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If You Would Not Criminalize Poverty, Do Not Medicalize It

William M. Sage and Jennifer E. Laurin

I. Introduction

"The very poor are different from you and me."
"Yes, they have less money."

As this rephrasing of a famous if apocryphal literary exchange between F. Scott Fitzgerald and Ernest Hemingway suggests, America has a deep-seated need for narrative when considering either poverty or wealth. Narrative that is, moreover, bidirectional. How did the poor become poor (and are the rest of us immune)? How might the poor become less poor (and is it their task alone)? And why is a static answer that fails to account for past or future so unsatisfying?

One can apply this insight to the wholesale engagement of U.S. medical resources in caring for the poor. A growing number of health policy scholars argue, with strong empirical support, that U.S. social policy is substantially over-medicalized. Both federal and state actors under-invest in education and neglect non-medical social services while massively indulging in overpriced, often ineffective medical care — a skew that is particularly bad for the poor. As explained below, law helped create and now perpetuates this gross misallocation of social resources.

Some participants in this Symposium appear to believe that medicalizing poverty is a *good* thing. Their reasons for favoring the medicalization of poverty are some combination of (i) "the poor have substantial medical needs," (ii) "health is necessary for success," (iii) "medicine is where the money is," and (iv) "we are smart, good people who can help the poor as we do our medical jobs."

Count us as skeptical. Having observed in recent decades that American society tends to criminalize that which it does not medicalize, we suspect that the measurably harsh consequences of criminalizing poverty offer cautions for its continued medicalization. The American moral and economic ideal of self-sufficiency unavoidably links poverty, criminality, and infirmity. Indeed, past reformers made arguments for a positive role of criminal justice in the relief of poverty that are similar to those aired in the healthcare con-

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text today. Juxtaposing medicalization and criminalization reveals the ambiguities of "opportunity" when capacity is compromised, and the consequent tension between liberty and welfare as the core objective of policy. Ultimately, we urge policymakers to disconnect the relief of poverty from medical care as much as possible — not only to avoid further disadvantaging the poor, but also to encourage investment in unadorned benefits to poorer Americans that have greater potential, particularly at the local level, to build trust and cooperation without the economic and social mischief that has accompanied the medical model.

The Steep Price of Medicalization

The U.S. healthcare system is massively inefficient. The U.S. healthcare system is also massively unfair. Neither fact was widely known a generation ago.

As recently as the 1990s, students of health policy were taught that, guided by the skilled American medical profession, a scientifically optimal method could be determined to treat each disease.[1] From this perspective, resources dedicated to the medical needs of the poor were well spent, a testament to both science and egalitarianism.

The challenge to medicalization seemed equally straightforward. Because resources are not unlimited, technologic progress would eventually require finding an appropriate balance among access to healthcare, medical spending, and healthcare quality.[2] When the Clinton administration invited a panel of bioethicists to join its health reform deliberations in 1993, many answered the call to help solve this problem.[3]

Students today are still taught the "3-legged stool" of access, cost, and quality, but they also learn the "Triple Aim": improving the patient experience of care (both objective and subjective), improving the health of populations, and reducing per capita cost. The Triple Aim differs from the access-cost-quality paradigm in two obviously important ways: acknowledging patients' preferences and engaging population health.

It also differs in a third, absolutely crucial way that is less obvious: the three parts of the Aim are not mutually exclusive, but are simultaneously achievable! Several decades of health services research have revealed an enormously wasteful and underperforming healthcare system rife with unexplained variation, major safety lapses, and poorly defined quality. Extrapolating from a report by the Institute of Medicine using 2010 data, over $1 trillion of annual U.S. health expenditures represent unnecessary services, inefficiently delivered services, excess administrative costs, prices that are too high, missed prevention opportunities, and fraud.[4] Worse yet, the system's failings are not evenly distributed, but more profoundly burden the less privileged based on race, ethnicity, and socioeconomic status.[5]

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These revelations cast a critical lens on medicalized poverty by reducing its direct benefits and increasing the opportunity costs it imposes. The persistence of such rampant waste is connected to the deep legal architecture of the healthcare system, which idealizes the therapeutic relationship between a single physician and an individual patient, attempts to wall it off from outside influences whether governmental or industrial or competitive, and lavishly subsidizes through public insurance entitlements and private tax forbearance its idiosyncratic and discretionary output.[6] Combining generosity with inefficiency under disaggregated physician control has inflated aggregate medical spending at an alarming rate, without providing an effective counterweight to either inequality or bias.

