

Chapter 2

Foundation of U.S. Health Care Delivery



INTRODUCTION

From an economic perspective, curative medicine seems to yield decreasing returns on health improvement while health care expenditures increase (Saward & Sorensen, 1980). There is increasing recognition of the benefits to society that can result from the promotion of health and the prevention of disease, disability, and premature death. Although the financing of health care has primarily focused on curative medicine, slow progress continues toward an emphasis on health promotion and disease prevention. The progress has been slow due to the insurance system, cultural values, and medical practice that emphasize disease rather than health. The common definitions of health, as well as measures for evaluating health status, reflect similar inclinations.

Demographic and health trends and initiatives focused on reducing disease and disability must govern the planning of health services. In addition,

the concepts of health and its determinants should be used to design appropriate educational, preventive, and therapeutic initiatives. This chapter proposes a comprehensive approach to health, although this model may be an ideal that the health care delivery system is simply not able to achieve under present conditions.

This chapter also explores the contrasting theories of market justice and social justice as they apply to health care. Beliefs and values ingrained in the American culture have also been influential in laying the foundations of a system that has remained predominantly private, as opposed to a tax-financed national health care program. In recent years, however, societal values have slowly shifted toward a social justice mindset, and the expectations of many Americans suggest that a gradual departure from traditional American values of self-reliance may be giving way to greater dependence on the government. Passage of the Patient Protection and Affordable Care Act (ACA) of 2010 presages a gradual shift from market justice to social justice in the U.S. health care system.

WHAT IS HEALTH?

In the United States, the concepts of health and health care have largely been governed by the medical model or, more specifically, the biomedical model. The *medical model* presupposes the existence of illness or disease, thereby emphasizing clinical diagnosis and medical intervention in the treatment of disease or its symptoms. Under the medical model, health is defined as the absence of illness or disease. The implication is that optimal health exists when a person is free of symptoms and does not require medical treatment; however, this reasoning does not actually provide a definition of health in the true sense, but rather a definition of what is not ill health (Wolinsky, 1988, p. 76). Accordingly, prevention of disease and health promotion are relegated to a secondary status; thus, when the term “health care delivery” is used, it actually refers to the delivery of medical care or illness care. A measure that is often used to indicate lack of health in a population is mortality or death (see [Figure 2.1](#) for death rates by age and cause in the United States).

Medical sociologists have gone a step further by defining health as the state of optimal capacity of an individual to perform his or her expected social roles and tasks, such as work, school, and household chores

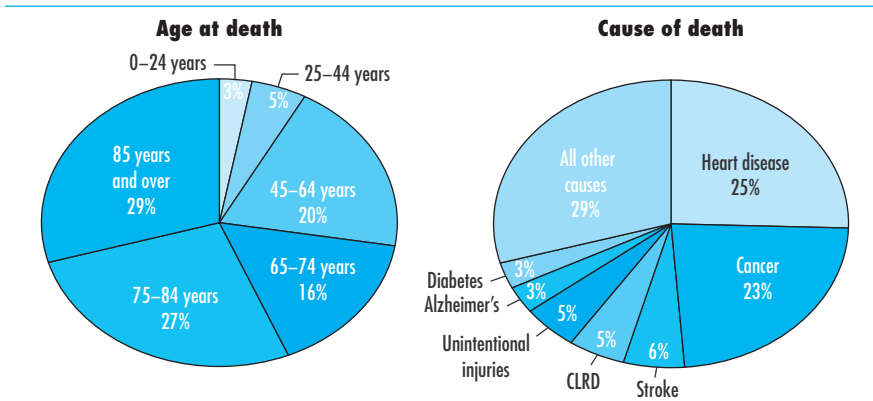


Figure 2.1 Deaths for All Ages, 2007. Note: CLRD: chronic lower respiratory diseases.
 Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Health, United States, 2010, Figure 24. Data from the National Vital Statistics Systems.

(Parsons, 1972). A person who is unable (as opposed to unwilling) to perform his or her social roles in society is considered sick even though many people continue to engage in their social obligations despite suffering from pain, cough, colds, and other types of temporary disabilities, including mental distress. Hence, a person’s engagement in social roles does not necessarily signify that the individual is in a state of optimal health.

An emphasis on both the physical and mental dimensions of health is found in the definition of health proposed by the Society for Academic Emergency Medicine (SAEM). This organization defines health as “a state of physical and mental well-being that facilitates the achievement of individual and societal goals” (SAEM, 1992).

The World Health Organization’s (WHO) definition of health is most often cited as the ideal that health care delivery systems should try to achieve. The WHO (1948) defines *health* as “a complete state of physical, mental, and social well-being, and not merely the absence of disease or infirmity.” This definition includes physical, mental, and social dimensions, which constitute the biopsychosocial model of health. The WHO has also defined a “*health care system*” as all of the activities aimed at promoting, restoring, or maintaining health (McKee, 2001). As this chapter points out, health care should include much more than medical care.

