

COMMENTARY

The One Taboo Question

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Income is an important social determinant of health, yet it is rarely discussed among patients and clinicians. Discussing income could open the door to addressing issues like high deductibles, prescription costs, copays, housing expenses, and medical debt. We identify ways to overcome obstacles to talking about this taboo subject. (J Am Board Fam Med 2024;00:000–000.)

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Walking into an examination room often means undressing. The patient will be naked. Exposed. Vulnerable. Even if undressing is not necessary, patients will disrobe figuratively. Just as it is necessary to ask about bowel movements or check the breast for lumps, inquiring about a patient's lifestyle is integral to providing high-quality care. It is now widely recognized that social determinants of health (SDOH)—those nonmedical factors that influence health outcomes—do indeed, determine health.¹ To effectively treat people, we must probe about the social aspects of health such as access to food, housing, and transportation. However, the 1 question seldom asked is, “*What is your annual income?*” Discussing a patient's income can provide a more complete picture of a patient's life, including their financial, social, and family context, all of which influence shared decision making during medical interactions.

Understanding a patient's financial circumstances is integral to effectively diagnosing and treating disease. Numerous studies show that income directly influences mortality,² rates of diabetes,³ blood pressure control,⁴ and clinical trial participation.⁵ Two-

thirds of older adults never told their provider that they planned to underuse medication because of the cost,⁶ and more than 9 million adults did not take prescribed drugs due to high costs.⁷ Furthermore, medical expenses are the leading cause of bankruptcies in America,⁸ and not only for those in poverty or the working class. Medical debt is one of the largest burdens on the middle class.⁹ Low income also influences whether patients live in places with mold, lead paint, poor air quality, and have access to fresh fruits and vegetables. When income information is shared with clinicians, it creates an opportunity to address obstacles such as high-deductible health plans, prescription costs, copays, travel, and housing expenses.

On the World Health Organization website, income tops the list of SDOH that influence health equity,¹ but health care organizations in the United States usually assess income indirectly, if at all. They inquire about financial stress with questions like, “*How hard is it for you to pay for the very basics, like food, housing, medical care, and heating?*” Alternatively, zip codes or geographic areas approximate an individual's socio-economic status. Epic, the largest electronic health record vendor, designed a SDOH wheel that indicates social risk through green, yellow, and red icons. The “financial resource strain” section of the wheel is gauged by patients' responses to ancillary survey questions related to money. While it is commendable that there is now a greater focus on addressing such topics, we must be even more direct. Asking about patients' income takes the ambiguity out of assessing financial strain. Knowing a patient's income complements information provided about food, housing, and medical care insecurity. Income is

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already the key reference point for the poverty line, whether individuals qualify for state-funded housing or food assistance, and shapes how a family decides whether there are enough diapers to last through the end of the month.

So why is it customary for clinicians to ask questions about sexual habits or alcohol consumption, but asking about income is taboo? One reason may be the power differential between patients and physicians. The median annual wage for physicians and surgeons in 2023 was \$229,300,¹⁰ yet the median household income in the US is \$70,784,¹¹ and more than 38 million people—12.4% of the population—live in poverty (\$30K for a family of 4).¹² With such inequality in the United States, it is no surprise that income is an uncomfortable topic. Just as the stigma of alcohol or drug abuse causes patients to conceal their use, patients may not reveal their incomes unless directly asked by a clinician trained to understand the importance of SDOH. Americans are more comfortable discussing marital discord, mental health, addiction, race, sex, and politics than money.¹³ Vulnerability and shame in regards to income is particularly acute in the United States, where social mobility is supposed to be the product of hard work, where theoretically, anyone can hoist themselves up by their bootstraps to achieve the American Dream. However, clinicians must recognize that the American Dream is unrealistic—rising above the class one is born into is increasingly unlikely in the US¹⁴ Meanwhile, these mistaken beliefs add shame to the other hardships of poverty like food insecurity and unreliable transportation. In the US, low-income patients often distrust their clinicians,¹⁵ and there is concern that directly asking about income may exacerbate that distrust. However, studies indicate that transparency and open communication enhance trust.¹⁶ Relationship-centered care, in which clinicians are active listeners who empathize with patients, fosters an environment where patients talk freely and feel comfortable with self-disclosure.¹⁷ If the rationale for asking about income is explained, and potential remedies are offered, such as prescription assistance, patients may be more inclined to reveal deeply personal aspects of their lives, such as income.

Attempts to collect income information should be supported by workflows that inform and educate patients about the importance of sharing income information. Nurses or navigators can discuss reasons for collecting income information in waiting rooms or as a part of the intake process. Patients' income data

can be collected and transferred to electronic medical records using digital medical history tools, which trigger alerts that recommend clinical actions. These alerts should flow to an interprofessional team comprised of stakeholders, clinicians, and community resource specialists to help patients navigate the social and environmental barriers impacting their health.¹⁸ Although some health systems may not have the necessary resources, medical systems can collaborate with community organizations and strive to address SDOH as a part of healing the whole person. In a range of contexts, even in countries with universal public health care, some of these kinds of workflows and education are already in place. For example, a community health center in Toronto, Canada used an online tool to gauge patients' financial circumstances and other SDOH, which prompted physicians to directly identify patients' needs and provide a tailored list of supplemental government benefits.¹⁹ In a systematic review of 138 studies, the vast majority of articles found benefits to asking about socioeconomic circumstances. These included improved treatment planning, shared decision making, greater patient satisfaction, and directly addressing social difficulties.²⁰ For instance, asking about income led to informing patients about state and federal programs that offer low-cost or free prescriptions.

How can health care providers break the income taboo? We can start by empathizing with patients, SDOH training, and collectively and systematically changing the narrative that revealing income benefits medical care. When clinicians take an interest in patients' financial and social lives outside of the examination room, they can build rapport, trust, and empathize with patients, which can lead to developing effective care plans aligned with a patient's financial capacity.²¹ Clinician training about income inequality are available and embedded within SDOH training, such as those offered in schools of public health and The Social Determinants of Health Academy, supported by the Health Resources and Services Administration of the US Department of Health and Human Services. Clinicians should also receive training on how to communicate with patients about income. Learning to discuss this topic sensitively can prevent perceived or actual discrimination, and would help to safeguard against patients feeling like they may not receive the best care due to their income. For example, medical students who received training on high-value care felt more confident about addressing economic concerns and costs

with patients, compared with students who did not receive training.²²

Talking frankly about income and the ability to pay for health care can help change how patients think about their health. Patients and clinicians should already discuss any recommended drug, treatment, or behavioral intervention, and within this conversation, clinicians can acknowledge that adherence may be costly. Most importantly, by bringing income into the conversation and normalizing it, clinicians can help to remove the stigma. Over the years, attitudes toward sexuality and the importance of mental health, for example, have become more accepted, enabling providers to inquire about these subjects in more detail. Attitudes and behaviors around income are also evolving. As of 2023, 8 US states passed salary transparency laws, in which organizations must disclose pay scales in job postings.²³ Salary transparency as the “new normal” is popular because it builds trust between employees and employers while improving workplace equity. The same can be true in health care. In addition to conversations about symptoms, medications, and daily lifestyle habits, transparent discussions between patients and clinicians should include whether the patient can afford care—diminishing income as a taboo subject. Asking is the first step.

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