

## CHAPTER 14

# HEALTH POLICY, HEALTH DISPARITIES, AND ETHICS

*The idea that some lives matter less is the root of all that is wrong with the world.*

—Paul Farmer, medical anthropologist and physician

### IMPORTANT TERMS

- Downstream social marketing
- Enlightened self-interest
- Health disparities
- Health equity
- Healthcare policy
- Implicit bias
- Patient dumping
- Social determinants of health
- Social marketing
- Upstream social marketing

### LEARNING OBJECTIVES

*Studying this chapter will help you to*

- explain the role of ethics in health policy and healthcare policy,
- understand the interrelationships of cost, quality, and access,
- assess how health policy may serve as an essential tool in times of crisis,
- explain social marketing and downstream and upstream approaches,
- assess the ethics of social marketing and public health initiatives through the lenses of ethical theories,

- explain the concept of health equity and discuss outcomes of health disparities, and
- understand structural racism and its effect on health.

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#### **healthcare policy**

The implementation of health goals that affect costs, quality, and access to healthcare.

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**T**his chapter focuses on the role of ethics and professionalism in health policy and healthcare policy. Health policy refers to strategies aimed at improving the health of the people and the communities in which they live, while **healthcare policy** refers to policies that directly affect healthcare costs, the quality of care, and access to care for the people in those communities. The three variables of cost, quality, and access are referred to as the *iron triangle*—so called because it is challenging, if not impossible, to provide low-cost, high-quality care and offer wide access simultaneously (Kissick 1994).

As discussed in chapter 11, the Affordable Care Act is an example of health policy designed to improve the health of the American people by establishing the goals of increasing access to healthcare, expanding Medicaid eligibility, and supporting healthcare innovation to lower costs. The distinction between health policy and healthcare policy is sometimes blurry, as the actions of one may affect the actions of the other (Acuff 2014, 225). Health policy that affects one side of the iron triangle, such as access to care, will have an impact on at least one of the other two sides: cost and quality. The 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) provides a classic example of this dilemma. Under this law, hospitals that offer emergency services are required to provide the following (CMS 2021):

1. Medical screening examination when a request is made for an emergency medical condition (including active labor)
2. Stabilization and further care as needed for all patients
3. Transfer of patients to another healthcare facility as appropriate, regardless of the patient's ability to pay.

However, the law allocates no funding to help hospitals provide these services. Thus, critical access hospitals and hospitals with emergency departments are left to figure out how to manage the costs incurred, which, in turn, may affect the quality of care and access to care.

Consider the iron triangle of cost, quality, and access with reference to this Case from the Field. The hospital administrators' focus on cost containment altered both the quality of care and access to care. Remember, though, that for emergency departments to provide quality care, they must remain open, and hospital administrators are acutely aware of the ethical dilemma they face—the need provide care and the need to remain in business to do so. The practice of **patient dumping**—refusing care or transferring medically unstable patients because of their inability to pay—violates the principles of nonmaleficence, beneficence, and justice, as the refusal to provide care causes harm and creates no benefit to the patient.

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#### **patient dumping**

To refuse care or transfer medically unstable patients because of their inability to pay.

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**CASE FROM THE FIELD****No Insurance, No Admission**

Documented real-life cases of patients being turned away from emergency departments or transferred from one emergency department to another helped spur the passage of EMTALA in 1986. For example, in 1980, a man in St. Louis, Missouri, arrived at a hospital with a steak knife in his back, but he was transferred from the emergency room because he did not have insurance. The hospital refused to provide aid to the patient because he could not pay \$1,000 out of pocket prior to treatment (Annas 1986).

A North Carolina general internist, Dr. Keith Wrenn, wrote to the *New England Journal of Medicine* to express his concerns about this “very disturbing trend” (Wrenn 1985, 373). In 1983, a car accident victim was brought to the emergency room at Wrenn’s small rural hospital. The patient required neurosurgery, which the hospital was not equipped to provide. Dr. Wrenn recounted that during his attempt to transfer the patient to a private tertiary care center in a well-endowed university setting where the appropriate care could be provided, he was asked, “Does the patient have insurance?”

A second experience occurred the following year and concerned another car accident victim who had experienced massive head trauma. The emergency room was able to stabilize her and attempted to relocate her for neurosurgery. However, the same tertiary care center refused to accept the patient on the grounds that she had no health insurance.

In 1985, a patient named Mr. Lafon entered Parkland Memorial Hospital in Dallas, Texas. He had third-degree burns on his back and needed immediate care, which the hospital provided. However, prior to his arrival at Parkland Memorial, he had been turned away from three other hospitals because he could not pay the \$500 to \$1,500 deposit required to receive care. He was 56 years old, a laborer, and did not have health insurance. Lafon said of the experience, “Kind of makes you feel like a dog” (Taylor 1985).

Before the passage of EMTALA, some hospitals made admission decisions based on the patient’s ability to pay, while other hospitals, such as Parkland Memorial, accepted patients because it was the right thing to do. However, the hospitals that accepted patients without insurance did so with increased cost responsibilities—to the tune of \$1.05 billion each year (Ansell and Schiff 1987, 1500). Before EMTALA, emergency department transfers increased 600 percent in Washington, D.C., from 1981 to 1984, and 520 percent in Cook County, Illinois (where Chicago is located), from 1980 to 1983 (Walker 2018). Consequently, concerns arose about patient dumping, access to care, and emergency department policy. The Joint Commission noted that people must be treated regardless of their ability to pay; the Hippocratic Oath requires that physicians must do no harm (Dossabhoy, Feng,

and Desai 2018; Joint Commission 2010). Other public hospitals joined with Parkland Memorial and advocated for passage of the EMTALA (Parkland Hospital 2021). The US Congress passed the legislation, and President Ronald Reagan signed it into law in 1986.

However, EMTALA was passed without allocating funds to allow hospitals to cover the costs incurred to care for patients who cannot pay (this is referred to as an *unfunded mandate*). In this case, the elements of cost, quality, and access are motivated and driven by policy outcomes (Cellucci, Meacham, and Farnsworth 2019). By 2003, about 1,100 hospitals had determined that closing their emergency departments was the best strategic option (*Emergency Medicine News* 2003). The passage of EMTALA was not the only reason these hospitals decided to close; however, it is one factor that illustrates how health policy affects healthcare policy (see also the discussion of Pungo Hospital in chapter 11).

Other legislated policies have affected the healthcare industry's ability to plan and be prepared for unexpected events, such as terrorist attacks, natural disasters, and pandemics. The following section discusses the effects of the Pandemic and All-Hazards Preparedness Acts of 2006, 2013, and 2019 on healthcare organizations' ability to respond effectively and ethically. The key ethical principle in this case is beneficence—that is, being better prepared at the front end allows healthcare organizations to provide better patient care during a crisis, such as a pandemic.

