

## Chapter 2

# Foundation of U.S. Health Care Delivery



## INTRODUCTION

From an economic perspective, curative medicine seems to produce decreasing returns in health improvement while health care expenditures increase (Saward & Sorensen, 1980). There is increased recognition of the benefits to society from the promotion of health and the prevention of disease, disability, and premature death. Although the financing of health care has focused primarily on curative medicine, some progress has been made toward an emphasis on health promotion and disease prevention; however, progress in this direction has been slow because of the social and institutional values and beliefs that emphasize disease rather than health. The common definitions of health, as well as measures for evaluating health status, reflect similar inclinations. This chapter proposes a holistic approach to health, although this may be an ideal that a health care delivery system may never fully achieve.

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. This chapter further explores the issue of equity in the distribution of health services using the contrasting theories of market justice and social justice. The conflict between social and market justice is reflected throughout U.S. health care delivery. Justice and equity in making health care available to all Americans remains a lingering concern.

Planning of health services must be governed by demographic and health trends and initiatives toward reducing disease and disability. The concepts of health and its determinants should be used to design appropriate educational, preventive, and therapeutic initiatives.

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## 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. It therefore emphasizes 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 optimum health exists when a person is free of symptoms and does not require medical treatment; however, it is not a definition of health in the true sense but 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; therefore, when the term “health care delivery” is used, it actually refers to the delivery of medical care or illness care.

Medical sociologists have gone a step further in defining health as the state of optimum capacity of an individual to perform his or her expected social roles and tasks, such as work, school, and household chores (Parsons, 1972). A person who is unable (as opposed to unwilling) to perform his or her social roles in society is considered sick; however, this concept also tends to view health negatively because many people continue to engage in their social obligations despite suffering from pain, cough, colds, and other types of temporary disabilities, including mental distress. In other words, a person’s engagement in social roles does not necessarily signify that the individual is in 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), according to which health is “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 has been most often cited as the ideal that health care delivery systems should try to achieve. The WHO defines health as “a complete state of physical, mental, and social well-being, and not merely the absence of disease or infirmity” (WHO, 1948). Because this definition includes physical, mental, and social dimensions, the WHO model can be referred to as the biopsychosocial model of health. The WHO has also recently defined a health care system as all of the activities whose primary purpose is to promote, restore, or maintain health (McKee, 2001). As this chapter points out, health care should include much more than medical care.

In recent years, there has been a growing interest in holistic health, which emphasizes the well-being of every aspect of what makes a person whole and complete. Thus, *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 point to an inverse association between religious involvement and all-cause mortality (McCullough et al., 2000). Religious and spiritual beliefs and practices have been shown to have a positive impact on a person’s physical, mental, and social well-being. They may affect the incidences,

### Exhibit 2.1 Indicators of Health

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

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 (discussed in Chapter 7) 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 determination that disease is present is based on a medical professional's evaluation rather than the patient's. 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, one may feel ill and 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. Treatment is generally provided in a hospital. Examples of acute conditions are a sudden interruption of kidney function or a myocardial infarction (heart attack). A *subacute* condition is between acute and chronic but has some acute features. Subacute conditions can be postacute, 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. The disease may be kept under control through appropriate medical treatment, but if left untreated, the condition may lead to severe and life-threatening health problems. Examples are 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 the experiences while receiving health care. 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 also can enhance a sense of fulfillment and self-worth.

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## 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. Instead, a more balanced approach must emphasize health determinants at an individual level, as well as broad policy interventions at the aggregate level (**Figure 2.1**).

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

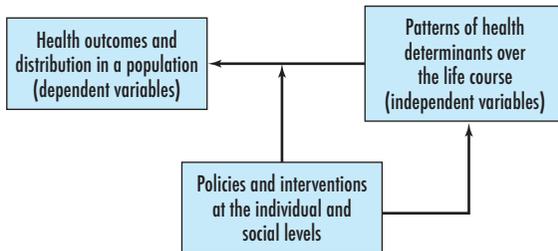
Environmental factors encompass the physical, socioeconomic, sociopolitical, and sociocultural dimensions. The physical environmental factors such as air pollution, food and water contaminants, radiation, and toxic chemicals

**Exhibit 2.2** Examples of Health Determinants

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

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 live in better homes and locations 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 the poor in a given geographic area, the worse the overall health status of the population of that area will be. It has been suggested that wide income gaps 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 do their better educated counterparts. Better educated people are more likely to avoid risky behaviors such as smoking and drug abuse.



