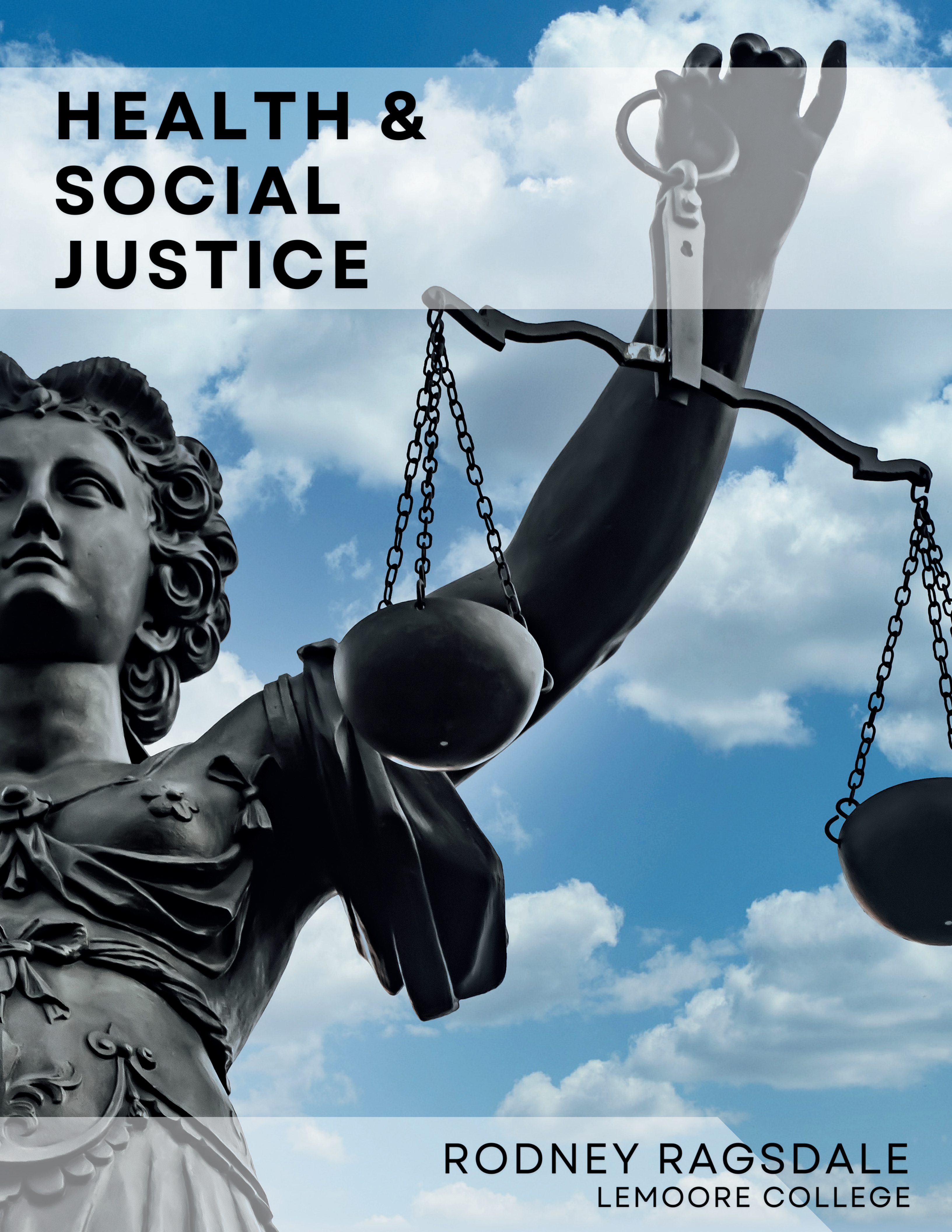

HEALTH & SOCIAL JUSTICE

RODNEY RAGSDALE
LEMOORE COLLEGE

HEALTH AND SOCIAL JUSTICE

RODNEY RAGSDALE

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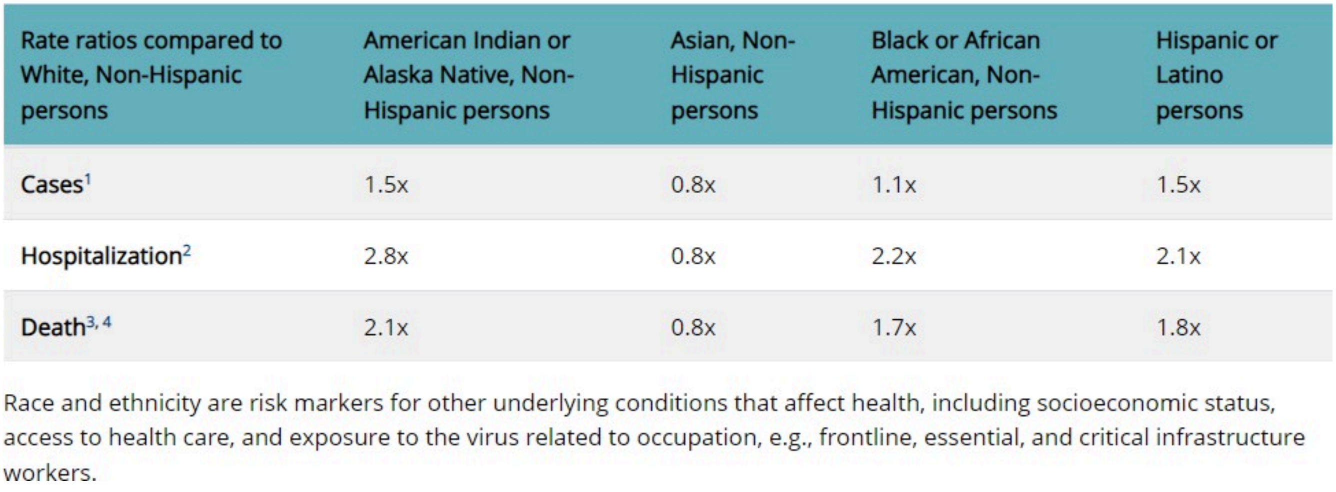
TOPIC: HEALTH AS A SOCIAL PROBLEM

By now, we probably can all tell a story about how COVID-19, an infectious disease caused by the SARS-CoV-2 virus (Coronavirus N.d.), has impacted our lives. Some of us have had family members or friends pass away. Some of us are still experiencing lingering symptoms from a COVID-19 infection, called long-haul or long COVID-19. Some of our kids felt achy or tired for a day and then got better. Some of us may not know anyone who was personally affected by COVID-19. Pause for a moment to think about your own COVID-19 health story and consider how this disease has affected society in the United States and worldwide.

However, we have learned that some social groups are more likely to be infected, hospitalized, and even die as a result of contracting COVID-19. The table in Figure 1 shows rates of cases, hospitalizations, and deaths due to COVID-19 by race and ethnicity as of July 2020. As you can see, non-Hispanic Black people died from COVID-19 at a rate twice that of White people during this time. Please take a moment to look race the other ethnicity related to race and ethnicity in this table.



Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases[1]	1.5x	0.8x	1.1x	1.5x
Hospitalization[2]	2.8x	0.8x	2.2x	2.1x
Death[3, 4]	2.1x	0.8x	1.7x	1.8x

Race and ethnicity are risk markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation, e.g., frontline, essential, and critical infrastructure workers.

Figure 1: Rates for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity, as of July 28, 2020. Race and ethnicity are risk markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure

Perhaps you noticed that the data show a gap between White non-Hispanic Americans and American Indian/Alaskan Native, Asian, Black people, and Latinx people. As you can see in the table, cases, hospitalizations, and deaths for all racial and ethnic groups except for Asians are substantially higher than for Whites. This experience of inequality demonstrates that health and illness can be social problems.

