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Money as Medicine — Clinicism, Cash Transfers, and the Political–Economic Determinants of Health

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The Covid-19 pandemic intensified many long-standing economic and health vulnerabilities, illustrating their fundamental interdependence and the hazards of imagining that public health could be effectively advanced by policy frameworks that fail to address its political–economic determinants.[1] In the United States, high Covid-19 mortality rates, which have disproportionately affected low-income communities and worsened what was already the lowest life expectancy among high-income countries, testify to the acute-on-chronic harm caused by decades of health policy characterized by what I call "clinicism."[2,3]

Clinicism is the reduction of health to individualistic biomedical paradigms that overemphasize clinical perspectives and interventions (even though clinical care is estimated to account for only 10 to 20% of modifiable factors shaping health in the United States[4]) while normalizing existing social conditions and neglecting to prioritize preventive policies that target other key drivers of health and disease. These include, for example, policies affecting labor and environmental conditions, poverty and associated housing and food insecurity, social isolation, and public infrastructures for community-building social care involving supportive interpersonal relationships. Despite its limitations, clinicism pervades U.S. public health efforts, which are primarily led by physicians more familiar with biologic and clinical sciences than with political economy and associated social sciences. Many scholars, recognizing this shortcoming, have called for greater attention to social determinants of health, including research on structural violence and the causes of the causes, commercial determinants, and "capitalogenesis" of disease.[5-9] Such paradigms, however, generally remain descriptive academic projects that have not been translated into prescriptive policy action and the political organizing such action requires.[10]

One reason for this lack of application is that scholars, university and health systems administrators, and public health officials face incentives, imposed by philanthropic funders and politicians, to abstain from foregrounding the political–economic determinants of health or insisting on specific policies to address economic inequality. In many cases, acting otherwise would entail challenging policies that have been embraced since the 1980s by both Republican and Democratic administrations that have overseen historic increases in inequality while defunding public support systems, empowering in their place private businesses or charitable organizations dependent on wealthy benefactors, and fueling the growth of an inefficient health care industry providing inequitable and limited benefits.[11,12]

In this context, Daniel Dawes has argued for explicitly emphasizing the political determination of social conditions that shape health.[13] Application of such a framework, however, has often been short-circuited by two simplistic assumptions: that politics are reducible to parties and electoral races, and that health is primarily the result of health care. In a highly polarized partisan context, these widespread assumptions have deflected attention from inequality-fostering policies supported by both major U.S. political parties and have intensified clinicism's influence on health policy.

But though the Covid-19 pandemic laid bare the consequences of long-standing U.S. health policy norms and partisanship, it also temporarily disrupted the status quo by provoking overwhelmingly popular emergency measures that illustrated both the potential of supportive social policies to improve health and the necessity of

approaching health, safety, and economic policy as intertwined. One early pandemic policy in particular, cash transfers, demonstrated the promise of a policy tool that could enable health scholars, clinicians, administrators, and public health officials to collectively overcome undue clinicism and expand health policy beyond just health care, rebuild trust in public health institutions, and directly address the political–economic determinants of health.

COULD CASH BE OUR BEST MEDICINE?

Beyond a staggering global death toll, one of the most concerning consequences of failed pandemic control was the rapid expansion of poverty. In 2021 alone, after three prepandemic years of annual reductions in the global poverty rate, an estimated 115 million people — nearly all in formerly colonized countries — were pushed into extreme poverty (i.e., subsisting on less than $2.15 per day), which brought the global population living in extreme poverty to nearly 700 million people.[14] But in the United States, where estimates suggest that poverty was the fourth-leading risk factor for death,[15] the pandemic led to sharp reductions in poverty owing to the expansion of eligibility for public aid in addition to emergency cash disbursements to large swaths of the population. Federal household subsidies in 2021 — nearly $570 billion in pandemic stimulus checks plus improved unemployment insurance and child tax credits — led to a historic 50% reduction in the child-poverty rate and a 15% decrease in overall poverty.[16]

The changes to the child tax credit that contributed to this shift were particularly effective — and instructive for health policy. Before 2021, the U.S. child tax credit provided a benefit of up to $2,000 per child, largely to middle-income families, since the credit had to be claimed as a tax refund and thus excluded millions of families whose income was so low that the full credit exceeded their tax liability and was therefore denied to them. In 2021, in light of the economic harms caused by the pandemic, eligibility criteria were expanded to reach more low-income families. The benefit was increased to $3,600 per child younger than 6 years of age and $3,000 per child 6 to 17 years of age. And rather than being offered as a lump-sum tax refund at the end of the year, the credit was provided as monthly advance payments by means of automatic bank transfers. Suddenly, the lowest-income families were receiving the same government benefits afforded to middle-class families, bureaucratic obstacles were largely eliminated, and more cash was directed to the households and local economies that most needed it.

