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Poverty, Precarity, and the Fracturing of Care Toward a New Model of Healthcare Inequity

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Abstract

This essay synthesizes theological, phenomenological, and clinical perspectives to argue that financial insecurity constitutes not a peripheral social determinant but a primary pathological condition reshaping disease expression, treatment access, and healing possibility. Drawing upon an extensive body of published work examining capitalism's corrosive effects on healthcare, the nature of physician bias, and the sacred dimensions of therapeutic encounters, I propose a comprehensive model of healthcare inequity grounded in narrative ethics, trauma theory, and a post-biomedical understanding of poverty as chronic illness. The model integrates three critical frameworks: the hermeneutics of patient suffering, structural competency as clinical obligation, and economic justice as preventive medicine. This integrated approach challenges the dominant epidemiological paradigm that quantifies inequity without transforming it, offering instead a praxis-oriented framework that recognizes the moral ecology of healing and the physician's role as interpreter of structural wounds.

Introduction: Poverty as the Unspoken Diagnosis

Across my published essays—from explorations of the patient as sacred text to examinations of the moral ambiguity inherent in the healer's role—a persistent theme emerges with striking regularity: patients do not arrive in our clinical spaces as isolated biological entities. They enter bearing the accumulated weight of worlds upon them: economic precarity, generational trauma, racialized structures, geographic dislocation, and the corrosive burden of shame. Financial insecurity, I contend, is not a background condition to be noted in a social history and subsequently ignored. It constitutes a pathology of the social body that expresses itself physiologically, psychologically, symbolically, and spiritually.

In my critique of capitalism's intersection with healthcare (Ungar-Sargon, 2024), I have documented how the profit-driven model has fundamentally distorted the healing encounter. As I wrote in my analysis of healthcare systems under capitalism, the corporate takeover of medicine has transformed patients into consumers, physicians into producers, and the sacred space of healing into a marketplace where vulnerability becomes commodity. This transformation has particularly devastating consequences for those living in poverty, for whom the healthcare system increasingly resembles what I have termed an "iron cage" of institutional coercion rather than a sanctuary of healing (Ungar-Sargon, 2025).

The evidence is overwhelming and damning. Healthcare disparities correlate consistently with socioeconomic status across virtually every disease category and treatment modality (Ungar-Sargon, 2024; Ungar-Sargon, 2025). Yet the dominant frameworks for understanding these disparities—epidemiological models that count and categorize without transforming—have proven woefully inadequate. They document the wounds without treating them. They measure the gaps without bridging them. What is needed is a fundamentally new paradigm, one that recognizes poverty itself as a diagnostic category requiring clinical intervention, structural transformation, and moral witness.

The Neurobiology of Financial Precarity

Chronic threat reshapes the brain. This is not metaphor but measurable neurobiological reality. Poverty constitutes precisely the form of chronic, inescapable threat that produces lasting alterations in neural architecture and physiological function. The mechanisms are now well-documented: chronic cortisol elevation disrupts hippocampal function and memory consolidation; allostatic overload accumulates as the body's stress-response systems remain perpetually activated; vagal dysregulation impairs the capacity for social engagement and parasympathetic recovery; persistent inflammation damages vascular endothelium and accelerates atherosclerosis; and the cognitive burden of scarcity depletes the executive function resources necessary for health-promoting decisions (Ungar-Sargon, 2025; Ungar-Sargon, 2025).

In my epigenetic trauma and fetal experience (Ungar-Sargon, 2025), I have explored how these neurobiological alterations can be transmitted intergenerationally. The child born into poverty inherits not merely social disadvantage but physiological vulnerability—a body already primed for threat, already bearing the marks of ancestral suffering. This is the biological embodiment of what liberation theologians might call structural sin: the inscription of injustice into the very cells of the oppressed.

The poor body, then, is not simply a poorer version of the healthy body. It is a body forced into physiological economies of survival, allocating limited resources toward immediate threat response at the expense of long-term health maintenance. It is a body shaped by scarcity into patterns that make perfect evolutionary sense for short-term survival but prove catastrophic for chronic disease management. When we fail to recognize this, when we treat the diabetic patient living in poverty as simply non-compliant rather than as someone whose biology has been systematically altered by their social circumstances, we perpetuate the very harm we claim to address.

The Psychological Toll of Healthcare Unaffordability

Perhaps nowhere is the violence of our healthcare system more acutely experienced than in the psychological torment of those who need medical care but cannot afford it. The act of walking into a physician's office, hospital, or clinic while carrying the knowledge that one cannot pay for the care one desperately needs constitutes a form of existential assault that our clinical literature has only begun to document, but which patients experience with devastating immediacy.

The Anticipatory Dread of Seeking Care

The psychological burden begins long before the patient enters the clinical space. A 2017 study by the American Psychological Association found that three in five Americans (57%) were stressed about medical bills, with 60% reporting anxiety about the cost of medications (American Psychological Association [APA], 2017). This is not merely financial concern but a form of chronic anticipatory anxiety that shapes healthcare-seeking behavior in profound ways. The Kaiser Family Foundation reports that 25% of insured adults and 39% of uninsured adults are "very worried" about not being able to afford needed healthcare services (Hamel et al., 2016). This worry is not occasional but persistent—a low-grade psychological fever that accompanies every symptom, every bodily concern, every contemplation of seeking care.

Research distinguishes between material financial burden—the concrete reality of unpaid bills and depleted savings—and psychological financial burden, which includes both the distress resulting from financial strain and the anticipatory worry about affording future healthcare (Gordon et al., 2017).

