CHAPTER 5

Poverty: More Than Just a Lack of Material Resources?

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Poverty is a complex phenomenon. Despite having once only encompassed financial and economic elements, the concept has since become multidimensional and now also includes the facets of health and psychology. The scientific literature has established a mutual relationship between health and psychology on the one hand and poverty trajectories on the other hand. However, exactly how important medical and psychological ideas, institutions, and actors are today and how their importance has developed are rarely researched. Therefore, this chapter focuses on the question of how medicine and psychology have developed and manifested in the scientific and political discourse and in welfare state institutions in the field of poverty. The discovery of an increase of—and a shifting meaning in—medical and psychological ideas, institutions, and actors would provide evidence of the medicalization and psychologization of poverty. This chapter proceeds as follows: First, poverty is placed in its historical context, and the changing definitions of the concept in recent decades are discussed. The second section follows up on the scientific discussion of poverty and examines whether and how scientific actors have increasingly

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come to include medicine and psychology in the discourse on poverty. The third part focuses on the German political discourse and on how political actors medicalize and psychologize this issue. The fourth section sheds light on the institutional setting of combatting poverty in Germany and investigates whether medical and psychological ideas were implemented during the early 2000s in the institutional reforms that led to the provision of minimum-income-replacement benefits.

5.1 Poverty Revisited: From Economic Measurements to the Concept of Multidimensionality

> 'Poverty' has joined that league of emotive words with slippery meanings—like 'freedom', 'liberty', 'justice', 'democracy' and 'dependency'; words which refer to powerful concepts, yet which are capable of being used or received in fundamentally different ways; words which convey diverse and complex associations, yet which can become so valorised or debased in ordinary discourse as to become meaningless or misleading. (Dean, 1992, p. 79)

The concept of poverty is difficult to define, and its meaning is highly context dependent. In the context of warzones and the poorest countries in the world, poverty is associated with fleeing from regions of crisis, with hunger, and with poor hygiene (United Nations, 2015). The lack of fulfillment of fundamental needs—such as access to clean drinking water and sufficient food—leads to the danger of malnutrition and death (United Nations, 2013). This *absolute poverty* ("having less than an objectively defined absolute minimum") is mainly found in the Global South. Poverty in the richer countries of the world, on the other hand, consists of *relative poverty*—that is, the inequal distribution of common goods ("having less than others")—or *subjective poverty* ("feeling you do not have enough to get along") (Förster, 1994). While extreme poverty means living on less than $1.25 a day and therefore also suffering from severe hunger, poverty in richer countries mostly involves having a specific income distribution of less than ca. 50%–60% of the median income (United Nations, 2013). This financial perspective on poverty is frequently used by a variety of indicators (e.g., the Gini-Coefficient, the Palma-Ratio, poverty rates before and after taxes and transfers, the poverty gap) (OECD, 2021a, b, c). Although even objective economic measures of the poverty line have always been subject to discussion, the core of this poverty line has always

lain in material imbalance (Goedemé & Rottiers, 2011). Poverty indices are thus based on financial elements and only indirectly refer to social elements and/or to appropriate participation in society (Thomas Lampert, 2011).

However, the economic perspective on relative poverty has developed into one of many dimensions of poverty in recent decades. In addition to Armatya Sen's capability approach (Sen, 1999), other dimensions have been highlighted in the literature:

> Beginning with a focus on command over market-purchased goods (income), the definition of poverty has expanded to embrace other dimensions of living standards such as longevity, literacy, and healthiness. (Kanbur & Squire, 2001, p. 183)

While broadening the definition of poverty has not necessarily changed the target group that is considered to be poor (because many dimensions of poverty are closely correlated), it has broadened our understanding of poverty itself (Kanbur & Squire, 2001). Moreover, this shift to a multidimensional approach to poverty opens up new possibilities for interventions. The promotion of healthy living conditions and unrestricted access to health services represents one dimension of poverty that the OECD considers to be an important building block for breaking the cycle of poverty (OECD, 2003). These interdependences constitute major changes in our understanding of poverty because income and consumption measures provide information on who is poor and additionally on wider determinants of a person's well-being, including their economic and social participation.

