THEORY

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Caring Relationships: An Investment in Health?

SYNOPSIS

Although the US has created the most expensive, technologically advanced medical system in the world, health outcomes are not commensurate with investment. The author argues that providers and policy makers have neglected the effect of human relationships on health, citing research showing that better relationships lead to better health. The author concludes with recommendations for improving public health by supporting society's investments in social capital.

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The US has established the most technologically advanced medical research and service delivery system in the world. We invest more than $3,500 per person per year to sustain the system we entrust with securing our population's health. Fully 15% of the US gross national product (GNP) is used to fund health care. This more than doubles the annual medical expenditures of any other nation and amounts to 10 times the total per capita GNP of *half* the entire world's population.[1] Based on these numbers, it would be reasonable to expect that Americans are among the healthiest people in the world. Sadly, however, that is not the case.

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DISPARITIES IN INVESTMENT AND OUTCOME

Several accepted measures of population health reveal that the health of Americans is surprisingly fragile. The US lags behind 20 other nations, not

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all of them with industrialized economies, in several national health statistics, including infant mortality, premature birth, chronic illness, and adult mortality.[2] We stand alone at the top of the world in other population health outcomes; the US ranks number one in the Western world in the incidence of child abuse, teen pregnancy, teen homicide and suicide, drug use, and child behavior problems, especially attention deficit and hyperactivity disorder (ADHD).[3]

US medicine has an unparalleled capacity to treat complex diseases, but 15% to 20% of our population cannot afford access to providers. Forty-three million Americans live without the security of health insurance. Millions more have limited coverage that provides only partial access to needed medical treatment. Fully one-quarter of the uninsured population in the US are children.[3] Since early health promotion and treatment supports optimal health and growth, our nation's future health status is deeply imperiled by such societal neglect. Exposing one of the most tragic myths in our culture today, we learn that 90% of the uninsured children live in families with at least one employed parent.[3]

Nor is our health care system able to protect all children equally, without regard to "race" or family income. Hispanic children are three times as likely to have poor health as white children in the US. African American children have twice the risk of white children for poor health over their lifetimes.[3]

The US rightly claims the strongest economy on earth. Americans enjoy the highest per capita wealth of any nation. At the same time, too many of our citizens are left out of this booming economic growth. Twenty percent of all children in the US currently live in poverty. Still more fatefully, a two-parent working family of four earning somewhat above the minimum wage cannot currently work its way out of poverty.[3] Contemporary political changes under the heading of welfare reform have added jobs that harden the condition of poverty with the combination of an unlivable wage and new expenses for child care and transportation.

Meanwhile, concentration of wealth at the highest pinnacle of American society has accelerated dramatically over the past decade. Today, the richest 10% of Americans hold the majority of the national wealth, while the poorest 20% have made no economic gains over the same decade.[4]

There are other ways to assess the wealth of a nation. Spiritual poverty, as evidenced by the rates of random killings, domestic violence, child abuse and neglect, and homelessness, reflect a people dispirited by inequities of social, economic, and educational opportunity, justice, and community. New prison construction reported the steepest growth of any sector of the American real estate market over the past decade. The spirit of our health professionals themselves appears to be suffering a setback. Now, as never before, the insurance industry reports sharp increases in the number of physicians taking medical disability leaves from their careers.

Better Relationships Improve Health

Why is this happening in the nation that has developed the most advanced medical treatment system in the world, the nation that spends so much of its national wealth on health care? Some of the answers reflect political and economic choices about health care financing. Deeper reasons unmask a false hope for the medical profession to exercise full responsibility for the health status of our people. On the surface, it is easy to note that upwards of 25% of the cost of health care in the US is spent on the business of administering our increasingly complex system of managed care.[5] And the lobbying directed toward sustaining political will to support our current model drains enough funds to make the health care lobby the highest paid influence peddler in the nation.

Only by raising the health status of the entire population, and thereby reducing the incidence of preventable disease and disability, will the high financial burden of complex medical interventions be lowered.

The limits of medicine. Ultimately, health care cost containment will demand a systemic reevaluation of our commitment to achieving population health through building an outstanding disease care system. The medical profession should not be expected to create and preserve public health. Training, research, and practice are all heavily weighted toward the diagnosis and treatment of pathology. Medicine is relatively less skilled in preventing untoward health outcomes or in promoting health. More important, the health of individuals and populations, as opposed to the medical treatment of disease, requires the shared responsibility of forces outside, yet in partnership with, the delivery of professional health care.

