

Episode: *Ethics Talk: How Medicalization Limits Public Health Effectiveness*

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[mellow theme music]

TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. How is it that people in the United States spend more money on health care per capita than any other country, but the US also ranks poorly among common measures of population health outcomes, such as infant mortality and life expectancy? Why has the US suffered some of the worst rates of infection and death throughout the COVID-19 pandemic? One possible answer might be surprising: medicalization.

Public health researchers have long known that health outcomes at a population level are not and cannot be results of what clinicians do during clinical encounters with individual patients only. Physicians, for example, are trained as diagnosticians to examine patients' troubles through a biomedical lens. This has great value, but the clinical perspective also has important limitations that deserve our regard and our respect. Medicalizing a problem can reveal physiological causes of illness or injury, but we must recognize that illness and injury happen in social and cultural contexts that determine how well diagnosing and intervening in a patient's illness or injury will translate into healing. Medicalization as a way of seeing and focusing attention tends to work in acute clinical encounters for the same reasons it tends not to work to help solve problems that are historically, socially, and culturally determined and expressed in social structures and policies.

DR PAULA LANTZ: Medicalization has contributed to a conflation of health with health care.

HOFF: That's our guest today, Dr Paula Lantz. As she has written in the past, medicalization can lead to a false assumption that individuals' and communities' health problems are best addressed by health service delivery streams when they're actually best addressed by collective community governance responses. Dr Lantz is the James B. Hudak Professor of Health Policy at the University of Michigan's Gerald R. Ford School of Public Policy. She is also director of the Ford School's BA program and holds an appointment as professor of health management and policy in the School of Public Health. She's with us today to discuss the medicalization of public health. Dr Lantz, thank you very much for being on the podcast with me. [music fades]

LANTZ: Well, thanks so much for having me today.

HOFF: So, to begin with, what should our listeners know about the differences between population health, public health, and population health management?

LANTZ: Great introductory question, and I think the definitions of these broad fields does matter for our conversation today. So, to start, population health is really, you know, it's about the health of the population, but also, it's actually a multi-disciplinary science that's about 200 years old with the focus being on really understanding the patterns and distributions of health outcomes and their causes in populations. People for a long time have noticed that within populations not everyone enjoys the same life expectancy and the same levels of health. And so, scholars and also practitioners, people who work for communities and for governments for a long time have been interested in, again, this field, population health, which has devoted significant attention to try to understand, well, what are the upstream, macro-level sort of structural factors in societies as well as the midstream and downstream factors—social, political and economic factors—that drive patterns of health within populations? And more recently, the field of population health has really been focused on what is the role of medical care, and actually, what are the limits of medical care in both producing health and reducing socially driven health inequities within populations?

So, public health then is a sister discipline. Public health is also concerned with the causes of health, illness, and injury in populations, and the unequal distributions of those within populations. And public health, as I think everybody knows, is really focused on prevention and other kinds of interventions at upstream, midstream, and downstream levels. We tend to think of public health more as a field of practice and policy, with public health primarily grounded in government agencies, but also in partnering organizations. And again, the focus is on disease prevention, injury prevention, prolonging life, and also a strong focus, again, on health equity. The approaches of population health and public health are primarily aimed at populations and communities, not individuals within them.

So, the other thing I think then we want to distinguish between population health and public health is medicine, which is a distinctly different enterprise than population health sciences and public health practice. Medicine's focus is on the diagnosis and treatment of illness and injury within individuals. And within the past 15 years, this term, "population health management," has emerged. It actually came out in 2007 as part of the Institute for Healthcare Improvement's triple aim for improving health care, which the triple aim was focusing on reducing health care costs while also improving quality of care and improving population health. But here, population is defined really differently. Population within population health management refers to patients who get their care through specific health care systems or even the beneficiaries of specific health care plans. So, population health management is a newer, but also, I would say, a much more narrow enterprise than the long-standing fields of population health and public health.

HOFF: I'd like to try to draw a pretty fine distinction here that might be helpful in determining when medicalization becomes an issue. So, we know that taking individualized approaches to problems that need collective solutions just doesn't work.