This distinction is clinically significant: anxiety and worry are associated with elevated cortisol levels and heart rate variability, creating a physiological stress response that itself worsens health outcomes (Gordon et al., 2017). The patient who worries about affording care is not merely experiencing an emotional inconvenience but is undergoing measurable physiological harm from the worry itself.

The Shame Spiral of Medical Debt

For those who have already accumulated medical debt—and two in five Americans carry such debt (Kluender et al., 2025)—the psychological burden intensifies into what can only be described as a shame spiral. Survey research reveals that medical debt is strongly associated with feelings of isolation and avoidance behaviors: 57% of respondents with medical debt reported refusing to answer phone calls, including calls from their healthcare providers; 39% reported avoiding opening mail (Neighborhood Trust and Undue Medical Debt, 2024). These are not simply practical responses to harassment but manifestations of shame so profound that it drives individuals to cut themselves off from the very communications that might help resolve their situations.

The stigma of medical debt carries particular psychological weight in American culture, where financial difficulty is often interpreted as moral failure. As one researcher noted, patients experiencing medical debt frequently describe feeling that their situation reflects personal inadequacy rather than systemic dysfunction (Olkin, 2024). This internalized shame is compounded by the often-humiliating process of seeking financial assistance, applying for public programs, or negotiating with billing departments. Cancer patients in qualitative studies have described the shame of using food stamps as "somewhat embarrassing," with many reporting they "never thought [they] would come to a day" where such assistance would be necessary (Banegas et al., 2016).

A systematic review of the literature demonstrates that individuals with debt are three times as likely to have a mental health problem, including anxiety, stress, and depression (Richardson et al., 2013). The Consumer Financial Protection Bureau has found that medical debt specifically worsens mental health conditions and is strongly correlated with increased risk of suicide (Consumer Financial Protection Bureau [CFPB], 2022). This is not merely correlation but a bidirectional causal relationship: medical debt produces psychological distress, which worsens physical health, which generates more medical bills, which deepens the debt, which intensifies the psychological distress. The patient is caught in a vortex from which escape becomes increasingly difficult.

The Terror of the Waiting Room

Consider the phenomenology of the poor patient in the waiting room. They sit surrounded by others who may or may not share their predicament, holding insurance cards that may or may not provide meaningful coverage, facing forms that ask about financial information with clinical detachment. They know that behind the doors to which they will soon be called lies not only the possibility of diagnosis and treatment but the certainty of bills they cannot pay. Every moment in that space is saturated with dread.

Studies of emergency department patients have found a three-fold increase in the total number of perceived barriers reported by those screening positive for depression compared to those without mental health challenges (De Jesus & Xiao, 2021). This suggests that psychological distress amplifies the subjective experience of every obstacle, making the already-difficult process of seeking care feel nearly insurmountable. The patient with depression who is also poor faces not merely additive difficulties but multiplicative ones—each barrier reinforcing and magnifying the others.

For patients with existing medical debt, the clinical encounter itself becomes threatening. Research shows that one in five indebted patients report avoiding the provider where they owe money due to concerns about being refused care (Perry Undem Research/Communication, 2023). Two in five report delaying care specifically to avoid accruing further debt (Perry Undem Research/Communication, 2023). The healing space has been transformed into a site of potential humiliation and exclusion. The patient approaches the physician not as a suffering person seeking relief but as a debtor approaching a creditor, already positioned in a relationship of shame and subordination.

The Cognitive Tax of Healthcare Decision-Making Under Scarcity

The psychological burden of healthcare unaffordability extends beyond emotional distress to cognitive impairment. Research on the psychology of scarcity demonstrates that financial constraint captures attention and depletes cognitive bandwidth, leaving fewer mental resources available for other decisions (Mullainathan & Shafir, 2013). When patients must constantly calculate whether they can afford care, weigh the relative urgency of symptoms against the certainty of bills, and navigate complex insurance systems while already depleted by illness, their decision-making capacity is systematically compromised.

This cognitive tax manifests clinically in ways that are often misinterpreted as non-compliance or poor health literacy. The patient who fails to fill a prescription may not be ignorant of its importance but rather engaged in an agonizing calculation about whether to pay for medication or food. The patient who misses follow-up appointments may not be careless but rather avoiding the accumulation of further debt. The patient who delays seeking care for worsening symptoms may not be in denial but rather engaging in a desperate hope that the problem will resolve itself without generating bills they cannot pay.

The statistics are stark: in 2023, more than one in four adults (28%) reported delaying or going without medical care, prescription drugs, mental health care, or dental care due to cost (Rakshit, 2025). Among those with heart failure—a condition requiring consistent monitoring and treatment—16% reported forgone or delayed medical care, with 60% of non-elderly patients citing financial barriers as the primary reason (Thomas et al., 2021). These are not marginal populations making marginal decisions; these are millions of Americans engaging in what might be called healthcare rationing at the individual level, allocating their limited resources across competing urgent needs and inevitably shortchanging their health.

How Financial Stress Worsens Health

The psychological toll of healthcare unaffordability creates a devastating feedback loop. Financial toxicity—the term

increasingly used to describe the psychological burden of healthcare costs—is now recognized as associated with worse health outcomes, including increased mortality. In cancer care, severe financial distress after diagnosis leads to 80% greater mortality risk in patients with colon and prostate cancer (Ramsey et al., 2016). This is not merely because patients forgo treatment but because the stress itself is physiologically damaging, triggering inflammatory cascades, disrupting sleep, impairing immune function, and accelerating disease progression.