Some pronounced trends underscore the limited contribution of health care to population health. Ninety-two percent of the decline in mortality rates in the US during the 20th century occurred prior to 1950, long before the more recent sharp rise in medical expenditures.[6] Most of the decline in mortality came from controlling infectious diseases long before medical science's discoveries of their causes or treatments. Public health efforts to standardize sanitary treatment of water and waste together with improved nutrition accounted for this salutary outcome. Today, heart disease, cancer, and stroke continue their relatively unabated ascent as the leading contemporary killer diseases of Americans, despite our enormous national

investment in reversing the rising morbidity and mortality from these three conditions.

The role of racism. Since 1970, deaths from all cancers have increased more than three times as much for black men as for white men. Diabetes rates are also increasing faster among African Americans than among white Americans. While the gap between the "races" has narrowed in income and education levels, the same is not true in health.

What accounts for health disparities by race in the US? Neither limited access to health care nor relative poverty can adequately account for unequal health status. Special population studies, such as the Madigan Army study of infant mortality,[7] have discovered persistent disparities in rates of preterm birth despite universal medical access or comparable education and income levels across racial groups. Moreover, a number of countries with lower standards of living and lower health care spending than the US boast better population health data. Finally, large population-based studies in the US are starting to confirm that the risky health behaviors often associated with morbidity and mortality that tend to cluster among people living in poverty explain only 12% to 13% of the predictive effect of income on bad health outcomes.[8] When researchers take into account psychosocial risk factors such as depression, hopelessness, perceived hostility, and lack of social support in addition to biologic and behavioral factors, the association between lower socioeconomic status and higher mortality becomes insignificant.

In other words, the disparities in health between white Americans and black Americans are not entirely explained away by disparities in education, income, or wealth. There remain unexplored, undiscovered, and underresearched reasons for these discrepancies, perhaps related to the psychophysiological effects of racism on minority populations. Racism, of course, is the ultimate failure of human relationships, debasing the personal, social, and economic order for both the victim and the perpetrator. In short, how we live together, the quality and meaning of our relationships in family, community, and society, seems to directly influence our individual and population health outcomes.

Access to and quality of medical care do not guarantee health.

A Relationship-Based Approach to Health

Perhaps a large piece of the puzzle can be explained by examining the limits of our health care system's conceptual framework. Western medicine operates from the belief that illness lies wholly within the sick person while effective treatment, conversely, is assumed to rest completely with the physician and outside the control of the patient. Yet much of the world, along with a growing segment of American health care consumers and providers, observes a vital clinical distinction between curing (the medical model) and healing (the relational model).

Differing from the more causal and procedural orientation on which American health research and practice is based, a relationship-based approach to healing requires three conditions essential to achieving positive results. First, the individual must recognize and acknowledge when a problem exists. Second, the healer must make a deep commitment to the person affected, viewing the health condition within the individual's broad life context. Finally, the two must share a belief in a healing force between the healer and the healed. In modern terms, healing demands personal responsibility by the afflicted, caring by the helper and a shared relationship imbued with trust and meaning.

The therapeutic power of relationships is receiving increasing attention among American medical scientists, practitioners, and funders. Researchers have examined the salutary effects of caring relationships and relationship-centered health care at both the individual and community levels. Lynch, in a series of psychophysiological studies on determinants of cardiovascular death, revealed the pathogenic force of unexpressed and unshared grief, anger, anxiety, loneliness, and fear.[9]

Relationship as a protective factor for health and development has been demonstrated at a social level of interaction as well. Greater connectedness to family and community correlates with better health and developmental outcomes. The benefits that accrue from social relationships and affiliations, sometimes referred to as social capital, include improved resistance to infectious disease,[10] higher resilience to the damaging effects of poverty and maltreatment,[11] and reduced exposure to violence.[12]

The protective influence of healthy community and caring relationships can be observed to occur as early as the first years of life. Exciting new neuroscience research on infant brain development in the context of emotional attachment further enriches our understanding of the relational bases of health and development. The human brain grows exponentially and organizes increasingly complex cybernetic regulatory mechanisms during the first years of life. These processes, largely occurring within the cortico-limbic system of the developing right hemisphere, appear to be directly responsive to the child's emotional interactions with consistent caregivers. During the first two to three years of life, these emerging pathways grow hardwired and, over a lifetime, affect the child's immune system functioning, biological stress reactivity, emotion regulation, and learning.[13] Long ago, researchers observed the behavioral effects of social deprivation versus community involvement. Today, modern science reveals the underlying anatomic and physiologic mechanisms and consequences.

