Commentary

The Ethics of the Medical Model in Addressing the Root Causes of Health Disparities in Local Public Health Practice

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The Challenge of Eliminating Health Disparities

The second goal of Healthy People 2010 is to “eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.” Although eliminating health disparities is not listed as one of HHS Secretary Mike Leavitt’s current HHS priorities, Secretary Leavitt has said that eliminating health disparities as they affect racial, ethnic, and underserved populations is a “critical goal” of HHS. US Centers for Disease Control and Prevention Director, Dr Julie Gerberding, looks forward to the day that eliminating health disparities will become “part of the backbone and the culture of CDC” rather than a separate activity.

Despite the apparently high priority that the elimination of health disparities receives in the public pronouncements of our nation’s federal public health leaders, the public health strategies and practices that would operate to eliminate health disparities appear to be lacking. Quantitative research indicates that an estimated 83,570 excess deaths each year could be prevented in the United States if the Black-White mortality gap could be eliminated. However, HHS’s Healthy People 2010 midcourse review indicates that there has been no overall progress in the nation regarding the second goal of eliminating health disparities. Bottom line, health disparities are worsening. So there appears to be a large gap between the stated goals of our national public health institutions and the presence of successful public health policies, strategies, and practices to eliminate health disparities.

PH has a code of ethics. There are several principles of the Public Health Code of Ethics that directly inform public health practice strategies for the elimination of health disparities.
health disparities. The public health code of ethics says that

- public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes (principle 1);
- public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all (principle 4); and
- public health programs and policies should be implemented in a manner that most enhances the physical and social environment (principle 9).

**How Does Our Public Health Practice Conform to the Dictates of This Challenge?**

The backbone of US public health system is that of a governmental enterprise with federal, state, and local components. While one can easily define the public health system in the United States as consisting of a much broader array of nongovernmental entities, both nonprofit and for profit in addition to the federal-state-local governmental enterprise, it should at least follow logically that if the federal government sets a goal such as those laid out in Healthy People 2010, the public health governmental enterprise must be expected to work toward achieving that goal.

Definitions of public health practice are few and, in general, quite nonspecific. One useful definition of public health practice is: “the strategic, organized, and interdisciplinary application of knowledge, skills, and competencies necessary to perform essential public health services and other activities to improve the population’s health.”76 To understand what constitutes US public health practice, one would presumably look for federal, state, and local governmental public health activities that are widespread across states and territories, have realistic per-capita funding, and commonly accepted as effective, or ideally, evidence-based. The practice of governmental public health in the United States is varied by virtue of the organizational and jurisdictional heterogeneity associated with what is constitutionally a state-led and driven function. Nevertheless, when the federal government establishes a health priority through a combination of funding incentives and mandates, it can greatly influence and direct governmental public health practice in all of the 50 states and 3000 or so local health departments at the county, city, and district levels throughout the country. In general, federal public health practice priorities can be categorized into four broad groupings: (1) specific communicable diseases (eg, sexually transmitted diseases, tuberculosis, and HIV/AIDS), (2) vulnerable populations (ie, maternal, child, and adolescent health), (3) critical healthcare services (eg, childhood and adult immunizations, healthcare for the homeless), and (4) issues of national security (eg, bioterrorism preparedness, pandemic influenza). Consequently, most state and local public health departments have developed corresponding practices in these areas. One of the common characteristics of these core public health practice areas is that they are generally disease-specific and “categorical” in that they are not structured in a way that facilitates an examination of root causes that may be shared by several diseases.

