

'medicalization' in current health policy



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Changing Public Health Priorities From Medicalization to Improving Built Communities

Laura Schultz, Brett Weed, Ashini Fernando, Carolyn Moore, Andrea Andersen, David Garcia

Medicalization has greatly increased the emphasis on the delivery of clinical services to individuals, often at the expense of population-based solutions. We examine this phenomenon and offer an alternative that promotes public health by improving social, environmental, and physical determinants of health[HS1].

' Medicalization' in Current Health Policy

' Medicalization' is the tendency for the practice of medicine to view a greater proportion of human behavior through a clinical lens (Zola, 1986). Among the examples of medicalization is the direct-to-consumer solicitation of prescription drugs for an arguably ever-increasing repertoire of conditions and afflictions (Frosch, Krueger, Hornik, Cronbolm, Barg, 2007) and increasing access to medical care as is evident through the initiatives implemented by the ACA[HS2].

Ever increasing amounts of money are being invested in treatment of chronic diseases, while a comparatively much smaller proportion is invested in preventing the same conditions (HHS, 2003). The United States spends more than 17% of their GDP on healthcare[HS3]. This per capita health expenditure is more than twice the average of countries of the Organization of Economic Cooperation and Development (Balding, 2014[HS4]), yet these

numbers have translated not into better health but instead, a worsening trend in chronic diseases. US citizens also have significantly lower life expectancy in comparison (Woolf & Aron, 2013).

Despite these considerable investments in health care delivery, the costs associated with treating the manifestations of poor health continue to rise unabated. Over the last five years in North Carolina alone, approximately USD 80 million of the federal budget for public health was appropriated for primary care for the underserved populations (Trust for America's Health, 2014[HS5]).

Public Health Spending

In contrast, public health only receives approximately 3% of the government budget and is underfunded (Balding, 2014). Nationally, 95% of health spending is for the apportionment of clinical services, while only 5% is invested in population-based solutions (Lantz, Lichtenstein, Pollack, 2007). In North Carolina this division is even more extreme, with less than 1% of health spending dedicated to public health operations (Table1[HS6]).

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Year	Public Health Appropriation[1]	State and Local Health Care expenditures[2]	Public Health as % of Healthcare
2009	147, 000, 000	18, 220, 000, 000	0. 81
2010	133, 000, 000	18, 810, 000, 000	0. 71

2011	132,000,000	19,520,000,000	0.68
2012	138,000,000	20,500,000,000	0.67
2013	122,000,000	21,470,000,000	0.57

Table 1. North Carolina Public Health Appropriations as a Percentage of Public Health Care Spending (Trust for America's Health, 2014; Chantrill, n. d.)

It is worth[CDL7]noting that the leading cause of mortality in the US, cardiovascular disease, accounts for annual healthcare costs that exceed USD \$312.6 billion (HHS n. d.), yet when diagnosed early, disease progression can be addressed with non-pharmacological interventions[HS8]. In North Carolina, a mere 0.81% (~ USD 15 million, 2013) of the federal budget for public health was appropriated for prevention measures of all chronic diseases (Trust for America's Health, 2014). These funding trends appear to support medicalization of health instead of prevention through public health efforts. Rather than continue to invest in a stopgap strategy of mitigating the impact of illness, we propose to instead invest in the prevention of illness[HS9].

Addressing Social Determinants

Population health investments within corporate environments have shown considerable financial success and value beyond return on investment (ROI). One corporate wellness program saw a ROI of close to 300%; another

company saved an estimated \$224 per employee in 2003 dollars from promoting health rather than treating a lack of it (HHS, 2003[HS10]).

Applying this same per capita savings rate to North Carolina, shifting funding to prevention and health promotion could yield savings of \$2.2 billion annually[3], more than offsetting the annual increases in health services expenditures. Value beyond ROI includes physical and mental health, quality of life, perceived health status and functional capacity. Workplace well-being also promotes other intangibles such as increased social cohesion (Pronk, 2014).