But individual patients do have health problems that are due to collective social determinants, and health professions students are taught to, and probably should be taught to, read and contextualize how social determinants affect individual patients. Is this process that clinicians go through with individual patients also medicalization of what are actually public health factors? And is it helpful to distinguish between “medicalization” that seems necessary to provide care for the patient that is in front of you and something like hyper-medicalization that undermines public health as a field and public health responsiveness?

LANTZ: So, a medicalized view of health, fundamentally, it is viewed as the encroachment of a biomedical lens and also, the authority of clinicians and especially physicians in society over all things related to health. Now, there are many different concerns about medicalization. My main concern is that in public policy, it’s fueled an overemphasis on personal health care services as the primary avenue for promoting health and for addressing health disparities, which we know the United States has significant longstanding problems with health inequality. So, a medicalized view of health focuses, again, mostly on individual approaches to improving health. And in the United States, we’ve been really focused on our big problem of, “Well, if we just had everyone have health insurance, we would improve health status.” But that’s really not true. And this focus on, “Well, it’s health care that’s going to solve all our health problems” obscures the fact that health is a population-level phenomenon that’s socially, economically, and politically driven.

So, again, at the foundation of the fields of population and public health is this deep and longstanding understanding of how the more proximate determinants of individual health like income, food, housing, safe environments, psychosocial factors, and yes, health care are influenced and unequally distributed within society. Medicalized approaches to health at a population level ignore a really basic principle in epidemiology, which is that we need to distinguish between sick people and sick populations. Medicalization has contributed to a conflation of health with health care, with health policy, with health care policy, and also, more recently, a conflation of the social determinants of health with individual patient social needs. I’ve been seeing this for many, many years within, certainly within discourse in health policy circles, within research endeavors, and also within health care systems that really sincerely and honestly are trying to do good things and believe they’re addressing social determinants of health, when in fact, really what they’re doing is simply identifying—it’s important—but they’re simply identifying individual patient social needs and wanting to try to address them one patient at a time.

HOFF: So, it sounds like it might be more of a difference of degree than a difference of kind and that individual clinicians are doing what they can with the tools that they have. But nonetheless, it’s still applying that biomedical lens and care model to problems that can’t really respond fully to those methods. Does that sound right?

LANTZ: Yeah, I don’t, because I’m so concerned about medicalization, I don’t see any gradations or distinctions within it. I think it’s a problem in any of its forms. And that’s not to say, again, that things that health insurance plans and health care systems and large

hospitals are trying to do is bad. My main mantra is it's necessary but not sufficient. It's necessary but not sufficient. And this conflation of health with health care brings more resources to the health care system for trying to address social needs, but it's leaving really untouched, in many ways, the more midstream and upstream drivers that really need reform and change if we're ever going to stop the flow of the causes of major health problems we have in this country, and again, health disparities.

HOFF: One focal point in the criticism of the medicalization of public health is the Centers for Disease Control and Prevention leadership. The vast majority of past directors of the CDC have been trained as MDs, have been physicians. Why do you think physicians have tended to be called upon to serve in these kinds of public health positions?

LANTZ: Well, for a long, long time in our society, there's been the assumption that all problems related to health have health care solutions. And so, when you think about who are the people in leadership positions protecting the health of the nation, it's assumed that person needs to be a health expert, which for many people is then assumed to be a physician. I personally do not have any concerns about a physician being the director of the CDC, as long as that person also has training in public health and population health and understands that public health is so much more than the sum of the individual health status of all the people in the population. Again, sick populations have different causes and need different remedies than individual sick people.

At the macro level, it's really the drivers here are public policy. It's public policy that both creates health problems and health inequities, but also, it's public policy that needs to be reformed to try to solve and address these problems. And so, I personally think the director of CDC, the person obviously needs to understand disease processes, pathogens, clinical treatment issues. There's no question about that. However, I think the director of CDC also needs to be a policy expert and more of an expert in social, environmental policy, and economic policy and also in public health law than in health care policy or health insurance policy.