**The Medical Model**

A disturbingly high proportion of state and federal grant–funded public health programs, including those designed to eliminate health disparities, are deeply rooted in the so-called medical model. Simply stated, the medical model posits that differential rates of disease and death between groups are primarily explained by differences in clinical risk factors, and risk behaviors, including healthcare seeking behaviors, among different population groups. The medical model focuses most heavily on certain proximate causes of morbidity and mortality, including genetics, healthcare access and quality, and individual behavior change strategies and health knowledge. As the medical model is focused primarily on individual behaviors and risks, it is most easily applicable to situations in which health disparities are narrowly defined as the differential incidence of certain specific diseases. Consequently, many federal health disparity elimination initiatives quickly devolve into a discussion of disease-specific strategies that largely ignore the socioecological context of those diseases. The medical model solutions proposed tend to involve the intensification of clinical services to specific populations and numerous variations on the theme of increasing patient-professional interactions among populations already afflicted with disease. Common disease roots in the socioecological context are often ignored. Examples of this narrow disease-specific focus abound.

For example, HHS’s Initiative to Eliminate Racial and Ethnic Disparities in Health immediately devolves into a set of disease-specific initiatives focused on six diseases, infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and immunizations. The “promising strategies” highlighted under each of these enumerated diseases are disproportionately clinically focused initiatives that are designed to improve individual health behaviors, increase early detection, and improve the clinical
The overwhelming emphasis of this HHS Initiative to Eliminate Racial and Ethnic Disparities in Health is the medical model. NIH’s Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities acknowledges that health disparities are “the result of the complex interaction among biological factors, the environment, and specific health behaviors,” and that “inequalities in income and education also appear to underlie many health disparities in the United States.”8(p2) The plan envisions directing resources to better understand “the role of the environment and socioeconomic status in health disparities.”8 Despite these important insights into the social determinants of disease, the NIH plan places only limited emphasis on funding research or activities that seek to understand the role of the physical or social environment, economic and social policy, racial discrimination, or any of the major social determinants that the plan itself acknowledges underlie the very health disparities that NIH is trying to strategically reduce and ultimately eliminate.

● The Socioecological Context of Health Disparities

While the medical model is undoubtedly important in ameliorating health disparities, particularly those related to the failures of our fragmented healthcare delivery system, the medical model alone can never successfully eliminate racial and ethnic disparities that are largely driven by social inequalities that are structural in nature and inextricably intertwined with profound racial and ethnic disparities in income, education, housing, employment, and other important indicators of social power and opportunity. The ethical practice of public health must acknowledge the profound influence of the socioecological context of health disparities and seek to define effective new strategies that are truly intended to eliminate these disparities. Such strategies must understand the relevance of the immediate social and physical environment to the development of risk behaviors, such as smoking, physical inactivity, and low consumption of healthy foods. These new strategies must also analyze and assess the health impacts of social policies related to land use planning, education, employment, housing, and wages, to name a few. Ultimately these new public health strategies must serve to build social, political, and economic power in low-income communities where health disparities are concentrated and exact an appalling human toll.

● Place Matters

The spatial concentration of poverty and race, the remnants of an American system of de facto apartheid, remains a persistent problem in many parts of the United States. There is some evidence of improvement in this basic American demographic pattern; however, the rate of this improvement is neither fast nor consistent. Consequently, the relevance of neighborhood, or place, to the geographical distribution of health disparities remains profound. Neighborhood remains an important context wherein individual decisions about health behaviors may be constrained by limited access to opportunities and amenities, and negative social messages that reinforce unhealthy individual behaviors. The performance and accountability of institutions within neighborhoods, including local government, schools, businesses, and employers, also contribute to creating conditions at the neighborhood level that are not conducive to healthy behaviors among residents of certain neighborhoods. Consequently, place matters. Successful public health strategies to eliminate

![FIGURE 1 Health Disparities Logic Diagram](image)

- **Upstream**
  - Social factors
    - Social inequalities: Classism, Racism, Sexism, Immigrant bias
    - Institutional power: Corporations and other businesses, Government, Schools
  - Neighborhood conditions: Environment - Social, Physical, Economic, Services, Segregation
  - Risk behaviors and factors: Smoking, Nutrition, Physical Activity, Violence

- **Downstream**
  - Diseases and injury: Chronic Disease, Infectious Disease, Injury
  - Mortality: Infant mortality, Life Expectancy

- **Health Care**
  - Health education

- **Health status**
  - Health care
health disparities must address the context of place in order to increase the likelihood that groups disproportionately affected by disparities will have greater opportunity to adopt healthy behaviors.