Care for the poor is particularly costly because of their higher disease burden and greater dependence

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on hospital-based evaluation and treatment. In his classic 1962 book about poverty, *The Other America*, Michael Harrington described it as a "vicious circle" of persistent, compound disadvantage:

> The poor get sick more than anyone else in the society. That is because they live in slums, jammed together under unhygienic conditions; they have inadequate diets, and cannot get decent medical care. … Because they are sick more often and longer than anyone else, they lose wages and work, and find it difficult to hold a steady job. … At any given point in this circle, particularly when there is a major illness, their prospect is to move to an even lower level and to begin the cycle, round and round, toward even more suffering.[7]

Medicare and Medicaid, federal health entitlements enacted and expanded after Harrington's book appeared, made it possible for many poor individuals to receive treatment when seriously ill. But "decent medical care" has not broken the cycle of poverty.[8] To the contrary, the cycle of poverty undermines the effectiveness of "decent medical care" in addressing the health needs of the poor. Much care — particularly in hospitals — is reactive, remote, unfamiliar, time-consuming, non-participatory, and expensive even when subsidized. A sick individual who does not have stable or safe housing, reliable heat and air conditioning, or ready access to transportation will be hard pressed to do the things — rest, medication, diet, follow-up — required of a "good patient." The inverse relationship between socioeconomic status and health expenditures at the neighborhood level offers a geographic counter-narrative to what has become conventional wisdom about local professional norms as the main cause of clinical variation.[9]

Meanwhile, resources to help avoid and address poverty have skewed sharply toward medical uses. Non-defense federal spending is dominated by Medicare, Medicaid, and Social Security (plus interest on the national debt), leaving relatively little for all other national needs. In state budgets, rising medical spending particularly crowds out educational spending, adding an element of tragic competition to two essential building blocks for human capital. The United States is a negative outlier: it not only devotes a much higher share of GDP to medical care than do other developed countries, but also dedicates less of its national output to non-medical social services that improve health.[10] This is the enormous price paid for medicalizing the needs of the poor.[11]

A Nation of "–zations"

American society in caricature is optimistic, confident, classless, and upwardly mobile. It is the land of opportunity, the incubator for the self-made millionaire. American society in reality is one of the most unequal in the world, with widening income inequality over the last three decades that has condemned at least forty million people to lives of poverty.[12]

The rhetoric of limitless potential could not diverge so sharply from the reality of constraint without a creation myth for poverty. Something to explain why those who are poor failed to attain the dream, and why we who have avoided poverty thus far are unlikely to descend into it. Something, typically, that casts poverty as susceptibility. Hence the many "-zations" that periodically attach to the social meaning of poverty — racialization, criminalization, and medicalization among them.

Harrington's book was written on the cusp of Lyndon Johnson's metaphorical "War on Poverty," before it and other Great Society programs became a fiscal and political casualty of the real war in Vietnam. *The Other America* sought to challenge presumptions of post-war prosperity and self-sufficiency and to bring visibility to millions of impoverished Americans whose suffering lay beneath a veneer of normalcy. When Harrington described a "culture of poverty" that focused on immediate needs to the exclusion of long-term goals, he did not mean to disparage or accuse, but to illustrate the quiet hopelessness of compound disadvantage.[13]

Harrington was heard very differently, however — as speaking to "normal" America about an underclass that did not share its values or its moral fiber.[14] The other America, though worthy of pity and assistance, could not be trusted with money or authority. While never endorsing the Dickensian nightmare of workhouses and debtor's prisons, political figures as disparate as Daniel Patrick Moynihan and Ronald Reagan recast poverty as a failure of character and therefore as a matter of setting limits, preventing abuse, and avoiding dependence.[15]

This paternalistic project replaced empathy and charity with supervision and "tough love," seldom consulting the poor about their most pressing needs and desires. It is true that calls to give the truly disadvantaged "opportunities" often ring hollow: if health, education, and other attributes of human capital are prerequisites to actually availing oneself of life's opportunities, offering those who lack them merely the opportunity to access them may change little. On the other hand, disciplining the poor in a directive fashion invited new constituencies, including both the healthcare system and the criminal justice system, to

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participate in the formative project of "curing" poverty by substituting a constrained option set for open-ended self-determination.