This chapter will explore the social elements of health, a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization 1946). We will look more deeply at why health is a social problem. We will explore collective and individual models of the social determinants of health. Asocial determinants of health of the social determinants of health, we will include the experience of individual and generational trauma as a factor in health outcomes. We will examine how sociologists make sense of health and illness by considering how these understandings develop over time. Like many other social problems, government policies and practices influence access to health resources and health outcomes. We will look at the differences in health systems internationally and decide if these systemic differences support health for everyone. Finally, we will come back to our own COVID-19 stories. The pandemic has both exposed and worsened existing inequalities. The pandemic is also inspiring creative action from individuals, communities, and governments. These generous responses demonstrate our interdependence and the need for the social justice of health.

Even with our brief explanation of COVID-19 statistics in the introduction of this chapter, we see that people experience unequal health outcomes based on their race and ethnicity. This is the health dimension of inequality in health outcomes. What else makes health and illness a social problem? Social problems characteristics of a social problem to health and illness.

Health and illness in society go beyond individual experience. We usually think of health, illness, and medicine in individual terms. When a person becomes ill, we view the illness as a medical problem with biological causes. A physician treats the individual accordingly. A sociological approach takes a different view. Unlike physicians, sociologists and other public health scholars do not try to understand why any one person becomes ill. Instead, we typically examine illness rates to explain why people from certain social backgrounds are likelier than others in society sick. Our social location in society—our social class, race and ethnicity, gender, and other dimensions of diversity—makes a critical difference.

Medical sociology is the systematic study of how societies manage issues of health and illness, such as diseases and disorders, healthcare access, and the larger picture of physical, mental, and social components of health and illness. Major topics for medical sociologists include the doctor/patient relationship, the structure and socioeconomics of healthcare, and how culture impacts attitudes toward disease and wellness. In the next section, we'll look at what medical sociologists find when they look at how experiences of health and illness can differ by social location.

How we get sick and how we stay healthy reveals both inequality and interdependence. For example, in Flint, Michigan, residents experienced higher-than-normal levels of lead toxicity, hair loss, rash, and other health issues when the local municipal government changed the water supply in 2013. Although government officials knew that the Flint River was contaminated with pollution from manufacturing, they decided to use this water for city residents because it was cheaper. Decisions at several interdependent layers of government resulted in this harmful action. Local citizens connected with doctors, health officials, and journalists to tell the story of the contaminated water and support a change.

More than 60% of the residents of Flint are Black. Over 40% of Flint's residents live below the poverty line. This combination of race and class influenced the original decision-making and community response. Eventually, the Michigan Civil Rights Commission cited systemic racism as the fundamental cause for the questionable decisions. Recovery required both individual agency and collective action.

The conflict between values may cause social problems to arise. We see this as people respond to government policies around COVID-19. Promote vaccinations, asserting that scientific knowledge and research should be used to ensure our health. You may know people who support vaccines and social distancing as a way to manage the pandemic. You may know other people who think vaccines are dangerous and that state-mandated quarantining is "un-American." This conflict in values creates the conditions in which a social problem is likely to arise.

Our ideas about what is healthy, what is illness, and what actions we should take to be healthy and treat illness are socially constructed. A sociological approach emphasizes that a society's culture shapes its understanding of health and illness and practices of medicine. In particular, culture shapes a society's perceptions of what it means to be healthy or ill, the reasons to which it attributes illness, and the ways in which it tries to keep its members healthy and cure those who are sick (Hahn & Inborn 2009). Knowing about a society's culture helps us to understand how it perceives health and healing. By the same token, knowing about a society's health and medicine helps us to understand important aspects of its culture. We'll look more deeply into cultural constructions of health and illness in the upcoming section, Sociological Theories of Health.