### **PANDEMIC AND ALL-HAZARDS PREPAREDNESS ACTS OF 2006, 2013, AND 2019**

The Pandemic and All-Hazards Preparedness Act (PAHPA; Public Law 109-417) was passed by Congress and signed by President George W. Bush in 2006. The law subsequently was reauthorized and updated by Congress and signed by President Barack Obama in 2013 (Public Law 113-5). The 2013 reauthorization included funding for public health medical preparedness programs to meet community needs during disasters and enhanced the authority of the US Food and Drug Administration. In 2019, President Donald Trump signed into law another updated version (Public Law 116-22), which added environmental health to the original components of public health and medical preparedness and response capabilities for emergencies.

Three events spurred the passage of the original 2006 law:

1. In September 2001, during President George W. Bush's first term in office, the United States experienced terrorist attacks on the World Trade Center in New York City and an attempted attack on the US Capitol.
2. In October and November 2001, anthrax attacks occurred in Washington, D.C., New York City, and West Palm Beach, Florida.
3. In 2005, Hurricane Katrina devastated parts of Mississippi and Louisiana.

On September 11, 2001, four passenger planes were hijacked by terrorists. Two of the planes crashed into the World Trade Center, another crashed into the Pentagon, and a fourth crashed into a field in Pennsylvania. Both World Trade Center towers collapsed, the Pentagon was damaged, and all passengers aboard the four aircrafts died. In total, about 3,000 people died because of the attacks, 2,700 of them in New York City (Gold 2020). In the aftermath of 9/11, assessments praised community and healthcare organizations' response efforts while also identifying system-level weaknesses in the ability to prioritize, cooperate, and respond to emergencies and a lack of reporting structure to coordinate responses.

Exhibit 14.1 summarizes the actions of five responding organizations to meet the needs of the crisis (Comfort and Kapucu 2006; Klitzman and Freudenberg 2003). The 9/11 Commission Report (2004) concluded that the emergency response efforts were cumbersome at times, disorganized, and “hampered by problems in command and control and in internal communications.” For example, even though air quality was known to be poor around the World Trade Center, personal protective equipment was not adequately supplied to those on-site. The events indicated a critical need to be better prepared.

Within a month of 9/11, the United States experienced a series of bioterrorist attacks, which also indicated a need for preparation. From October 4, 2001, to November 20, 2001, 22 people were exposed to deadly anthrax spores that had been prepared in a powder. People became exposed to the disease when they breathed or touched the spores. As the

#### EXHIBIT 14.1

Organizations and  
Actions Taken to  
Respond to 9/11

Organization	Example of actions taken
New York City Department of Health	Monitored food and drinking water to people at Ground Zero
American Red Cross	Set up emergency shelters
New York City Department of Health and Mental Hygiene	Provided crisis intervention via hotline to survivors, bereaved family members, and workers at Ground Zero. Followed up with the establishment of Family Assistance Centers to provide counseling and assist as appropriate (e.g., file death certificates)
Agency for Toxic Substances and Disease Registry	Tested people around the Trade Center and residents in Lower Manhattan for asbestos and fiberglass fibers
Greater New York Hospital Association	Informed responders of medical transport bed availability at New York hospitals

*Sources:* Information from CDC (2014); Klitzman and Freudenberg (2003); National Commission on Terrorist Attacks Upon the United States (2004).

anthrax powder was enclosed in mailings sent to politicians and news media organizations (the three major networks—ABC, CBS, and NBC—as well as the *New York Post* and the Associated Press), it was more likely to infect mail workers and media company employees who had contact with the mail (Jernigan et al. 2002). This event indicated the need to be better prepared against a future bioterrorist attack.

In August 2005, Hurricane Katrina highlighted the need for more coordinated public health emergency preparedness and response to environmental disasters. Along the Gulf Coast, infrastructure was destroyed as schools, businesses, and neighborhoods were flooded and experienced severe wind damage. Houses that had stood for hundreds of years were destroyed (de Montluzin and de Montluzin 2011). Systemic organizational breakdowns occurred, and the Federal Emergency Management Agency was slow to respond, showing a lack “of visibility in the resource ordering process, difficulty deploying sufficient numbers of trained personnel, unreliable communication systems, and insufficient management controls for some assistance programs” (OIG 2006, 2). For instance, following the storm, Mississippi received less than 50 percent of the supplies needed, and in Louisiana, more than 22,000 people arrived at the Superdome for shelter but were met with woefully inadequate support—only two trucks of food and five trucks of water (OIG 2006). Stranded workers at Charity Hospital in New Orleans cared for patients there, rationing food and hydrating themselves intravenously while they waited for five days for help (Freemantle 2005). Hurricane Katrina indicated a need to be better prepared for natural disasters.

These three events underscored the need to develop a stronger infrastructure to address future terrorism, bioterrorism, and other crises that affect people’s health. Senator Richard Burr of North Carolina introduced the PAHPA legislation, noting that “the federal [government] must ensure that all state and local public health departments and health care facilities are prepared and have the tools they need to confront the unpredictable challenges that [lie] ahead—whether it’s a hurricane, a terrorist attack or a pandemic” (Morhard and Franco 2013, 146).

PAHPA provided important outcomes to help systems be better prepared. Most notably, it established a process to develop new vaccines quickly to respond to emergencies. This action had a significant impact during the COVID-19 pandemic. PAHPA also defined which organizations would serve as response leaders and established coordination protocols for organizations responding to disasters. Importantly, the legislation also included funding to strengthen biological laboratories so as to identify infectious diseases quickly and then distribute medicines appropriately. Another outcome was the identification and certification of medical volunteers to be ready for emergency response.

With legislation passed and updated to address health needs during times of crises, the next need concerned the importance of communicating to the public about public health crises and their responsibility to take action to protect their health and the health of others in their communities. This is illustrated in the concept of social marketing and efforts made to disseminate vaccines to address the COVID-19 pandemic.



## SOCIAL MARKETING

Philip Kotler and Gerald Zaltman (1971, 5) are regarded as the founders of **social marketing**, which they defined as “the design, implementation, and control of programs calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communication, distribution, and marketing research.” Kotler and Zaltman proposed that marketing tools and techniques could be applied not only to selling products but also to influencing the behavior of individuals and the community to achieve a common good. For example, in 2021, social marketing was employed to persuade Americans to get the COVID-19 vaccine, both for their own good and for the good of those around them.

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**social marketing**

Influencing the behavior of individuals and the community to achieve a common good.