By the 1980s, both the medical and the criminal justice systems had been primed to assume this role with accelerating determination and at growing expense. If the poor could not be trusted with money, they could instead be offered in-kind services that non-poor taxpayers were willing to support, while being monitored closely for signs of misbehavior. If the poor were unhealthy, the passage of Medicare and Medicaid in 1965 brought the fiscal capacity of the federal government to render service with few constraints on medical professional discretion. And if the concentration of crime and violence in poor communities created a structural barrier to advancement, so much the better (for the poor) that crime fighting and "anti-delinquency" be championed on their behalf. Such aims of the Great Society programs converged with the (racialized) law-and-order response of the Nixon administration to the social upheavals of the 1960s. The prolonged economic downturn of the 1970s further weakened American cities, boosted trade in street drugs, and worsened public fears of violent crime, prompting states and the federal government to harshen laws and build prisons.[16]

Thus emerged a false rhetoric of prevention for both illness and crime. Powerful interest groups in each domain would "talk the talk" of why addressing the root causes of social problems would be cheaper and more humane than dealing with the aftermath. As they lamented alongside the taxpaying public the high cost of reactive approaches to healthcare and criminal justice, however, they would be paid handsomely to implement exactly those approaches.

In the case of criminal justice, it has not gone well. In the case of medical care, there is less and less reason to believe that it will. Of all the "-zations," however, the most powerful remains rationalization.

II. A Short History of Medicalized Poverty

It is tempting to think of medicalization and criminalization as opposite approaches to poverty: the former driven by compassion and the latter by condemnation. Historically, however, a range of deviant behaviors — physical illness, behavioral health problems, and antisocial conduct — were seen as divine judgments, often of a punitive character.

Over the decades, claiming assistance when ill has been drained of moral opprobrium. The (presumably frail) elderly, the blind, and the disabled clearly could not support themselves. Even the large cohort of (relatively) healthy families in which women raised children alone, a group one might imagine to be morally suspect, was seen as "deserving" because the shadow of death — early widowhood — hung heavily upon it.

Advances in biomedical science and technology accelerated the transformation of illness from blameworthy to blameless conduct, in part because curing the disease implied curing its cause. With this altered understanding came a charitable entitlement to medical services, increasingly administered through public programs, as well as to public health and environmental protection. In the United States, however, medical and public health functions diverged early in the 20th century, with greater authority and support attaching to the therapeutic imperative of the private medical profession.

The medicalization of poverty has been amplified by deference to individual physician judgment, which in turn generates a host of costly services to be mobilized by physicians' prescriptions, orders, and referrals. There is little doubt that the watershed moment was the enactment in 1965 of Medicaid for the deserving poor and Medicare for elderly survivors of the Depression and two world wars, most of whom also were poor and had short life expectancies. A crossover point was reached by the early 1980s, when aggregate medical expenditures for the poor — driven largely by the hospitalization of Medicare beneficiaries — began to exceed those for the non-poor.

This medical model for aiding the poor through federal entitlements coincided with a backlash against welfare dependency and cash assistance. Competing narratives of medical innocents, on one hand, and "predators" and "welfare queens," on the other, achieved rough equipoise in the welfare reforms of the mid-1990s. Federal cash welfare was drastically curtailed, and converted into a program (TANF) that emphasized work and made nearly all assistance temporary. Medicaid, by contrast, emerged intact from the 1996 negotiations, protected sufficiently by the politics of medical care. In hindsight, channeling welfare benefits almost exclusively through medical processes had unanticipated adverse effects. One was reduced take-up of Medicaid once it had been decoupled from cash assistance.[17] Another was the greater need to establish eligibility for assistance through the diagnosis of disability — often by claiming chronic, pain-producing injuries that required prescription opioid medication.[18]

Despite growing partisanship, the 1990s settlement held until the passage of the Patient Protection and Affordable Care Act (ACA) in 2010. The ACA challenged the narrative of blamelessness in two principal ways. First, it mandated the private purchase of health insurance on similar financial terms between the young and healthy and the old and infirm, in essence rewarding the unhealthful behaviors that were

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increasingly recognized as root causes of chronic disease. Second, it expanded Medicaid to healthy adults with low-wage jobs on a nationally uniform basis that starkly reversed over a decade of deference to state and regional differences in attitudes toward the poor. The post-2016 congressional repeal of the tax penalty associated with the individual mandate, the withholding of cost-sharing subsidies by the Trump administration, the administration's support for risk-rated "short-term" health plans, and the Secretary of Health and Human Services' approval of Medicaid waivers instituting work requirements for Medicaid recipients all evidence a resurgence in attributing moral failings to the poor.