International research has found poor health to be both an effect and a cause of various other dimensions of poverty, such as unemployment (Herber et al., 2019; Nichols et al., 2013; Vaalavuo, 2016; see also Chap. 4), employment income and wealth (Hajat et al., 2010), living conditions (Eikemo et al., 2016), migration (Gkiouleka & Huijts, 2020; Jayaweera & Quigley, 2010; Kirmayer et al., 2011; Missinne & Bracke, 2012), and education (van Zon et al., 2017). Similarly, for the case of Germany, illness and poor health have been shown to affect and be affected by various poverty dimensions (Kroll et al., 2016; T. Lampert & Kroll, 2006; Thomas Lampert & Ziese, 2005; Rathmann et al., 2018; Wittig et al., 2008). People in poverty experience a greater risk of a downward spiral that will eventually impair their mental health (Gallie et al., 2003): Indeed,

unemployed people are at a higher risk of being poor and stigmatized and are therefore also at higher risk of being socially isolated. All of these factors decrease the chances that the unemployed will return to work and get out of poverty. Hence, health restrictions serve as an explanation as to *why* someone is suffering from poverty, but they are also an indication *that* someone is suffering from poverty. Focusing on the individual and their employability goes hand in hand with psychological concepts. Furthermore, the technologies of the self (Martin et al., 1988) include the responsibility that the individual has in creating resources that could lead to more stress and strain. In addition, psychological concepts appear to have generally become more important in society (Rose, 1998). In general, medicine—with its concepts of physical health—and psychology—with its concepts of mental health—are two major facets in the outlined shift of the concept of poverty away from an economic issue and toward a multidimensional issue. But how has this change in the *idea* of poverty come about? What *actors* have pushed and carried out this development? How is this new understanding translated in existing welfare state *institutions* that address poverty?

5.2 Scientific Actors in the Medicalization and Psychologization of Poverty

An important part of medicalization (and accordingly also of psychologization) is conceptual medicalization—that is, the use of medical concepts to understand certain problems. The process by which more and more elements of society are affected by medical knowledge is one key aspect of medicalization (Conrad, 1992). Various discourses have brought medical and psychological language into everyday life and into areas not commonly associated with medicine and have thus contributed to diffusing medical and psychological knowledge within society. Political, public, and scientific discourses shape the perception and interpretation of social phenomena (Bourdieu, 2015; Ferree et al., 2002; Keller, 2013; Ullrich, 2008; Peter Weingart et al., 2008). Whether these discourses are political (e.g., different parties express their values and attitudes on social issues), public (e.g., the media frames different perspectives), or scientific (e.g., new knowledge is generated and disseminated throughout society), they all

contribute to the perception of a certain topic (Ferree et al., 2002). However, discourses do not develop on their own; rather, they are shaped by the actors who (are able to) participate in them. If particularly powerful actors propose a certain position, it is likely that this position will prevail on a broad scale (Ferree et al., 2002).

The scientific discourse and the scholars of various disciplines shape both how poverty is understood in the scientific community and how it can be taken up in political and public discourses. It is possible to measure which actors are important in the scientific discourse on poverty using two different methods—that is, we can measure the actors who publish extensively in a field and therefore gain attention on the one hand (quantity) or the actors who have a high reach via many citations and reads in the scientific community (quality) on the other hand. Hence, medicalization and psychologization in the scientific discourse take place if medical and psychological disciplines publish an increasing share of all scientific output on poverty and if the publications of medical and psychological disciplines are cited more frequently than are those of other disciplines.

The changing concept of poverty described in the previous section is evident in the scientific discourse, which has become more multidimensional over time through the growth of the disciplines of psychology and public health, in particular. A comprehensive scientific discourse analysis using research articles from the Social Science Citation Index (SSCI) from 1956 to 2019 that deal with issues of poverty in their title indicates that a shift is currently taking place. In the SSCI provided by the literature-citation database Web of Science (WoS), scientific disciplines are aggregated as research areas. In the last 30 years, "Public, Environmental & Occupational Health" and "Psychology" have replaced former top research areas to become the two fastest-growing areas in the SSCI in terms of research on poverty. The discourse in these areas is growing stronger than is the scientific poverty discourse in general. In the 1960s and 1970s, "Business & Economics" and "Government & Law" represented the majority of publications. Since the 1980s, however, "Public, Environmental & Occupational Health" and "Psychology" have grown substantially and have constituted the Top 2 research areas since the 1990s. These areas are growing at an above-average rate compared with the overall scientific poverty discourse such that today, one in three studies on poverty stems from one of these two disciplines (Krayter & Reibling,