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Let’s apply the concept of social marketing to the 2021 “We Can Do This” campaign of the Centers for Disease Control and Prevention (CDC), which aimed to increase vaccinations to prevent COVID-19 infections. This campaign communicated its message through a variety of channels, including television and social media platforms, and featured famous people such as actor Angela Bassett, singer John Legend, comedian and musician Steve Martin, and the Philadelphia Flyers hockey team receiving or talking about receiving their COVID-19 vaccinations (Adams 2021). Former presidents Jimmy Carter, Bill Clinton, George W. Bush, and Barack Obama and their spouses also participated in an “It’s Up To You” public service announcement urging people to “protect those you love” and help “get rid of this pandemic” (VOA News 2021).

Corporations also joined the vaccination campaign. For example, Walgreens distributed ads featuring John Legend, who said, “COVID -19 has taken so much from so many, but this is our shot at returning to the faces and places we love and miss . . . This is our shot at bringing our communities back together . . . This is our shot.” Walt Disney World and Universal Orlando supported Florida’s campaign, “I Got My Shot,” aimed at educating Floridians about the vaccine and encouraging vaccinations by providing a mobile vaccine unit to increase access (Adams 2021; WDW News Today 2021). McDonald’s coffee cups displayed the message “We Can Do This” and featured stickers explaining where vaccines could be obtained (Kurtz 2021). Discussing the McDonald’s campaign, Xavier Becerra, secretary of the US Department of Health and Human Resources, explained that “this effort will help more people make informed decisions about their health and learn about steps they can take to protect themselves and their communities” (Kurtz 2021).

The goals of the CDC’s We Can Do This campaign were to educate people about the vaccines, to encourage them to get vaccinated, and to point them to available vaccination sites. Although the campaign primarily targeted those who had not yet obtained the vaccine, it also aimed to reach the vaccinated, in the hope that they would encourage others to do the same. The messages directed at this secondary group focused on affirming their action and the positive outcomes for family and community to build grassroots momentum for vaccinations.

### ASSESSMENT THROUGH AN ETHICAL LENS

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**enlightened self-interest**

An ethical theory that holds that individuals maximize benefits to the self while minimizing harm to others.

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We can evaluate the ethics of social marketing efforts through the lenses of several ethical theories. In chapter 2, we discussed the ethical philosophies of deontology, consequentialism, Rawls's principles of justice, and the ethics of care. Here, we introduce another theory, called **enlightened self-interest**, which holds that individuals who act in the best interests of other ultimately serve their own self-interest. In other words, according to this philosophy, individuals maximize benefits to the self while minimizing harm to others. The concept of enlightened self-interest is rooted in corporate social responsibility policy. When it is applied to rationalize corporate social investment, for example, enlightened self-interest illustrates that companies invest in social and environmental causes that will "secure long-term economic performance by avoiding short-term behavior that is socially detrimental or environmentally wasteful" (Porter and Kramer 2006, 82). Simply put, a company may invest in the local environment; although this investment may not maximize shareholder value in the short term, it serves the company's best interests by creating goodwill, providing a service to its workers and families as well as the community at large, and encouraging prospective employees to work for the company.

A social marketing ethical assessment may aid in the process of evaluating social marketing efforts (Kirby and Andreasen 2001). This kind of analysis indicates how targeted groups will be identified and addressed through ethical philosophies (or lenses) that justify the campaign actions. For example, the targeted groups in the We Can Do This campaign were those who had received the vaccine as well as those who had not. The ethical theories that are relevant to this case include consequentialism, deontology, Rawls's principles of justice, ethics of care, and enlightened self-interest (review chapter 2 for the definitions of these theories).

Consequentialism focuses on the consequences of an action and holds that the result determines the moral rightness or wrongness of that action. In this case, the positive messaging was communicated to both targeted groups, acknowledging that those who had received the vaccine had done their part to promote health while encouraging those who had not received the vaccine do so for the benefit of themselves and their family, friends, and larger community.

Deontology centers on the action independent of the consequences. The focus is on the action done because it was the right thing to do for the right reasons. The positive messaging communicated that the vaccinated had done the right thing and encouraged the unvaccinated to do so as well because it was simply the right thing to do.

Rawls's principle of justice emphasizes the importance of fairness. The positive messaging in this campaign educated all audiences, giving the same message to both the vaccinated and the unvaccinated. Moreover, the people communicating the message represented diverse backgrounds.

The ethics of care focuses on nurturing and relationships. Moreover, it highlights that care is an end in itself. The positive message in the We Can Do This campaign focused



on the benefit to self and others. The communications were inspirational, including video images accompanied by music that illustrated family and friends gathering in better times. This was possible, the videos communicated, because the vaccinated cared. The unvaccinated were encouraged to act with care as well and become vaccinated.

Enlightened self-interest is about maximizing benefit to yourself while minimizing harm to others. The positive messaging targeted the unvaccinated with the message that one person's choice to receive the vaccine could help stop the spread of COVID-19 while reinforcing the positive action already taken by the vaccinated to do their part.

The CDC's We Can Do This campaign focused on influencing and changing individual behavior; this is known as **downstream social marketing**. This approach allows social marketers to assess whether they are indeed creating and delivering a campaign that is ethical and, more importantly, to modify the campaign if ethical challenges are identified.

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**downstream social marketing**

A social marketing campaign that focuses on influencing or changing individual behavior.

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## UPSTREAM SOCIAL MARKETING

Downstream social marketing efforts are usually more effective when they are coupled with **upstream social marketing** efforts—that is, efforts focused on influencing or changing systems, policies, or structural components. An example is a campaign aimed at changing laws to protect the health and well-being of a population. Essentially, upstream social marketing is about influencing policymakers and changing their behavior (Goldberg 1995). Upstream social marketing influenced legislation regarding COVID-19 vaccinations, but with mixed results. In July 2021, the US Department of Justice (DOJ 2021) concluded that “federal law does not prohibit public or private entities from imposing vaccination requirements for vaccines that are subject to emergency use authorizations from the US Food and Drug Administration.”

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**upstream social marketing**

A social marketing campaign that focuses on influencing or changing systems, policies, and other structural components.

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Immediately following the DOJ's determination, the US Department of Veterans Affairs (VA 2021) mandated that all VA healthcare providers be vaccinated. That same month, California governor Gavin Newsom and New York State governor Andrew Cuomo issued vaccine mandates for state government employees. Cuomo remarked, “It's smart, it's fair, it's in everyone's interest” (Davis 2021). In August, Governor Ralph Northam in Virginia and Jay Inslee in Washington State mandated COVID-19 vaccinations for state employees, while in Hawaii, Governor David Ige mandated vaccinations for both state and county employees. Oregon governor Kate Brown mandated that all state healthcare workers must be vaccinated, and Maryland governor Larry Hogan issued a mandate for state employees in health, juvenile services, veterans affairs, and public safety and corrections (Davis 2021).

