

The medicalization of society

Reno Gazette-Journal / RGJ.COM

Tuesday, June 22, 2010

In 1970, Americans spent about \$75 billion on health care or \$356 per resident. We currently spend over \$2.5 trillion on health care services and products, or \$8,160 per person. The percent of U.S. gross domestic product spent on health care has grown from 7.2% in 1970 to 17.6% in 2009.

Numerous factors are responsible for increased spending on health care, including an aging population, growing per capita income and national wealth, and the expansion of both public health insurance programs and employer-sponsored health coverage.

Partly motivated by a desire to “bend the cost curve” via improved access to primary care and preventive health services over the long run, national health insurance reforms will undoubtedly produce additional demand for health services from historically underserved populations and, thus, result in even more spending on health care in the short term.

Greater spending on health services is also clearly a function of increasingly technologically intensive medical care and our society’s penchant toward “gizmo idolatry.” Writing in the medical journal JAMA, Drs. Bruce Leff and Thomas Finacune describe gizmo idolatry as the willingness of clinicians, patients, policymakers, and importantly, health insurers “to accept, in fact to prefer, unproven, technologically oriented medical measures” over less technological (and less costly) measures.

One explanation for increasing health care costs that has received comparatively little attention, though, is the phenomenon of medicalization.

Sociologist Peter Conrad defines medicalization as the “process whereby non-medical problems become defined and treated as medical problems, usually in terms of illnesses and disorders.” He argues that the transformation of human conditions into treatable disorders is largely a social process, not unlike globalization, secularization and other trends accompanying the evolution of modern society over the past half century.

Examples of “medicalized” conditions include menopause, alcoholism and substance related disorders, attention deficit/hyperactivity disorder (ADHD), the expansion of depression to include normal sadness, post traumatic stress disorder (PTSD), anorexia, infertility, sleep disorders, erectile dysfunction, panic disorder, male pattern baldness, obesity, social anxiety disorder or social phobia, chronic fatigue syndrome, and all sorts of body image conditions, among others.

And the medicalization of new conditions marches on.

The New York Times recently reported that the German pharmaceutical giant Boehringer is seeking approval from the Food and Drug Administration for a drug that it claims will treat “hypoactive sexual desire disorder” (low libido) in women. Boehringer’s medical director, Dr. Peter Piliero, maintains that “this is a real disease” and that “there’s an unmet medical need among premenopausal women to have a treatment.”

Conrad insists that the medicalization of society does not imply a change that is good or bad, or that the medical treatment of these conditions does not confer real benefits to many individuals. Rather, he simply maintains that, over the last four or five decades, medicine’s reach has been extended to formerly non-medical problems and life experiences and, consequently, has contributed to spiraling health care costs in the US and other rich societies.

In a recent report published in *Social Science and Medicine*, Conrad and colleagues conservatively estimate that spending on twelve specific medicalized conditions alone totals \$77 billion. While this represents only 3.9 percent of total domestic expenditures on health care, these figures exceed what local and state governments in the US annually spend on routine public health services.

Dr. H. Gilbert Welch, an internist for the Department of Veteran Affairs, goes one step further contending that “the most fundamental life events – birth and death – increasingly involve more and more medical care ... my profession has gotten pretty good at terrifying (and operating on) pregnant women during what should be one of the great experiences in life. And we are equally proficient at dragging the elderly through all sorts of misery on the road to death.”

On the front end of life, he cites the ubiquitous use of ultrasound and electronic fetal monitoring – tests that have been shown to have had no effect on identifying the need for neonatal intensive care or infant survival, yet have been a key factor for why the beginning of life now involves major surgery (Cesarean sections) one third of the time. On the back end of life, he notes that, while most Americans say they would like to die at home, the most common place of death is still the hospital or, to be more precise, in a costly hospital intensive care unit.

Like most commentators on medicalization, Welch concludes that medical care has a great deal to offer. Nonetheless, medicalization of society continues to turn more and more people into patients and it expands what is a treatable medical condition. He adds “everyday experiences get turned into diseases, the definitions of what (and who) is normal get narrowed, and our ability to affect the normal course of aging get exaggerated.”

The proliferation of medical categories and treatments for human problems and common life conditions thus represents another important reason why health care costs so much.

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