III. Like Medicalization, Like Criminalization

Being poor has at times been a crime. However, a series of U.S. Supreme Court rulings in the 1960s and 1970s rendered constitutionally suspect this low-hanging fruit of criminalization. Thus, in *Robinson v. California*,[19] the Supreme Court held that the Eighth Amendment to the U.S. Constitution prohibits making a mere status (addiction) a crime. Constitutional law also has been used to challenge criminal laws that target the poor for doing things poor people often do simply to survive, such as peaceful panhandling and vagrancy.[20]

Today, the criminalization of poverty takes the less direct approach of using criminal law and the criminal justice system to mediate society's response to the problems of the poor. The criminalization of poverty in this sense did not set out to be malign or perverse. Early social reformers in both England and the United States regarded prisons as potential sites for moral instruction and vocational training. During the Great Society years, well-intentioned people working in the criminal justice system imagined ways in which the warm embrace of criminal law might actually help the poor. These hopes have almost entirely been abandoned.

Contemporary forms of criminalization include (1) interactions between welfare and criminal law, (2) "broken windows policing" and related law enforcement strategies that target perceived disorder, particularly in low-income communities, (3) the use of cash bail to detain poor criminal defendants, and (4) the use of fines and fees in criminal adjudication and the criminalization of non-payment of civil debts.[21] While these criminal interventions have a punitive valence that medical care appears to lack, many effects of criminalization stand as cautionary tales for the medicalization of poverty as well.

A. Goals and Assumptions

A useful starting point for a criminal justice-medical care comparison is to examine the intent of each "system" and its respective attitude toward the poor. Does it aim to benefit the already poor, to incentivize thrift or industry and therefore avoid poverty, or to protect the non-poor from the social problems putatively created by the poor?

1. Separation.

The central institution of healthcare remains the hospital, that of criminal justice the jail or prison — with similarities in design that reflect not only isolation from the outside world but also the need for close monitoring — and loss of privacy — in each enterprise. Outside the walls of prisons and hospitals, complex dynamics largely beyond the capability or experience of either institution expose poor communities to illness and criminality. Yet these facilities stand as reminders that residential separation, more than any other attribute, has defined their roles. Historically, separation in medicine was necessitated by communicable disease, impending death, or both. Only recently has residential separation been justified by the efficiency of consolidating personnel and technology, a rationale that has declined as outpatient treatment becomes feasible even for serious illness. Similarly, separation in criminal justice addressed inmates' individual risk to law-abiding citizens and perceptions of collective threat to morality and social stability, as well as providing the prisoner solitude to enable spiritual and moral healing.

2. Incapacitation.

Symptom progression in the chronically ill and recidivism among inmates often render only transitory any return to full personhood from the status of patient or inmate. In their day-to-day operations, both the medical and criminal justice systems therefore emphasize the incapacitation of criminality or disease. Although most chronic illness is avoidable through behavioral change, screening, and early intervention, medical offices and clinics with highly directive professionals offering a limited set of billable interventions are too remote from the sources of underlying risk — blighted neighborhoods, gun violence, poor diet — to be effective in prevention. Analogously, criminal incarceration seems largely to have abandoned rehabilitation through education, vocational training, or family services as a realistic goal because of their high cost and limited success, relying instead on repeated arrest, incarceration, and monitored probation or parole.

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3. DISORDER.
The direct causes of hospitalization and treatment are disease entities; the direct causes of arrest, conviction, and detention are criminal acts. But the underlying causes tend to be social and behavioral — a modern version of the "miasma" once thought to contaminate poor neighborhoods before the germ theory of disease took hold. In both contexts, society risks conflating the effects of cumulative disadvantage with an immutable "cultural otherness" that includes an accusation of immorality. Residents of communities with economic and demographic challenges will struggle to avoid illness, yet smoking, excessive drinking, poor diet, and inadequate physical activity are bad habits readily attributable to personal irresponsibility. In criminal justice, the use of profiling as a community-level heuristic for risk assessment and targeting "disorder" in low-income neighborhoods both reinforce the notion that the poor *are* risky and disordered.[22]

4. DEPENDENCY.
It is ironic that cash welfare assistance was criticized by conservatives as fostering a "culture of dependency" when its medical and criminal justice substitutes only magnified the effect. Despite the best efforts of bioethicists to instill autonomy, turning the poor into medical patients saps them of agency, and subjects them to misguided paternalism or worse. Similarly, disorder-based policing has created a misdemeanor-based system for surveilling and controlling millions of mainly poor people without the safeguards of judicial process.[23] As in hospital emergency departments, criminal justice begets "frequent fliers" — largely poor, mentally ill, and addicted individuals who have vastly more arrests and jail stints than the population at large.[24] Even incarceration can be rationalized as desirable. During recent hearings in Houston on cash bail practices that often resulted in jail time, the county's lawyer suggested that incarceration helped the poor escape the streets in cold weather. The judge replied: "[I]t is uncomfortably reminiscent of a historical argument that used to be made that people enjoyed slavery, because they were afraid of the alternative. ... [B]ut you didn't see a lot of people running towards enslavement. You don't see a lot of people volunteering for jail in order to get warm."[25]