What the expanded child tax credit essentially did, at a cost of $128 billion over 1 year (less than 2% of the federal budget, 3% of 2023 U.S. health care spending, or 7% of the 2023 U.S. defense budget), was provide a guaranteed basic income for families with children. For many of the nearly 40 million U.S. residents living in poverty, this provision of public support in the form of basic income didn't merely reduce poverty; it had a dramatic stabilizing effect and substantially improved their health and experience of everyday life.[17]

Financial insecurity is a major driver behind cycles of poor mental health, disease, violence, crime, and incarceration — all of which, in turn, further entrench poverty, destabilize families, undercut public health and childhood education, and constrain people's life opportunities.[18,19] Historically, most U.S. policymakers have ignored this reality, constructing one of the most insufficient, inefficient, and onerous welfare systems among wealthy countries, exacerbating instability for people living in poverty and making receipt of public support unnecessarily restrictive, time-consuming, unpredictable, and stigmatizing.[20] This failure has wide-ranging consequences for the country as a whole, affecting everything from public health to economic growth and the declining competitiveness of the U.S. workforce.[21]

At scale, guaranteed basic income, by providing financial predictability to people and families who have been deprived of it, has the potential to mitigate much of the economic, medical, social, and psychological harm that inadequate U.S. welfare programs alongside tax breaks for the rich have enforced. A study of the child tax credit expansion in 2021, for example, examined the benefits of the basic income the credit provided beyond the dramatic reductions in childhood poverty.[22] It showed that, although the use of mental health services didn't change, receipt of monthly income from the tax credit was as-

sociated with substantial reductions in symptoms of depression and anxiety among adults. This benefit was especially pronounced in Black, Latinx, and other racialized populations that are disproportionately subjected to chronic stress caused by financial hardships and inequalities in income, wealth, housing, and health care.[23-25] Other studies showed that the expanded child tax credit was associated with immediate reductions in emergency-department visits attributable to child abuse or neglect, as well as with improved overall health among adults and food security among both adults and children.[26-28] Such findings are consistent with the long-observed health benefits of both cash transfers in general and child tax credits in particular that have led organizations such as the American Academy of Pediatrics and the National Academy of Medicine to call for their expansion.[29]

In a national political context in which debate continues over whether various public support systems are effective, the 2021 expanded child tax credit made clear what such systems can do. As more research on the effects of guaranteed basic income is published, it will join a large body of literature showing that cash transfers to poor households have substantial ripple effects beyond financial benefits, underlining that people who care about addressing poverty — and who need to generate mass popular support to do so — should stop talking about basic income as simply an antipoverty policy. Investments in such programs also return major benefits for shared public health, public safety, and collective economic prosperity — population-wide gains that improve quality of life for everyone.[30-32]

Many studies have shown that cash-transfer programs lead to substantial reductions in homicide, assault, intimate partner violence, property crimes, recidivism, and overdose deaths.[33-38] And a growing body of research demonstrates that such programs can generate major health gains, mental health improvements (sometimes greater than those achieved by professional mental health services), substantial reductions in both childhood and adult mortality, and education benefits.[30-32,39-43] Many of these effects have been observed since the 1960s, when President Richard Nixon proposed guaranteeing $1,600 annually (more than $13,000 in today's dollars) to every family of four. Guaranteed-income research has long confirmed that public health, public safety, and economic security are necessarily interwoven projects. We can't effectively build any of them without building all three.

DECOMPARTMENTALIZING HEALTH POLICY

Governance is shaped by the metrics by which policies are judged. Accordingly, researchers need to start measuring the effects of public policies — whether they are said to serve health, poverty alleviation, or safety — in a more holistic way so that we can better understand and show the public the effects spanning all three domains. If a safety policy appears to reduce violence or crime rates in the short term, for example, but does so by means that exacerbate poverty or undermine health, society will ultimately pay for it in myriad ways over time.[19,44] Conversely, if a traditional health policy — such as Medicaid expansion — improves safety or housing stability, reduces arrests and incarceration, or reduces poverty, policymakers should account for these effects in deciding whether to allocate public funds to it or to other programs.[45,46]

Advancing such analytic frameworks, reducing the influence of clinicism, and redesigning the metrics shaping public policy will require "resocializing" increasingly subspecialized, technocratic health and social sciences whose sociopolitical vision has become correspondingly narrow and detached from local context.[6] That work entails prioritizing the resocializing disciplines — anthropology, sociology, and social history — to foreground dispossessed communities' lived experiences, unmet needs, existing capacities, and ideas for change, and ensuring these communities' direct and systematic inclusion in policy formulation, implementation, and evaluation.[3,6] It will also require linking of diverse data sets and greater collaboration across currently distinct areas of expertise.