Exhibit 2.1 Indicators of Health

- | | |
|-------------------------------|--------------------------|
| • Self-reported health status | • Social functioning |
| • Life expectancy | • Functional limitations |
| • Morbidity (disease) | • Disability |
| • Mental well-being | • Spiritual well-being |

There has been a growing interest in holistic or comprehensive health, which emphasizes the well-being of every aspect of what makes a person whole and complete. *Holistic medicine* seeks to treat the individual as a whole person (Ward, 1995). Holistic health incorporates the spiritual dimension as a fourth element in addition to the physical, mental, and social aspects necessary for optimal health. Hence, the holistic model provides the most complete understanding of what health is (see **Exhibit 2.1** for some key examples of health indicators). A growing volume of medical literature now points to the healing effects of a person's religion and spirituality on morbidity and mortality (Levin, 1994). Numerous studies have identified an inverse association between religious involvement and all-cause mortality (McCullough et al., 2000). Religious and spiritual beliefs and practices have been shown to positively influence a person's physical, mental, and social well-being—they may affect the incidences, experiences, and outcomes of several common medical problems (Maugans, 1996).

The spiritual dimension is often tied to one's religious beliefs, values, morals, and practices. More broadly, it is described as meaning, purpose, and fulfillment in life; hope and will to live; faith; and a person's relationship with God (Marwick, 1995; Ross, 1995; Swanson, 1995). The holistic approach to health also alludes to the need for incorporating alternative therapies into the predominant medical model.

Illness and Disease

The terms *illness* and *disease* are not synonymous, although they are often used interchangeably, as they are throughout this book. Illness is recognized by means of a person's own perceptions and evaluation of how he or she feels. For example, an individual may feel pain, discomfort, weakness, depression, or anxiety, but a disease may or may not be present; however, the ultimate determination that disease is present is based

on a medical professional's evaluation rather than the patient's assessment. It reflects the highest state of professional knowledge, particularly that of the physician, and it requires therapeutic intervention (May, 1993). Certain diseases, such as hypertension (high blood pressure), are asymptomatic and are not always manifested through illness. A hypertensive person has a disease but may not know it. Thus it is possible to be diseased without feeling ill. Likewise, a person may feel ill, yet not have a disease.

Disease can be classified as acute, subacute, or chronic. An *acute condition* is relatively severe, episodic (of short duration), and often treatable (Timmreck, 1994, p. 26). It is subject to recovery, and treatment is generally provided in a hospital. Examples of acute conditions include a sudden interruption of kidney function or a myocardial infarction (heart attack). A *subacute condition* lies between the acute and chronic extremes on the disease continuum, but has some acute features. Subacute conditions can be post-acute, requiring further treatment after a brief stay in the hospital. Examples include ventilator and head trauma care. A *chronic condition* is less severe but of long and continuous duration (Timmreck, 1994, p. 26). The patient may not fully recover from such a condition. The disease may be kept under control through appropriate medical treatment, but if left untreated, it may lead to severe and life-threatening health problems. Examples include asthma, diabetes, and hypertension.

Quality of Life

The term *quality of life* is used in a denotative sense to capture the essence of overall satisfaction with life during and after a person's encounter with the health care delivery system. Thus the term is used in two different ways. First, it is an indicator of how satisfied a person was with his or her experiences while receiving health care services. Specific life domains such as comfort factors, dignity, privacy, security, degree of independence, decision-making autonomy, and attention to personal preferences are significant to most people. These factors are now regarded as rights that patients can demand during any type of health care encounter. Second, quality of life can refer to a person's overall satisfaction with life and with self-perceptions of health, particularly after some medical intervention. The implication is that desirable processes during medical treatment and successful outcomes would subsequently have a positive effect on an individual's ability to function and carry out social roles and obligations. It can also enhance a sense of fulfillment and self-worth.

DETERMINANTS OF HEALTH

The *determinants of health* have made a major contribution to the understanding that a singular focus on medical care delivery is unlikely to improve the health status of any given population. Multiple factors determine health and well-being. Hence, a more balanced approach must emphasize health determinants at an individual level as well as broad policy interventions at the population level (**Figure 2.2**).