5. RACIAL AND GENDER BIAS.
The medical and criminal models both exacerbate racial and gender biases around poverty, most perniciously with respect to reproduction and family composition. When policing prioritizes "disorder" in poor communities, the fact of economic and geographic stratification by race dictates that people of color will bear the brunt of that enforcement (even assuming counter-factually that racial groups are not specifically targeted).[26] A 2017 study of Texas counties found that black individuals were dramatically over-represented among those jailed for non-payment of fines and court fees.[27] More generally, the public imagination frequently, if wrongly, explains the poverty-crime connection as attributable to single motherhood in black families. When lawmakers invoke "welfare queens" to engage the criminal justice system in policing fraud, they wield both a racialized and a gendered archetype. The narrative in healthcare is shockingly similar: from the "crack babies" of the 1980s (who were often seen as future criminals) to the prosecution of substance use disorder during pregnancy today.[28] Even a core premise of the medical model — that providing health services directly to struggling women and innocent children in lieu of cash assistance keeps charitable resources from being misappropriated by able-bodied men — reinforces destructive racial and gender stereotypes.

B. Incentives and Temptations
Crime may not pay, but apprehension, adjudication, and incarceration certainly do. A criminal justice system preoccupied with the poor will be rewarded for its efforts, typically more so than other methods of engaging the problems of poverty, and regardless of its impact. Medical services for the government-funded poor are similarly profitable.

1. LOCAL EMPLOYMENT.
Healthcare and criminal justice are local and labor-intensive. As a consequence, they are economic lifelines in smaller cities and towns that lack a secure jobs base from industries capable of surviving globalization, automation, consolidation, and the decline of organized labor. According to the U.S. Census Bureau, "Education, health and hospitals, and police protection constitute the largest functional categories of public employment nationwide. In March 2012, 14.1 million public employees (63.8%), were employed on a full or part-time basis in a capacity related to these functions."[29] Hospitals are routinely the largest local employers, and efforts to close them are contentious. Similarly, state politicians considering proposals to close corrections facilities, decriminalize conduct, or reduce sentences face predictable opposition — particularly in rural towns.[30]

2. REVENUE GENERATION.
Many of these activities appear not to increase local taxes, and often generate revenue, which adds to their political appeal. Hospitals and hospital associations boast of their local economic impact, and public schools

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and social service agencies (and even jails) structure their medical components to maximize federal matching funds. On the criminal justice side, some of the worst practices with respect to the poor are undertaken for budgetary reasons. Although police violence toward minority residents drew national attention to Ferguson, Missouri, the Department of Justice's scathing critique of policing and court practices emphasizes the "Focus on Generating Revenue."[31] The report documented a pattern and practice of police enforcement and court assessment of fines and fees driven intentionally by city budgetary priorities.

3. Privatization and Special Interests.
Hospitals and criminal justice centers attract and support related businesses. These "fellow travelers" on medicalized or criminalized poverty play a useful political role: private constituencies lobby aggressively to loosen public purse-strings and counter anti-redistributive attitudes in the general population. In return, however, they exact a substantial price. At the extreme, public functions are fully privatized in order to forestall budgetary crises, blunt criticism of big government, or secure new political patronage. Special interests in healthcare are too numerous to describe here, but include Medicare's private carriers and intermediaries, Medicare Advantage and Medicaid health plans, home healthcare agencies, and the legions of businesses that bill government payers for services. The rise of private prisons and probation, and the privatization of discrete prison functions such as communications systems, highlight similar incentives in criminal justice. Short of privatization, various interests lobby to avoid competition or innovation. The bail bond industry opposes ending cash bail or facilitating pre-trial release. Corrections unions halt facilities closures and sentencing reform.[32] Local criminal defense bars fight the development of higher-quality public defender offices in order to protect lucrative assignments as court-appointed counsel.[33]

4. Fraud and Its Detection.
Some private parties engage in outright fraud. The criminalization of poverty creates opportunities not only for overbilling the government but also for financial exploitation of the poor. Atlanta, Chicago, Nashville, and other communities have struggled to displace politically savvy bondsmen who defend counterproductive cash bail requirements that lure minor offenders into debt traps with the constant threat of incarceration. So-called "Medicaid mills" are notorious for churning unnecessary healthcare services based on bribery or coercion. Dental clinics in Florida paid bribes for thousands of poor children to undergo repeated, useless services; mental hospitals in Texas kept patients against their will in order to bill for continued treatment.[34] Physical harm associated with these services represents as great a risk to the poor as direct financial loss.