At the same time, however, governors in other states signed legislation limiting vaccine mandates, such as Arkansas governor Asa Hutchinson, who ordered that state agencies may not require vaccination as a condition of employment. Utah governor

Spencer Cox and Ohio governor Mike DeWine both signed orders stating that agencies (state agencies in Utah and state and private entities in Ohio) may not require vaccinations that have not been approved by the US Food and Drug Administration (Mitchell 2021).

Other public and private entities also established vaccination policies. For example, many public and private colleges and universities—838 as of August 2021—mandated that students, faculty, and staff be vaccinated to return to campus. Duke and Cornell Universities were the first to require students to be vaccinated (Best Colleges 2021). Harvard and Princeton mandated that all students, faculty, and staff be vaccinated, along with the university systems in California, Maryland, and Virginia (Thomason and O’Leary 2021). The University of Virginia disenrolled more than 200 students for the fall 2021 term for not reporting their vaccination status or filing for a medical or religious exemption (Best Colleges 2021).

Hospitals and assisted-living facilities also imposed vaccine mandates on their employees, including Vidant Medical Center in North Carolina, Benefits Health System in Montana, Houston Methodist Hospital in Texas, and Sunrise Senior Living, based in Virginia with facilities throughout the United States, Canada, and the United Kingdom (Basen 2021; Gooch 2021; Vidant Health 2021; Wu 2021).

Examining both upstream and downstream campaigns using ethical perspectives is important because the outcomes of such efforts affect people. Healthcare professionals engaged in social marketing efforts should be mindful of behaving ethically and understand the value of applying an ethical lens to social marketing endeavors, especially with regard to public health initiatives, health disparities, and justice.

## **PUBLIC HEALTH INITIATIVES**

In 1970, the Institute of Medicine was formed as part of the National Academy of Sciences. In 2015, the institute changed its name to the National Academy of Medicine (NAM), as it works with the National Academies of Sciences and Engineering to advise on matters of science, technology, and health (AJMC 2015). By 2021, NAM reported a membership of about 2,200 professionals in healthcare, sciences, law, administration, engineering, and the humanities whose primary goal is to provide information about health and healthcare in the United States. NAM’s vision is to achieve a “healthier future for everyone” by “advancing science, accelerating health equity and providing independent, authoritative, and trusted advice nationally and globally” (NAM 2021).

In its now-classic report *The Future of Public Health* (1988)—written in response to concerns among the organization’s broad membership that the United States had “lost sight of its public health goals”—the Institute of Medicine addressed the status of the public health system and defined public health, the public health mission, the substance

of public health, and the organizational framework of public health. These four definitions serve as the foundation of today's public health initiatives in the United States (IOM 1988, 19, 40–42):

- ◆ *Public health.* What we, as a society, do collectively to ensure the conditions for people to be healthy
- ◆ *Public health mission.* To fulfill society's interest in ensuring the conditions in which people can be healthy
- ◆ *Substance of public health.* Organized community efforts aimed at the prevention of disease and the promotion of health
- ◆ *Organizational framework of public health.* Activities undertaken within the formal structure of government and the associated efforts of private and voluntary organizations and individuals.

Fulfilling the mission of public health requires three actions:

1. Dissemination of information for the purpose of education
2. Allocation of resources to outreach programs through an organizational framework that includes participation by government agencies and private and voluntary organizations
3. Socially responsible behaviors by individuals and organizations

The success of public health initiatives depends on individuals and organizations acting ethically and responsibly. Again, let's apply these concepts to the COVID-19 vaccination campaign.

### SOURCES OF INFORMATION AND THEIR TRUSTWORTHINESS

The CDC and other government agencies produced and circulated information about COVID-19 and its harmful effects on individual and community health as well as resources to obtain the vaccine. The primary responsibility of the US surgeon general—the nation's doctor—is to provide the “best scientific information available on how to improve [people's] health and reduce the risk of illness and injury” (HHS 2021b). To that end, the Office of the Surgeon General generated and disseminated information about the vaccine and about public health threats such as COVID-19 (HHS 2021b; King 2021). Surgeon General Vivek Murthy spoke to the need to communicate with people, especially those in rural communities, about the need to get vaccinated against COVID-19.

For distributed information to yield the desired results and to serve as a guide, it has to be accurate, evidence based, and trustworthy. The majority of the public typically trusts the information generated by public health entities such as the CDC and the surgeon general. Simply put, we trust that certain people and groups are telling the truth because doing so is part of their job as stewards of public health. Additionally, they have nothing to gain—financial or otherwise—by giving false, outdated, or misleading information.

## OUTCOMES

COVID-19 in the United States is a public health issue. The disease has cost many lives and poses a major threat to the country's economy. Direct economic losses attributable to the virus have been estimated at about \$16 trillion (Cutler and Summers 2020). Thus, vaccination initiatives remain ongoing. However, the rollout of vaccinations beginning in January 2021 showed that Asians and white Americans were being vaccinated at higher rates relative to their shares of the population, whereas Hispanic and Black Americans were being vaccinated at slower rates compared with their shares of the population (see exhibit 14.2).

Responding to disparities in access to the vaccine, the CDC's We Can Do This campaign delivered messages in both English and Spanish, and the public health announcements

### EXHIBIT 14.2

Vaccination  
Demographics as a  
Percentage of Total  
US Population,  
September 2021

<b>Race/ethnicity</b>	<b>Received at least one dose (percentage among those with at least one dose)</b>	<b>Fully vaccinated (percentage among those fully vaccinated)</b>	<b>Percentage of US population in this demographic category</b>
American Indian/Alaska Native, Non-Hispanic	1.1%	1%	0.8%
Asian, Non-Hispanic	6.2%	6.5%	5.8%
Black, Non-Hispanic	10.3%	9.8%	12.4%
Hispanic	17.2%	16.3%	17.2%
Native Hawaiian or Pacific Islander, Non-Hispanic	0.3%	0.4%	0.3%
White, Non-Hispanic	60.6%	62%	61.2%
Multiple/Other, Non-Hispanic	4.5%	4.1%	2.3%

Source: CDC (2021b).

featured people of diverse backgrounds. In addition, Secretary Becerra and Secretary of Housing and Urban Development Marica L. Fudge initiated a joint effort to increase equitable access to vaccinations by “meeting people where they are” (HHS 2021c). As Secretary Fudge elaborated (HHS 2021c),

More than 100 million Americans are now fully vaccinated. Yet there are many others who still need help getting the vaccine. To raise our vaccination numbers even higher, we must continue to center our efforts around the guiding principle of equity.

Vaccination efforts to “meet people where they are” included setting up vaccination clinics in local community public health clinics, pharmacies, community centers, and churches, as well providing mobile vaccination units to reach those who lacked access to transportation (Adams 2021; CDC 2021c; Choi 2021). While the ethical principles of justice and beneficence justify such efforts, a key public health issue drove this effort. In May 2021, about 575,000 people had died from COVID-19: in 90 percent of these cases, COVID-19 was the underlying cause of death, while in less than 10 percent of cases, it was a contributing cause of death (CDC 2021e). While time will tell how effective the United States’ social marketing campaign was in influencing behavior, to do nothing would have set the stage for unimaginable tragedy.