The leading determinants of health (see examples in **Exhibit 2.2**) can be classified into four main categories:

- Environment
- Behavior and lifestyle
- Heredity
- Medical care

Environment

Environmental factors encompass the physical, socioeconomic, sociopolitical, and sociocultural dimensions of life. Physical environmental factors such as air pollution, food and water contaminants, radiation, and toxic chemicals are easily identified as factors that can significantly influence health; however, the relationship of other environmental factors to health may not always be so obvious. For example, socioeconomic status is related to health and well-being. People who have higher incomes often live in

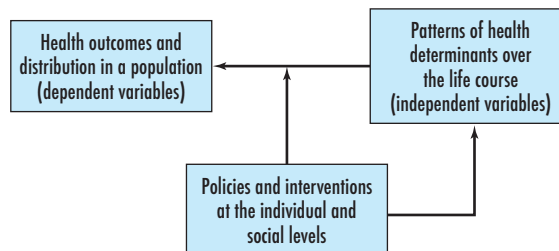


Figure 2.2 Schematic Definition of Population Health

Source: Adapted from Kindig D, Stoddart G. What is population health? *Am J Public Health*. 2003;93(3):380–833.

Exhibit 2.2 Examples of Health Determinants

- | | |
|-------------------------------|-------------------------|
| • Physical activity | • Mental health |
| • Overweight/obesity | • Injury and violence |
| • Tobacco use | • Environmental quality |
| • Substance abuse | • Immunization |
| • Responsible sexual behavior | • Access to health care |

areas where they are less exposed to environmental risks and have better access to health care. The association of income inequality with a variety of health indicators such as life expectancy, age-adjusted mortality rates, and leading causes of death is well documented (Kaplan et al., 1996; Kawachi et al., 1997; Kennedy et al., 1996; Mackenbach et al., 1997). The greater the economic gap between the rich and poor in a given geographic area, the worse the overall health status of the population in that area will be. Moreover, wide income gaps may produce less social cohesion and greater psychosocial stress and, consequently, poorer health (Wilkinson, 1997).

The relationship between education and health status is also well established. Less-educated Americans die younger than their better-educated counterparts. One possible explanation for this relationship is that better-educated people are more likely to avoid risky behaviors such as smoking and drug abuse.

The environment can also have a significant influence on developmental health. Neuroscientists have found that good nurturing and stimulation during the first three years of life—a key period for brain development—activate the brain’s neural pathways and may even permanently increase the number of brain cells. Hence, the quality of child care provided in the first three years of life is of monumental importance (Shellenbarger, 1997). Early childhood development has an enormous influence on a person’s future health.

Behavior and Lifestyle

Individual lifestyles or *behavioral factors* are also a key determinant of health. For example, diet, exercise, a stress-free lifestyle, risky or unhealthy behaviors, and other individual choices have been found to play a major role in most of the significant health problems of today. Heart disease,

diabetes, stroke, sexually transmitted diseases, and cancer are just some of the ailments with direct links to individual choices and lifestyles.

Heredity

Heredity is a key determinant of health because genetic factors predispose individuals to certain diseases. There is little anyone can do about the genetic makeup he or she has already inherited, but engaging in a healthy lifestyle and health-promoting behaviors can significantly influence the development and severity of inherited disease in those predisposed to it, as well as the risk for future generations.

Medical Care

Although environment, behavior and lifestyle, and heredity are more important in the determination of health, well-being, and susceptibility to premature death, access to medical care is nevertheless a key factor influencing health. Both individual health and population health are closely related to access to adequate preventive and curative health care services. The health care delivery system and the way that care is delivered can have a major effect on a person's health. In the United States, most health care expenditures are allocated to the treatment of medical conditions, and not to the prevention or control of factors that contribute to these medical conditions. This misallocation can be attributed to many factors, including the insurance system, cultural beliefs, and traditional medical training and practice.

CULTURAL BELIEFS AND VALUES

A value system orients members of a society toward defining what is desirable for that society. It has been observed that even a society as complex and highly differentiated as the United States can be said to have a relatively well-integrated system of institutionalized common values at the societal level (Parsons, 1972). Although such a view may still prevail, the current American society now incorporates several different subcultures that have grown in size because of a steady influx of immigrants from different parts of the world. Such diversity promotes sociocultural variations in how people view their health and, more importantly, how such differences influence people's attitudes and behaviors concerning health, illness, and death (Wolinsky, 1988, p. 39). Historically, cultural beliefs and values

have been strong forces against attempts to initiate fundamental changes in the financing and delivery of health care.

STRATEGIES TO IMPROVE HEALTH

Healthy People Initiatives

Since 1980, the United States has undertaken a series of 10-year plans outlining certain key national health objectives to be accomplished during each of the 10-year time frames. These initiatives have been founded on the integration of medical care with preventive services, health promotion, and education; integration of personal and community health care; and increased access to integrated services. The *Healthy People 2010: Healthy People in Healthy Communities* initiative was launched in January 2000. Its objectives were defined in the context of changing demographics in the United States, reflecting an older and more racially diverse population. The *Healthy People 2010* objectives also defined new relationships between public health departments and health care delivery organizations (U.S. Department of Health and Human Services [DHHS], 1998). *Healthy People 2010* specifically emphasized the role of community partners such as businesses, local governments, and civic, professional, and religious organizations as effective agents for improving health in their local communities. The objectives had a particular focus on determinants of health, discussed earlier in this chapter.