**Figure 2.1** Schematic Definition of Population Health. Adapted from Kindig, D., and G. Stoddart. 2003. What is population health? *American Journal of Public Health* 93 (3):380–3.

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 prime time for brain development—activate the brain neural pathways that might otherwise atrophy and may even permanently increase the number of brain cells. Hence, the importance of the quality of child care provided in the first three years of life is monumental (Shellenbarger, 1997). Early childhood development influences a person's health in later years.

## **Behavior and Lifestyle**

Individual lifestyles and behaviors are also a key determinant of health. For example, diet, exercise, stress-free lifestyle, promiscuous sex, and other individual choices such as smoking 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 a healthy lifestyle and health-promoting behaviors can have a significant influence on the development and severity of inherited disease in those predisposed to it, as well as on future generations.

## **Medical Care**

Even though the other three factors are more important in the determination of health, well-being, and susceptibility to premature death, access to medical care is nevertheless a key determinant of health. Both individual health and population health are closely related to access to adequate preventive and curative health care services.

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# **CULTURAL BELIEFS AND VALUES**

A value system orients the 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 has several different subcultures that have grown in size because of a steady influx of immigrants from different parts of the world. There are 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). Cultural beliefs and values are strong forces against attempts to initiate fundamental changes in the financing and delivery of health care; therefore, enactment of major health system reforms would require consensus among Americans on basic values and ethics (Koop et al., 1993).

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## STRATEGIES TO IMPROVE HEALTH

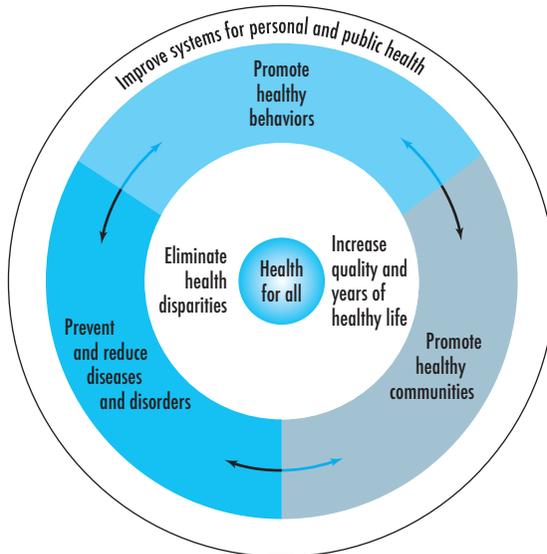
### Healthy People Initiatives

Since 1980, the United States has undertaken 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 current initiative, *Healthy People 2010: Healthy People in Healthy Communities*, was launched in January 2000. The context in which national objectives for *Healthy People 2010* have been framed take into account the realities of the 21st century: Advanced preventive therapies, vaccines and pharmaceuticals, and improved surveillance and data systems are now available. Demographic changes in the United States reflect an older and more racially diverse population. Global forces such as food supplies, emerging infectious diseases, and environmental interdependence present new public health challenges. The objectives also define new relationships between public health departments and health care delivery organizations (U.S. DHHS, 1998). *Healthy People 2010* specifically emphasizes 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. Also, the objectives specifically

focus on the determinants of health, as discussed earlier. The graphic framework for *Healthy People 2010* is presented in **Figure 2.2**.

*Healthy People 2010* was designed to achieve two overarching goals (U.S. DHHS, 2000).

- *Increase quality and years of healthy life.* This first goal aims to help individuals of all ages increase life expectancy and improve their quality of life. Differences in life expectancy among populations especially suggest a substantial need and opportunity for improvement. At least 18 countries with populations of 1 million or more have life expectancies greater than those in the United States for both men and women. Similar to life expectancy, various population groups show dramatic differences in quality of life. A disproportionate number of women—those in low-income households and those living in rural areas—report their health status as fair or poor.



**Figure 2.2** Healthy People 2010: Healthy People in Healthy Communities. From US DHHS. 2002. *Healthy People 2010*. Washington, DC: DHHS.

- *Eliminate health disparities.* The second goal of *Healthy People 2010* is to eliminate health disparities among different segments of the population. These include differences that occur because of gender, race or ethnicity, education or income, disability, living in rural localities, or sexual orientation. The greatest opportunities for reducing health disparities are in empowering individuals to make informed health care decisions and promoting community-wide safety, education, and access to health care.

To realize these two broad goals, measurable targets to be achieved by the year 2010 have been identified in 28 focus areas that span a variety of health status domains such as morbidity incidence and/or prevalence, injury, violence, and access to care.

