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Beyond Charity—Social Justice and Health Care

Justin M. List, MD, MAR

The passage of the Affordable Care Act in 2010 took a step towards ensuring that every citizen in the United States has access to affordable health care. Still, the current system contains a number of health coverage and treatment gaps for those living in poverty. Physicians who treat patients without insurance and who cannot pay often do so under the term "charity care." But the charity care model, for all its good intent, is severely limited as an approach to resolving the problem of the underserved. A better conceptual approach to securing care for uninsured individuals in the United States is a social justice framework, and incentives for achieving social justice may be different from those that induce physicians to deliver charity care.

Loosely defined, charity care entails physician care provided to patients for free or at significantly reduced payment rates. Physicians who deliver charity care may earn less than their peers with better-insured patient panels. Some include patients on Medicaid in the term "charity care," since Medicaid's payment for physician services is lower than that of Medicare and private insurance. The term itself is not without controversy. Charity implies the performance of a good deed or action, particularly to the needy. Although its definition denotes generosity, it is often construed as connoting "self-sacrifice." That is, the term as often used focuses on the benevolence of the doer, e.g., physician, rather than on systemic injustice experienced by the receiver, e.g., the needy patient, in the case of health insurance in the United States.

An emphasis on charity reflects attention on fixing short-term needs rather than on addressing systemic inequities that create an environment in which charity is necessary. Sociologist Janet Poppendieck explains this concept by arguing that "the resurgence of charity is at once a symptom and a cause of our society's failure to face up to and deal with the erosion of equality. It is a symptom in that it stems, in part at least, from an abandonment of our hopes for the elimination of poverty" [1]. The applicability of this critique to charity care medicine is probably limited; addressing the medical needs of the poor is not incompatible with addressing their social needs. Social justice asks physicians to advance professional values by calling for a critique and reversal of systemic factors that create an environment where charity care finds need. At the very least, as physician Paul Farmer writes, "charity medicine should avoid, at all costs, the temptation to ignore or hide the causes of excess suffering among the poor" [2].

Social justice is defined as a just distribution of goods within society and examines the relationships between groups and individuals that influence the distribution of

goods. Such work entails advocating both for the poor on an individual level and for solutions to the structural barriers that deny them access to affordable, adequate health care. As educator and theorist Paulo Freire puts it, “True generosity consists precisely in fighting to destroy the causes which nourish false charity” [3]. A social-justice approach nourishes the “true generosity” for which Freire argues. While different, charity medicine and social-justice work can be seen as part of a comprehensive solution to the problem of the uninsured and underinsured. Are the motives for engaging in charity care and social-justice work the same? The answer to that question depends on why and how physicians engage with the underserved.

Motives for Providing Charity Care

A simplistic way to explore physician motives to provide charity care is to consider them ranging along a continuum from altruism at one end to self-interest at the other. In reality, they do not fall on such a linear continuum but rather reflect a web of various influences. For some, knowledge of the health disparities in the United States engenders a commitment to charity care. A sense of justice (and injustice) informed by personal experiences, reflection, medical education and training, and peer influences functions as a strong motivator to engage the underserved. Religious and other humanistic beliefs also motivate a number of physicians to provide charity care despite financial disincentives to do so.

Psychological motives may also be at play for physicians who practice charity care. It may be the case that physicians derive added personal and professional satisfaction from caring for patients at the margins of society, although this can erode over time, given the difficulties of caring for impoverished patients living in precarious conditions, and especially if physicians feel their work is not valued by society at large.

Practicing some charity care medicine may confer a sense of redemption, duty fulfilled, or guilt assuaged. It is conceivable, for example, that a physician who maintains a panel of wealthier patients would feel drawn to delivering episodic charity care. The social-justice question we must pose to that physician is: Are you willing to advocate for changes to the medical system that creates the need for you to take on charity patient cases in the first place? If the answer is “no,” one could argue that the physician is passively complicit with a health care arrangement in which charity care is the only chance underserved patients have at receiving health care.

Beyond Charity Care

Will the same range of motives—from altruism to self-interest—that prompt physicians to provide charity care move them to social justice work? Although a number of considerations factor into answering that question, the answer is most likely “no.” Ever-increasing medical educational debt, lower payments for primary care services than for specialty procedures, growing costs for maintaining individual and group medical practices, widening wealth disparities in the U.S. leading to more uninsured patients, and population shifts toward urban centers are a few of the reasons altruism and self-interest will not necessarily lead doctors to social-justice

work. In truth, many of these factors may perpetuate the need for charity care, as physicians worry about their own financial solvency in addition to that of their patients. A social-justice framework requires that physicians speak out against the forces that continue to make meaningful, truly universal health care unattainable, even when to do so temporarily contradicts their own financial interests.

Acknowledging that financial incentives, such as loan repayment or increased salaries for those who provide primary care and work in resource-poor areas, may be needed to narrow or close the gaps in access does not necessarily reflect poorly on the state of medicine's professional conscience. Doing so merely recognizes the practical fact that physicians face barriers to caring for the underserved in contemporary America from the moment they learn of the lower remuneration physicians receive for such care. The current payment system encourages physicians to practice medicine in any sector of the health care field other than primary care for the underserved, one of the areas in which they are most needed [4].

The political will to ensure that every citizen has adequate access to affordable care has not yet arrived in the United States, despite the fact that every other high-income country has such a system. A society free of charity care, with a fundamental respect for human dignity, would allow the medical profession to maximize patient care. Ridding U.S. society of the need for charity medicine would free physicians to spend more time and energy on patient care, instead of being forced to balance charity care with making ends meet in a medical practice. Taking a social-justice approach to health disparities may be the best way to achieve this. It requires physicians to take the lead.

At the heart of the social-justice approach to ensuring care for the underserved is the need for physicians, collectively and individually, to be agents of social change. Physicians have enormous opportunity to see how poverty, lack of insurance, and other determinants of health impact their patients and to advocate based on this knowledge. Yet there is an insidious temptation for physicians to feel victimized by other decision makers in the health care system who seem to reap more financial benefits, and that feeling can compromise physicians' sense of empowerment as agents of change for disenfranchised patients. I have discussed the many disincentives to caring for underserved patients, but, at the end of the day, physicians have significantly more influential social and political cachet than their underserved patients. To be sure, there is much work to be done in the area of physician remuneration to reduce physicians' sense of disenfranchisement. But social justice demands that physicians actively advocate for social change in patient care that eclipses the continued need for charity care.

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Justin M. List, MD, MAR, is a second-year resident in the Yale University primary care program in New Haven, Connecticut. He was a fellow in the American Medical Association Institute for Ethics and a research assistant and editor at the Yale University Interdisciplinary Center for Bioethics. His interests include global health systems strengthening, health and human rights, and global health clinical education.

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