The current initiative, *Healthy People 2020*, was launched in December 2010. *Healthy People 2020* takes into account some of the achievements made over the last decade, such as increased life expectancy and a decreased death rate from coronary heart disease and stroke, and identifies other areas for improvement over the next decade. *Healthy People 2020*'s objectives include identifying nationwide health improvement priorities; increasing public awareness and understanding of the determinants of health, disability, and disease; providing measurable objectives and goals that are applicable at all levels; engaging multiple sectors to take action to strengthen policies and improve practices that are driven by the best scientific evidence and knowledge; and identifying critical research, evaluation, and data collection methods. *Healthy People 2020* will assess progress through measures of general health status, health-related quality of life and well-being, determinants of health, and disparities (DHHS, 2011).

The overarching goals of *Healthy People 2020* include the following:

- Attaining high-quality, longer lives free of preventable disease, injury, and premature death
- Achieving health equity, eliminating disparities, and improving the health of all groups
- Creating social and physical environments that promote good health for all
- Promoting quality of life, healthy development, and health behaviors across all life stages

The graphic framework for *Healthy People 2020* is presented in **Figure 2.3**.

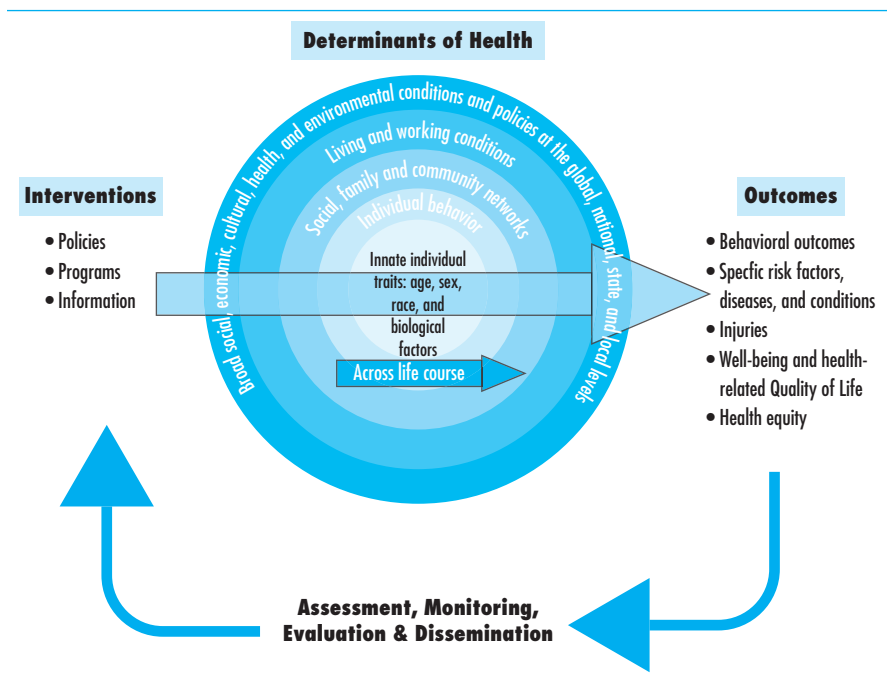


Figure 2.3 Action Model to Achieve *Healthy People 2020* Overarching Goals

Source: Secretary’s Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020. Phase I report recommendations for the framework and format of *Healthy People 2010*, p. 8, Exhibit A. <http://www.healthypeople.gov/2010/hp2020/Advisory/PhaseI/PhaseI.pdf>.

Distribution of Health Care

In a perfect world, the production, distribution, and subsequent consumption of health care would be perceived as equitable. Unfortunately, no society has found a perfectly equitable method to distribute limited economic resources; in fact, any method of resource distribution leaves some inequalities. Societies, therefore, try to allocate resources according to some guiding principles acceptable to each society. Such principles are ingrained in a society's values and belief systems. It is generally recognized that not everyone can receive everything that medical science has to offer. The fundamental question that deals with distributive justice or equity is who should receive the medical goods and services that society produces (Santerre & Neun, 1996, p. 7). By extension, this basic question about equity encompasses not only who should receive medical care, but also which types of services and in what quantity. Even though various ethical principles can be used to guide decisions pertaining to just and fair allocation of health care in individual circumstances, the broad concern about equitable access to health care services is addressed by theories referred to as *market justice* and *social justice*. These two contrasting theories govern the production and distribution of health care services.