Research using nationally representative data demonstrates that people who delayed or forwent medical treatment were significantly less likely to report excellent or very good health status and had significantly lower quality-of-life scores compared with those who never delayed necessary care (Chen et al., 2011). Importantly, these effects persisted even after controlling for baseline health status, chronic conditions, and socioeconomic factors. The delay itself—driven by financial barriers—independently worsens outcomes.

Among elderly patients with heart failure who reported forgone or delayed care, annual healthcare expenses were over $10,000 higher than those without care lapses (Thomas et al., 2021). This paradox—that avoiding care to save money ultimately costs more—reflects the biological reality that delayed treatment allows disease progression, converts manageable conditions into medical emergencies, and transforms outpatient problems into inpatient crises. The patient who delays a primary care visit because they cannot afford the copay may ultimately require hospitalization that costs orders of magnitude more. The healthcare system punishes poverty with compounding interest.

Family Systems under Siege

The psychological burden of healthcare unaffordability extends beyond the individual patient to encompass entire family systems. Medical debt and healthcare-related financial stress are leading causes of family tension, contributing to arguments about spending and debt management, stressful decisions regarding assets and financial plans, and feelings of isolation within families and social circles (Bhattacharjya, 2025). The patient's struggle becomes the family's struggle; the patient's shame becomes shared shame.

Studies of family caregivers of persons with mental illness have found that the majority report financial difficulties in supporting their ill family members, with many requiring financial assistance from other family members (Ballard Brief, 2025). The ripple effects extend through generations: parents unable to save for children's education because of medical bills; adult children depleting retirement savings to help aging parents; families making impossible choices between treatment for one member and basic needs for others.

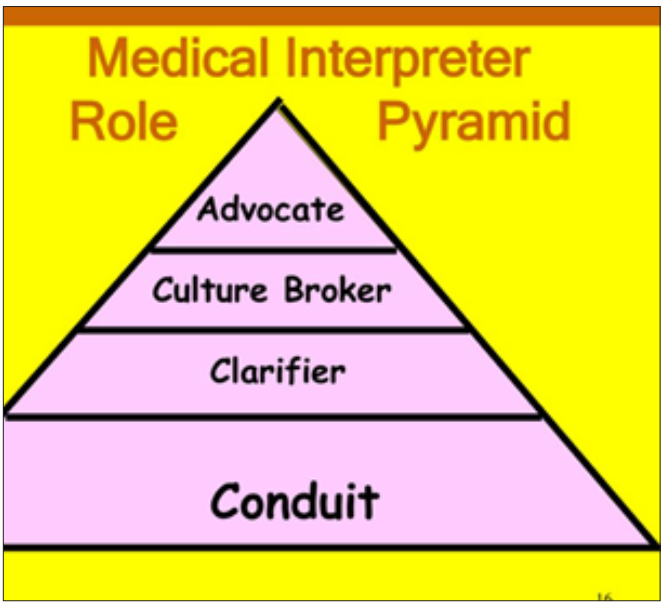
Medical bankruptcy—and over 66% of personal bankruptcies in America are tied to medical issues (Himmelstein et al., 2019)—represents the catastrophic endpoint of this family system collapse. The emotional toll includes not only the shame and stigma of bankruptcy itself but the loss of financial stability that can trigger feelings of hopelessness and depression. For some, this toll becomes unbearable: studies show that individuals facing bankruptcy are more likely to experience depression and, in extreme cases, suicidal ideation (Himmelstein et al., 2019).

Shame, Humiliation, and the Erosion of Agency

If the neurobiology of poverty describes how bodies are reshaped by financial precarity, the phenomenology of shame reveals how selves are diminished. In my explorations of the therapeutic encounter as sacred space (Ungar-Sargon, 2025), I have emphasized the crucial importance of what I term "sacred listening"—the practice of receiving another's narrative as one would approach a sacred text, with reverence, attention, and interpretive humility. But shame is the enemy of authentic narrative. It silences. It distorts. It fragments the coherent story that healing requires.

Poverty's emotional signature is humiliation. The experience of economic precarity in contemporary capitalist society is not merely material deprivation but a systematic assault on dignity. The inability to pay bills, the reliance on charity, the visible markers of disadvantage, the bureaucratic gauntlets of public assistance programs—all these carry messages of worthlessness that become internalized as shame. This internalized shame then erodes the very capacities necessary for effective healthcare engagement: self-advocacy, the ability to trust healthcare providers, narrative honesty about symptoms and circumstances, and the sense of autonomous agency required for treatment adherence.

Shame silences. Silence distorts diagnosis. Distorted diagnosis worsens disease. This is not a theoretical construct but a clinical reality I have witnessed countless times over five decades of practice. The patient who minimizes symptoms because they fear being judged. The patient who fails to disclose medication non-adherence because they cannot afford to admit they cannot afford their prescriptions. The patient whose shame prevents them from describing living conditions that directly impact their health. Each of these silences represents a failure of the therapeutic encounter—not because the patient has failed to communicate, but because we have failed to create a space where authentic communication becomes possible.



The Physician as Interpreter of Structural Wounds

In my hermeneutic approaches to medicine (Ungar-Sargon, 2025), I have developed the concept of the patient as sacred text—a framework that reconceives the clinical encounter as an act of interpretation requiring the same reverent attention we might bring to scripture. This hermeneutic lens becomes particularly crucial when we recognize that poverty appears clinically not as a single symptom but as a pattern of distortions that the attentive physician must learn to read: missed appointments that signal transportation barriers or competing survival demands; uncontrolled chronic disease that reveals inability to afford medications, testing supplies, or appropriate nutrition; medication rationing that speaks to impossible choices between health and other necessities; and what I have called the "currency of symptoms"—the ways patients learn to present their suffering in forms the healthcare system will recognize and reimburse.