There is an established correlation between positive social relationships and health. As Robert Putnam wrote in 2000 in *Bowling Alone*, "social capital" conveys the essential health promoting value of communities[HS11]. It is defined as "the social networks and interactions that inspire trust and reciprocity among citizens" (as cited in Leyden, 2003). Social isolation, independent of other lifestyle factors, is linked to premature death and decreased resistance to disease (Cohen, 2001). Beyond individual health, social capital is associated with political engagement, volunteerism, decreased crime rates and economic development (Leyden, 2003). Research has shown that when we design our communities to encourage social engagement there is a positive effect on the psychological and physical health of the residents (Leyden, 2003[HS12]).

Since the advent of the automobile, the design of our communities has included limited transportation choices. Most individuals choose to travel by car because urban design has made most options for pedestrians unsafe (Vandergrift, 2004). The US, compared to other high income European

countries with better health measures, have at least 25% more automobiles per 1000 people (Woolf & Aron, 2013). European Countries also have policies which limit sprawl and prioritize "urban centralization". Though difficult to quantify, these environmental factors are likely to contribute to the health disparities and disadvantages in the US (Woolf & Aron, 2013).

Political and social conditions and constructs, racism for example, also results in poor urban design that compound health disparities including limited access to businesses and markets, exposure to environmental toxins, and lack of opportunities for social participation. Specifically, infrastructure investment decisions, such as libraries, parks, public safety and maintenance are likely to be allocated to geographic areas populated by citizens with greater socioeconomic status and political power, which further marginalize disadvantaged socioeconomic groups (Schulz & Northridge, 2004).

Alternatively, mixed use, pedestrian friendly communities are based on thoughtful design and include intact town centers, multiple income residences and well linked streets that are designed for people, not automobiles (Walkable Communities, n. d.). Prioritized determinants of health, which we expect to improve because of innovative planning include increased social engagement, improved economic status and increased physical activity (Walkable Communities, n. d.). As of 2012, approximately 50% of the US adult population has been shown to suffer from chronic diseases. However, adequate physical activity has been scientifically proven to prevent or improve these chronic disease conditions[HS13]. Yet, according to a 2011 statistic from the CDC, 76% of adults did not meet the

recommendation for muscle-strengthening physical activity which is a known risk for heart disease (CDC, 2014).

There are states where the built environment is viewed as worthy of significant investment to improve population health. Specifically, in Massachusetts there are two examples of lower than average socioeconomic status communities where health impact assessments indicate that built environmental improvements would improve social factors and likely decrease expenses in medical intervention. In Somerville, there is a community driven planned change to a bisecting interstate. This plan, made with consideration for social health determinants of the residents includes multi use bike and walking paths with increased access to all areas of the community[HS14]. Community-wide access will provide opportunities for social interaction, physical activity and increased choices for employment (MassDOT, 2013). A community with similar demographics, Fall River, has proposed common trails for recreation and pedestrian and bicycle travel that connect residents to businesses. This is predicted to improve every health determinant the HIA evaluated (MAPC, 2013).

Based on a review of state sponsored health impact assessments in other communities, there is a significant relationship between communities with walkable pathways and health (Rails to Trails Conservancy, 2013). We propose that thoughtful environmental structure enhancements such as multi-use walking and biking paths will connect neighborhoods and businesses. In turn, we believe these changes will positively affect social cohesion, economic viability and physical activity, which are all key

determinants of health that can improve with innovative public policy implementation [HS15].

Conclusion and Recommendations

Evidence from state sponsored health impact assessments in other communities, indicates that there is a positive correlation between communities with walkable pathways and health (Rails to Trails Conservancy, 2013). Environmental structure enhancements such as multi-use walking and biking paths that connect neighborhoods and businesses could positively influence population health in North Carolina. We believe these changes will positively affect social cohesion, economic viability and physical activity, which are all key determinants of health that can improve with innovative public policy implementation.