COVID-19 statistics show the disparate effect of the virus on the US population. We now turn our attention to the concepts of health disparities and the social determinants of health and discuss why they matter ethically.

## HEALTH DISPARITIES

Research on **health disparities** began to appear in the 1990s (Milburn, Beatty, and Lopez 2019). In 2000, Congress passed the Minority Health and Health Disparities Research and Education Act to address health disparities, which, in turn, led to the creation of the National Institute on Minority Health and Health Disparities within the National Institutes of Health. In 2002, the Institute of Medicine published a landmark report titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley, Stith, and Nelson 2003). Since then, addressing health disparities has been a focus of health researchers, government agencies, healthcare organizations, and professional groups.

Health disparities are measurable differences in health outcomes that are specifically linked to disadvantage. This emphasis on disadvantage is important, as all differences in health outcomes do not constitute health disparities. The concept of health disparities rests on a concern for fairness and social justice and the belief that all individuals have a right to health. Disparities are created when the benefits of health are unfairly constrained for certain groups (Braveman 2014; Braveman et al. 2011). This is captured

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### **health disparities**

A particular type of health difference linked to social, economic, or environmental disadvantage that is unjust and avoidable.

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in the definition provided by the Healthy People 2020 initiative (Secretary's Advisory Committee 2008, 28):

a particular type of health difference that is closely linked with economic, social or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

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**health equity**

Pursuing the highest standards of health for all people, including the elimination of health disparities.

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In contrast, **health equity** is a broader term that refers to striving for the best possible health for all people (Braveman 2014; Gómez et al. 2021). Health disparities are thus a moral or ethical concern for both the health professions and society. While Blacks and other racial and ethnic minorities have been the historical and continuing focus of health disparities research, those affected by health disparities encompass a wide range of populations that have experienced systematic discrimination and exclusion that has adversely affected their health (e.g., services for LGBTQ people; see Aleshire et al. 2019).

Health disparities exist across many areas of health, including infant mortality, asthma, cancer, cardiovascular disease, diabetes, HIV disease, obesity, mental health, and substance abuse. These disparities are associated with greater morbidity and mortality risk among low-income and minority groups, especially people of color. These disparities are attributable to differences in the quality of healthcare received and access to care, as well as social determinants of health, including the historical and current impact of racial discrimination in society (Joynt Maddox and James 2021).

## SOCIAL DETERMINANTS OF HEALTH

Health and health outcomes are greatly influenced by “the environments in which people are born, live, learn, work, play, worship, and age” (Gómez et al. 2021, 1). The concept of **social determinants of health** was first embraced by the World Health Organization. In the United States, it has been articulated by a government-wide collaboration known as Healthy People (see <https://health.gov/healthypeople>). Now in its fifth decade, the Office of Disease Prevention and Health Promotion, an agency of the US Department of Health and Human Services, oversees this collaborative initiative, which establishes national health objectives, guidance, data, and tools every ten years for those working in public health, with the goal of achieving health equity for all.

The Healthy People 2020 initiative set trackable objectives in 42 topic areas, such as access to health services, environmental health, family planning, immunization and infectious diseases, and so on. The initiative's end-of-decade snapshot (Office of the Assistant

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**social determinants of health**

The environments and conditions in which people are born, grow, work, live, and age, including factors that affect their health, functioning, and quality of life.

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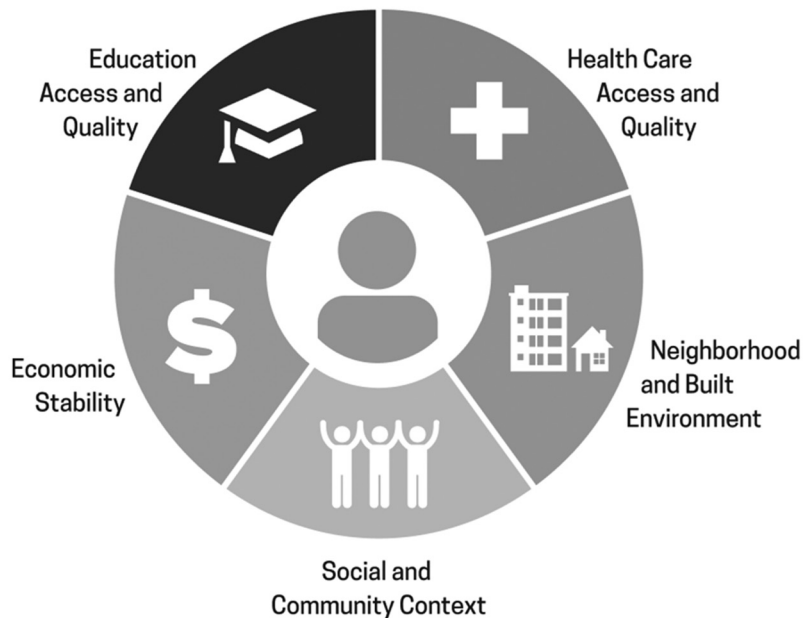
Secretary for Health 2020) showed that some leading health indicators (e.g., people with health insurance coverage, adults with controlled hypertension, adolescent smoking) significantly improved from 2010 to 2020, while others showed limited change (e.g., people diagnosed with diabetes, childhood obesity, dentist visits in the past year, reproductive health services). Overall, about one-third of the trackable objectives were met or exceeded goals, and about 20 percent showed improvement.

Within the Health People framework, the social determinants of health are organized into five place-based categories, as illustrated in exhibit 14.3. In addition to access to care and healthcare quality, people also need education, economic stability, safe neighborhoods, and communal support to lead healthy lives. Examples include preschool education, access to nutritious food, and health literacy.

Health People 2030, the initiative that began in 2021, focuses on these social determinants of health, with a goal to “create social, physical, and economic environments that

### EXHIBIT 14.3

Social  
Determinants of  
Health



**Social Determinants of Health**  
Copyright-free

 **Healthy People 2030**

Source: Healthy People 2030 (2021).

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promote attaining the full potential for health and well-being for all” (Healthy People 2030, 2021). These determinants are strongly related to the distribution of economic and other resources, and they are acknowledged to be the major contributors to health disparities (Gómez et al. 2021).