2020). These findings indicate that the disciplines of public health[1] and psychology have increased their standing in the discourse. Although scholars from one discipline do not have a uniform perspective on one issue, their research is nevertheless shaped by the prevailing concepts and theories of their discipline. These findings mirror the transformation of the concept of poverty. This mere quantitative increase in the number of public health and psychology articles could be argued to be insufficient for substantiating the claim that the discourse on scientific poverty has been medicalized or psychologized. Indeed, researchers in health-related or psychological disciplines *may merely publish a lot but not be noticed in the overall scientific poverty discourse and may therefore also be less influential in public discourses.*

However, our data demonstrate that psychological and health-related research on poverty also matters in qualitative terms. We analyzed the amount of works cited in Web of Science from a health-related or psychological perspective, which yielded more information about whether research from this perspective matters in the overall discourse. We then examined the Top 50 cited research articles in each decade. Figure 5.1 reveals that in the 1960s, only about one-fifth of all citations in the Top 50 most-cited articles stemmed from health-related and psychological disciplines. On the other hand, in articles from the 2000s and 2010s, this figure increased to almost two-thirds, which demonstrates the ongoing and increasing impact of these disciplines. This finding reveals the importance of these research areas for further scientific research, which indicates that other researchers rely on findings from both a health-related and a psychological perspective.

Hence, health-related and psychological research on poverty gained significance in the scientific discourse between 1960 and 2019. Not only do these research areas publish more articles on poverty today compared with in earlier decades, which means that they shape the discourse in a quantitative manner, but they also shape the discourse by contributing the majority of the citations.

[1] In the present analysis, we only refer to the two individual WoS research areas of "Public, Environmental, & Occupational Health" and "Psychology." In upcoming analyses in this book, we expand our focus to include medical areas such as "General & Internal Medicine" and "Pediatrics." Our aggregation of the "health-related" perspective is therefore broader and includes strictly medical aspects and aspects of public health.

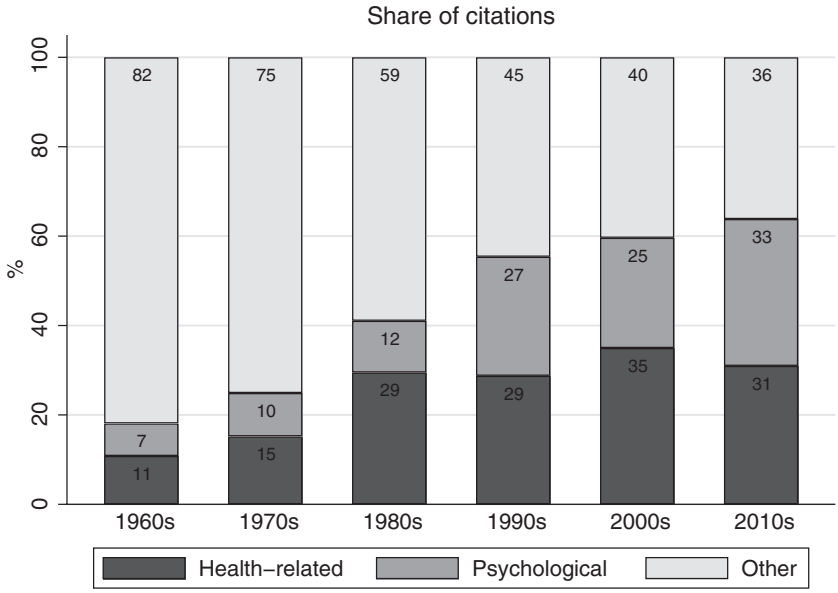

Fig. 5.1 Share of health-related and psychological research areas in the Top 50 most-cited articles on poverty

In delving deeper into the content of these Top 50 articles via a quantitative content analysis of the articles' abstracts, we uncovered interesting results. By creating the three distinctive categories of a *health & psychological dimension*, a *measuring poverty & economic dimension*, and a *social & political dimension*, we coded the abstracts of the Top 50 cited articles into these three categories by analyzing their focus and content.[2] About one-third of the abstracts discuss the *health and psychological* concepts of poverty, such as theories on the causal relationship between poverty and health, cognitive functioning, and brain development (e.g., children's developmental disabilities when exposed to poverty in their living environments, including poor parental health literacy). Seventeen percent of the abstracts discuss *measurements* of poverty, such as statistical methods

[2] Any given abstract can be assigned either to only one category if its focus is unambiguously related to only one field of research or to more than one category if its focus has a broader perspective and includes several areas.