5. Fetishizing Moral Hazard.
Assumptions about dependence and disorder among the poor also affect public perceptions of how incentives operate on the beneficiary side. As private interests gathered to feed at the government trough, both medical care and criminal justice witnessed a hypocritical backlash that blamed users of each system for rising costs. Such concerns are used to justify surveilling the poor and invading their privacy. Kaaryn Gustafson describes home visits nominally intended to verify welfare eligibility but "used by the government to police crimes, both those involving welfare and those unrelated to welfare."[35] The receipt of publicly supported medical care similarly requires the disclosure of extensive personal information, and attaches severe penalties to misrepresentation. Disincentives are also common. In medical care, user fees generally take the form of co-payments for services — which the federal Medicaid program continually faces pressure to increase — and, recently, work requirements to remain eligible. In criminal justice, public as well as private actors argue that it is just for offenders to pay for their own incarceration or probationary monitoring. In Rutherford County, Tennessee, many poor defendants released to private probation officers are afraid to make court appearances because inability to pay is grounds for detention, after which "failure to appear" becomes an independent cause for arrest.[36] Although the original offenses are often minor ones, defendants eventually acquire a reputation for flouting the law — much as poor people with illnesses come to be seen as exploiting the healthcare system — while the underlying cause of high utilization in both domains, poverty itself, escapes notice.

6. Professionalization.
It may be largely coincidental that America's two "sovereign professions" — medicine and law — control the medicalization and criminalization narratives. But the overall influence of professions in each domain is substantial and not entirely benign. Because of the expertise they assert and the ethical duties they espouse, professions enjoy privileges and power denied to the vast majority of laborers. This includes deference to their collective judgment, even when financially self-interested, tolerance of paternalism that masquerades as beneficence, and relative freedom from direct accountability. Although physicians and attorneys or

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judges exercise the greatest authority in their respective domains, the professions most empowered by the medicalization or criminalization of poverty are often allied or subordinate ones such as nurses, therapists, social workers, corrections officers, and court personnel.

IV. Conclusion: Gee, Officer Krupke

> Judge: *The trouble is he's lazy*
> Psychiatrist: *The trouble is he drinks*
> Social Worker: *The trouble is he's crazy*
> All: *The trouble is he stinks*
> *The trouble is he's growing*
> *The trouble is he's grown*
> *Krupke, we got troubles of our own!*
>
> — Stephen Sondheim, *West Side Story* (1957)

Insularity is seldom a virtue, and efforts to solve complex social problems by drawing on other disciplines are not necessarily bad. But each such foray should be approached with humility, and with careful attention to possible unintended effects. Medical approaches are no exception.

Because two wrongs may not make a right, interactions between medicalized and criminalized poverty merit scrutiny. Thousands of individuals with mental illness and substance use disorder are housed in jails and prisons, often without receiving medical treatment.[37] Over the last ten years, there has been a significant expansion of specialized courts for non-violent drug offenders, and for defendants with behavioral health conditions. These courts use the threat of criminal punishment to persuade poor and working class people to accept "treatment." This may help some individuals who need incentives to take prescribed medication.[38] However, most regimens have burdensome reporting requirements and very uncertain outcomes — and may end up being more punitive than spending a couple of months in jail.[39] Some programs require defendants to pay for their own treatment, move people through quickly to increase revenue, and manipulate their "success rates" by excluding those who are re-incarcerated.

Similar cautions apply to efforts by medical care providers to reach beyond their core competencies in pursuit of population health improvement. Engagement strategies such as "community-centered health homes" are proliferating.[40] Gathering insights from communities in order to improve how hospitals and clinics perform their medical missions could be valuable, as could using medical encounters to screen for health-related problems best solved in collaboration with others.[41] By contrast, heavy-handed attempts to use medical funding streams to remake non-medical social supports in disadvantaged communities are likely to fail, displacing established organizations and individuals in the process. Moreover, the language used by many population health advocates — building a "culture of health" — is uncomfortably evocative of Harrington's "culture of poverty" from decades ago, as some communities that embraced health improvement only to suffer rapid gentrification have discovered.