The physician, in this framework, functions not merely as technician but as moral witness—one who sees and names the structural violence inscribed in their patients' bodies. This is what I mean by the physician as interpreter of hidden wounds (Ungar-Sargon, 2025). The diabetic foot ulcer tells a story not only of neuropathy but of inadequate housing that makes proper foot care impossible. The recurrent asthma exacerbation speaks not merely of bronchial hyperreactivity but of substandard living conditions. The poorly controlled hypertension narrates chronic stress, food insecurity, and the toxic exposure that concentrated poverty produces.

Yet the physician who would interpret these structural wounds must first confront their own biases. In my comprehensive review of healthcare biases (Ungar-Sargon, 2024), I documented how unconscious prejudices shape clinical decision-making in ways that systematically disadvantage the poor. Studies consistently demonstrate that physicians provide less thorough care to patients perceived as lower socioeconomic status, spend less time with them, offer fewer treatment options, and are more likely to attribute their conditions to personal failings rather than structural factors. These biases operate largely outside conscious awareness, making them particularly insidious and difficult to address.

When Poverty Becomes a Clinical Category

The argument I am advancing requires us to reconceptualize poverty not as a social circumstance that affects health outcomes but as itself a clinical condition requiring direct intervention. This is not merely semantic play. It carries profound implications for how we train physicians, structure healthcare delivery, and allocate resources.

Consider poverty through the lens of established medical categories. As a chronic inflammatory state, poverty produces measurable elevations in C-reactive protein, interleukin-6, and other inflammatory markers that drive atherosclerosis, autoimmune disease, and accelerated aging. As a trauma response, poverty activates and perpetuates the hypervigilance, dysregulated affect, and relational difficulties characteristic of PTSD. As a cognitive tax, poverty depletes the executive function resources necessary for planning, decision-making, and impulse control. As a shaper of identity, poverty determines how individuals understand themselves, their possibilities, and their relationship to healthcare systems. And as a determinant of access, trust, and continuity, poverty fundamentally structures the healthcare encounter in ways that current models fail to address.

What would it mean to treat poverty with the same seriousness we bring to diabetes or hypertension? It would mean screening for financial precarity as routinely as we screen for depression. It would mean developing evidence-based interventions for economic stress as rigorously as we develop protocols for sepsis. It would mean tracking financial health indicators as standard components of the medical record. And it would mean recognizing that treatment for any other condition will be compromised until the underlying condition of poverty is addressed.

Why Current Models of Healthcare Inequity Fail

The dominant epidemiological frameworks for understanding healthcare inequity, while valuable in documenting disparities, have proven inadequate for transforming them. They enumerate differences in outcomes without addressing root causes. They correlate social factors with disease patterns without challenging the structures that produce those patterns. In short, they describe without disturbing.

In my critique of capitalism's effects on healthcare (Ungar-Sargon, 2024), I traced how the commodification of medicine has exacerbated these failures. The profit motive that now dominates healthcare delivery has no incentive to address structural inequities. Indeed, it profits from them—extracting maximum revenue from those who can pay while providing minimal care to those who cannot. The "fundamental cause" that social epidemiologists have identified—socioeconomic position—remains fundamental precisely because our profit-driven healthcare system is not designed to address it.

Current models fail for several interconnected reasons. First, they miss the lived experience of scarcity—the daily reality of impossible choices, the cognitive burden of constant calculation, the exhausting vigilance that poverty requires. Second, they neglect the hermeneutics of illness—the ways that disease means differently to those living in poverty, the interpretive frameworks that shape symptom experience and healthcare-seeking behavior. Third, they ignore the spiritual violence of inequity—the assault on dignity and meaning that poverty represents. Fourth, they evade the moral obligations of the healer—the demands that justice places on those who would claim to serve the sick. And fifth, they leave untouched the capitalist structures that reproduce inequality generation after generation.

Toward a New Model: The Hermeneutics of Healthcare Inequity

The model I propose integrates insights from narrative medicine, trauma-informed care, liberation theology, and structural competency into a comprehensive framework for understanding and addressing healthcare inequity. It rests on six foundational principles.

First, poverty as chronic illness. *We must recognize financial precarity as a pathological condition with its own etiology, pathophysiology, clinical manifestations, and treatment requirements. This means moving beyond the social determinants framework to understand poverty as itself a disease requiring direct clinical intervention.*

Second, the therapeutic encounter as sacred space. *Drawing on my work integrating Kabbalistic concepts with clinical practice (Ungar-Sargon, 2025), I propose that the physician-patient relationship represents a site of potential transformation—a space where healing becomes possible through the quality of presence, attention, and witness the clinician provides. This is the clinical application of what I have called tzimtzum: the divine contraction that creates space for another to exist. The physician who would heal must first contract their own expertise, assumptions, and agendas to create room for the patient's authentic story to emerge.*

Third, narrative medicine as corrective justice. *The practice of attending to patient narratives—really attending, with the reverence we would bring to sacred text—represents a form of justice. In a world that silences the poor, that renders their stories invisible or unintelligible, the physician who truly listens performs an act of repair. This is what I have termed hermeneutic medicine (Ungar-Sargon, 2025): the practice of treating patients as texts requiring interpretation rather than as problems requiring solutions.*