Market Justice

The principle of market justice proposes that market forces in a free economy can best achieve a fair distribution of health care. Within such a system, medical care and its benefits are distributed on the basis of people's willingness and ability to pay (Santerre & Neun, 1996, p. 7). In other words, people are entitled to purchase a share of the available goods and services that they value. They must purchase these valued goods and services by using the financial resources acquired through their own legitimate efforts. This is how most goods and services are distributed in a free market. The free market implies that giving people something they have not earned would be morally and economically wrong. The principle of market justice is based on the following key assumptions:

- Health care is like any other economic good or service and, therefore, can be governed by the free market forces of supply and demand.
- Individuals are responsible for their own achievements. When individuals pursue their own best interests, the interests of society as a whole are best served (Ferguson & Maurice, 1970).

- People make rational choices in their decisions to purchase health care products and services to rectify their health problems and restore their health.
- People, in consultation with their physicians, know what is best for themselves. This assumption implies that people place a certain degree of trust in their physicians and that an ongoing physician–patient relationship exists.
- The marketplace works best with minimum interference from the government. In other words, the market, rather than the government, can allocate health care resources in the most efficient and equitable manner.

Under market justice, the production of health care is determined by how much consumers are willing and able to purchase at prevailing market prices. It follows that in a free market system, individuals without sufficient income or who are uninsured face a financial barrier to obtaining health care (Santerre & Neun, 1996, p. 7). Thus prices and ability to pay combine to ration the quantity and type of health care services people consume. Such limitations to obtaining health care are referred to as *demand-side rationing* or price rationing. The key characteristics of market justice and their implications are summarized in [Table 2.1](#).

Market justice emphasizes individual, rather than collective, responsibility for health. It proposes private, rather than government, solutions to the social problems of health.

The principles of market justice work well in the allocation of economic goods when their unequal distribution does not affect the larger society. For example, based on their individual success, people live in different sizes and styles of homes, drive different types of automobiles, and spend their money on different things; however, market justice principles generally fail to rectify critical human concerns such as crime, illiteracy, and homelessness, which can significantly weaken the fabric of a society. Many Americans believe that health care is also a social concern.

Social Justice

The idea of social justice is at odds with the principles of capitalism and market justice. According to the principle of social justice, the equitable distribution of health care is a societal responsibility. This goal can best be achieved by letting a central agency—generally the government—take

Table 2.1 Comparison of Market Justice and Social Justice

| Market Justice | Social Justice |
|--|--|
| Characteristics | |
| <ul style="list-style-type: none"> • Views health care as an economic good • Assumes free market conditions for health services delivery • Assumes that markets are more efficient in allocating health resources equitably • Production and distribution of health care are determined by market-based demand • Medical care distribution is based on people’s ability to pay • Access to medical care is viewed as an economic reward of personal effort and achievement | <ul style="list-style-type: none"> • Views health care as a social resource • Requires active government involvement in health services delivery • Assumes that the government is more efficient in allocating health resources equitably • Medical resource allocation is determined by central planning • Ability to pay is inconsequential for receiving medical care • Equal access to medical services is viewed as a basic right |
| Implications | |
| <ul style="list-style-type: none"> • Individual responsibility for health • Benefits are based on individual purchasing power • Limited obligation to the collective good • Emphasis on individual well-being • Private solutions to social problems • Rationing based on ability to pay | <ul style="list-style-type: none"> • Collective responsibility for health • Everyone is entitled to a basic package of benefits • Strong obligation to the collective good • Community well-being supersedes that of the individual • Public solutions to social problems • Planned rationing of health care |

over the production and distribution functions. Social justice regards health care as a social good—as opposed to an economic good—that should be collectively financed and available to all citizens regardless of the individual recipient’s ability to pay for that care. Most industrialized countries long ago reached a broad social consensus that health care was a social good (Reinhardt, 1994). Public health also has a social justice orientation

(Turnock, 1997). Under the social justice system, an inability to obtain medical services because of a lack of financial resources is considered unjust. The principle of social justice is based on the following assumptions:

- Health care is different from most other goods and services. Health-seeking behavior is governed primarily by need rather than by cost.
- Responsibility for health is shared. Individuals are not held totally responsible for their condition because factors outside their control may have brought on the condition. Society feels responsible for a lack of control over certain environmental factors such as economic inequalities, unemployment, unsanitary conditions, or air pollution.
- Society has an obligation to the collective good. The well-being of the community is held to be superior to that of the individual. An unhealthy individual is a burden on society; a person carrying a deadly infection, for example, poses a threat to society. Society is obligated to eliminate (cure) the problem by providing health care to the individual because doing so benefits the society as a whole.
- The government, rather than the market, can better decide through rational planning how much health care to produce and how to distribute it among all citizens.