As you think about your experience with COVID-19, have you changed how you think about your own health? Many people who became severely ill or died from COVID-19 had other health issues, such as hypertension and obesity. Do you know people whose attitudes about their general health have changed? Do you know people who are suspicious of the government's intentions or less likely to listen to doctors or scientists? What do you think will be the best way to prevent illness and death should another pandemic strike? Each of these questions highlights a topic related to the social construction of the social problem of health and illness.

Epidemiology in the US: Health Disparities by Social Location

Doctors and medical professionals focus most on the health of a health dual. Sociologists and public health professionals focus on the health of health. This specialty is called epidemiology, the study of disease and health and their causes and distribution health Epidemiology can focus on the differences between neighborhoods, states, or countries. As we look at health in the

Unhealth States, we see a complex and often contradictory issue. On the one hand, as one of the wealthiest nations, the United States fares well in health comparisons with the rest of the world. However, the United States lags behind almost every industrialized country in providing care to all its citizens. This gap between the shared value of health and unequal outcomes makes health and illness a social problem.

Sociologists and others who study human health have a detailed model that helps them make sense of health in groups. This model is called the social determinants of health. More specifically, the social determinants of health are the circumstances in which people are born, grow up, live, work, and age and the systems put in place to deal with illness (World Health Organization 2013). While ethnicity may seem to correlate with these elements, it is misleading to assume that all members of a specific racial group will experience the same health outcomes (Whitemarsh and Jones 2010). Instead, while certain diseases are linked to racial identity, lifestyle factors such as smoking and diet also play a role. These, of course, are also influenced by racial identity! These circumstances are shaped by a wider set of forces: economics, social policies, and politics.

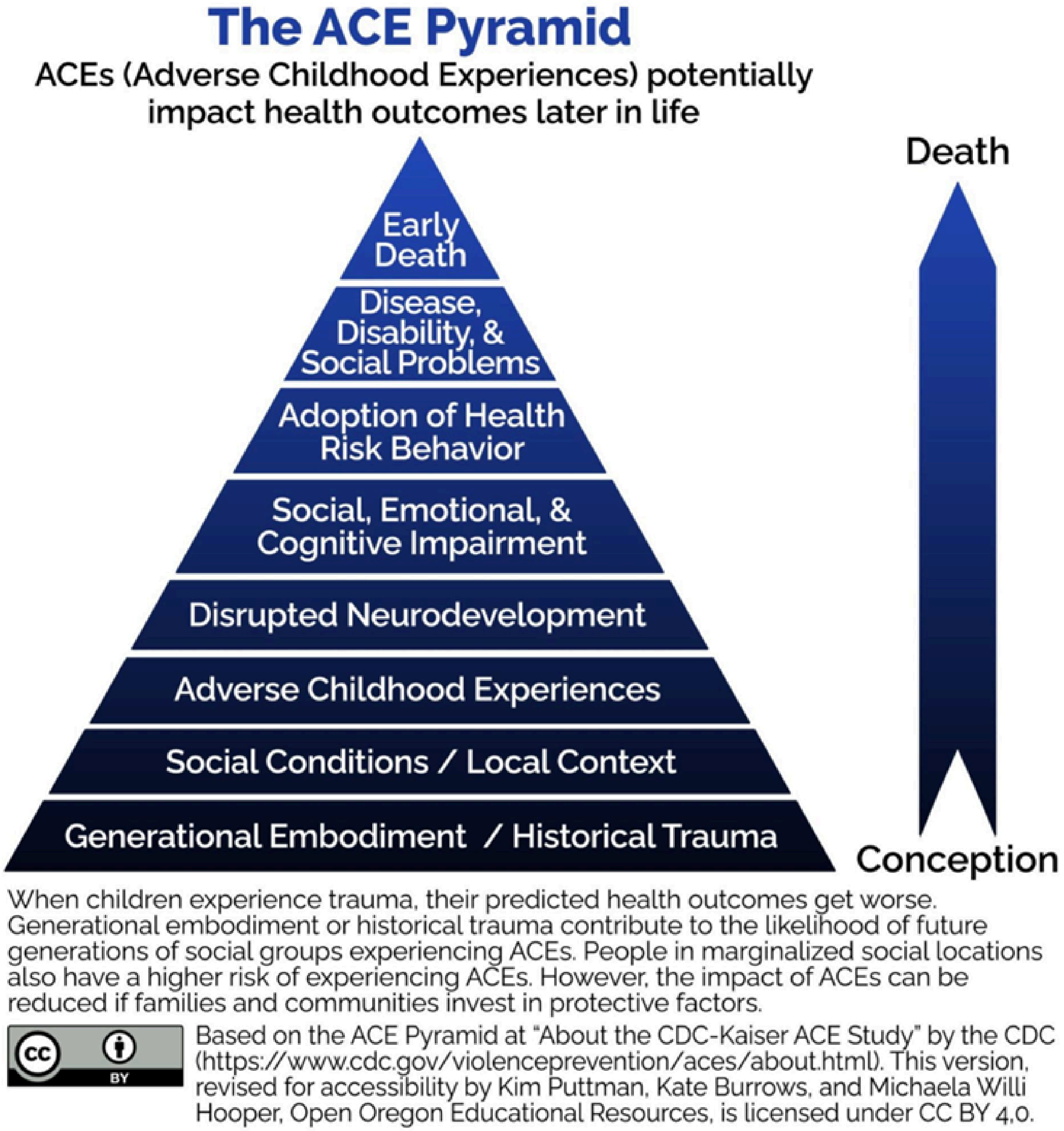
Unpacking Oppression, Healing Justice: Social Determinants of Health and ACES