Fourth, structural competency as clinical obligation. *Just as we require cultural competency in medical education, we must develop and require structural competency—the capacity to recognize how social structures shape health and disease. This means training physicians to diagnose not merely biological pathology but structural violence; to prescribe not merely pharmaceuticals but advocacy; to treat not merely individuals but systems.*

Fifth, healthcare as moral ecosystem. *The healing encounter does not occur in isolation but within systems of meaning, value, and power. A model adequate to healthcare inequity must attend to this moral ecology—to the ways that institutional structures, economic incentives, professional cultures, and societal narratives shape the possibilities for healing. This is what I have explored in my work on the sacred and profane in therapeutic encounters (31): the recognition that healing happens not through technique alone but through the transformation of the space in which technique is applied.*

Sixth, economic justice as preventive medicine. *Finally, and most radically, the model I propose recognizes that true healthcare reform cannot be separated from economic justice. As I have argued in my critiques of capitalist healthcare (32), the most effective intervention for the diseases of poverty is the elimination of poverty itself. This means physicians must expand their understanding of their role to include advocacy for living wages, affordable housing, food security, and the redistribution of wealth that genuine health equity requires.*

Clinical Applications and Transformative Practice

The theoretical framework I have outlined demands translation into clinical practice. In my work on transformative healthcare spaces (Ungar-Sargon, 2025) and integrative treatment models (Ungar-Sargon, 2025), I have begun developing concrete applications of these principles. These include: systematic screening for financial precarity using validated instruments; integration of community health workers and social workers into primary care teams; creation of patient navigation systems to address structural barriers; development of sliding-scale payment models and medication assistance programs; training in trauma-informed care that specifically addresses poverty-related trauma; and the establishment of what I have termed "healing spaces"—clinical environments designed to counteract the institutional violence that poor patients typically experience in healthcare settings.

Perhaps most importantly, the model requires a transformation in how we train physicians. As I have argued in my critiques of medical education (Ungar-Sargon, 2025), current training reinforces the biomedical reductionism and class-based biases that perpetuate healthcare inequity. We need an educational revolution that teaches physicians to see structural violence as clearly as they see anatomical pathology; to hear narratives of poverty as attentively as they listen to heart sounds; to advocate for justice as readily as they prescribe medications.

Conclusion: Toward a Medicine of Restored Dignity

Poverty is the unacknowledged demon of modern medicine—a concealed wound distorting both disease and diagnosis. The model I have proposed recognizes this and responds with what I call structural compassion: a form of care that attends not only to individual pathology but to the social conditions that produce and perpetuate it. This is not merely a clinical intervention but a moral stance—a refusal to accept as natural or inevitable the suffering that poverty inflicts.

True healing, in this framework, requires the integration of moral presence, clinical excellence, and economic justice. It demands that physicians reclaim their role as healers in the deepest sense—not merely technicians who repair biological mechanisms, but witnesses who name structural violence, interpreters who decode the inscriptions of poverty on bodies and souls, and advocates who work for the transformation of unjust systems.

Medicine must become, finally, a practice of restored dignity. This means creating clinical spaces where the poor are treated not as problems to be managed but as sacred beings worthy of the same attention, time, and resources we lavish on the wealthy. It means transforming our institutions from engines of extraction into sanctuaries of healing. And it means recognizing that genuine health—for individuals and for communities—begins with justice.

The hour is late, but the work is possible. In every clinical encounter, in every policy decision, in every act of advocacy, we choose between perpetuating the violence of poverty and participating in its undoing. The model I have proposed is not a blueprint but an invitation—a call to imagine and create a healthcare system worthy of human dignity. May we find the courage to answer.

ADDENDUM

The Particular Vulnerability of the Elderly: The Gray Tsunami Meets the Rising Tide of Precarity

The preceding essay examined how financial insecurity functions as a chronic pathological condition reshaping disease expression, treatment access, and healing possibility across populations. This addendum extends that analysis to address what may be the most vulnerable population of all: the elderly. As the demographic transformation accelerates—with the population aged 65 and older projected to reach 77 million by 2034, up from 52 million today (West Health-Gallup, 2022)—the intersection of aging and financial precarity demands particular attention. For the elderly, the consequences of healthcare unaffordability are not merely amplified; they are qualitatively transformed by the biological, psychological, and social realities of aging itself.

The elderly occupy a paradoxical position in our healthcare system. On one hand, Medicare provides near-universal coverage for those 65 and older, theoretically insulating this population from the most catastrophic financial consequences of illness. On the other hand, the realities of Medicare's coverage gaps, rising out-of-pocket costs, and the particular healthcare needs of aging create a landscape where financial insecurity continues to exact a devastating toll. What emerges is a picture of a population caught between the promise of security and the reality of precarity—a population for whom the psychological and physiological costs of financial stress compound the already-significant burdens of aging.

The Economic Landscape of Aging in America

Most seniors live on modest retirement incomes that are often barely adequate—and sometimes inadequate—to cover the costs of basic necessities while supporting a simple, dignified quality of life (Cooper & Gould, 2013). This economic reality creates the backdrop against which all healthcare decisions must be made. The median income of households headed by someone aged 65 or older hovers around $24,500, a figure that must stretch to cover housing, food, utilities, and the healthcare costs that Medicare leaves behind (Briesacher et al., 2007).