Under a system based on social justice, the amount of health care produced is determined by the government. Of course, no country can afford to provide unlimited amounts of health care to all of its citizens (Feldstein, 1994, p. 44). Thus the government must find ways to limit the availability of certain health care services by deciding, for instance, how technology will be dispersed and who will be allowed access to certain types of high-tech services, even though basic services may be available to all. This concept is referred to as *planned rationing* or *supply-side rationing*. The government makes deliberate attempts, often referred to as “health planning,” to limit the supply of health care services, particularly those beyond the basic level of care. The main characteristics and implications of social justice are summarized in Table 2.1.

Justice in the U.S. Health Care System

It is important to recognize that the current U.S. health care system is not a market-justice based system because American health care delivery

does not follow free-market principles. A significant shift away from market justice began in 1965 with the creation of Medicare and Medicaid. Since then the move toward social justice has been gradual and ongoing. Currently, a little less than half of the financing for health care services in the United States comes from the government. The government also plays a major role in exercising a significant degree of control over the system through various policies governing insurance, payment to providers, availability of new drugs and procedures, use of information systems, funding for medical research, and quality initiatives, to name a few.

In the United States, the principles of market justice and social justice complement each other. Private, employer-based health insurance—mainly for middle-income Americans—is driven by market justice. Publicly financed Medicaid and Medicare coverage for certain disadvantaged groups and workers' compensation programs for those injured at work are based on social justice. The two principles collide, however, regarding the large number of uninsured who cannot afford to purchase private health insurance and do not meet the eligibility criteria for Medicaid, Medicare, or other public programs.

With the passing of the ACA of 2010, the question of how insurance can be provided to all Americans was, for the first time, addressed in a major way (details are furnished in subsequent chapters). The Act's major changes are scheduled to take effect in 2014, with the goal being that all Americans have health insurance in the near future. This is an example of a major step in moving the U.S. health care system toward the goals of social justice.

Public Health System

Public health is a reflection of society's desire and effort to improve the health and well-being of the total population, and relies on the role of government, the private sector, and the public in addition to focusing on the determinants of population health. The *public health system* reflects an organized effort to deliver public health services within a jurisdiction with the goal of improving health and well-being of the population.

Research evidence indicates that public health contributes positively to population health. Indicators at the national, state, and local levels should be developed to measure public health performance along with a national surveillance system to consistently track indicators so as to gain a better understanding of the system's effectiveness. In addition, innovative efforts by

states to improve their public health systems' infrastructure, practices, and performance should be encouraged and evaluated, given that most significant reforms take place at this level than at the federal or municipal level.

Turning Point

Turning Point is an initiative of the Robert Wood Johnson Foundation to transform and strengthen the public health system, in which 21 states currently participate. As part of this initiative, multisector partnerships to produce public health improvement plans employ strategies that include institutionalization within government, establishing “third-sector” institutions, cultivating relationships with significant allies, and enhancing communication and visibility among multiple communities (Shi and Stevens, 2010).

Focusing on Determinants

To improve the nation's health and minimize disparities among its vulnerable populations, development of a framework embodying social and medical determinants is warranted. This framework, presented in **Figure 2.4**, puts a balanced emphasis on both social and medical care determinants because it is the combination of these factors that ultimately shapes health and well-being. This model synthesizes multiple health influences and highlights points for intervention. “Health” in this model is not just a state of being free of disease and injury, but also includes the positive concept of well-being and encompasses the physical, mental, social, and spiritual aspects of health.

Social Determinants of Health

The framework acknowledges the effects of demographics, socioeconomic status, personal behavior, and community-level inequalities and their defining influence on health. Personal demographics (e.g., race/ethnicity or age) directly contribute to vulnerability levels. Whether socioeconomic status is defined by education, employment, or income, both individual- and community-level socioeconomic status have independent effects on health. The health impact of personal behaviors (e.g., smoking or exercise) is well documented, but such behavior is rarely isolated from the social and environmental contexts in which choices are made.

