IDEAS

Take this cash and call me in the morning

Can financial prescriptions cure America's health problems?

By **Julia Hotz** Updated March 24, 2022, 3:00 a.m.

As COVID and its consequences intensified poverty, many health care workers became more active in prescribing financial resources. A growing body of evidence says those prescriptions might be just as important as pharmaceutical ones. GLOBE STAFF ILLUSTRATION/KLYAKSUN/ADOBE

Nine years ago, Dr. Gordon Schiff, a physician at Brigham and Women's Hospital, offered a patient a medicine that his textbooks had never mentioned: $30 in cash.

Schiff had learned that his patient could not afford the out-of-pocket cost to fill his prescription and didn't have the time to deal with insurance. So Schiff figured cash from his own pocket would help his patient find quicker relief. But the trainee shadowing Schiff disagreed, and reported him for being "unprofessional."

The cash got Schiff in trouble, but it also started a conversation. When he wrote about the experience in the Journal of the American Medical Association, hundreds of doctors responded, sharing that they, too, had paid for things like patients' prescriptions, groceries, and cab rides. If doctors were to honor their Hippocratic oath to treat the whole patient's needs and not just the ones healed through "the surgeon's knife or chemist's drug," why, they wondered, were nonmedical prescriptions "unprofessional"? In 2019, Schiff co-led a study, published by the Journal of General Medicine, surveying a random sample of more than 1,500 physicians throughout the United States, and found that 34 percent had paid for their patients' prescriptions.

Now, as COVID and its consequences have intensified the breadth and depth of poverty, eviction, unemployment, and food insecurity, many health care workers are actively prescribing financial resources. More often, however, financial prescriptions aren't for dollars out of the pockets of doctors like Schiff. Today they're increasingly coming from teams of health workers who collaborate with local government and nongovernmental groups to get patients relief through more formal forms of financial support, like benefits on their tax returns and link-ups with local food groups.

A growing body of evidence says those prescriptions might be just as important as pharmaceutical ones. Some researchers have estimated that 80 percent of a person's health is determined by social, economic, and environmental factors. And the push to confront those factors more directly is being driven, in part, by doctors themselves. Recent surveys of physicians and hospital leaders find more than 80 percent agree that they need to help address the social determinants of health.

But these same surveys suggest that doctors and hospitals usually still have to address these issues on an ad hoc basis. Doctors often lack the time and staff support to prescribe the sort of socioeconomic care their patients truly need.

Nono Pierre, Zakiya Alake, Sophia Michel, Star Hackett, Daniel Vilmont, and Elizabeth Ventura all work with the Neighborhood Food Action Collaborative, a Boston group that addresses food insecurity. SARAH PRIMEAU

More money, worse outcomes

In 1965, decades before Gordon Schiff was censured for his "unprofessionalism," a physician named Jack Geiger faced a similar accusation. Geiger, then a doctor at Boston City Hospital and a volunteer medic at the Selma-to-Montgomery marches in Alabama,

realized that most of his patients suffered mostly from nonclinical issues like poverty, hunger, and joblessness. He imagined a place where patients could seek treatment for all of their unmet needs. And so, inspired by a similar model in South Africa, Geiger launched two of the country's first community health clinics, in rural Mound Bayou, Miss., and urban Columbia Point, Boston.

The clinics seemed in line with Lyndon B. Johnson's national "war on poverty," but Geiger faced immediate resistance, much as Schiff would in 2013. When the governor of Mississippi learned that Geiger had prescribed food to patients and charged the cost to the health center's pharmacy budget, he sent a federal official to complain to Geiger that the program had misused its funds. The official said that the funds were strictly meant for medical therapies, but Geiger, undeterred, quipped: "The last time I checked my textbooks, the specific therapy for malnutrition was food."

Geiger ultimately won the battle: Community health clinics today serve an estimated 30 million Americans, with at least one in every state — and with measurable success. For example, in a 2018 study of a community health center run by the Mayo Clinic, researchers found that its efforts to address the social determinants of its patients' health had decreased both outpatient and emergency department visits and lowered the patients' cost of care.

Still, community health clinics don't reach millions of other patients served by health care professionals who are in traditional settings and who lack the tools and time to consider their patients' social needs.

That was the case for Jennifer Valenzuela, a social worker who started her career working with adolescent moms at Boston Children's Hospital. There, she met one of her favorite patients, a young woman she calls Julie, who had been struggling with severe depression. Eager to uncover the root causes of Julie's depression, Valenzuela started asking about her childhood. But Julie stopped Valenzuela before she could continue and

said she could only think about one thing: how to put food on the table for her two young kids.