If officials and researchers applied such long-term, integrated, bottom-up policy frameworks to the implementation and evaluation of the more than 100 cash-transfer pilot programs under way throughout the United States, they could optimize the programs' potential to meet both individual- and community-level economic, safety, and health needs.[47] Such pilot programs have

repeatedly proven to be successful. But regardless of the evidence for adopting guaranteed basic income as permanent public policy, political resistance to moving beyond pilots and implementing these programs as durable policy remains high; this resistance works in synergy with academic research incentives to focus primarily on experimental trials and the lack of incentives, institutional support, or training for scaling up effective interventions. For several years after the Social Security Act was passed, critics described it as a radical, socialist program; today, many political opponents of guaranteed basic income programs disparage them similarly. But as the popularity of federal initiatives such as Social Security, child tax credits, earned income tax credits, and unemployment insurance reflects, the United States has a long history of and widespread support for using cash transfers to mitigate and prevent financial hardship. The truth is that cash-transfer programs don't represent a radical shift from conventional U.S. policy; they're a continuation and expansion of what have long been America's most effective and popular government programs.[48]

What has often been missing from public perception of such programs is recognition of their importance not only for their direct beneficiaries, but also for everyone else. The failure to clarify this importance contributes to their underuse. Even the 2021 child tax credit expansion, which effected historic reductions in child poverty, was allowed to expire in 2022 as part of congressional negotiations over the Inflation Reduction Act. The consequences were swift: from 2021 to 2022, the year-over-year increase in U.S. child poverty was the highest on record: the child poverty rate jumped from a historic low of 5.2% to 12.4%, putting 5.2 million more children below the poverty line. It is estimated that child poverty would have been nearly 47% lower in 2022 if the expanded credit had been continued.[49]

Many lawmakers argue that social welfare programs are costly, but when such programs are administered as crisis-prevention systems that keep people out of poverty rather than as barebones "safety nets" to catch people after they fall into crisis, strong welfare policies ultimately deliver public savings and often pay for themselves.[50-52] In a country with out-of-control health care spending — already by far the highest in the world and on track to increase by more than 50% to $6.8 trillion by 2030 — as well as mortality and health care access that rank last among peer countries,[53] the savings that expansion of guaranteed income could achieve by reducing mental health, emergency-department, medication, and hospitalization needs would most likely be considerable.[54-58]

When additional cost savings from violence prevention and reduced reliance on policing, jails, prisons, homeless shelters, and crisis-oriented social services are factored in, expanding existing cash-transfer programs to bring every U.S. household out of poverty would most likely, over time, substantially offset these programs' upfront costs and might ultimately save taxpayer dollars going forward.[33-38,50-52] Public initiatives such as antipoverty cash-transfer programs should therefore not be viewed as charity for the poor but should be regarded, codified, and funded as essential public health and safety infrastructure.

In addition, investing in the basic financial security and well-being of people is simply the right thing to do in a country that has more than enough wealth to meet the needs of every resident. But there is a possible pitfall: guaranteed basic income should supplement, not replace, public systems for essential services such as health care, housing, and education. If guaranteed income is used to justify the further weakening of regulatory systems (e.g., rent controls) and already-insufficient public-support systems (e.g., public housing and health care) that help keep market dynamics in check, then the dollars distributed could yield rapidly diminishing individual and population-wide benefits.[59,60] In such a scenario, guaranteed income could be used as an alibi for further privatizing essential services and deepening the immiseration of poor communities.[11,12]

If understood as one piece of a renewed public system for ensuring the well-being of each U.S. resident, implementation of guaranteed basic income as permanent health and safety policy could be an essential step in addressing profound inequality and deteriorating trust in government and public health.[61] Given its easily explained character and widespread popularity, supportive rather than restrictive nature, immediately tangible personal benefits, and effectiveness in addressing the political–economic determinants of health, guaranteed basic income may be an ideal policy

with which to begin the essential work of redefining public health and the scope of health policy for an American public that is rapidly losing faith in their importance.

As social medicine experts have long emphasized, delivering effective clinical care and ensuring robust public systems for social care are interdependent and synergistic projects.[6] It is difficult to care for patients as effectively as possible without addressing root political–economic causes of sickness and death, from poverty, malnutrition, homelessness, and mass incarceration to health care exclusion. In the United States, medical institutions have often neglected this reality and sometimes even leveraged their political influence to oppose investments in social care that they saw as threats to their economic interests.[62,63] This attitude has undermined both public health and the medical profession, which is now facing a related crisis of demoralization and attrition.[62,64] For the sake of the profession and our patients, it is time to reassert a concept of medicine that goes beyond the clinic alone to advance supportive social policies without which our work cannot succeed.

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