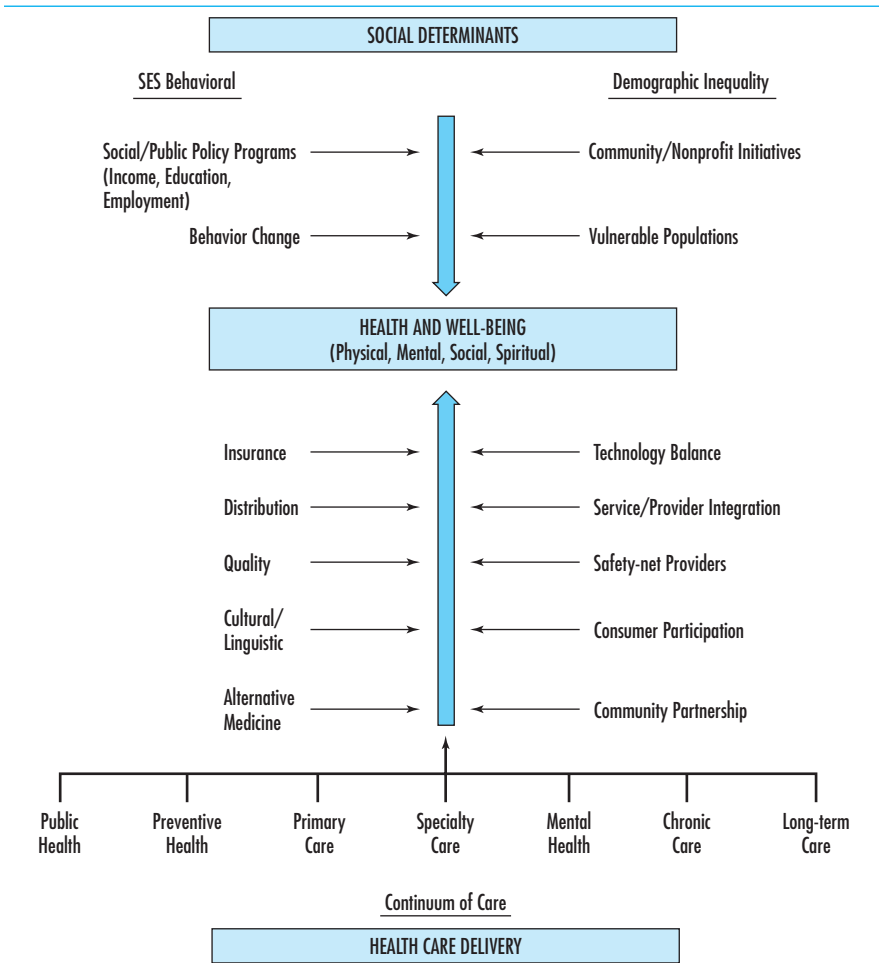


Figure 2.4 Health Determinants and Strategies to Improve Health

Social and income inequalities have also been shown to contribute to disparities in health. Underinvestment in human capital, erosion of social cohesion, and the consequences of relative deprivation are mechanisms by which income inequalities can lead to poorer health outcomes. For example,

discrimination—the difference in one’s actions toward an individual or group based on the innate personal characteristics of that group, such as race and/or ethnicity—has direct consequences for individual health. Many of the social factors of health care are also the root causes of poor health; thus addressing them is vital to the improvement of population health and health disparities.

Medical Care Determinants of Health

Although social determinants influence people’s health status, the medical care system primarily focuses on treating illness or poor health. Preventive care is an exception to this rule, but understanding the influences of medical care on health should also take into consideration disparities that exist in basic health care access and quality. The framework includes a broad spectrum of medical care services and interventions to improve health. Whereas some services (preventive and primary care) contribute to general health status, others are more influential in end-of-life situations (specialty and long-term care). As patients move across the spectrum, they are likely to contend with issues of fragmentation, poor continuity of care, and insufficient coordination of care for multiple health needs.

The relative value of each health service in the spectrum should be evaluated in determining health policy. For example, should equal investments be made in each service, or are some investments better than others (e.g., primary versus specialty care)? How can we optimize the medical system’s potential for eliminating disparities with limited resources (e.g., focusing on primary care for all versus higher levels of technology care for certain populations)? Other health care factors, such as the quality of care, access to alternative therapies, and technology, will further affect a patient’s health care experience and health outcomes.

Social and Medical Points of Intervention

Considering that social and medical determinants are responsive to numerous outside forces, the framework highlights important points for intervention. Dramatic reductions in health disparities are obtainable through interventions in both the social and medical domains and are grouped according to four main strategies: (1) social or medical care policy interventions, (2) community-based interventions, (3) health care

interventions, and (4) individual interventions. The following sections elaborate on these strategies.

Policy Interventions Social or public policy affects the health of the population in many ways. Product safety regulations, screening food and water sources, and enforcing safe work environments are just a few of the ways in which public policy directly guards the welfare of the nation. With fewer resources at their disposal, however, vulnerable populations are uniquely dependent on social and public policy to develop and implement programs that address basic nutritional, safety, social, and health care needs. Many of the mechanisms relating vulnerable status to poor health are amenable to policy intervention, and policy initiatives can be primary prevention strategies to alter the fundamental dynamics linking social factors to poor health.