In light of these concerns, unadorned benefits that are less encumbered by the assumptions and temptations of the medical model may be preferable. For example, some community health advocates argue that homelessness is the root cause of many social ills and that addressing it should be the highest priority.[42] Others have made similar arguments about jobs, or about social capital. The best approach to poverty will almost certainly vary from place to place, and will require sustained effort to build trust, gather resources, and evaluate impact. But there is very little reason to believe that medicalizing the problem will work, and substantially greater reason to believe that what would help is to give the poor more money.

The best approach to poverty will almost certainly vary from place to place, and will require sustained effort to build trust, gather resources, and evaluate impact. But there is very little reason to believe that medicalizing the problem will work, and substantially greater reason to believe that what would help is to give the poor more money.

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References

1. S. Glied, *Chronic Condition: Why Health Reform Fails* (New York: Oxford University Press, 1998).
2. G. Calabresi and P. Bobbitt, *Tragic Choices* (New York: W.W. Norton, 1978); W. Kissick, *Medicine's Dilemmas: Infinite Needs Versus Finite Resources* (New Haven, Yale University Press, 1994).
3. N. Daniels and J.E. Sabin, *Setting Limits Fairly: Can We Learn to Share Medical Resources?* (New York: Oxford Univ. Press, 2002).
4. Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (2012).
5. D.B. Smith, *Health Care Divided: Race and Healing a Nation* (Ann Arbor: University of Michigan Press, 1999); D.B. Matthew, *Just Medicine: A Cure for Racial Inequality in American Health Care* (New York: NYU Press, 2015).
6. W.M. Sage, "Fracking Health Care: The Need to Safely De-Medicalize America and Recover Trapped Value for Its People," *NYU Journal of Law and Liberty* 11, no. 2 (2017): 635-671
7. M. Harrington, *The Other America: Poverty in the United States* (New York: Simon & Schuster, 1962), at 15.
8. Institute for Policy Studies, *Facts: Income Inequality in the United States*, *available at* <https://inequality.org/facts/income-inequality> (last visited July 19, 2018).
9. R. Cooper, *Poverty and the Myths of Health Care Reform* (Baltimore: Johns Hopkins University Press, 2016).
10. E.H. Bradley and L.A. Taylor, *The American Health Care Paradox: Why Spending More is Getting Us Less* (New York: Public Affairs, 2013).
11. D.M. Cutler, "What is the US Health Spending Problem?" *Health Affairs* 37, no. 3 (2018): 493–497.
12. G. White, "U.S. Ranks 23rd Out of 30 Developed Countries for Inequality," *The Atlantic*, Jan. 16, 2017, *available at* <https://www.theatlantic.com/business/archive/2017/01/wef-davos-inequality/513185> (last visited July 19, 2018); Statement on visit to the USA, by Professor Philip Alston, United Nations Special Rapporteur on extreme poverty and human rights, December 15, 2017.
13. M. Isserman, "50 Years Later: Poverty and The Other America," *Dissent* (Winter 2012), *available at* <https://www.dissentmagazine.org/article/50-years-later-poverty-and-the-other-america> (last visited July 19, 2018).
14. B. Ehrenreich, "Michael Harrington and the 'Culture Of Poverty,'" *The Nation*, March 14, 2012.
15. D.P. Moynihan (ed.), *On Understanding Poverty : Perspectives from the Social Sciences* (New York: Basic Books, 1969).
16. E. Hinton, *From the War on Poverty to the War on Crime: The Making of Mass Incarceration in American* (Cambridge: Harvard University Press, 2016).
17. S. Rosenbaum and K.A. Maloy, "The Law of Unintended Consequences: The 1996 Personal Responsibility and Work Opportunity Reconciliation Act and Its Impact on Medicaid for Families with Children," *Ohio State Law Journal* 60, no. 4 (1999): 1443-1478.
18. M. Nadel, S. Wamhoff, and M. Wiseman, "Disability, Welfare Reform, and Supplemental Security Income," *Social Security Bulletin* 65, no. 3 (2003/2004): 14-30.
19. 370 U.S. 660 (1962).
20. *Papachristou v. City of Jacksonville*, 405 U.S. 156 (1972).