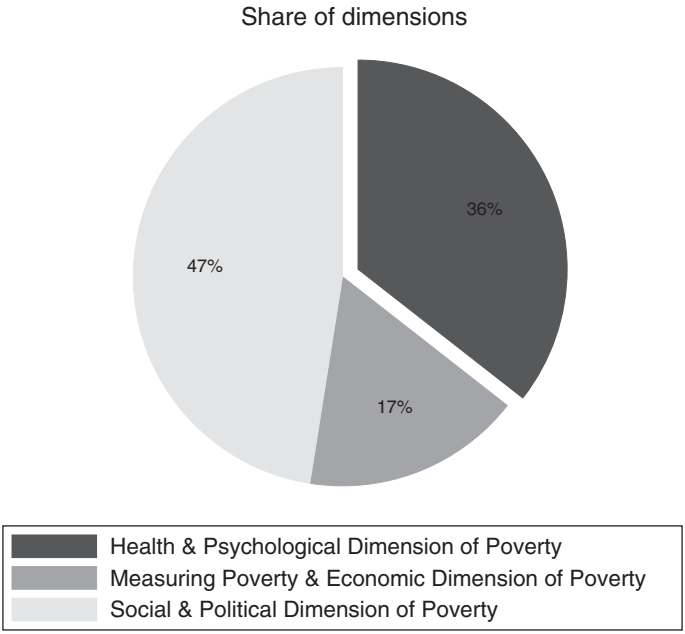

Fig. 5.2 Different dimensions of poverty in the Top 50 most-cited articles of all time

(e.g., human capital, poverty traps, or poverty lines), and about half of the abstracts discuss *socio-political* aspects of poverty, such as gender, ethnicity, geography, and education (see Fig. 5.2).[3]

In summary, these results establish a strong link between poverty and health and show that actors from health-related and psychological disciplines increasingly shape the scientific poverty discourse. In this way, ideas are created in which actors build up and expand their power of interpretation and might thus—in a further step—extend their influence to the political arena. These results are in line with findings on the medicalization and psychologization of poverty at the level of policies (Friedli, 2016; Mathieu, 1993; Schram, 2000; Wong, 2016). While medicalization and

[3] The high level of aggregation in the dimension of socio-political aspects was necessary to represent in a reasonable way the high number of subcategories that exist within the fields of sociology and political science.

psychologization could still be argued to be phenomena that unfold in the scientific arena, with health sciences and psychology being disciplines that stretch into the scientific poverty discourse, this argument would not necessarily mean that medicalization and psychologization are also found in arenas that are much more closely related to the poor—that is, in political arenas. The transfer of concepts from scientific debates to other arenas is complex and does not necessarily follow a certain pattern, meaning that only particular elements of the discourse will be transferred. However, science does have an impact in the political process (P. Weingart et al., 2009).

5.3 The Role of Political Actors in the Medicalization and Psychologization of Poverty

With the substantial increase of the use of the concepts of psychology and public health in the scientific discourse, it would be easy to wonder whether this increase has been echoed in the political discourse on poverty. Research ideas and results are often taken up by political actors, for example, by consulting scientific experts in political commissions (Falk et al., 2019). Hence, whether medicalization and psychologization processes have occurred not only in the scientific arena but also in the political arena is an open question. To answer this question, we analyzed the parliamentary debates on minimum-income-replacement benefits in Germany at two time points: after the introduction of a new minimum-benefit scheme via the Hartz reforms in 2002/2003 and after the changes made to this benefit scheme in 2016. At these time points, the German government implemented measures that were largely influenced by a neoliberal paradigm (2002/2003) on the one hand and by a social-investment paradigm (2016) on the other hand. These general ideas can be exemplified by two statements: Then-Chancellor Gerhard Schröder declared in 2001 that "people"—meaning the unemployed—had "no right to laziness" (Helm, 2001), whereas then-Minister of Labor Andrea Nahles argued in a press statement in 2016 that the unemployment agency should "actively support and accompany the unemployed" (Nahles, 2016).