The healthcare costs facing the elderly are not trivial. Per capita healthcare spending for older adults was already significantly higher than for younger populations decades ago—$2,026 in 1978 compared to $286 for young people—and this disparity has only grown (Chen et al., 2023). Medical expenses for senior citizens now account for more than a quarter of total healthcare expenditures, with projections suggesting this proportion will exceed 66% in some urban areas by 2030 (Chen et al., 2023). These costs are driven by the reality that aging bodies require more medical attention: more chronic disease management, more hospitalizations, more medications, more specialized care.

Comparative international data reveals the particular severity of this burden in the United States. Older adults in the U.S. and Switzerland are most likely to spend $2,000 or more annually on healthcare out of pocket; in contrast, fewer than

10% of adults in France, the Netherlands, Sweden, and the United Kingdom face such costs (Gunja et al., 2024). This international comparison illuminates a fundamental truth: the financial burden facing America's elderly is not an inevitable consequence of aging but a policy choice—a reflection of how we have chosen to structure our healthcare system.

The Particular Vulnerabilities of Aging

The elderly face financial insecurity with a particular disadvantage: their capacity to increase income is severely constrained. Unlike younger adults who might work additional hours, seek promotions, or change careers in response to financial pressure, most seniors live on fixed incomes from Social Security, pensions, and retirement savings. When healthcare costs rise—as they invariably do—there is often no possibility of earning more to compensate. The only available responses are reducing consumption of other necessities or forgoing care entirely.

This dynamic creates what economists call "economic vulnerability"—a state in which even modest financial shocks can precipitate crisis. Research using the Supplemental Poverty Measure demonstrates that a majority of seniors could be pushed into economic insecurity by proposed changes to Medicare or Social Security. A 50% increase in out-of-pocket health expenses would raise the share of economically vulnerable elderly by 4.5 percentage points; a doubling of these costs would push nearly 56.4% of seniors below the threshold of economic security (Cooper & Gould, 2013). These are not abstract projections but descriptions of populations living at the margin, for whom financial stress is not an occasional inconvenience but a constant companion.

Polypharmacy and the Prescription Drug Burden

The elderly take more medications than any other demographic group. According to the Kaiser Family Foundation, 89% of adults aged 65 and older take at least one prescription medication, and 54% take four or more (Kaiser Family Foundation, 2022). This polypharmacy is medically necessary—the accumulation of chronic conditions with age requires ongoing pharmacological management—but it creates a financial burden that can become crushing.

Cost-related medication nonadherence among the elderly has reached alarming proportions. A 2022 national survey found that 20.2% of adults aged 65 and older reported some form of cost-related medication nonadherence—deciding not to fill prescriptions, skipping doses, taking less medication than prescribed, delaying fills, or using someone else's medications (Dusetzina et al., 2023). More troubling still, surveys indicate that up to 32% of older adults take less medication than prescribed specifically to avoid costs (Briesacher et al., 2007). This is not occasional corner-cutting but systematic undertreatment driven by financial constraint.

The consequences of medication nonadherence in the elderly are severe. Because this population manages multiple chronic conditions simultaneously, undertreatment of any single condition can trigger cascading deterioration. The diabetic who skips insulin doses to save money risks not only hyperglycemic crisis but accelerated nephropathy, neuropathy, and cardiovascular disease. The hypertensive who stretches medication intervals courts stroke and myocardial infarction. The pattern is consistent: short-term savings generate long-term catastrophe, as manageable chronic conditions become acute emergencies requiring hospitalization and intensive intervention.

The Long-Term Care Catastrophe

Perhaps nowhere is the financial vulnerability of the elderly more starkly revealed than in the domain of long-term care. Nursing home stays cost on the order of $77,000 to $88,000 annually—figures that will impoverish most individuals within months (French & Jones, 2017). Medicare provides virtually no coverage for custodial long-term care; private long-term care insurance remains uncommon; and the result is that most individuals must spend down their assets until they qualify for Medicaid, the means-tested program of last resort.

The statistics are sobering: approximately 29% of nursing home costs are paid out of pocket, while Medicaid ultimately finances 63% of nursing home residents after they have been financially devastated (French & Jones, 2017). This is not a safety net but a cliff—a system that catches people only after they have fallen into poverty. The psychological burden of this reality weighs on the elderly long before they need care: the knowledge that disability could mean not merely physical dependence but financial ruin shapes how aging Americans think about their futures, their healthcare decisions, and their very identities.

Microsimulation modeling reveals the scope of this threat. While 15% of older adults who survive to age 65 will have household income fall below the federal poverty level for at least one year using traditional measures, this figure explodes to 69% when healthcare and long-term care spending are subtracted from income (Johnson et al., 2021). Critically, this risk extends across the income distribution: approximately three in ten older adults in the top quintile of lifetime earnings will experience economic hardship for at least three years after accounting for health-related spending (Johnson et al., 2021). No amount of prudent saving can fully protect against the financial catastrophe of extended care needs.

The Psychological Toll of Financial Insecurity in Aging

Depression is one of the most common geriatric psychiatric disorders and a major risk factor for disability and mortality in elderly patients, yet it remains undiagnosed in approximately half of cases (Zenebe et al., 2021). The World Health Organization estimates that global depressive disorder among older adults ranges between 10 and 20%, with systematic reviews finding pooled prevalence rates approaching 19.2% globally (Zenebe et al., 2021; Jalali et al., 2024). Among the constellation of risk factors for late-life depression, financial insecurity occupies a central position.

