

Medicalizing Marginalization: The Role of Family Physicians in Treating the Social Determinants of Health

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The idea that health outcomes have social determinants has wide-reaching significance and deep roots that are increasingly relevant to medicine. Enhanced recognition and understanding of the upstream drivers of health disparities such as socioeconomic status, risk exposure, and structural racism have encouraged family physicians and other community-centered clinicians to incorporate broader approaches to addressing the downstream effects on patient's health. This inclusive framework expands treatment options, increases trust, and leads to better patient outcomes.

The current understanding and implementation of the social determinants of health (SDoH) framework are relatively recent and developing fast. As an undergraduate student, I watched as these ideas were incorporated into medical school curriculums and admissions processes. As a medical student, I was incredibly excited to take whole classes devoted to the subject and found the lectures to be especially meaningful and humanizing. But as I've learned and listened to things change, some of the phrasings began to give me pause.

In some resources there were mentions of doctors "treating" the SDoH, and there was an especially memorable lecture slide that read, "Poverty is one of the leading diseases of childhood." I sat with those words for a long time, wondering what kind of medicine I would learn that could cure poverty. While not technically incorrect and absolutely well-intentioned, this pattern of conflating upstream social factors with downstream health effects is worrying.

A deeper dive into the context surrounding the growth of the SDoH framework reveals that this language may be due to increasing pressure on healthcare to be the first line of defense against systemic injustice. The growing emphasis on social factors' contributions to health coincides with the decline of social services and community programs designed to combat upstream effectors directly. This leads to increased pressure on physicians to apply skills designed for clinical care to things like poverty, racism, and food insecurity. While doctors can absolutely recognize inequality and refer patients to resources, there are no medicines, therapies, or surgeries that can prevent discrimination or change the built environment. Additionally, pressures to use those tools instead of engaging social services can lead to dangerous dynamics and undue strain on the physician-patient relationship.

The rise of the SDoH framework represents both a necessary advance in knowledge and empathy, and a shifting of an incredible burden onto family physicians and other healthcare workers. Deeper understanding of the wider history of SDoH and the limitations of applying downstream skills to upstream factors is needed to keep the framework sustainable, address problems with appropriate solutions, and deliver both effective community support and empathetic medical care.

History of the Social Determinants of Health Framework

Though connections between poverty and poor health have been observed at least since the Industrial Revolution, many scholars trace the beginnings of the framework that would lead to the modern social determinants of health to the United Kingdom in the 1960s.¹ In 1967, the Whitehall Study examined mortality rates among workers of different social classes. It demonstrated a clear relationship between health and socioeconomic status that sparked much

further investigation.² Around the same time, British physician Thomas McKeown noticed falling mortality rates that did not necessarily coincide with recent medical developments. Although some aspects of his analysis remain controversial, his claim that improved economic conditions, better nutrition, and hygiene efforts impacted public health provided an important foundation for later work.³

By the 1980s, studies began including other social factors in their research. *The Report of the Secretary's Task Force on Black and Minority Health* was the first nationwide study of health in the context of race. The report demonstrated that the considerable gains in health outcomes for Americans in the preceding decades often left Black, Hispanic, and Indigenous populations behind.^{1,4}

In 1990, Michael Marmot and Richard Wilkinson published *Social Determinants of Health*, a book that presented evidence that socioeconomic status and social position are key causes of health inequalities.⁵ In 2005, the WHO established the Commission on Social Determinants of Health and appointed Marmot to lead them in their mission to “[i]mprove daily living conditions, tackle the inequitable distribution of power, money, and resources, and measure and understand the problem.”⁶

Since then, the incorporation of SDoH frameworks into research, legislation, and everyday use has grown exponentially. From 1990 to 2000, the number of times the phrase “social determinants of health” was used in printed sources rose by 155%. From 2000 to 2010, it grew by 500%.⁷ Those time periods specifically saw unprecedented expansion of these standards into the legislature.

In 1993, the Health Revitalization Act mandated the inclusion of women and minorities in NIH-funded research and created the Office of Research on Minority Health. In 1997, an

additional Advisory Committee on Research on Minority Health was established and, in 2000, a National Center on Minority Health and Health Disparities joined the ranks.⁸ In 2001, Congress increased funding for scientists from disadvantaged backgrounds and institutes committed to health disparity research. They declared that the information gained through these efforts should be “disseminated to all health care professionals so that they may better communicate with all patients, regardless of race or ethnicity, without bias or prejudice.”⁹

In 2009, the Liaison Committee on Medical Education introduced expanded diversity standards for medical school including training students in “[r]ecognition of health care disparities and the development of solutions to such burdens.”¹⁰ In 2013, the Accreditation Council for Graduate Medical Education added population health to its mission statement and included it in new educational standards for residencies, acknowledging that social conditions have the “greatest impact on health outcomes overall.”¹¹

This exponential rise in healthcare’s acceptance and promotion of the social determinants of health as a needed and necessary factor in the way we educate doctors and treat patients is absolutely a reflection of changing scientific understanding and increased emphasis on equity and diversity. However, while these ideas flourished in healthcare and medicine, the social services designed to directly address the upstream issues declined.