We analyzed the two reforms using a quantitative content analysis that employed issue frames. Put simply, "framing is concerned with the presentation of issues" (Vreese, 2005, p. 53), and we investigated how important the issues or frames of medicine and psychology were in both reforms. Based on the different direction of the reforms and the different views on

the unemployed—views that are guided by the neoliberal and the social-investment logic of the reforms—it was expected (1) that medical and psychological ideas *are* discussed by political parties because both paradigms can be connected to the spread of medicalization and psychologization and (2) that political parties employ medical and psychological ideas with a different intention. Our results reveal that the political parties do not medicalize or psychologize the issue of poverty, nor do they connect the implemented policies to medical or psychological categories. This non-medical and non-psychological framing was used both during the Hartz reforms and in the recent reforms. The issue framing in the Hartz reforms and in the reforms to the unemployment and poverty system in 2016[4] indicates that medical and psychological issues were nearly non-existent in the parliamentary debates on these reforms. Medical framing can be found in two paragraphs for the first time point and in four paragraphs for the second time point, amounting to 0.2% of all frames in 2002/2003 and 0.5% in 2016. Psychological framing was used more often than medical framing but still only accounted for a small proportion of issue framing. A total of 2.2% of all frames employed psychological terms and issues in 2002/2003, and this figure rose to 3.8% for the year 2016 (Fig. 5.3).

However, the use of psychological frames differs in qualitative terms between the two time points. In the Hartz reforms, psychological framing was targeted at large groups of "the people" or at "the unemployed and the economy." The psychological frames in 2016 mainly focused on the individual level. Key words that were used include "motivation," "self-confidence," and "stamina." This move from societal to individual psychology frames can be evaluated as a form of psychologization. However, in comparison with other issue frames, the extent of psychologization is still quite low.

> Additionally: Not only are the people against whom sanctions are imposed affected by these sanctions, but so too are many others because for them, there is a constant threat of having such a sanction arbitrarily imposed. This, of course, creates corresponding fears. (Deutscher Bundestag, 2016)

[4]The Hartz laws are called "laws on modern services in the labor market" (in short, "Hartz legislation," which was named after the head of the reform commission). They were passed in 2002 and 2003. The "law on strengthening further vocational training and the insurance coverage of unemployment insurance" (in short, AWStG) and "the ninth revision of Social Codebook II" were passed in 2016.

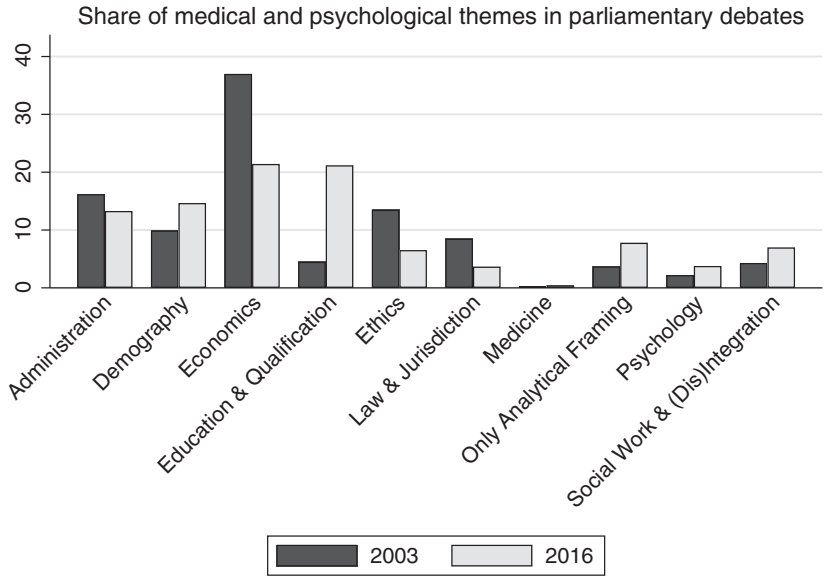

Fig. 5.3 Bar chart on the share of medical and psychological themes in parliamentary debates

While parliamentary debates on poverty-related policies are not framed using medical or psychological concepts and language, they do appear to matter in governmental reports on poverty. Since 2001, the Ministry for Employment and Social Affairs has published the Poverty and Wealth Reports (Armuts- und Reichtumsberichte) once per legislative period. The focus of these reports is on describing poverty (and wealth) trends and governmental actions that target poverty. We analyzed all five published reports from the years 2001, 2005, 2008, 2013, and 2017 and found that health was an important issue throughout the time period and that it had increased slightly in importance over time (Ariaans & Reibling, 2021). Health is mentioned in separate sections and in connection with other poverty-related items. As shown by the following quote, the fiscal risk of poverty is connected to social concepts of poverty and to various mental and physical health risks for children.