21. K. Gustafson, "The Criminalization of Poverty," *Journal of Criminal Law and Criminology* 99, no. 3 (2009): 643–716; D. Livingston, "Police Discretion and the Quality of Life in Public Places: Courts, Communities, and the New Policing," *Columbia Law Review* 97, no. 3 (1997): 551–672; J. Simonson, "Bail Nullification," *Michigan Law Review* 115, no. 5 (2017): 585–638; A. Harris, *Pound of Flesh: Monetary Sanctions as Punishment for the Poor* (New York: Russell Sage 2016).
22. B. Harcourt, "Reflecting on the Subject: A Critique of the Social Influence Conception of Deterrence, the Broken Windows Theory, and Order-Maintenance Policing New York Style," *Michigan Law Review* 97, no. 2 (1998): 291–389.
23. I. Kohler-Hausmann, *Misdemeanorland: Criminal Courts and Social Control in an Age of Broken Windows Policing* (Princeton: Princeton University Press, 2018).
24. M. Chandler Ford, "Frequent Fliers: The High Demand User in Local Corrections," *Californian Journal of Health Promotion* 3, no. 2 (2005): 61-71.
25. Transcript of Motion Hearing Before the Honorable Lee H. Rosenthal, Chief United States District Judge, *Maranda Lynn O'Donnell v. Houston, Texas* (C.A. NO. H-16-1414), Feb. 8, 2017, at 20.
26. J. Fagan and E. Ash, "New Policing, New Segregation: From Ferguson to New York," *Georgetown Law Journal Online* 106 (2017): 33-133.
27. Texas Appleseed & Texas Fair Defense Project, *Pay or Stay? The High Cost of Jailing Texans for Fines and Fees* (Austin: Texas Appleseed & Texas Fair Defense Project 2017).
28. K. Hull, C. Angelotta, and C.E. Fisher, "Criminalizing Substance Use in Pregnancy: Misplaced Priorities," *Addiction* 112, no. 7 (2017): 1123–1125; E. Duggan, "A Velvet Hammer: The Criminalization of Motherhood and the New Maternalism," *California Law Review* 104, no. 5 (2016): 1299-1332.
29. L. Jessie and M. Tarleton, *2012 Census of Governments: Employment Summary Report*, March 6, 2014.
30. T. Huling, *Prisons as a Growth Industry in Rural America: An Exploratory Discussion of the Effects on Young African American Men in the Inner Cities* (Washington, D.C.: Prison Policy Initiative, 1999).
31. United States Department of Justice, Civil Rights Division, Investigation of the Ferguson Police Department, March 4, 2015, at 9.
32. J. Forman, Jr., "The Black Poor, Black Elites, and America's Prisons," *Cardozo Law Review* 32, no. 3 (2011): 791–806.
33. J. Ulloa, "Judges, Attorneys Debating Changes to Public Defense Services in Travis County," *Austin American Statesman*, March 22, 2013, *available at* <https://www.statesman.com/news/crime--law/judges-attorneys-debating-changes-public-defense-services-travis-county/RNZbpT9Nqc2E7ds-GQPEwXM> (last visited July 19, 2018).
34. D. Canedy, "Children Are Prey in a Medicaid Dental Scheme," *New York Times*, Aug. 17, 2001; C. Sims, "Hospital Chain Said to Settle Fraud Case for $300 Million," *New York Times*, April 15, 1994.
35. K. Gustafson, "The Criminalization of Poverty," *supra* note 21, at 666.
36. P. White, "High Bail, Empty Pockets and a Full Jailhouse," *Tennessee Tribune*, Dec. 1, 2017.
37. A. Roth, *Insane: America's Criminal Treatment of Mental Illness* (New York: Basic Books, 2018).
38. J. Monahan, M. Swartz, and R.J. Bonnie, "Mandated Treatment In The Community For People With Mental Disorders," *Health Affairs* 22, no. 5 (2003): 28-38.
39. E.J. Miller, "Drugs, Courts, and the New Penology," *Stanford Law & Policy Review* 20, no. 2 (2009), *available at* <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1464353> (last visited July 19, 2018); J. Bowers, "Contraindicated Drug Courts," *UCLA Law Review* 55, no. 3 (2008):783-835.
40. J. Cantor et al., *Community-Centered Health Homes: Bridging the Gap Between Health Services and Community Prevention*, Prevention Institute (2011).
41. B. Krishnamurthy, S. Hagins, E. Lawton, and M. Sandel, "What We Know and Need to Know About Medical-Legal Partnerships," *South Carolina Law Review* 67, no. 2 (2015-2016): 377-388.
42. M. Sandel and M. Desmond, "Investing in Housing for Health Improves Both Mission and Margin," *JAMA* 318, no. 23 (2017): 2291-2292.

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