The COVID-19 epidemic highlighted the significance of health disparities. Minority groups, such as African Americans and Hispanics/Latinos, were affected disproportionately by the virus and had higher rates of hospitalization and death. Writing in the journal *Nursing*, Kathleen Pecoraro (2021) connects this increased risk directly to the social determinants of health and illustrates how these factors influence people’s lived experience. For example, the coronavirus was passed through air droplets, yet social distancing was more difficult for individuals living in high-density areas or crowded apartments. Individuals with less education were also more likely to be working in essential service jobs and unable to work from home. Moreover, minorities in the United States have a greater burden of chronic disease (e.g., diabetes, hypertension) or comorbidities that put them at greater risk once infected. They are also more likely to be disenfranchised from healthcare in terms of historical mistrust and obstacles to seeking vaccination. During the COVID-19 pandemic, health inequalities translated into increased health risk for society generally.

Understanding the mechanisms by which social factors and life stressors shape health across the life span will require more research (Ehrlich 2020; Milburn, Beatty, and Lopez 2019). Retrospective research has demonstrated that cumulative adverse childhood experiences are associated with disease, but interdisciplinary longitudinal research, including research on biological markers (e.g., inflammation) and psychosocial conditions, is needed to understand the processes involved and to develop effective interventions. The Healthy People 2030 initiative recognizes this need. Its core objectives focus on high-priority public health issues for which there are reliable measurements and evidence-based interventions. Developmental objectives include health issues for which reliable public health baseline data are lacking. Research objectives pertain to health issues that have high burden or significant disparities but for which evidence-based interventions have not yet been developed (see Dankwa-Mullan et al. 2021 for a summary of health disparities research). Healthy People 2030 recognizes that no single organization, community, or sector of society alone can address the social determinants of health that cause health disparities or achieve health equity for the population. Greater social cohesion and collaboration will be needed to address the social determinants of health and the root causes of health inequalities (Gómez et al. 2021).

## DISPARITIES IN HEALTHCARE

It is critical for healthcare managers to understand the healthcare disparities that may arise from health policies, organizational practices, and provider interactions. Generally, the topic of health disparities within the healthcare sector starts with a discussion about access. Although the Affordable Care Act (introduced in chapter 11) helped increase the number of Americans

### ? Racism Affects Public Health

Racism has long been recognized as a plight on American ideals. For too long, it has been a difficult conversation for Americans to acknowledge racism and discuss its legacy (Brown 2016). In 2021, CDC director Dr. Rochelle Walensky spoke about how racism threatens our nation's health and announced that the CDC would focus on developing interventions to address racism and its impact on social determinants of health (CDC 2021d; Wamsley 2021). Racism results in conditions that advantage some and disadvantage others throughout society. The impact of racism is deeply embedded in social conditions and determinants of health. As a result, racial and ethnic minority groups experience higher rates of illness and death across a range of health conditions.

One example of the impact of racism on health is disparities in the incidence of cancer. African Americans experience disproportionate rates of cancer and have the highest death rates and the lowest survival rates for most cancers, including breast, lung, and prostate cancers. These disparities reflect a lack of insurance and access to care for early screening and detection, as well as chronic life stress exposure and depression. These factors lead to both more cancer-promoting behaviors, such as smoking, and biologic mechanisms, such as increased expression of pro-inflammatory genes and accelerated tumor growth.

Another example is the known impact of structural racism on cardiovascular health. Black Americans experience 30 to 45 percent higher mortality from cardiovascular disease than other ethnic groups. State-level indicators of structural racism (e.g., voter registration, employment, judicial treatment) have been associated with higher myocardial infarction rates among Blacks. These higher rates also may reflect the effects of chronic stress and unhealthy coping methods (e.g., smoking) that affect health.

The CDC has launched a web portal to serve as a hub for both scientific information and public discourse on the topic of racism and health.

*Sources:* CDC (2021d); Coke and Hayman (2021); Minas et al. (2021).

with health insurance, in 2021, roughly 12 percent of people under age 65 still lacked insurance. Twelve states have not expanded access to Medicaid, leaving many working people without coverage. Minority groups are overrepresented among those (roughly 24 percent) without a regular healthcare provider (Office of the Assistant Secretary for Health 2020). Hospital closures in inner-city and particularly rural areas have had a negative impact on timely access to care; increased resources may be needed to support rural health clinics and Federally Qualified Health Centers that serve high proportions of individuals with limited means (Joynt Maddox and James 2021).

Examining the quality of care delivered by health organizations to disadvantaged groups and looking for quality improvements to address health disparities is another area requiring development (Wasserman et al. 2019). All too often, the care delivered to disadvantaged populations is suboptimal or does not meet the evidence-based recommendations for accepted practice standards. Understanding how care is delivered is critical to address health disparities; more quality improvement research (i.e., monitoring process and intervention outcomes over time) focused on known health disparities is urgently needed. We know that low-income patients with chronic and multiple health needs benefit from more case management. Similarly, we know the disadvantaged groups underutilize preventive health services, but we lack a full understanding of the reasons for this disparity (Wasserman et al. 2019).

The Agency for Healthcare Research and Quality (AHRQ) is the government organization that is charged with improving the safety and quality of America's healthcare system. The AHRQ develops knowledge through research and disseminates data and monitoring tools to healthcare organizations to assess and improve the quality of the services that patients receive. Here are a few examples of this work (AHRQ 2021):

Project ECHO provides training and support for primary care clinicians in rural communities to provide specialty care for patients with conditions such as HIV and Hepatitis C and has been expanded to include behavioral health.

EvidenceNOW is a grant program that provides practice support (i.e., knowledge, tools) to primary care physicians with the goal of increasing the capacity of practices to improve heart health.

The Comprehensive Unit-based Safety Program (CUSP) promoted effective methods for reducing healthcare-associated infections (HAIs), and combines improvements in safety, teamwork, and communication together with a checklist of proven practices for preventing HAI in high-risk areas like intensive care units.

The AHRQ promotes the use of QI surveys, such as the Consumer Assessment of Healthcare Providers and Systems, to provide valid assessments of patients' care experience in hospitals, nursing homes, and ambulatory care settings. The Centers for Medicare & Medicaid Services chose the hospital version of the AHRQ survey to be the measure used in its Hospital Quality Initiative.

Improving provider–patient interactions is also crucial for addressing disparate health practices. As American society has become increasingly diverse, it has become more important for healthcare providers and organizations to be recognize how patients' individual and cultural identities can affect the quality of care they receive and to provide culturally responsive care to all patients (Wasserman et al. 2019). Racial and ethnic minorities, individuals with limited English proficiency, and disadvantaged social groups may experience ineffective care if they are made to feel unwelcome or experience poor communication with their providers. Providers may appear more disengaged with disadvantaged minorities

and therefore ask fewer questions, provide less health information, or offer fewer treatment options. This may be the result of less familiarity with a patient's culture, stereotypes, or implicit racial and ethnic biases that have been learned (Hall et al. 2015). Such biases can also affect clinical decision-making. An example of an **implicit bias** is associating drug use with people of color, and therefore writing fewer prescriptions for legitimate pain for minorities than other patients (Pecoraro 2021).