HOFF: Yeah, I'm glad you mentioned law specifically, as I think we've seen a lot of discussion over the course of the pandemic about the legal limits of public health agencies to enforce policy that protect the health and welfare of populations under their jurisdiction, although that might be a little bit beyond the scope of this particular interview.

So, moving on, you suggest that one reason medicalization of public health is problematic is that it, "shrinks the denominator when we try to identify groups at risk." Can you tell our listeners more about this problem and its implications?

LANTZ: Sure. So, I have used the term "denominator shrinkage" to describe how the health care system has usurped the term "population health" and narrowed it and conflated it with population health management. In population health management, the denominators of interest, rather being broad populations and subpopulations within cities, counties, states, and even countries, become the patients who have a

relationship, and it's often a very temporary relationship, with a specific health care provider or an insurance plan. And so, in population health management, the populations of interest are patients who go to a certain place for care or are part of a specific health insurance plan. We are not going to improve overall population health and reduce health inequities by focusing only on patients who have health insurance and/or who have encounters with health care providers. The other concern with many of the interventions going on under the guise of population health management being offered by health care systems is that they're downstream, and they're addressing only the acute social needs of individuals rather than their more midstream and upstream root causes.

HOFF: So, it sounds like we should be scrutinizing these interventions for how they might lead to or encourage medicalization. But the fact remains that individual patients do end up going to individual health professionals to help address the downstream effects on their own health of upstream drivers of health. So, which interventions are the appropriate domain of health systems, and what potential justice concerns should we be aware of when for-profit health systems are put in the position of responding to population health problems?

LANTZ: Well, my take on this is that if an intervention is well designed and actually achieves its goals—and that might include a goal of economic efficiency—I'm actually not that worried about who designed it. However, I am worried about some specific interventions that are being implemented under the guise of population health management almost always with the promise of cost savings to the health care system so that they'll essentially pay for themselves. I'm worried about these efforts because I think many of them are mostly smoke and mirrors. So, let me give you a couple of examples.

There are so many efforts going on right now in terms of screening patients for "social determinants of health." Most of these screening efforts are really, as I mentioned already, screening patients for acute social needs. And then some health systems aren't really doing anything with that information they collect. In other cases, health systems, insurance plans are doing their best to try to address some of those acute social needs. But for the most part, they're really just referring them to community-based resources and beleaguered social safety nets and other programs that already exist in the community and are underfunded and overwhelmed, especially since the pandemic. So, I'm worried about these efforts for screening patients. We know with any other kind of screening, it doesn't do any good to screen something, somebody for a problem if you can't intervene and do anything about it. So, I worry about those efforts.

Also, another example is what's referred to as super-utilizer interventions. So, within population health management, there is a strong emphasis—and it's important and good—a strong emphasis on using data, the data that's collected on your patient population, to understand more about the population and some of their needs. Super-utilizer interventions use data analytics to identify the highest cost or the utilizers who are at the tail end of that distribution who are highest cost patients. And then interventions typically use a case management approach. There's some other themes

and variations on it, but a case management approach is then implemented with super-utilizers that attempts to address both their medical needs in a better fashion but also their social needs. Now, simple pre-test/post-tests of these interventions—an evaluation design looking at how much did these patients cost us the year before the intervention? How much do they cost us the year after an intervention—almost always do show a decrease in costs of the super-utilizers, especially high care costs like emergency department use and hospitalizations.

However, [chuckles] more rigorous evaluations and ones that use a control group, including there's been some randomized controlled trials, these studies reveal that even in the control group that's getting no intervention, health care costs go down from one year to the next in groups of super-utilizers. So, even without an intervention, you would expect the high health care costs in this outlying group of patients to go down. And part of that is because the population of super-utilizers isn't stable. It's different people from year to year. And it actually turns out that some people just they have really bad years, and they cost the health care system a lot of money. And those people almost always have serious ongoing social issues as well. But again, that population is not stable. And when people have some of their worst years, many of them have a better year the next year, and so the health care costs go down. It's, you know, for those listeners who do evaluation research, this is your typical regression to the mean problem, actually.