Social Services in the Time of Social Determinants

The 1990s saw some of the most significant cuts to social services in American history. In 1993, there were federal cuts to Social Security and reductions or removals of the Aid to Families with Dependent Children (AFDC) program in forty states.¹² In 1996, Bill Clinton

followed through on his campaign promise to enact “a plan to end welfare as we know it”¹³ with the passage of the bipartisan Personal Responsibility and Work Opportunity Reconciliation Act.¹⁴

This bill was primarily aimed at redesigning the AFDC, but wide-reaching additions affected the majority of the nation’s welfare programs. It restricted or redesigned social services like disability benefits, child nutrition programs, food stamps, and social security.¹⁵ These new deficits directly impacted known social determinants of health.

The AFDC was replaced with the Temporary Assistance for Needy Families (TANF) program that not only restricted the number of people deemed needy enough for support, it also placed employment requirements and time restrictions designed to reduce overall reliance on welfare.¹⁵

In addition to cutting benefits more generally, the bill also targeted a number of populations most vulnerable to health outcome-determining social change such as immigrants, children, and single mothers. Supplemental Security Income (SSI) eligibility for disabled children and access to subsidized childcare were restricted and many school nutrition programs were eliminated. Most non-citizens, including legal residents, were newly allowed to be barred from receiving TANF, food stamps, SSI, and Medicaid, among others.¹⁴ Specific sanctions against teenage and unmarried mothers were included, along with stricter requirements for paternal involvement.¹⁵

Though the bill is celebrated for bringing the unemployment rate below 4% and cutting the number of people receiving welfare by half over the next four years, these metrics were not reflected in the overall poverty rate.¹⁶ Families living at or near the poverty line tended to benefit, but the number of people living in extreme poverty rose, with even sharper increases in financial hardship for African American families. Many previous welfare recipients were only able to take

low-wage jobs where the increase in income was canceled out by the loss of benefits. The impact on immigrants, children, and young and single mothers has been especially criticized for removing vital supports from already vulnerable populations.¹⁷

Another section of the bill decoupled welfare and Medicaid eligibility, drawing a new line between social services and healthcare.¹⁷ Despite cuts to the programs that served as the first line of defense against upstream determinants of health for many Americans, funding for programs that addressed health directly actually increased. The same year PRWOP passed, the Children's Health Insurance Program provided care to eleven million previously uninsured children, and in 2003, the Medicare Prescription Drug Improvement Act included private health coverage and eventually prescription drug benefits for Medicare recipients. In 2010, the Affordable Care Act massively expanded Medicaid, especially for people below or near the poverty line, reduced the rate of uninsured people, and implemented reforms to streamline the health insurance market.¹⁸

So as national priorities shifted away from supporting social programs, they moved toward expanding healthcare. With less funding and infrastructure combating upstream determinants of health disparities and more access to treatment of downstream effects, it was only natural for healthcare to step up and try to fill the gap.

The Medicalization of Social Determinants of Health

When legislators decreased programs that addressed inequality directly, they increased spending on accessible healthcare. The rise of the social determinants of health framework during this time period was likely, among other factors, a response to that shifting of resources

and priorities. The new emphasis was both a response to new desires to increase equity and diversity in healthcare and also a necessary response to a growing crisis.

While the original framework encourages physicians to understand systemic injustice and collaborate with communities, the lack of resources and social services puts additional pressure on doctors to reach beyond their abilities. Requiring that doctors use clinical skills to attempt “treatment” of upstream determinants of health leads to increased medicalization of inherently non-medical issues.

The paper *Health Policy Approaches to Population Health: The Limits of Medicalization*, addresses the policy patterns that have led to the current dilemma by noting that “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.”¹⁹ These efforts to expand healthcare to underserved populations are fantastic components of a larger plan to address inequality, but when they are offered without additional support, they may have unintended results.