As an example, in 1970, the Occupation Safety and Health Act was passed, which created the Occupational Safety and Health Administration (OSHA). The goal of OSHA is to protect employees of companies from the potential dangers of an unsafe environment that may exist at the workplace. For example, OSHA established the Injury and Illness Prevention Program that requires employers to implement a system that would ensure employees' compliance with a safe and healthy work environment. This is part of an overall effort to more effectively identify hazards in the workplace to protect employees who otherwise may be working in dangerous work environments (U.S. Department of Labor, 2011).

Community-Based Interventions Many of the sources of health disparities may be addressed at the community or local level. Neighborhood poverty, the presence of local health and social welfare resources, and societal cohesion and support are all likely to contribute to inequalities in a community. An understanding of the multidimensional risks and needs in a particular community can better equip local agencies responsible for designing interventions to successfully address health disparities in their communities (see the examples in [Exhibit 2.3](#)). Because community partnerships reflect the priorities of a local population and are often managed by members of the community, they minimize cultural barriers and improve community buy-in to the program.

Addressing disparities using community approaches has several other advantages. For example, the use of resources that directly help needy

Exhibit 2.3 Strategies to Improve Health and Reduce Disparities

- Nutrition programs
- Work/environment safety efforts
- Community-based partnerships
- Culturally appropriate care
- Patient safety/medical error reduction
- Prevention-oriented effort
- Coordinated care for chronically ill persons

members of the community can provide businesses and other local partners with greater incentive to contribute to local health causes. Communities should be seen as action centers for development, progress, and change, with local members and leaders playing a central role in planning and managing strategies for health improvement. Community solutions also benefit from participatory decision making. Local researchers, health practitioners, social services, businesses, and community members can be invited to contribute to the process of designing, implementing, evaluating, and sustaining programs. Moreover, many community programs are run by nonprofit organizations, and in exchange for providing services, these organizations are subsidized through federal, state, or local funds and receive tax exemptions. Thus they are able to offer services at lower cost than private health organizations that are obligated to their shareholders to price their services competitively.

As an example, in an effort to counteract the recent rise in childhood obesity rates, many schools are beginning classroom-conducted nutritional programs. These multicomponent nutritional interventions involve administrators, food services staff, teachers, parents, and students. The goal is to reach multiple levels of the community in an effort to increase community-wide participation and expand the program's effectiveness. Teaching students about proper nutrition in the classroom while concurrently educating parents increases the possibility of the program's success in fighting childhood obesity (DeMattia & Denney, 2008).

Health Care Interventions Although social policy and community-level interventions are designed to address social disparities in health, billions of public and private dollars are spent annually to monitor and improve facets of the U.S. health care system. For example, interventions such as integrated electronic medical records systems have been designed to potentially

improve patient care while also reducing waste in the health care system (Dorman & Miller, 2011; Hillestad et al. 2005; Sperl-Hillen et al., 2011). It is estimated that if integrated electronic medical records are used by 90% of providers in the United States, it could potentially save \$77 billion per year by improving the health care system's efficiency. Electronic health records also hold the promise of improved quality through better coordination and integration of care among various providers. Coordinated and integrated care is particularly important in light of the increasing burden of chronic disease. For example, coordination of care and counseling for type 2 diabetes has been shown to improve blood glucose management in patients.

Individual-Level Interventions Where policy and community-level interventions are unable to reduce either the occurrence of compromising social determinants or their consequences, individual-level initiatives can attempt to intervene and minimize the effects of negative social determinants on health status. Altering individual behaviors that influence health (e.g., reducing smoking and increasing exercise) is often the focus of these individual-targeted interventions, and numerous theories have been promulgated to identify the complex pathways and barriers to eliciting changes or improvements in behavior. The integration of behavioral science into the public health field has been a valuable contribution, providing a toolbox of health-related behavior-changing strategies.

CONCLUSION

Health and its determinants are multifactorial. Although important, medical care is only one factor that contributes to health and well-being. Factors such as physical, social, cultural, and economic environments; behaviors and lifestyles; and heredity play a greater role in determining health and well-being for both individuals and populations. The delivery of health care is primarily driven by the medical model, which emphasizes illness rather than wellness. Even though major efforts and expenditures have been directed toward the delivery of medical care, they have failed to produce a proportionate impact on the improvement of health status. Holistic concepts of health care, along with integration of medical care with preventive and health promotional efforts, should be adopted to significantly improve the health of Americans; but such an approach would require a

fundamental change in how Americans view health. It would also require taking individual responsibility for one's own health-oriented behaviors, as well as forging community partnerships to improve both personal and community health. An understanding of the determinants of health, health education, community health assessment, and national initiatives such as *Healthy People 2020* are essential for accomplishing such goals. Over the years, the U.S. health care system has been gradually transitioning toward social justice, yet all Americans still do not have equal access to health care services. To improve the nation's health and resolve disparities among its vulnerable populations, it is critical to address both the social and medical determinants of health.

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