Training in cultural competence is meant to address such concerns in healthcare. Based on a review of studies, cultural competence training may improve the knowledge and attitudes of health professionals and promote greater satisfaction with care, but there is less evidence of improved outcomes and impacts on health disparities (Wasserman et al. 2019). Physicians may need a broader understanding of how social and environmental determinants of health affect a patient's ability to adhere to a care plan (Houlihan and Leffler 2019).

At the organizational level, healthcare facilities should evaluate whether they are meeting Culturally and Linguistically Appropriate Services (CLAS) standards of care. The National CLAS standards are meant to advance healthcare equity by assuring that services are appropriately tailored to diverse patients (see <https://thinkculturalhealth.hhs.gov/clas/standards>). CLAS encompasses 15 standards that establish a blueprint for organizational action, including governance and leadership, patient communication and language assistance, community engagement, and continuous improvement. Healthcare organizations are asked to be respectful and responsive to patient health needs and preferences by considering each patient's culture and health beliefs, health literacy level, preferred language, and communication needs.

Finally, addressing disparities in the healthcare system will likely require the adoption of newer models of care (Houlihan and Leffler 2019; Wasserman et al. 2019). One such model is the *patient-centered medical home* (PCMH; see Jackson et al. 2013; Miller et al. 2017). According to the AHRQ, this framework promotes comprehensive care, patient-centered care, coordinated care, and accessible services and addresses quality and safety. Research suggests that the PCMH model has potential for improving patient and possibly staff satisfaction as well preventive services (Jackson et al. 2013). However, while PCMH enrollment has been associated with an increased likelihood of receiving recommended services (i.e., quality care), the data on racial disparities have been inconsistent to date (Swietek et al. 2020).

Most PCMH projects have been conducted in primary care settings serving populations with chronic illness and in consultation with payer organizations. The goal is not only to improve the quality of care provided to patients with complex needs but also to reduce the associated healthcare costs accrued in more fragmented health systems. Integral to this aim is the development of alternative payment systems (e.g., pay for performance, bundled payments, capitation) to incorporate behavioral health treatment (Miller et al. 2017).

The PCMH concept is closely related to the movement toward integrated healthcare. Healthcare leaders recognize that among the many health disparities, mental health equity

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**implicit bias**

Unconsciously associating stereotypes with certain groups of people and behaving accordingly.

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is central to meeting the health needs of vulnerable populations and achieving health equity (Satcher and Rachel 2017). Mental health conditions such as depression greatly impact and interact with physical health conditions, such that screening for depression is now a recommended practice for all health settings. Given the many barriers to patients obtaining needed mental health services, integrated care—in which behavioral health services are integrated into primary care—has become the model for addressing these unmet needs of patients.

The shift to value-based care is a transformation in the way providers and payers address the social determinants of health (Houlihan and Leffler 2019). Many healthcare organizations now screen for social determinants such as food insecurity and other needs, linking patients to social services. Many states are now requiring managed care organizations serving the Medicaid population to incorporate such screening programs. For example, North Carolina requires participating managed care organizations to use a statewide screening tool covering housing, food, transportation, and interpersonal violence to better identify patients' unmet health-related needs. Researchers have found that healthcare spending is reduced when patients are connected to social services, demonstrating the business case for addressing social determinants of health as an overall population health strategy. It is expected that future payment arrangements for health services will not only incentivize quality improvements but directly measure and reward equity (Joynt Maddox and James 2021; Wasserman et al. 2019).

There is increased recognition that many of the root causes of disparate health outcomes are related to factors outside the clinic, although healthcare organizations have a definite role to play in promoting community policies and practices that improve opportunities for achieving health equity (Woolf 2017). Some health systems are staffing hospitals with social workers and case managers; they are also entering into community partnerships to meet patient needs.

One successful program, Racial and Ethnic Approaches to Community Health (REACH), involved the use of trained community health workers to meet the needs of different communities. By designing and implementing culturally tailored and community-led interventions, the program addressed existing gaps between healthcare services and ethnic community members, improved health knowledge and practices in designated areas, and built individual and community capacity to plan and implement future interventions (Cosgrove et al. 2014). Achieving health equity will depend on such programs and greater cross-sectoral collaborations between healthcare and education, business, and community leaders. It will also require further research on how sociocultural, behavioral, and health system factors converge and produce disparities in the quality of healthcare (Wasserman et al. 2019).

The US healthcare system compares unfavorably with developed European countries on standardized international measures of health, despite relatively higher expenditures; moreover, this gap appears to be widening (Schroeder 2016). This may be explained by the far greater portion of the US population that lacks health insurance and the greater income and wealth inequality in America. Steven Schroeder (2016) makes the case that the direct



reason for the relatively poor health performance in the United States is the poor health status of Americans of lower socioeconomic class, predominantly living in the Southeast. He uses the example of cigarette smoking, which remains the most significant preventable health risk factor for associated deaths. While rates of smoking have declined significantly overall in the US population, smoking and other threats to health (e.g., obesity, diabetes, heart disease, HIV disease, violence, teenage pregnancies) are now concentrated among those living in poverty. Approximately 6 percent of the population (some 18.5 million people) are living in what is termed *deep poverty* (Abrams 2019), with incomes less than 50 percent of the federal poverty threshold. For a single person, that means living on \$6,243 per year, and for a family of four, less than \$12,170. People living in poverty experience higher rates of physical and mental health problems and face a stigma that results in cumulative disadvantage that persists over generations.

All of these factors underscore the inextricable relationships between cost, quality, and access when we view disparities through the ethical principles of social justice, beneficence, and nonmaleficence. We cannot improve the health of our nation without actions aimed at education and achieving greater income equality, with an explicit focus on the health of vulnerable populations. With the understanding that health disparities are complex, consider the following Mini-Case Study, which highlights the structural roots of racism and discrimination in lactation care.

### MINI-CASE STUDY: THE STRUCTURAL ROOTS OF RACISM AND DISCRIMINATION IN LACTATION CARE

The practice of breastfeeding infants offers health benefits to both the infant (e.g., reduces the risk of developing asthma, type 1 diabetes, and gastrointestinal infections) and the mother (e.g., lowers the risk of high blood pressure and type 2 diabetes). Dr. Ruth Petersen (CDC 2021a), director of the CDC's Division of Nutrition, Physical Activity and Obesity, noted that "breastfeeding provides unmatched health benefits for babies and mothers. It is the clinical gold standard for infant feeding and nutrition, with breast milk uniquely tailored to meet the needs of a growing baby. We must do more to create supportive and safe environments for mothers who choose to breastfeed."