In North Carolina there are 31 completed Rails to Trails programs (NC Rails-Trails, 2014). This national program improves the built environment by converting former railroad routes to pedestrian and bike friendly paths. However, only 2 of the 31 completed trails are located in counties with the poorest health scores (RWJF 2014; NC Rails to Trails, 2014). Eastern North Carolina, where 9 out of 10 of the most poorly rated counties for health outcomes are located, also have the fewest trail initiatives (NC Rails-Trails, 2014). This skewed distribution of environmental improvements further demonstrates the way in which populations within poor socioeconomic communities are financially neglected, and thus likely to continue to suffer from worse health outcomes. Using Massachusetts as an example, the state's Department of Health and Human Services has initiated a program to

identify communities with the lowest socioeconomic status and assist them to “ build policies, systems and environments that promote wellness and healthy living” (MassDOT, 2013).

In partnership with state and county planning officials, public health leaders, and state demographers, our plan is to target lower socioeconomic communities, initially focusing on a county with the poorest health indicators, to plan and build multi-use trails. We request priority funding allocated through the US Department of Transportation via the Moving Ahead for Progress in the 21st Century ACT (MAP-21), as well as private foundation grants that prioritize state population health improvements like the Annie E. Casey and Doris Duke foundations. Our plan for advocacy is to engage community members in the trail project as stakeholders. Specifically we will encourage our members to influence policy decisions through community informational meetings, including letter writing assistance intended to exert pressure on local politicians. We intend to host community or health center “ coffees” with opportunities to meet county commissioners and planners. Media coverage in the local newspaper is another part of our advocacy plan. Specifically, we will engage local media in an effort to “ frame” the problem of poor environmental design and how it impacts health by profiling one citizen with health risks and limited transportation options who lives on a pedestrian unsafe street, visually depicting the social isolation inherent in this environment though a photolayout[HS16].

By engaging our most vulnerable North Carolina citizens to take part in improving their quality of life and ultimately their health and longevity, we will have the best chance at community environmental improvement as a <https://assignbuster.com/medicalization-in-current-health-policy/>

long term effort. The time is now to refocus our priorities on health investment through prevention and promotion of public health efforts rather than treatment of diseases.

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Team	Possible Pts.	Earn
1. Concise statement of topic and why important	1.5	1.5
2. History of issue, previous action/policy	1.5	1.5
3. Description of current status of issue	1.5	1.5
4. Includes an analysis of issue(s) and implications of addressing or not addressing the issue, policy implications, costs/rewards to agency, community, etc.	1.5	1.5
5. Conclusion & recommendations for action supported by the paper's content and analysis, based on fact and analysis vs personal opinions.	1.5	1.5
6. Appropriate use of the literature and proper citations and references in APA format sytle.	1.5	0.75
7. Well-written and logical organization of content, including	1	1

grammatically correct writing

Total Points

10

9.25

+5 p

extra

[1]Rounded to nearest million

[2]Rounded to nearest ten million; represents NC state and locality public health care spending

[3]Based on 2013 NC Population Estimate of 9, 848, 060 (US Census Bureau 2014).

[HS1]Nice introduction to your paper

[HS2]Good examples

[HS3]Is this from your Balding reference? This statement needs to be referenced.

[HS4]This is listed asBlandington your reference list.

[HS5]Very nice section, your reader will have a good understanding of *medicalization* after reading this section

[HS6]Great reference and statistics that support your premise

[CDL7]Do not use this construct in this class, " it is", " there are", etc.

[HS8]Such as implementing lifestyle changes with diet & exercise.

[HS9]Very good!

[HS10]Impressive!

[HS11]Very interesting, I will be reading this.

[HS12]Great examples and points being made, excellent references.

[HS13]You need a reference here

[HS14]This entire section isn't referenced. Unless this information is considered to be " common knowledge" e. g. it came from your own brain & or was information you were aware of prior to writing this paper, it needs to have a citation. Please review when to cite from UNC libraryhttp://www2.lib.unc.edu/instruct/citations/index.html?section=why_we_cite

[HS15]Great ideas

[HS16]Great ideas and plan of action