy eggs in the health care access basket. This temptation is further increased by a host of political, social, and economic factors that favor increased medical investments.

Given these pressures, participants in health policy must remind citizens and policymakers that lack of access to health care is not the fundamental cause of health vulnerability or social disparities in health. Medical care rarely addresses the early-life conditions that are fundamental causes of health vulnerability later in life.[22] Medicalization prioritizes health care vulnerability over health status vulnerability, and it encourages us to believe that expanding access to personal health services is the best policy response. Ironically, social and economic inequalities in access to health care are often smaller than corresponding inequalities in access to housing, education, nutrition, and other resources. Although these resources lie outside the traditional domain of medical care, they are often more important than personal health services in generating or ameliorating health inequalities.[23]

If public investments were channeled to ensure that more citizens have economic security, receive a high-quality education, and grow up and live in thriving communities, medical care would be one resource among many to improve the health of vulnerable populations. This would enable us to provide medical services for "fine tuning" the health of vulnerable populations, instead of using health care as the primary way to address vulnerabilities that derive from complex social environments and extend far beyond the scope of the health care safety net.

The authors thank Nonie Hamiilton and Helen Reid for research assistance.

NOTES

1. N.E. Adler and K. Newman, "Socioeconomic Disparities in Health: Pathways and Policies," *Health Affairs* 21, no. 2 (2002): 60–76.
2. A. Furumoto-Dawson et al., "Early-Life Conditions and Mechanisms of Population Health Vulnerabilities," *Health Affairs* 26, no. 5 (2007): 1238–1248.
3. D. Leon and G. Walt, eds., *Poverty, Inequality, and Health: An International Perspective* (Oxford, England: Oxford University Press, 2001).
4. G. Rosen, "Public Health: Then and Now: Social and Health Problems Are Inseparable," *American Journal of Public Health* 61, no. 11 (1971): 2311–2312.
5. D. Cutler and G. Miller, "The Role of Public Health Improvements and Health Advances: The Twentieth-Century United States," *Demography* 42, no. 1 (2005): 1–22.
6. P. Conrad, "The Shifting Engines of Medicalization," *Journal of Health and Social Behavior* 46, no. 1 (2005): 3–14.
7. I.K. Zola, "Medicine as an Institution of Social Control," in *The Sociology of Health and Illness—Critical Perspectives*, ed. P. Conrad and R. Kern (New York: St. Martin's Press, 1986), 379–390.
8. E.G. Gallagher and J. Ferrante, "Medicalization and Social Justice," *Social Justice Research* 1, no. 3 (2005): 377–392.
9. P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982); and T. Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in United States* (Cambridge, Mass.: Harvard University Press, 1995), 714.
10. M.B. Katz, *In the Shadow of the Poorhouse* (New York: Basic Books, 1996).
11. Starr, *The Social Transformation of American Medicine*; and V. Berridge, "Health and Medicine in the Twentieth Century: Contemporary History and Health Policy," *Social History of Medicine* 5, no. 2 (1992): 307–316.
12. H. Waitzkin, "The History and Contradictions of the Health Care Safety Net," *Health Services Research* 40, no. 3 (2005): 941–952.
13. J.S. Ross et al., "Quality of Care for Acute Myocardial Infarction at Urban Safety-Net Hospitals," *Health Affairs* 26, no. 1 (2007): 238–248; and P.B. Bach, "Racial Disparities and Site of Care," *Ethnicity and Disease* 15, no. 2, Supp. 2 (2005): S31–S33.
14. G.E. Thomson et al., eds., *Examining the Health Disparities Research Plan of the National Institutes of Health* (Washington: National Academies Press, 2006).
15. J.M. McGinnis, P. Williams-Russo, and J.R. Knickman, "The Case for More Active Policy Attention to Health Promotion," *Health Affairs* 21, no. 2 (2002): 78–93.
16. Social Security Administration, *Social Security for People Living with HIV/AIDS*, Pub. no. 05-10019 (Washington: SSA, February 2005).
17. B.G. Link and J.C. Phelan, "Fundamental Sources of Health Inequalities," in *Policy Challenges in Modern Health Care*, ed. D. Mechanic et al. (New Brunswick, N.J.: Rutgers University Press, 2005), 71–84; and Furumoto-Dawson et al., "Early-Life Conditions."
18. U.K. Department of Health, *Inequalities in Health: Report of an Independent Inquiry Chaired by Sir Donald Acheson* (London: Stationery Office, 1998).
19. A. Oliver and D. Nutbeam, "Addressing Health Inequalities in the United Kingdom: A Case Study," *Journal of Public Health Medicine* 25, no. 4 (2003): 281–287.
20. A.R. Tarlov, "Public Policy Frameworks for Improving Population Health," *Annals of New York Academy of Sciences* 896 (1999): 281–293.
21. D.A. Kindig, "Beyond Health Services Research," *Health Services Research* 34, no. 1, Part 2 (1999): 205–214.
22. Furumoto-Dawson et al., "Early-Life Conditions."
23. R.F. Schoeni et al., eds., *The Health Effects of Social and Economic Policy* (New York: Russell Sage, forthcoming).