> The monetary poverty risk is only somewhat correlated with the limited chances for children to participate. Children and young people have particu-

> lar development deficits and social disadvantages and may even be underprovided for, which results in potential health problems. In socially disadvantaged families, children are often obese, display socially challenging behavior more frequently than in other families, and participate less in active leisure-time activities, such as sports. (BMAS, 2008, p. XXII)

The reports are published by the Ministry of Employment and Social Affairs and thus contain the ideas, views, and reform concepts of the national government of the time. However, the reports are developed in consultation with scientific experts, who are also responsible for inserting the most recent scientific ideas and data (Ariaans & Reibling, 2021). Hence, diffusing scientific ideas and evidence into the reports is politically desired. Thus, on the level of political-administrative-poverty discourse, medical terms, concepts, affiliations, and interventions play a role and are diffused by scientific experts.

The role of health in the public and political discourse and in political practice can also be exemplified via the annual German Congress of "Poverty and Health." Held for the first time in 1995 with about 200 participants and with a focus on three topics, the Congress now describes itself as the largest public health congress in Germany and includes about 2300 participants and 25 topics. The Congress brings together researchers, interest organizations, and policy-makers on the interrelations between poverty and health and contributes to disseminating scientific knowledge, evidence, and proposals throughout policy-making (Kongress Armut und Gesundheit, 2021).

While our empirical evidence only covers two reform packages for which we tested whether political actors have promoted medical and psychological frames, we can conclude that this has rarely been the case. Unlike in other countries, medical and psychological concepts in Germany are not important in high-level politics (Holmqvist, 2009; Mathieu, 1993). However, medical and psychological concepts have nevertheless gained in importance in poverty-related policy-making. Scientists are actively involved in disseminating medical and psychological frames through their involvement in key framing processes, which include writing and consulting on governmental reports and being involved in conferences, such as the "Poverty and Health" Congress, which bridges the gap between science and practice.

5.4 The Role of Institutions in Medicalizing and Psychologizing Poverty: Medical Status as a Determinant of the Eligibility for Benefits

The above-described findings establish that medical and psychological ideas are diffused into policies on poverty via scientific experts and interprofessional conferences. Hence, it is possible to wonder whether and how medical and psychological ideas have been intentionally or unintentionally integrated into and implemented in these institutions of the welfare state that target the poor. Germany is a highly developed and juridified welfare state in which the rights acquired by social-insurance contributions play an integral role. Institutions are often described as being coherent and stable entities and have—especially in the German context—been labeled as "frozen" (Esping-Andersen, 1996). However, neoliberal reforms—such as the Hartz reforms in the early 2000s and many small-scale social-investment reforms in the 2010s—have altered institutions of the German welfare state that deal with the issue of poverty. Thus, if we argue that the welfare state is transforming into a biopsychosocial welfare state, we should be able to find such a perspective in the institutions that constitute the German welfare state. However, institutions are not only the result of ideas and interests that actors have set in place; indeed, the institutions themselves create path dependencies. We therefore investigated the extent to which the institutional setup of the German welfare state has encouraged or hindered a medicalization or psychologization of social-policy programs that address poverty.

In general, the topic of poverty has gained political and societal importance in Germany due in large part to the increasing poverty rate. In Germany, poverty rates (defined as income that lies 50% under the median) since the 1990s both before and after taxes and transfers have increased (see Fig. 5.4). Since the 2000s, the poverty rate before taxes and transfers has been even higher than for the liberal welfare state of the United Kingdom. However, welfare state systems have reduced poverty in all countries by a large degree. All advanced welfare states now show lower poverty rates and economic inequality after taxes and social transfer. The social-democratic welfare state of Denmark shows the greatest reduction in poverty rates after taxes and transfers, and the liberal welfare state of the United Kingdom shows the lowest drop. In the conservative welfare regime of Germany, the level of poverty decreased by about 20 percentage points after taxes and transfers in 1990 and by about 22 percentage points in 2017. However, in 2017, the poverty rate after taxes and transfers was