However, Black infants are 15 percent less likely to be breastfed than white infants in the United States (CDC 2021a). The Healthy People 2030 initiative set targets to increase the share of breastfed babies through six months of age from 24.9 percent in 2015 to 42.2 percent. Strategies to meet this goal include increasing education efforts and providing breastfeeding support to mothers in the hospital (HHS 2021a). Healthcare providers may seek certification to serve as an International Board-Certified Lactation Consultant (IBCLC). This credential requires a health sciences background, at least 95 hours of lactation education, clinical experience, and

adherence to the International Board of Lactation Consultant Examiners' Code of Professional Conduct, which includes a personal integrity section (IBLCE 2015):

6.3. Treat all clients equitably without regard to ability/disability, gender identity, sexual orientation, sex, ethnicity, race, national origin, political persuasion, marital status, geographic location, religion, socioeconomic status, age, within the legal framework of the respective geo-political region or setting.

Thus, an IBCLC is a professional who provides lactation support for new mothers equitably and spends time to encourage, educate, and assist mothers with breastfeeding. Research fellow Erin V. Thomas (2018) interviewed 36 IBCLCs employed at hospitals. The interviews revealed differences in how mothers from different racial backgrounds were treated. Thomas categorized instances of overt racism, such as a caregiver making a stereotypical comment, as well as instances of implicit bias, such as providing less quantity or quality of care based on associated stereotypes. Examples of overt racism included statements such as, "We don't want these people having any more babies than they already do" (Thomas 2018, 1054). Implicit bias included actions such as designing educational literature and handouts that only showed white women breastfeeding, leaving women of color invisible in the educational literature. Tina, a 35-year-old Black IBCLC explained her reaction when she saw the whites-only literature (Thomas 2018, 1056):

In my opinion, for people to be successful at something, at anything, it is good for them to see images of people who like them that are successful . . . I thought [choosing only white images for a pamphlet] was a great oversight.

When she pointed out the invisibility of Black women, her supervisor noted that it was too late to change the material, as it had already gone to print. The key point about implicit bias is that assumptions are made about patients of color, and subsequent actions—even if committed unconsciously—yield unequal treatment. Another example of implicit bias was reported by a 30-year-old Black IBCLC (Thomas 2018, 1054):

I see Black moms come in there outside of means and no one really helps them with breastfeeding because the statistics say that they don't really breastfeed. So why waste the money if they are not going to do it?

### **MINI-CASE STUDY QUESTIONS**

1. Explain the concept of implicit bias as it is illustrated in Thomas's article.
2. Explain what ethical principles were violated by implicit bias.
3. Discuss the role of healthcare managers in addressing breastfeeding disparities.

## POINTS TO REMEMBER

- Health policy refers to strategies aimed at improving the health of the people and the communities in which they live, while healthcare policy refers to policies that directly affect healthcare costs, quality of care, and access to care for the people in those communities.
- Social marketing is the practice of influencing the behavior of both individuals and the community for the common good.
- Ethical theories serve as lenses through which to evaluate the ethics of social marketing efforts. One of them is enlightened self-interest, which maximizes benefits to self and minimizes harm to others.
- Downstream social marketing focuses on influencing or changing individual behavior.
- Upstream social marketing focuses on influencing or changing systems, policies, and other structural components.
- Health status is greatly influenced by social determinants of health, which are related to the environments in which people are born, live, learn, work, play, worship, and age.
- Health disparities are unjust differences in health attributable to disadvantage. Health disparities persist in many areas of health, with negatively effects particularly on racial and ethnic minority populations and the poor.

## CHALLENGE YOURSELF

1. Consider the chapter-opening quote by Dr. Paul Farmer: “The idea that some lives matter less is the root of all that is wrong with the world.” Think of an example in which you might witness or experience this in your work as a healthcare manager.
2. What factors influenced Congress to pass the 1986 Emergency Medical Treatment and Active Labor Act? Why do you think the legislation was not funded?
3. What factors influenced Congress to pass the Pandemic and All-Hazards Preparedness Acts of 2006, 2013 and 2019? Why do you think this legislation was funded?
4. How would you assess a healthcare organization’s response to health disparities? Would the results of such an assessment influence your desire or decision to work for the organization? Why or why not?

## FOR YOUR CONSIDERATION

- 14.1 Social determinants of health affect patients’ physical and mental health outcomes. Consider one of the examples of social determinants of health examined in this chapter and assess how that determinant might be addressed in your community. For

example, map out distances to locations that offer nutritious food. If transportation is an issue, the distance to a grocery store or farmers market may negatively affect a person's ability to eat well. Consequently, the lack of access to good nutrition may cause increased risk of heart disease, diabetes, and obesity. What could your community do to mitigate the negative effects of this social determinant of health so that people have better access to nutritious food? What ethical perspectives would influence your ideas?

- 14.2 The surgeon general leads the US Public Health Service Commissioned Corps, which is composed of public health professionals. Its mission is to “protect, promote and advance the health of our nation.” Using the ethical lens presented, assess one of its priorities. This exercise requires you to become familiar with the Office of the Surgeon General's website ([www.hhs.gov/surgeongeneral/index.html](http://www.hhs.gov/surgeongeneral/index.html)). For example, as of May 2021, the site included information on topics such as opioids and addiction, tobacco, and oral health. Gain an understanding of one of these priorities and the surgeon general's strategy to address it. Then conduct an ethical assessment, employing the method used to assess the CDC's COVID-19 vaccination strategy. Remember to identify the target markets as you work. Does the strategy fit the mission of the US Public Health Service? Explain.

## CHECK THESE OUT

Want more information about the organizations discussed in the chapter? Check these websites out.

- Emergency Medical Treatment and Labor Act: [www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA](http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA)
- Pandemic and All-Hazards Preparedness Acts of 2006, 2013, and 2019: [www.phe.gov/preparedness/legal/pahpa/pages/default.aspx](http://www.phe.gov/preparedness/legal/pahpa/pages/default.aspx)
- US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response: [www.phe.gov/about/aspr/Pages/default.aspx](http://www.phe.gov/about/aspr/Pages/default.aspx)
- COVID-19 Public Education Campaign: [www.hhs.gov/coronavirus/education-campaign/index.html](http://www.hhs.gov/coronavirus/education-campaign/index.html)
- Agency for Healthcare Research and Quality: [www.ahrq.gov/cpi/about/profile/index.html](http://www.ahrq.gov/cpi/about/profile/index.html)
- National Institute on Minority Health and Health Disparities: [www.nimhd.nih.gov/about/overview/](http://www.nimhd.nih.gov/about/overview/)
- Healthy People 2030: <https://health.gov/healthypeople>
- CDC Racism and Health: [www.cdc.gov/healthequity/racism-disparities/index.html](http://www.cdc.gov/healthequity/racism-disparities/index.html)
- National Collaborative for Health Equity: [www.nationalcollaborative.org/](http://www.nationalcollaborative.org/)
- National CLAS Standards: <https://thinkculturalhealth.hhs.gov/clas/standards>

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