## Distribution of Health Care

The production, distribution, and subsequent consumption of health care must be perceived as equitable. 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 generally ingrained in a society's values and belief systems. It is generally recognized that not everyone can receive everything 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 includes not only who should receive medical care but also what type of services and in what quantity.

A just and fair allocation of health care poses conceptual and practical difficulties; hence, a theory of justice is needed to resolve the problem of health care allocation (Jonsen, 1986). The principle of justice is derived from ethical theories, especially those advanced by John Rawls, who defined justice as fairness (Darr, 1991). 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 services is addressed by the 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. 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 are to purchase these valued goods and services by means of wealth 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, it can be governed by 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. People demand health care because it can rectify a health problem and restore health, can reduce pain and discomfort and make people feel better, and can reduce anxiety about health and well-being; therefore, people are willing to purchase health care services.
- 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 the physician–patient relationship is ongoing.
- 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 the consumers are willing and able to purchase at the prevailing market prices. It follows that in a pure 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 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**.

**Table 2.1** Comparison of Market Justice and Social Justice

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

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 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 can best be achieved by letting a central agency, generally the government, take 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. Canadians and Europeans, for example, 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. A just distribution of benefits must be based on need, not simply on one's ability to purchase in the marketplace (demand). The need for health care is determined by either the patient or a health professional. The principle of social justice is also based on certain assumptions.

- Health care is different from most other goods and services. Health-seeking behavior is governed primarily by need rather than by how much it costs.
- Responsibility for health is shared. Individuals are not held totally responsible for their condition because factors outside of 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 superior to that of the individual. An unhealthy individual is a burden on society. A person carrying a deadly infection, for example, is a threat to society. Society, therefore, is obligated to cure the problem by providing health care to the individual because by doing so the whole society benefits.
- 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 social justice, how much health care to produce is determined by the government; however, no country can afford to provide unlimited amounts of health care to all of its citizens (Feldstein, 1994, p. 44). The government then also finds 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.

## Health Insurance

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, falls under the heading of market justice. Publicly financed Medicaid and Medicare coverage for certain disadvantaged groups and the workers’ compensation program for those injured at work fall under the heading of 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. Americans have not been able to resolve the question of who should provide health insurance to the uninsured.

## Organization of Health Care Delivery

In the United States, private and government health insurance programs enable the covered populations to have access to health care services delivered by private practitioners and private institutions (market justice). Tax-supported county and city hospitals, public health clinics, and community health centers can be accessed by the uninsured in areas where such services are available (social justice). Publicly run institutions generally operate in large inner cities and certain rural areas. Conflict between the two principles of justice arises in small cities and towns and in rural areas where such services are not available.

## Public Health Systems

“Public health” is a reflection of society’s desire and effort to improve the health and well-being of the total population, by relying 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,” then, reflects the organized effort to deliver public health services within a jurisdiction with the goal of improving health and well-being of the population.

Significant evidence indicates that public health contributes positively to population health. Indicators at the national, state, and local level should be developed to measure public health performance that improves population health and reduces health disparities along with a national surveillance system to track the indicators consistently in order to gain a better understanding of the system. In addition, the innovative effort of the states to improve their public health systems’ infrastructure, practices, and performance should be encouraged and evaluated as most significant reforms take place at this level, more so 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 with 21 states currently participating. Multisector partnerships to produce public health improvement plans employing strategies that include institutionalization

within government, establishing “third-sector” institutions, cultivating relationships with significant allies, and enhancing communication and visibility among multiple communities (Shi, 2008).

## Focusing on Determinants

To improve the nation’s health and resolve disparities among its vulnerable populations, a framework embodying the social and medical determinants is warranted. This framework, presented in [Figure 2.3](#), is built on the ballasts of both social and medical care determinants because it is the combination of these factors that ultimately shapes health and well-being. It synthesizes these multiple health influences and highlights points for intervention. Health, in this model, however, is not merely being free of disease and injury but 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 confounding 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 behavior is rarely isolated from the social and environmental contexts in which choices are made.

Social and income inequalities have also recently 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. 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), for example, is an inequality prevalent in the United States that has direct consequences for individual health. Because many of the social factors of health care are the root causes of poor health, addressing them is vital to the improvement of population health and health disparities in the country.

