Playing the poor in the US

KILLED BY A THOUSAND CUTS

Writing about the state of health care in the US these days is like standing on a dismasted ship in the middle of a hurricane. No one knows where this all is going. Those who saw hopeful signs of a country on the verge of agreeing that universal coverage should be a bedrock principle on which to recraft and remodel the clinical and educational health systems have seen that movement undermined at a federal level. Those who saw socialist conspiracies on every page of the Affordable Care Act (ACA, Obamacare) railed against government health care but lost 'bigly' in the Congress. Now they have infiltrated the federal government with managers whose sole goal is to kill the ACA by a thousand cuts. To keep going, those of us educating future family doctors to practise in underserved communities often engage in magical thinking and pray for pixie dust.

San Diego, CA, US — 22 October 1984, President Ronald Reagan giving a speech at a campaign rally at the San Diego County Administration building. iStock.

HOLDING THE 'UNDESERVING POOR' HOSTAGE

As always, those in communities with the fewest resources, who have just recently begun to believe that health care would be there when they needed it, stand to lose the most. Beginning with Nixon and expanded dramatically by Reagan, and now enshrined by the current administration, Republicans have always played the 'undeserving poor' card. The stereotype of low-income families as lazy, entitled, and lacking in self-reliance has been countered by the facts for decades. Yet, the latest administration fantasy — that Medicaid recipients should all be working — seems to ignore the fact that most recipients who are not children, older people, or the disabled are already working,[1] but those who are working are not earning enough to escape poverty or to afford health insurance. That was the whole point of expanding Medicaid, the government insurance programme for low-income families, under Obama.

The most recent irony however is that the rural and urban white poor continue to vote against their own interests in staggering ways. The CDC maps of US morbidity and mortality[2] are terrific teaching tools. One can look at a map of any health issue and speculate about reasons why it looks like it does. But the 2016 presidential voting map is almost superimposable on the counties and states with the poorest health outcomes.[3] A normal response to neglect would be communities demanding that local, state, and federal governments do more to remedy the disparities in Appalachia, the South, and the industrial heartland. Developing social policies addressing those issues, rather than its current focus on special-interest politics, was what built Democratic coalitions in the late 20th century. Instead, voters bought the argument that government and immigrants were the problem, and elected an administration that seems determined to make their own voters' lives, and the disparities that go with them, worse.

All the contrived 'showdowns' on the federal budget have held programmes for the poor hostage. Two widely supported safety net health programmes, the Children's Health Insurance Program and federal funding for community health centres, were in jeopardy. Both federal affordable housing and food security programmes are being cut dramatically. The blaming of 'immigrants' for the plight of the poor has restricted legal immigration and stripped away protection for children who came to the US with their parents. Because they are not citizens, these young people cannot qualify for health insurance. Bottom line: it is a mess and getting worse, and the cruelty behind the politics grows worse daily.

Family medicine, through its professional and educational organisations, has stood firmly for improving and expanding the ACA, and has consistently taken a progressive stance on health care and payment reform. Family doctors see patients who live on the edge of despair affected by poverty, underemployment, poor education, and lack of housing. We know that what we are able to

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do in our offices is a small part of the solution. The changes that were on the horizon with the ACA feel like they are receding. The talk these days is about exhaustion, low morale, and abandonment by the health systems that previously had put primary care at the centre of their strategies. Reading recent concerns about general practice in the NHS sounds sadly familiar. But general practice retains the support of the public in a way that family medicine has never achieved. US medicine is hospital- and technology-centric because that is where the money is, whereas, in the NHS, hospitals are where the costs are. One system suffers from overinvestment and the other from underinvestment.

A DIRE NEED FOR MORE FAMILY DOCTORS

Despite statements lamenting the lack of generalists, academic medical centres bristle when anyone reminds them that one of their social missions, like the Canadian schools, should be responsibility for educating the workforce that is appropriate for the needs of the country. US institutions are more interested in mobilising public sentiment about loss of NIH research support over which they have no control than applying serious measures to produce more generalists through changing their recruitment and educational programmes, which they do control. US graduates going into family medicine has been stuck at 10–15% for decades.[4] The increased intensity of care and administrative workload in family medicine is not helping recruitment.[5]

So, in many ways, the situation for family medicine is very similar to the time of its creation in the US 50 years ago: political turmoil and division, the promise of a national health system lost to military priorities and domestic troubles, and relatively meagre numbers of replacements for an ageing workforce. I was one of those replacements then and now I am part of the ageing workforce.

Gayle Stephens famously wrote that perhaps the chief strength that helped create family medicine was its 'moral credibility' and the public trust of the GP by communities. Its chief threat was the 'toxic cultural and political alliance' of medicine centred on increasing physician compensation and the overuse of technology.[6] However, a lot of moral credibility is lost when the press repeatedly asserts that financial factors are the rationale for medical students not choosing primary care careers. Starting salaries for family doctors that are three to four times the median family income in America doesn't feel like a hardship to working families who have seen their income fall below the median over the past decade.

San Diego, California, US — 27 May 2016, Latinos against Donald Trump march behind a banner of unity outside a Trump rally held at the San Diego Convention Center. iStock.

Doctors are in danger of becoming the 'elites' that angry low-income voters revile, rather than allies in the struggle for social and economic justice.

Leading reform on behalf of the dispossessed in our communities rather than trailing it should be the role of family doctors. Currently, learning advocacy and strategies for reform is not part of the curriculum for residency training. The advocacy should not be within increasingly tone-deaf academic health centres but with local and state governments, public policy, and large health systems. Like the national debt, the cost of health care is becoming unsustainable. I wrote almost a decade ago that health care would be the next big financial bubble to burst in America.[7] The banking and housing bubble got there first, but health care is closing fast, resulting in a painful ride for everyone.

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