Data from multinational studies of infant mortality reveal a most compelling finding: perinatal outcome (and, as it turns out, most other lifespan health measures as well) for each member of a community is largely dependent upon the social health of *all* members of the community. Wilkinson documents that where wide disparities exist with respect to income distribution and social opportunity, the health of the advantaged as well as the disadvantaged suffers.[14]

Social ties appear to mediate their effects on children's health and development through at least two mechanisms: physiological and behavioral. Early and sustained stress due to depression, isolation, or hostile conflict causes enduring perturbations in brain chemistry via the cortical-pituitary-adrenal axis. Additionally, people often react to stressful conditions with self-destructive behavior, including smoking, excessive alcohol ingestion, and lack of physical exercise. Relationships that sustain community actively safeguard against such untoward psychophysiological and behavioral consequences by teaching and reinforcing responsibility, caring, and persistence—necessary cornerstones of a healthy life. Community health relies on sustaining four forms of capital: natural (the earth's air, water, soil, plant and animal life), human (education), financial, and social. Diminishing any one of these reduces the health of the community and its individual members.

Disease care cannot produce health for individuals or populations existing in pathogenic circumstances.

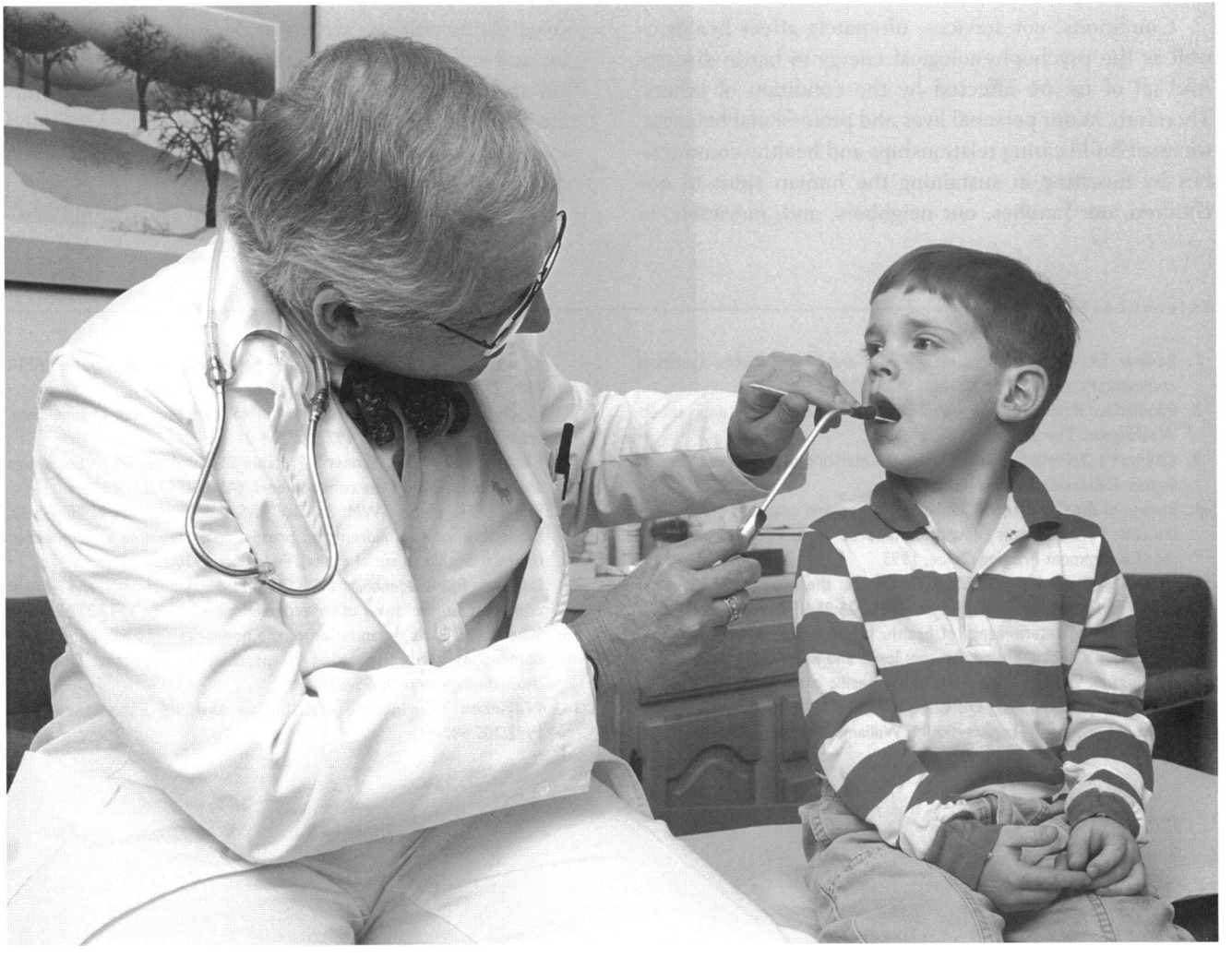
RECOMMENDATIONS

The lessons recounted above can direct individual and collective action to promote children's health. Health care, public policy, and personal behavior all play significant roles in erecting humane building blocks for health.

Shift from managed care to community health. Recognizing the connection between healthy communities and human health, the health care system must integrate the administrative principles learned from our national experiment in managed health care with a principled dedication to a public health model. Health care that has as its primary goal the public's health measures success in terms of the physical, mental, social, economic, and spiritual health of communities. Means to such ends include jobs, decent housing, social and economic justice, and the elimination of poverty and racism as well as universal access to quality health care.

In contrast, managed health care, as we experience it for the most part, is driven not by shared values or mutual obligations but by the economics of maximizing investment. Controlling costs by cutting services is the standard—and, I submit, erroneous—means to achieving profitability. Only by raising the health status of the entire population, and thereby reducing the incidence of preventable disease and disability, will the high financial burden of complex medical interventions be lowered. While public health concerns the health status of an entire population, managed care aims first to satisfy the well-being of paying subscribers and invested shareholders.

