Family Practice Forum

Family Medicine and the Poor

Robert Drickey, MD, MPH
San Francisco, California

A growing number of people in the United States are unable to afford medical services. With high rates of unemployment, "the new poor" are unprotected by medical insurance. With fewer government resources devoted to human services and changing criteria for eligibility in Medicaid, many people find themselves unable to afford basic medical services, but not poor enough to receive government aid.

As a consequence, community clinics report more people seeking services in the underfunded public sector. People seek care later in the natural course of disease and are often sicker when care is sought. Already the infant mortality rate is increasing in several parts of the country, a fact due in part to decreased access to care.[1] Mortality rates for other age groups, particularly the elderly, may rise as well.

The medical profession has responded to times of economic hardship with attempts at self-protection. State and national medical societies spend large amounts of money on lobbying activities and, of course, support candidates who are sympathetic to the causes of organized medicine. But who in the medical profession is an advocate for the poor?

Family practice is a natural field in which concern for disadvantaged people should find expression. Traditionally family physicians have cared for people regardless of the ability to pay. The general practitioner of years past treated all who presented themselves for care and often would charge only what the patient could afford to pay, occasionally even bartering for food items or services in trade. That tradition has been abandoned in large measure by modern private practitioners, especially those practicing in large cities. Many physicians in urban areas will not even accept Medicaid or Medicare, and few charge on a sliding fee scale.

But with the economic constraints of today's world, why should family practice be a "champion of the poor"? First, because no other specialty, except perhaps for public health and preventive medicine, is recognized as an advocate of the poor, family practice has an opportunity to lead in an area of medicine where leadership is lacking. Second, because family practice emphasizes the biopsychosocial aspects of health care and recognizes the importance of family and environment in health and disease, family physicians know that to provide comprehensive care for the patient, one must be concerned about all of the patient's circumstances.

What can family physicians do to help the cause of people in need? As individuals, family physicians can be effective advocates for disadvantaged people. Letters about health matters to representatives, senators, and other officials will help increase their awareness of the realities faced by people without financial resources. Family physicians should develop sliding fee scales based on patients' incomes. They should endeavor to practice highly cost-effective medicine. They should be willing to accept Medicaid and Medicare payments, even if it means less income than from private patients. Professional organizations in family medicine should speak out on issues affecting health care services for low-income people.

Family practice training programs provide ideal settings for teaching the concepts and principles of health care for disadvantaged people. Traditionally, family practice programs train some physicians who will work in geographically underserved areas in rural America. However, that training often assumes a stereotypical rural community with an

Continued on page 728

From the Department of Health Services and Department of Family Medicine, University of Washington, Seattle, Washington. Requests for reprints should be addressed to Dr. Robert Drickey, Family Health Center, San Francisco General Hospital and Medical Center, 1001 Potrero Avenue, San Francisco, CA 94110.

Continued from page 726

economic base capable of supporting a physician and a medical program. That assumption may not be valid for work with cultural, ethnic, or socioeconomic minority groups. Often medical work with those groups is more difficult than work with more affluent populations because of cultural differences between the provider and the recipients of care (eg, differences in health beliefs, values, and language). Training in family practice must go beyond the rural-urban dichotomy to address social, cultural, economic, and political issues. Satellite clinics in low-income rural and urban areas should be established to serve people in those areas while providing training sites for students and residents. Research in clinical, epidemiological, and health services delivery issues among low-income populations is needed to resolve longstanding questions that increasingly impinge on the entire nation. The recent upsurge of interest in geriatric health care offers opportunities for research among a population with large numbers of low-income or no-income people.

I am not suggesting that all family practice programs completely reorient themselves to work with poor people. But all family practice programs should devote a portion of their resources to training and service with disadvantaged people. The "charity" model based upon the largesse of individuals will not be adequate to meet the medical needs of the growing number of low-income people in this country. A systematic approach is required so that family physicians are trained to recognize and meet the medical needs of people who are unable to afford care. With such training, family physicians can become effective agents of change for medically indigent people in the United States and abroad.

The public image of physicians has declined in recent years. In fact, the family practice movement was an attempt to respond to some of the public's concerns regarding organized medicine. As a leader in the cause of health care for disadvantaged people, family medicine can help reverse the image of organized medicine as more interested in profits than in people.

Reference

1. Walker B: The impact of unemployment on the health of mothers and children in Michigan; recommendations for the nation. A paper prepared for a hearing of the Committee on Education and Labor, Subcommittee on Labor Standards, Washington, DC, January 31, 1983.