Cross-national research from the WHO's Study on Global Ageing and Health (SAGE) demonstrates strong associations between financial stress and subjective health, depression, quality of life, and life satisfaction among older adults across diverse national contexts (Huang et al., 2020). The relationship is bidirectional but the directionality matters less than the recognition that financial insecurity and psychological distress form a mutually reinforcing cycle. The elderly person worried about healthcare costs experiences heightened anxiety and depressive symptoms, which impair their capacity to manage their health, which generates more healthcare costs, which deepens the financial stress.

The psychological burden manifests in characteristic ways among the elderly. Social isolation and loneliness, which affect approximately one quarter of older people, are key risk factors for mental health conditions in later life (World Health Organization [WHO], 2025). Financial insecurity intensifies isolation: the elderly person who cannot afford to participate in social activities, who avoids phone calls from collectors, who feels shame about their economic circumstances, withdraws further from the social connections that might otherwise buffer psychological distress. The result is a spiral of loneliness, depression, and declining health.

Cognitive Consequences of Financial Stress

The cognitive dimension of financial insecurity in aging deserves particular attention. Depression and cognitive impairment frequently coexist in older adults, with approximately 44.3% of patients with cognitive disorders also presenting with depressive symptoms (Giebel et al., 2016). The relationship appears to be bidirectional and potentially synergistic: depression increases the risk of cognitive decline and dementia, while cognitive impairment intensifies vulnerability to depression (Yan et al., 2024). Financial stress may accelerate this dangerous spiral.

Research on financial capacity—the cognitively complex ability to manage money, pay bills, and make financial decisions—reveals particular vulnerability in aging populations. Financial capacity is among the earliest capacities to decline in pre-dementia syndromes, and its impairment can both result from and exacerbate financial stress (Marson et al., 2000). The elderly person whose cognitive resources are already strained by financial worry may find it increasingly difficult to navigate complex billing systems, insurance claims, and medication management, creating further financial problems that intensify cognitive burden. This is the scarcity trap applied to the aging brain: limited cognitive resources captured by financial stress, leaving fewer resources for the health management tasks that might alleviate that stress.

The Specter of Suicide

The most devastating psychological consequence of financial insecurity in aging is its connection to suicide. Suicide rates in the elderly, while declining, remain higher than in younger adults and are more closely associated with depression than at earlier ages (Fiske et al., 2009). The WHO reports that globally, approximately one-sixth of deaths from suicide (16.6%) occur among people aged 70 or over (WHO, 2025). Financial stress and the loss of dignity associated with economic dependence contribute to this risk.

The trajectory from financial insecurity to suicidal ideation often passes through medical bankruptcy, which carries profound emotional and psychological consequences for the elderly. The stigma of bankruptcy, the shame of perceived failure, the loss of financial stability—all can generate feelings of hopelessness and depression (Himmelstein et al., 2019). For an elderly person whose identity has been built on independence and self-sufficiency, the humiliation of financial ruin may feel unbearable. Studies show that individuals facing bankruptcy are more likely to experience depression and, in extreme cases, suicidal thoughts (Himmelstein et al., 2019).

The Mortality Costs of Financial Hardship

Delayed and Forgone Care

The consequences of financial insecurity in the elderly manifest most directly in delayed and forgone care. The West Health-Gallup survey found that approximately 12% of those 65 and older—representing roughly 6.5 million people—had a health problem in the preceding year for which they did not seek treatment due to cost (West Health-Gallup, 2022). Similarly, 11% (approximately 6 million people) reported that they or a family member skipped prescribed pills to save money. These are not marginal figures but substantial proportions of the elderly population systematically undertreating their conditions due to financial barriers.

The pattern of sacrifice extends beyond direct healthcare to basic necessities. Approximately one in four adults aged 65 and older—and three in ten aged 50-64—report cutting back on food, utilities, clothing, or medication due to healthcare costs (West Health-Gallup, 2022). This hardship is experienced to a greater degree by older women and Black Americans, revealing the intersectionality of age, gender, and race in creating vulnerability. The elderly person who reduces food consumption to pay for medications risks malnutrition; the one who skips utility payments risks hypothermia or heat stroke; the one who forgoes medication to buy food risks disease progression. Every choice is a losing proposition.

The Mortality Connection

Financial hardship in the elderly is not merely associated with reduced quality of life but with increased mortality. Longitudinal research using the Health and Retirement Study demonstrates that specific financial hardships predict mortality even after controlling for traditional socioeconomic measures (Tucker-Seeley et al., 2011). For women, receiving Medicaid benefits—a marker of financial devastation—was associated with a more than doubled risk of mortality (HR=2.23). For men, both Medicaid receipt (HR=2.11) and food stamp receipt (HR=1.59) independently predicted death (Tucker-Seeley et al., 2011).

The mechanisms connecting financial hardship to mortality in the elderly are multiple and synergistic. Delayed care allows

disease progression. Medication nonadherence destabilizes chronic conditions. Nutritional compromise weakens physiological reserves. Psychological distress accelerates biological aging. Social isolation eliminates protective social connections. And the stress of financial uncertainty itself—the chronic activation of threat-response systems documented in the main essay—produces its own physiological damage through inflammatory pathways, immune dysregulation, and cardiovascular strain.

The Paradox of Forgone Care and Increased Costs

Among the elderly, the paradox documented earlier—that avoiding care to save money ultimately costs more—reaches its most extreme expression. Research on heart failure patients found that among elderly patients (aged 65 and older), those reporting forgone or delayed care had annual healthcare expenses more than $10,000 higher than those without care lapses, with inpatient costs alone $7,500 higher (Thomas et al., 2021). The overall medical expenditures for elderly heart failure patients with forgone or delayed care were approximately 25% higher than the general population and 33% higher than all patients over 65 (Thomas et al., 2021).