Narrow economic and social gaps. Securing the health of our nation's children can also be aided through the political will to enact public policies that strengthen the four essential forms of capital: human (education), economic, social (relationship), and natural (environment). Since population health depends on narrowing existing gaps in wealth, education, and social opportunity, the burden of medical care would lighten if we increased the minimum wage, raised tax credits for child care for



working parents, enhanced the quality and affordability of high-quality child care, and increased the wage scale and accountability of licensed child care providers and early childhood educators. Similarly, laws that protect our natural environment and policies that preserve and promote peace in our homes, streets, and nations build the biological and psychological foundations for lifespan health.

Develop healthy personal relationships. The most direct route to population health relies on personal action. Healthy relationships begin between and among individuals who value one another, challenge and support personal goals and efforts, exercise shared responsibilities for the well-being of others, seek and develop assets, strengths, and talents within themselves, their neighbors, and their communities, and inspire hope, affiliation, and dignity in fellow human beings. A date tree first bears fruit about 80 years after its seed is planted in the soil. Those who plant such trees do so for unborn beneficiaries. Health trajectories, likewise, get seeded very early in life. Indeed, even before the moment of human conception, the broad range of conditions that contribute influences over a lifetime have begun to set a biobehavioral course for each infant.

CONCLUSION

While the health care system can become more responsive and accountable to the health interests of the population rather than to the financial interests of health care companies, and while it is the moral responsibility of a civil society to insure access to quality health care services for all, *access to and quality of medical care do not guarantee health!* Our medical care system is most skilled at diagnosing, treating, and managing health problems. Disease care cannot produce health for individuals or populations existing in pathogenic circumstances.

Conditions, not services, ultimately affect health as well as the psychophysiological energy to battle disease. And all of us are affected by the condition of others. Therefore, in our personal lives and professional behavior, we must build caring relationships and healthy communities by investing in sustaining the human spirit in our children, our families, our neighbors, and, inevitably, in ourselves. As citizens, serving at the same time our altruism and self-interest, we can influence public deliberation and political action to create policies that will nurture the essential building blocks for health: social and economic justice, environmental protection, peace, and a national spirit of human kindness.

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