The two spent the rest of the session Google-searching food-access options — a pattern Valenzuela says was the rule, not the exception. “I have my master’s degree, and often I’d wonder, ‘Why, in the richest country in the world, am I spending my time finding a grocery gift card, when I should be spending my time getting to the deeper things impacting them psychologically?’”

Valenzuela’s frustrations lessened when she learned about Health Leads, a project started by undergraduate student Rebecca Onie. In 1996, while volunteering with Boston Legal Services, Onie met hundreds of underserved clients like Julie and thought her fellow students could help. Piloted at Boston Medical Center, Health Leads invited doctors and social workers to “prescribe” resources like food. Student volunteers, meanwhile, staffed help desks to manage the prescriptions’ logistics — like organizing transportation and making phone calls. That way, health professionals like Valenzuela could spend their time offering the therapy they were trained to provide while patients could still have their whole needs treated.

Valenzuela now serves as executive director of Health Leads’ Massachusetts initiatives, and the group’s model has expanded to work with other groups that provide resources, so patients have a more permanent source of support. If she were with Julie today, Valenzuela says, she could directly connect Julie to an organization such as the Neighborhood Food Action Collaborative, a Boston group that would help her choose the kinds of food she wants and where she wants it.

Other organizations around the country have since rolled out similar models — so much so that Dr. Laura Gottlieb, a professor of family and community medicine at the University of California, San Francisco, helped to create the Social Interventions Research & Evaluation Network, a database chronicling the evidence for the integration of medical and social care.

When it comes to health care in the United States, "we're paying more money and seeing worse outcomes," says Gottlieb. But she says something has changed in the last decade, especially with COVID, where "our poor outcomes are pushing us to search for different solutions." She says clinicians, beyond referring patients to social services, should directly talk to patients about their financial situations in order to inform their treatment plan. A recent Gallup survey found that 18 million Americans can't afford the medication they're prescribed.

Treating poverty like smoking

Dr. Gary Bloch, a Toronto-based family physician at St. Michael's Hospital and Inner City Health Associates, is known in Canada for his innovative system of prescribing income to his patients.

Bloch begins by asking his patients a simple question: "Do you ever have difficulty making ends meet at the end of the month?" If that patient is in a group that has specific benefits available to them — like families with children — he asks if they've received those benefits. If not, Bloch "treats" them immediately by filling out the proper forms for them in his office or by connecting them to income-support specialists in his practice. These specialists help patients navigate the complexities of obtaining benefits in the short term, and they help patients become more financially literate in the long term.

Bloch says it has been important to "reframe the issue" of economics in a language and format doctors can understand. "We have clinical tools we use on the front lines for a host of other health issues," Bloch says, like screenings for cancer or sexually transmitted diseases. "So I thought, let's do the same for poverty."

Not all Canadian practices have staff support like Bloch's, nor do all explicitly "prescribe" income, but Bloch's screening and treatment tool has spread to other parts of the country. Evidence suggests that this and other social screening tools pay off. In a study of five Vancouver health care providers that addressed structural determinants of health,

their patients were more confident of their ability to manage or prevent future health problems. That confidence, in turn, strongly correlated with decreases in depression and PTSD.

“If you go back 50 years, doctors said about smoking what we say about poverty now — that it’s a social issue, not a medical one,” Bloch says.

Gary Bloch at his practice in November 2019. YURI MARKAROV

Most physicians in Canada now report that they engage in some degree of social intervention. And certain developments would suggest the tide is turning in the United States too. In 2014, just one year after Schiff was punished for giving a patient money, the Institute of Medicine recommended that physicians start capturing social determinants of health in patients’ electronic health records. In 2017, the Centers for Medicare & Medicaid Services released a 10-item “Accountable Health Communities” screening tool for doctors.

And yet, unlike in Canada, where such systemic tools seem to have spread, the United States' national numbers tell a different story. A 2019 JAMA Network study found that only 16 percent of physician practices and 24 percent of hospitals currently screen for social risks.

One reason might be the sheer size and patchwork nature of the US health system.

Massachusetts, for instance, recently began requiring accountable care organizations — groups of doctors, hospitals, and other health care providers serving Medicare patients — to screen for their patients' social needs. Since January 2020, MassHealth, the state's Medicaid and Children's Health Insurance Program, has been allowed to pay for certain members' nutrition and housing support, based on those screenings. And North Carolina, just this month, launched a project that will use Medicaid dollars to pay for patients' food, transportation, housing, and safety services.

But even before more tools and funds arrive to help physicians treat social factors, Gordon Schiff says there's a simple practice health workers can follow: "to encourage patients to identify what is most important to them," he co-wrote in a 2020 JAMA article. And that's because, he wrote, the relationship between the patient and the health professional is "one of the most powerful diagnostic and therapeutic tools in medicine."

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