EDITORIAL

Medical Debt as a Social Determinant of Health

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The profound influence of social determinants of health (the conditions in which people are born, learn, play, work, and age) has become widely recognized and accepted.[1] Recent work on health-related social determinants and risk factors has focused mostly on factors such as poverty and income insecurity, housing and employment instability, and structural racism and other forms of discrimination. For example, important studies in this area have convincingly demonstrated enormous health and health care inequities for people in the lowest income brackets, for people experiencing homelessness and housing instability, and for those who have inadequate employment and wages.[2,3]

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There is also emerging evidence related to the deleterious health effects of perceived discrimination and an increasing recognition of the need to investigate and address the structural forms of racism and their relationship with health.[4] However, across the spectrum of social determinants of health, the relationship between wealth and health has received relatively less attention, even though wealth is possibly the most distinctive feature of the persistently growing socioeconomic inequalities in the US population.[5]

In this issue of *JAMA*, Kluender et al[6] report on medical debt as an important aspect of wealth as it relates to health and health care. Medical debt is incurred due to rising health care prices and increased cost sharing in the context of no or inadequate health insurance, leading to high out-of-pocket costs for individual patients. The authors present their findings in terms of 2 indicators of medical debt in the US: the stock of debt (defined as the total amount of all unpaid medical debt) and the flow of medical debt (defined as the debt that appears on individuals' credit reports during the last 12 months). The data were based on a random 10% sample of the debt listings covering the years 2009-2020 reported to 1 credit report bureau (TransUnion).

In 2020, based on an analysis of data from nearly 40 million unique individuals, the mean amount of medical debt in the US was $429. Among the 17.8% of persons with medical debt, the mean debt stock was $2424 and the mean debt flow was $2396. Based on their data, the authors project that the estimated total amount of medical debt in the US population could be as high as $140 billion. Medical debts in stock and flow tended to increase after 2009 but began to decline around 2014. Nonmedical debts started to decline after 2012. After 2014, the total amount of medical debt exceeded nonmedical debt as the highest single source of debt.

The report by Kluender et al[6] also provides data on several contextual correlates of medical debt in the US. For example, mean medical debt per person tended to be highest in the South and lowest in the Northeast, and not surprisingly, highest among persons living in zip codes with the lowest average income levels. In addition, the secular course of medical debt showed a greater decline after 2014 in states that expanded Medicaid under the Affordable Care Act (ACA) relative to states that have not expanded Medicaid. The decline of medical debt in states that expanded Medicaid in 2014 was 34.0 percentage points greater (from $330 to $175) relative to the decline in states that did not expand Medicaid (from $613 to $550), whereas the decline in states that expanded Medicaid after 2014 was 20.4 percentage points greater (from $401 to $288) relative to the decline in states that did not expand Medicaid. A series of robustness analyses provided additional evidence that these findings were unlikely due to the influence of other economic or policy factors in these states during this time.

This study provides an important estimate of the total burden of medical debt in the US population and its variation across aggregate socioeconomic and geographic contexts. The observed patterning of these contexts follows similar patterns of well-established health inequities that contribute to unpaid medical bills and debt. For example, people with fewer economic resources and those living in southern states tend to have higher morbidity across a spectrum of illness conditions.[3,7] People who lack adequate health insurance are also at greater risk of incurring medical debt.[8,9]

Medical debt and associated financial hardship are likely to be associated with substantial adverse health effects. For example, medical debt may compromise seeking or receiving appropriate medical care[10] that may lead to delayed diagnosis of health conditions or exacerbations in preexisting conditions and may potentially contribute to increased risk of premature mortality. There is also clear evidence for a link of personal debt and financial hardship with poor mental health,[11] which in the case of medical debt could worsen the adverse effects of medical conditions on mental health or vice versa. Although little information is available on the downstream health effects of medical debt, there is solid evidence regarding the association of wealth with important health metrics, such as mortality and disability,[12] and the likelihood of recovery after illness.[13] In addition, the sudden loss of wealth (such as what may occur after serious illness and because of medical bills not covered by health insurance) has been associated with a significant increase in mortality risk.[14]

In addition to the potential consequences for health and health care use, the economic and social ramifications of medical debt are likely equally consequential, if not more so. Unlike secured debt (such as a mortgage or automobile loan), which can help people build wealth, personal debt sent to collections decreases wealth and limits access to credit. The inability to

obtain credit, in turn, limits autonomy in managing daily life and may lead to serious disruptions in personal and household stability. Lack of economic opportunity decreases the likelihood of obtaining basic security in other essential life domains (such as access to healthy food, high-quality housing and education, employment, and transportation). Personal debt, of which medical debt is now the largest contributor,[6] may force individuals into a spiral of economic disadvantage, including a lack of stability and security in personal life, housing and work, and social stigma. Furthermore, this pattern of economic disadvantage and lack of stability and security in essential life domains tends to cluster in families and communities and to crossover to subsequent generations.

Addressing the problem of medical debt in the US health care system must be a high priority. From a policy perspective, decreasing medical debt as reported by Kluender et al[6] provides further evidence of the many benefits of the ACA and specifically Medicaid expansion. The increase in insurance coverage and access to care following implementation of the ACA have been documented.[15,16] Importantly, the number of individuals who reported skipping medications or having difficulty paying medical bills declined in concert with increased health insurance coverage.[17] Other reports suggest that Medicaid expansion is associated with improvements in care for and outcomes of health conditions as well as reductions in specific health disparities.[18,19] However, the overall evaluation of the influence of the ACA on population health will remain elusive until its implementation has been sustained over a longer period. In addition, despite its many benefits, the current version of the ACA continues to provide challenges for many individual patients and their families related to deductibles, rising out-of-pocket expenses, and inadequate coverage. Based on data from the early years of ACA implementation, the coverage does not seem to have produced a noticeable decline in bankruptcies due to medical debt.[20]

Nonetheless, the findings reported by Kluender et al[6] suggest that effective health care policies could lead to substantial reductions in overall medical debt. Further improvements will depend on sustained advocacy for universal access to affordable health care that will not saddle patients with inadequate health care or high out-of-pocket costs. Medical debt and the burden it poses on families and communities serve as yet another reminder of how social determinants of health (as they manifest through the financing of the US systems of health care, education, and housing) reinforce and perpetuate inequities in health and inequities in economic promise and prosperity.

ARTICLE INFORMATION

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