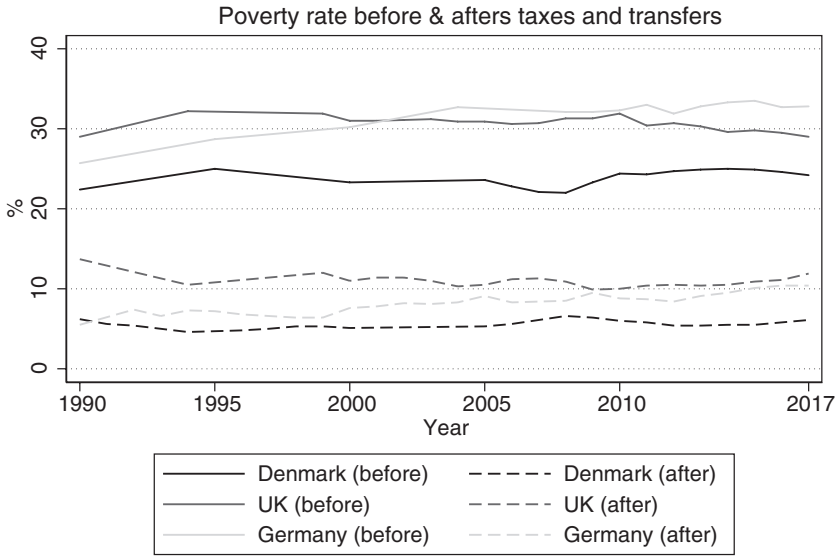

Fig. 5.4 Poverty rate before and after taxes and transfers

10.4%, whereas it was 5.5% in 1990. Hence, the German welfare state has become less effective at preventing poverty.

These increasing poverty rates have contributed to a developing public discourse on poverty in Germany—a discourse that was virtually non-existent until the early 1990s (Leisering, 1993). The term "poverty" has also come to be replaced by different concepts and terms, such as "unemployment" or "social assistance" (Leisering, 1993). This substitution of poverty by different concepts and its shift to other areas of discourse can be partly attributed to the design of the German welfare state, which is built around the principle of standard employment by a male breadwinner (Bender et al., 2007; Ferragina & Seeleib-Kaiser, 2014; Miller et al., 2021). In social-insurance contributions derived from labor market employment, basic social risks (illness, longevity, unemployment, disability) for employees and their spouses and children are covered. Hence, the risk of poverty is first tackled by these social-insurance systems. For those who are not employed, the history and future prospect of employment play an important role in determining how poverty is handled. Until 2005, the last safety net for the poor had two systems: The first system included people who had had a job in the past and who were able to search for a job. These people

received unemployment assistance. This benefit followed after unemployment benefits had ceased, and the amount was based on prior wages. Although unemployment agencies administered this benefit, it was paid through general taxes (Berthold et al., 2000). The second system subsumed all other people who were not eligible for unemployment-assistance benefits but who fell below the poverty line. These people received social-assistance benefits. Benefits from social assistance were also tax-financed and were generally lower than unemployment-assistance benefits. Separating the poor into two systems—the unemployed poor on the one hand and the poor due to other reasons on the other hand—seemed reasonable in the 1950s and 1960s. However, beginning with the onset of—and increase in—mass unemployment in the 1980s, the boundaries between the two systems became blurred (Berthold et al., 2000). Criticism was directed at the dual structure of the system, at injustices between the people in both systems, and at the low incentives that both systems offered for gaining employment, which eventually led to the merger of the two systems (Knuth, 2006; Seeleib-Kaiser & Fleckenstein, 2007). The so-called Hartz reforms—which passed in 2002 and 2003 and have been in effect since 2005—merged both systems on the benefit level of social-assistance benefits. Furthermore, incentive structures for taking up employment and sanctions in the form of benefit cuts in case of non-compliance with general and individual obligations were tightened. In this new system, merely being poor (and having an employment history) does not qualify an individual for benefits. The new benchmark for receiving minimum-income benefits is determined by employability, which is defined as follows:

> Someone is considered able to work if they are not incapable of working at least three hours per day for the foreseeable future due to illness or disability under the usual conditions of the general labor market. (§8 (1), German Social Code (SGB) II)

Hence, employability is defined in negative terms as the absence of (severe) medical limitations. As a result, medical status instead of (prior) employment status—or the mere existence of material need—is now decisive for receiving minimum-income benefits.