Sociologists and health researchers use two different models to predict health outcomes. Social determinants of health measure the social factors that may impact a community's health outcomes. Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood (0-17 years). The ACEs model measures the amount of trauma a child experiences and describes the impact of trauma on health outcomes. Trauma is a person's (or group's) response to a deeply distressing or disturbing event that overwhelms one's ability to cope. Trauma causes feelings of helplessness, diminishes self-esteem and limits a person's ability to feel a full range of emotions and experiences (Onderko 2018). Let's examine both of these models.

Figure 2: This is a model of the Social Determinants of Health (SDOH), provided by the CDC. How do these factors impact your own health or the health of your family? How might these factors impact the health of families who are different from you? Image Descript

Epidemiology in the US: Health Disparities by Social Location

We see that access to quality health care influences how healthy you might be. Whether your neighborhood is located next to an oil refinery, changes your health outcomes. You might be surprised that education access and quality also impact your health. However, you might remember that education and wealth are correlated. Wealthy people can pay more money for healthcare. Additionally, they get better educations, which sometimes leads to better health choices. The way organizations and institutions create models for the social determinants of health can change what we see. If you'd like to explore this question more deeply, here is a model from the World Health Organization and an SDOH model from the Canadian First Nations Peoples. Why might these models be different from each other? In a slightly different social model of health, researchers look at how trauma over time affects health outcomes.



When children experience trauma, their predicted health outcomes get worse. Generational embodiment or historical trauma contribute to the likelihood of future generations of social groups experiencing ACEs. People in marginalized social locations also have a higher risk of experiencing ACEs. However, the impact of ACEs can be reduced if families and communities invest in protective factors.

Based on the ACE Pyramid at "About the CDC-Kaiser ACE Study" by the CDC (https://www.cdc.gov/violenceprevention/aces/about.html). This version, revised for accessibility by Kim Puttman, Kate Burrows, and Michaela Willi Hooper, Open Oregon Educational Resources, is licensed under CC BY 4.0.