One of the authors, Paula M. Lantz, expands further on the pressures placed on healthcare by these patterns in her article *The Medicalization of Population Health: Who Will Stay Upstream?* She notes that “Medicalization provides medical professionals the primary authority to ‘diagnose’ and ‘treat’ what are ostensibly social problems within the boundaries of biomedical expertise and clinical practice. And, importantly, medicalization leads to a conflation of ‘health’ and ‘health care,’ giving credence to the fallacy that societal problems having to do with health primarily need health care solutions.”²⁰

Not only is a healthcare-only approach to social issues ineffective, it may also have negative consequences for patients and clinicians. The paper *Pathologizing Poverty: New Forms*

of Diagnosis, Disability, and Structural Stigma under Welfare Reform, links the 1996 restrictions to social services to “dramatic increases in medicalized forms of support for indigent people.”²¹ When individuals in need of societal support can no longer rely on receiving benefits because of poverty, “a diagnosis of permanent medical cognitive pathology becomes a valuable survival strategy.”²¹ The article links a decline in poverty or situation-based benefits to a rise in disability claims for mental health and chronic pain conditions. The lack of community resources may place pressure on physicians to use medical systems to provide social support and on patients to shape medical narratives to fit existing benefits structures. These dangerous dynamics are especially present in the offices of community-based and equity-oriented clinicians like family physicians.

Family Medicine on the Front Lines

As primary care clinicians and community-based practitioners, family physicians are uniquely positioned to address social determinants of health. In 2019, the American Academy of Family Physicians made health equity a strategic priority and noted that family physicians are called to be champions of the SDoH framework because of their focus on primary care and tendency to serve disadvantaged communities.²²

A 2019 study found that 81.1% of family physicians were engaged in at least one clinical action to address social determinants of health and 43.4% were engaged in at least one population-based action. Clinical actions targeted downstream factors that could be addressed at the appointment like screening patients for hardships and referring them to resources. Population-based actions were aimed at upstream effectors like supporting public policies or collaborating with community health initiatives.²²

Although the majority of participants were in support of the SDoH framework and aware of the need to address upstream factors, many reported barriers to providing relevant care, especially when it came to population-based actions. 80% of participants said they didn't have time, 64.5% said they didn't have the staff, and 55% said they didn't have the ability. Others reported a lack of resources in their community that patients could be referred to, which the authors attributed to the "recent funding reductions for housing, public health, and other social service programs."²² These conclusions demonstrate the overwhelming desire of family physicians to help and the underwhelming resources they have to do so effectively.

Solutions and Next Steps

A number of physicians and organizations, including the AAFP, have already recognized the need for distinction between clinical care and community action when addressing the SDoH. In the 2019 AAFP position paper *Advancing Health Equity by Addressing the Social Determinants of Health in Family Medicine*, there are clearly defined and explicitly collaborative roles outlined for physicians. This includes understanding patients' histories and cultures, connecting them to community resources, and being aware of potential biases or systemic inequalities.²³

The article doesn't include any recommendations for treating upstream determinants with clinical skills. Instead, it addresses the current lack of resources and social support by encouraging physicians to move their efforts outside the clinic. A list of relevant policy goals gives physicians an excellent place to start their advocacy.²³

Strategies that directly address the cuts made in the 1990s feature prominently on the page. Support for anti-poverty programs, nutrition assistance, equitable housing, and civil rights

are all included. There are additional ideas, such as combining health goals with social programs and bringing equity-based approaches to education and payment models.²³ These advances would go beyond the systems of the past and ideally provide willing family physicians with the time, resources, and education to address the SDoH without undue strain.

Individual physicians like Dr. Rishi Manchanda have also recognized the limitations of clinical care without community support. He refers his patients needing help with social issues to a network of health advocates, social workers, and lawyers that he calls “upstreamists.” Dr. Manchanda estimates that we need around 25,000 upstreamists to effectively collaborate with all American physicians and notes that we currently only have a few thousand.²⁴

This led him to start an organization called Health Begins which trains upstreamists to work alongside patients and clinicians. The diverse group of professionals address local factors that may be affecting patients’ health and partner with healthcare workers to create connections and community.²⁵ This enables patients to have the root causes of their health issues addressed by experts and gives clinicians the support they need to use their specialized training, limited time, and unique perspective to focus on delivering excellent care for the downstream health effects.

Conclusion

One of the primary missions of the social determinants of health framework is to call physicians to broaden their understanding of the societal and historical contexts that surround their patients. The aim of this paper is not to critique the SDoH framework or discourage physicians from broadening their practice; instead, it is a continuation of that original call for increased understanding.

By viewing the growth and development of the SDoH framework through a historical lens, potential pitfalls and additional inequalities can be identified. And by continuing to broaden views of the intersectional determinants of patient health, physicians can be empowered to treat downstream health issues in the office and advocate for more equitable upstream systems in the community.

It isn't fair to family physicians that the immense burden of unjust social structures is being shifted onto their clinics. But just as the profession has adapted to changing science and social structures in the past, I am confident we will not only adjust to the current reality but also continue to advocate for a better future.

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