Furthermore, the merger of unemployment assistance and social assistance means that poor people who are not able to work account for a significant portion of the eligible people in the system. However, the entire system was designed to promote and invest in employability and to sanction those who do not follow the conditions of the new

unemployment system. People who are deemed healthy are assessed as being able to work. They must comply with all obligations and can be sanctioned in case of non-compliance. Obligations—which lead to sanctions if not met—include regular consultations with an unemployment agency and submitting a defined number of job applications each month. Exceptions to these obligations are only granted for caring duties or illness (see Chap. 4). Thus, illness is one of the few pathways out of actively seeking a job. People who are assessed as being physically or mentally ill do not need to follow most rules, and benefit cuts for them are practically impossible (§56 SGB II). Moreover, not only can illness mean that benefits are not allowed to be cut, but some illnesses can also lead to higher unemployment benefits (§21 Abs. 5 SGB II). For example, additional expenses for medically indicated nutritional needs are covered:

> In the case of beneficiaries with expensive nutrition requirements for medical reasons, an additional sum of a reasonable amount is to be granted. (§21 Abs. 5 SGB II (5))

5.5 Poverty: A Medicalized and Psychologized Issue in the Welfare State, But to What Extent?

In summary, this chapter focused on the question of whether poverty is becoming more frequently connected with medical and psychological ideas, actors, and institutions and also focused on developments to the German welfare state. Poverty—mostly in the sense of relative poverty—is a social problem that all developed welfare states face. How a welfare state conceptualizes and treats individuals with the lowest level of economic and social power might reveal a lot about its society and about the goals and ideas behind the state. Developments on the level of ideas, actors, and institutions might indicate how poverty is conceptualized and treated by the welfare state. Irrespective of whether medicalization and psychologization tendencies are intended or unintended processes, they might cause the social problem of poverty to become individualized. Medicalization and psychologization processes might also contribute to the further neglect of poverty as an issue, which has to be tackled mainly on the societal rather than on the individual level—especially in the German welfare state, where poverty has long been a neglected social-policy issue.

In general, the concept of poverty has changed in recent decades. Its definition has transformed from being mainly economic in nature to being

a multidimensional concept. Both sociological and political dimensions on the one hand and health-related and psychological dimensions on the other hand have been added to the dominantly economic and financial understanding of poverty. However, medicine and psychology have not merely been added as dimensions to the concept of poverty; rather, they have risen to become the most significant areas in poverty research. The results in the political discourse are less clear cut. On the one hand, political parties rarely employ medical or psychological concepts in reforms of welfare state systems that target the poor. On the other hand, the Poverty and Wealth Reports that are published by the government have increasingly often adopted medicine and psychology as important topics. These topics are disseminated throughout the political discourse by scientific health experts, who have a consulting role in governmental reports and engage in promoting their ideas at conferences at which the scientific community and interest groups meet. Medicalization and psychologization are thus clearly not the top-down processes that the early scientific literature suggested (Ballard & Elston, 2005); rather, these processes take place at various levels. Accordingly, medicalization and psychologization are visible on the level of institutions that focus on the poor. Such institutions increasingly often incorporate medical and psychological ideas into their processes. German minimum-income-replacement schemes have been transformed and now focus less on prior employment status or need and more both on health status in determining obligations for receiving benefits and on the level of these benefits.

The receipt of minimum-income benefits is now based on the medically defined employability of the benefit claimant. However, minimum-income benefits are not only for the claimant; indeed, they are also for the claimant's children. In 2020, 33% of all households that received minimum-income benefits included underage children, and about half of these households had a single parent (Bundesagentur für Arbeit, 2020). Overall, in 2017, 20.4% of all minors were at risk of poverty and thus lived under conditions of less than 60% of the median income. This figure was about 5% higher than in the overall population (BMAS, 2021). Hence, children in—or at risk of—poverty are also an important target group for poverty interventions. As the citation in this chapter from the Poverty and Wealth Reports exemplifies, poverty-related problems and interventions increasingly often focus on health and psychology. In the following chapter, the way in which children and childhood are medicalized and psychologized is examined.

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