Figure 1 is an oversimplified framework for better understanding the context of health disparities in the United States. The framework incorporates and legitimizes the medical model as an important part of the pathway leading to differential rates of disease and death between various population groups. However, the framework expands “upstream” and illuminates the socioecological model that recognizes that social inequalities in power drive biased institutional decision-making that creates adverse physical and social environmental conditions in low-income communities of color throughout the United States.

Public Health as a Social Justice Enterprise

Today social justice lives as more than an ideal; social justice serves as the underlying principle of many efforts to define and create a civilized society. It involves partnership among those affected by social justice issues and those who make policy to create change. Social justice policies address disparities between people and are designed to establish and improve equal treatment under the law, equal access to opportunity, and fair and equitable distribution of resources. Social justice policies often call for social change—The Minneapolis Foundation, A Framework for Social Change.11

Public health practitioners who purport to be committed to “eliminating health disparities” cannot labor in ignorance of the persistent social, political, and economic forces that create and reinforce such striking patterns of residential racial segregation, educational disparities, and profound wealth gaps. Ultimately, when forced to examine how these enduring, structural patterns of societal organization are maintained, despite the successful elimination of legalized forms of racism following the civil rights movement, one cannot but conclude that at its very roots, the problem lies with a persistent inequity in the distribution of social, political, and economic power among racial groups in the United States. If one accepts this conclusion, then the relevant and ethical question for public health practitioners is how to build social, political, and economic power for low-income communities of color.

Public health practice as a social justice enterprise is a concept of public health that recognizes and targets roots causes of social inequity. Social justice is a dynamic concept that takes on many different forms in different settings. Fundamentally though, the need for social justice efforts arises wherever significant power imbalances are found. In settings in which justice is in short supply, power will tend to concentrate according to lines of privilege. In this society, privilege primarily flows according to race, class, gender, and, to some extent, immigration status. Consequently, many social, political, and economic policies tend to favor Whites, particularly wealthy White men. There are numerous specific examples of this including the GI Bill, red-lining practices, welfare policy, urban renewal policies, education funding policies and practices, drug use and incarceration policies, federal housing subsidization policies, and health insurance policies. One can easily describe these policies and practices collectively as affirmative action for Whites. Cumulatively, these policies and practices have created and continue to reinforce America’s unique form of apartheid. Any general strain on society whether it be economic recession, new drug epidemics such as crack cocaine, communicable disease epidemic such as influenza, or natural disaster such as Hurricane Katrina, will exact its greatest toll on low-income communities of color that are at the very bottom of the American privilege and power totem pole.

Justice has two key ingredients: truth and power. Without either one of these ingredients, there cannot be justice. Public health practitioners are experts at identifying truth. We have innumerable detailed studies published in peer-reviewed journals describing the clear relationship between various “social determinants of health” and health outcomes. In fact, we have entire journals dedicated to these topics. Yet despite the truth being out there, we see relatively little evidence of steady progress in core health measures for our most socially, politically, and economically marginalized populations. This is because public health practice has still largely ignored the issue of power and its skewed distribution throughout our society. Our work in communities tends to focus on individual-level behavioral change models, intensification of service delivery, and issue-specific community mobilization efforts, namely, the medical model. Rarely do public health agencies focus squarely on building upon indigenous social, political, and economic power in low-income communities of color. Given the ethical precepts outlines in the Public Health Code of Ethics, that public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes; that public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all; and that public health programs and policies should be implemented in a manner that most enhances the physical and social environment, can we honestly say that our current American public health practice is ethical?
REFERENCES