This pattern reflects the biology of aging: elderly patients have less physiological reserve, fewer compensatory mechanisms, and more fragile homeostasis. When care is delayed, deterioration is faster and more severe. Conditions that might have been managed with outpatient intervention become emergencies requiring hospitalization. Hospitalizations in the elderly carry their own risks—delirium, falls, infections, deconditioning—that generate further complications requiring further care. The elderly patient who skips primary care visits to save copays may ultimately require intensive care at costs measured in tens or hundreds of thousands of dollars.

Food Insecurity: The Intersection of Hunger and Illness

Food insecurity among the elderly represents a particularly devastating intersection of financial constraint and health vulnerability. When healthcare costs consume available resources, food is often what remains to be sacrificed. Research using linked data from the Medical Expenditure Panel Survey and National Health Interview Survey demonstrates that food-insecure older adults have higher healthcare costs than food-secure older adults regardless of chronic disease status (Garcia et al., 2018). The relationship is synergistic: food insecurity exacerbates the deleterious effects of chronic health conditions irrespective of the type of condition, generating higher healthcare costs than either factor alone would predict (Garcia et al., 2018).

The biological mechanisms are straightforward. Adequate nutrition is essential for chronic disease management: the diabetic requires consistent carbohydrate intake for glycemic control; the heart failure patient needs sodium restriction and balanced fluid intake; the elderly patient on multiple medications needs food to prevent gastrointestinal irritation and ensure proper absorption. When financial stress forces choices between food and medication, both nutrition and pharmacological management are compromised simultaneously.

The healthcare costs associated with food insecurity in the United States were estimated at $160.7 billion in 2014, a figure that includes but extends far beyond the elderly (Garcia et al., 2018). For older adults specifically, food insecurity adds significant healthcare costs even after controlling for chronic conditions, suggesting that hunger itself—independent of the diseases it exacerbates—constitutes a clinical burden requiring attention and intervention.

Implications for Clinical Practice and Policy

The evidence reviewed in this addendum demands both clinical and policy responses tailored to the particular vulnerabilities of aging. At the clinical level, providers caring for elderly patients must recognize financial insecurity as a core determinant of health outcomes, as significant as any biomedical factor. This means: systematic screening for financial stress, food insecurity, and medication affordability concerns; direct conversations about cost that many providers currently avoid; familiarity with patient assistance programs, generic alternatives, and community resources; and willingness to adjust treatment plans based on what patients can actually afford rather than what textbooks recommend.

Research indicates that cost conversations do not routinely occur in primary care settings—in one study, fewer than half of visits included any discussion of cost, and patients with affordability concerns were no more likely to have such conversations than those without (Fazzino et al., 2023). This represents a failure of clinical practice with measurable consequences. When providers fail to discuss costs, patients engage in silent rationing—skipping medications, delaying refills, stretching doses—without clinical guidance about which compromises are most dangerous.

At the policy level, the findings reviewed here argue for fundamental reforms in how we structure healthcare financing for the elderly. The coverage gaps in Medicare—particularly for dental care, hearing, vision, and long-term care—create predictable financial catastrophes for those who need these services. The complexity of navigating Medicare, Medicare Advantage, supplemental coverage, and prescription drug plans imposes cognitive burdens that themselves contribute to poor outcomes. And the reliance on Medicaid as the ultimate backstop—available only after impoverishment—represents a cruel system design that protects the elderly only after destroying their financial security.

Social Security and Medicare are the bedrock of financial security for America's elderly. Any proposed changes to these programs must be evaluated not merely for their budgetary implications but for their impact on the living standards, health outcomes, and mortality rates of the elderly population. The evidence reviewed here suggests that policies that increase out-of-pocket costs for the elderly will predictably generate: increased medication nonadherence, delayed and forgone care,

nutritional compromise, psychological distress, and ultimately excess mortality. These are not acceptable tradeoffs.

Toward a Geriatric Medicine of Economic Justice

The elderly occupy a unique position in the landscape of healthcare inequity. They are simultaneously among the most vulnerable to the health consequences of financial insecurity and among the most likely to experience such insecurity given the intersection of fixed incomes, escalating healthcare needs, and inadequate coverage for long-term care. The psychological toll of financial stress compounds the biological vulnerabilities of aging; the cognitive burden of financial worry depletes resources already strained by normal aging processes; and the mortality costs of delayed and forgone care are amplified by the reduced physiological reserves of older bodies.

A medicine adequate to these realities must integrate economic awareness into every dimension of geriatric care. It must recognize that the elderly patient presenting with uncontrolled diabetes may be rationing insulin; that the one with recurrent heart failure exacerbations may be skipping diuretics to buy food; that the one declining in cognition may be overwhelmed by the financial complexity of managing multiple conditions. It must create clinical environments where financial concerns can be voiced without shame, where solutions are actively offered rather than passively awaited, and where treatment plans reflect economic realities rather than ignoring them.

But clinical accommodation alone cannot solve what is fundamentally a structural problem. The financial insecurity facing America's elderly is a policy choice—a reflection of decisions about how to distribute the costs of aging across society. Other nations have made different choices, with measurably different outcomes in out-of-pocket costs, healthcare access, and health equity. The question before us is not whether we can afford to do better for our elderly but whether we will choose to do so. The evidence reviewed here suggests that the current path imposes costs measured not merely in dollars but in suffering, disability, and premature death. A society that honors its elders cannot accept such a calculus.

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