Figure 3: The ACE pyramid: Many of us experience some adverse childhood events. When communities and families invest in protective factors, the impact of ACEs on our future health outcomes decreases. Adverse Childhood Experiences (ACEs) potentially impact health

Figure 3 shows the ACE Pyramid distributed by the Centers for Disease Control and Prevention. Adverse Childhood Experiences (ACEs) potentially impact health outcomes later in life. An arrow on the side shows the progression from conception (at the bottom) to death (at the top). The levels, from conception to death, are:

- Generational Embodiment/Historical Trauma
- Social Conditions/Local Context
- Adverse Childhood Experiences
- Disrupted Neurodevelopment
- Social, Emotional, & Cognitive Impairment
- Adoption of Health Risk Behavior
- Disease, Disability, & Social Problems
- Early Death

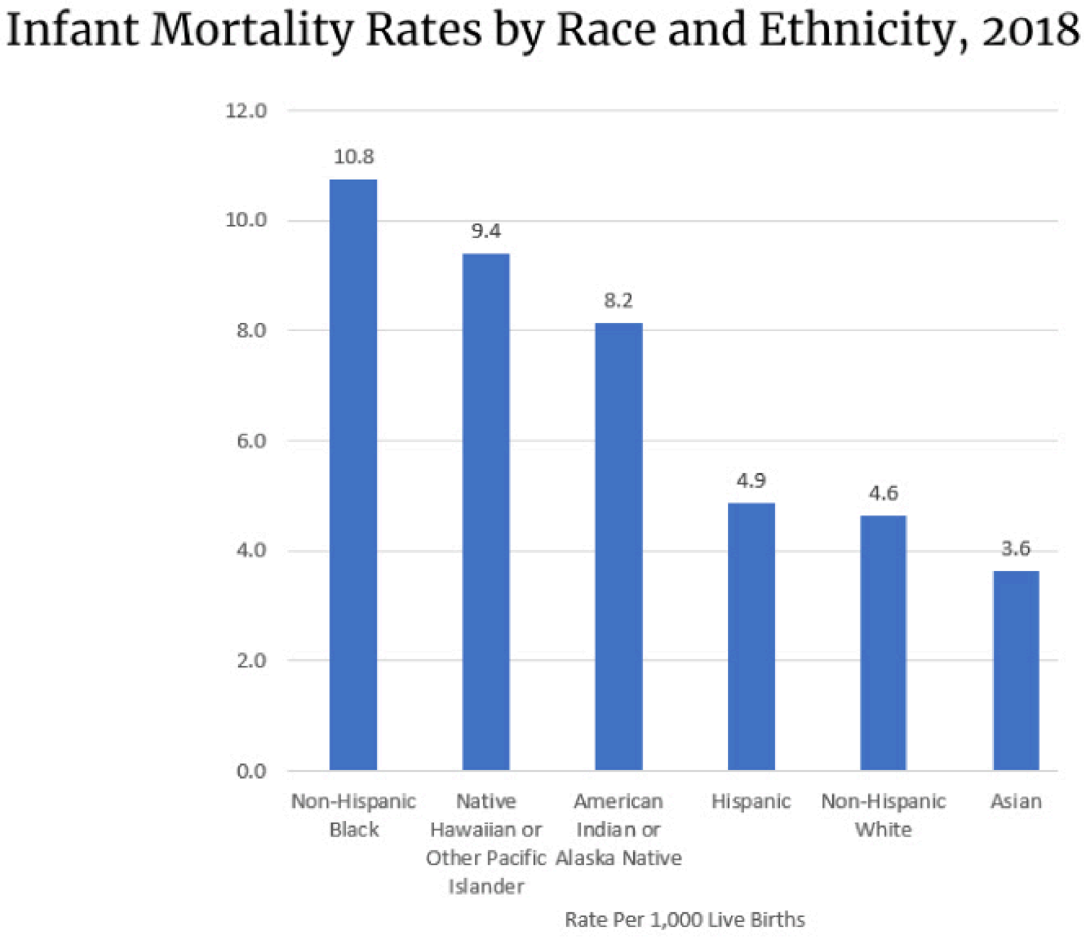
When children experience trauma, their predicted health outcomes get worse. These adverse or traumatic experiences may include growing up in a family with mental health or substance abuse issues, child abuse, or other experiences of violence. Because a person who experiences these events is more mental healthiness some physical and mental health challenges in childhood, they are more likely to adopt risky behaviors as an adult. Additionally, the more ACEs an adult has, the more it can predict that person's risk of developing health problems such as diabetes, heart disease, and cancer. If left untreated, the related diseases and disabilities can lead to early death. However, when children get help from caring adults, are connected with others, or receive competent professional support, they can recover from this early trauma. These interventions and others are known as protective factors. If families and communities support children with protective factors, the negative health impacts of trauma decrease.