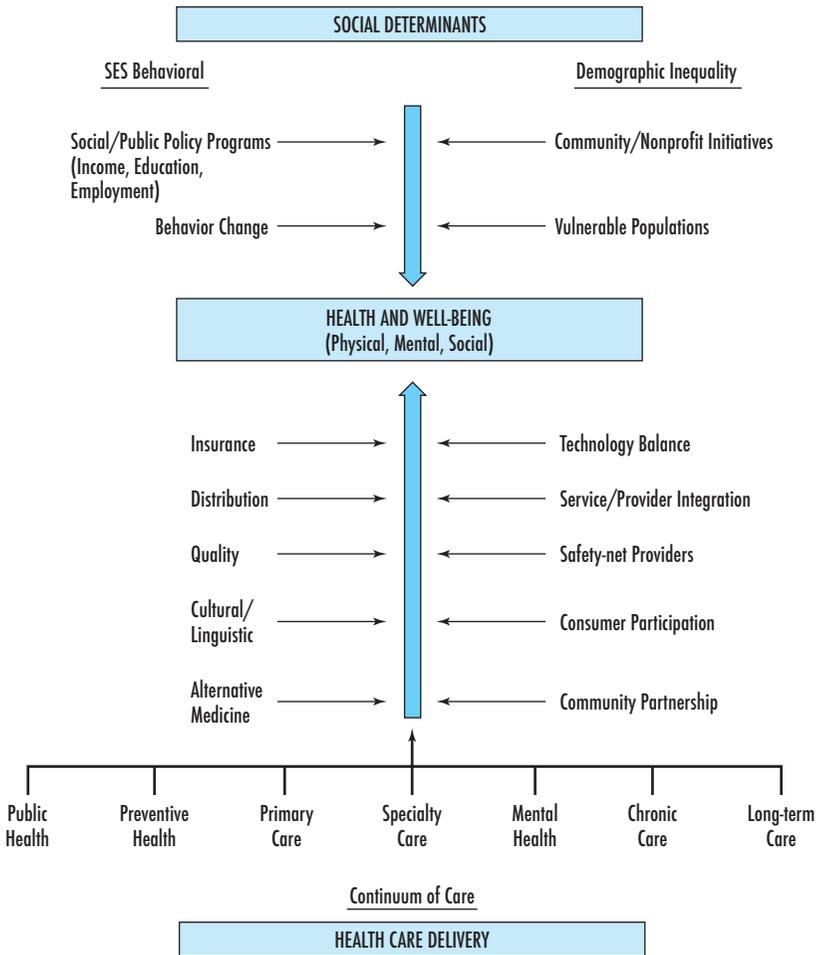


Figure 2.3 Health Determinants and Strategies to Improve Health

### Medical Care Determinants of Health

Although social determinants influence the health status that patients bring to the health care system, the medical care system focuses primarily on treating illness or poor health. Preventive care is an exception to this rule, but understanding the influences of medical care on health should

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). Patients moving across the spectrum will 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 or 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 the 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 merely 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.

**Community-Based Interventions** Disparities in health exist nationally, but they also vary substantially at the community level. This suggests that 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. Armed with a greater understanding of these community-based challenges to health, those designing strategies to address disparities by race/ethnicity have adopted a renewed interest in tailoring interventions to address the multidimensional risks and needs in a particular community (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.

Community-based strategies have the particular benefit of mobilizing resources at the local level to address these problems. There are several other advantages to addressing disparities with community approaches. Community resources can be applied directly to community members, providing businesses and other local sources 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. Through community mobilization, skill-building, and resource sharing, communities can be empowered to identify and meet their own needs, making them stronger advocates in supporting the vulnerable populations within and across their community. Community solutions also benefit

**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

from participatory decision making. Local researchers, health practitioners, social services, businesses, and community members are invited to contribute to the process of designing, implementing, evaluating, and sustaining the program. 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 shareholders to price competitively.

**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. Interventions have been designed for health systems (e.g., integrated electronic medical records systems to better coordinate care for populations with multiple chronic and acute conditions), providers (e.g., continuing education for pediatricians to better target developmental services to children most in need), and patients (e.g., educating pregnant mothers to attend regular prenatal care visits).

**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 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.

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## CONCLUSION

The system of health care delivery in the United States is predominantly private. Many of the peculiarities of this system can be traced back to the beliefs and values underlying the American culture. 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, need to be adopted to significantly improve the health of Americans. Such an approach would require a fundamental change in how Americans view health. It would also require individual responsibility for one's own health-oriented behaviors, as well as 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 2010* are essential for accomplishing such goals. The emphasis on market justice in the U.S. health care delivery system, however, leaves the critical problem of access unaddressed. 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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