So, you don't really know what the impact of interventions on outlying groups within a population are unless you have a control group. You really need that to know. And the randomized controlled trials of super-utilizer interventions have produced disappointing results overall. This includes the evaluation of the Camden Coalition intervention. I personally don't think we should be too surprised that these kinds of interventions fail to immediately improve serious ongoing health conditions and social challenges that people have been exposed to probably over a lifetime. So, I'm not surprised that these super-utilizer interventions aren't working, but I know they've been a great disappointment to a lot of people. But you're not, again, you're not going to see it unless you have a good evaluation design.

People with serious medical and social needs live within all these systems we have in our society that are broken in many ways. Let's just talk about housing. There is currently no community in the United States where a person making the federal minimum wage can afford a two-bedroom apartment on that level of income. We have a huge crisis in this country everywhere with housing affordability. It's more visible in some major cities. But housing affordability and housing security is a huge problem. The health care system is not in any position, nor is it its comparative advantage to solve the housing crisis in the United States, right?

We could talk about poverty and income security. We could talk about high quality education for kids. We could spend a lot of time talking about structural racism. These are huge problems in our society that are the core drivers of many of the health problems we see and also health inequity problems that we continue to experience. But again, so, it's not the health care delivery systems' job or the comparative advantage of

the people who work within it to address and reform all of the structural determinants of health and health inequality.

HOFF: Are you aware of any interprofessional education models that promote public health without medicalizing it? And if so, do you see these as successes that can be scaled nationally and internationally? And if I can make this a multipart question, what's your advice to health professions students and trainees who are interested in population health and who might want to pursue some of that interprofessional training?

LANTZ: I think there are many good models for interdisciplinary training for people who are going into the broad field of health care but who are also interested in addressing health inequalities and understanding that health is produced by so much more than health care. So, for example, I think many medical schools are redesigning their curricula and having a stronger focus and training regarding the social determinants of health. Also, the majority of people—and this has been true for a while—being trained as health care administrators at the master's level are actually getting that training in schools of public health. So, I actually, I don't think there's necessarily a problem in education or training. I think the main problem is trying to center the work of population health and health equity within the health care delivery system. Medicine is all about identifying and addressing acute needs and primarily individual medical needs. The efforts to address social determinants of health are hamstrung and limited when they're located within the health care delivery system and insurance plans, for-profit or non-profit. I'll say again that it is not the health care delivery systems' job or comparative advantage to attempt to address and reform the structural determinants of health.

So, I would say of someone who's interested in health care and interested in working in a field where you do work with individuals and try to make their health better through clinical care—and that's fantastic—but if they also want to work on health equity and work on the social determinants of health, my main recommendation is that they get some additional training in public policy. And this is why personally, I made a switch in my own career eight years ago. I moved from being primarily located in a school of public health to a school of public policy, where for the last eight years, I've been surrounded by colleagues who are really experts on poverty prevention policy, social welfare policy, environmental policy, transportation policy, education policy, employment and labor policy. The list goes on and on. In my dedication in my career to be understanding how to reduce the very serious health inequities we have in the United States, I have made a move to understand more about the policy drivers and where policy reform needs to be at these upstream fundamental places. So, efforts within the health care system, again, I applaud many of them. [theme music slowly returns] They are necessary, but they are woefully insufficient if we really want reform in the United States and we really want to improve what is our embarrassing place in the world in terms of overall levels of population health and also our disparities that we have by race, ethnicity, and socioeconomic position.

HOFF: Dr Lantz, thank you so much for your time on the podcast today and for sharing your expertise with us.

LANTZ: Thank you for the opportunity!

HOFF: That's all for this episode of *Ethics Talk*. Thanks to Dr Lantz for joining us. Music was by the Blue Dot Sessions. To read this month's full issue on Clinicians in Government for free, visit our site, [JournalofEthics.org](http://JournalofEthics.org). For all of our latest news and updates, follow us on [Twitter](#) and Facebook [@JournalofEthics](#). And we'll be back next month with a new episode on the ethics of meat production and consumption. Talk to you then.