Many people experience at least one Adverse Childhood Experience in their lifetime. However, people in marginalized social locations have more risk of ACEs. Beyond the experience of an individual, generational embodiment or historical trauma contributes to the likelihood of future generations of social groups experiencing ACEs. Historical trauma is multigenerational trauma experienced by a specific cultural, racial or ethnic group (Administration for Children and Families N.d.). It is related to major events that oppressed a particular group of people because of their status as oppressed, such as slavery, the Holocaust, forced migration, and the violent colonization of Indigenous people in North America. The generational embodiment of this trauma means that trauma responses of a previous generation are passed down to future generations unless they are healed.

Health Inequalities by Race and Ethnicity

When looking at the social epidemiology of the United States, it is easy to see health disparities between people of different races and ethnicities. The discrepancy between Black and White Americans shows the gap clearly. In 2018, the average life expectancy for Black expectancy was 73 years. The average life expectancy for White males was 78.5 years. This is a gap of almost 5 years

(Wamsley 2021). Mortality measures how many people die at a particular time or place. Many families have experienced the tragedy of losing an infant, and it can be hard to talk about. We see similar disparities when we look at how many babies die or infant mortality. The 2018 infant mortality rates for different races and ethnicities are as follows:



Source: CDC / CDC

Figure 4: Infant Mortality by Race and Ethnicity, 2018. Infant mortality varies significantly by race and ethnicity.

According to a report from the Kaiser Family Foundation (2007), African Americans also have a higher incidence of several diseases and causes of mortality, from cancer to heart disease to diabetes. Mexican Americans and Native Americans also have higher rates of these diseases and causes of mortality than White people.

Lisa Berkman (2009) notes that this gap started to narrow as a result of the Civil Rights movement in the 1960s but began widening again in the early 1980s. What accounts for these persistent disparities in health among different groups? Much of the answer lies in the level of healthcare that these groups have access to. The level of healthcare is measured by specific quality measures, and standards that measure the performance of healthcare providers for patients and populations. For example, quality measures include how many people get a flu shot, how long someone has to wait to see a doctor, or how often medication given for low blood pressure results in lower blood pressure. Quality measures can identify important aspects of care like safety, effectiveness, timeliness, and fairness.

The National Healthcare Disparities Report used quality measures and social location to examine healthcare inequality. Even after adjusting for insurance differences, they found that Black, Indigenous, and People of Color receive poorer quality of care and less access to care than White dominant groups. The report identified these racial inequalities in care.

- Black people, Native Americans, and Alaska Natives receive worse care than Whites for about 40 percent of quality measures, which are standards for measuring the performance of healthcare providers to care for patients and populations.
- Hispanics, Native Hawai`ians, and Pacific Islanders receive worse care than White people for more than 30 percent of quality measures.
- Asian people received worse care than White people for nearly 30 percent of quality measures but better care for nearly 30 percent of quality measures (Agency for Healthcare Research and Quality 2020).

Although there are multiple, complex reasons for discrepancies in care, a simple illustration may help make the point. Medical professionals and public health workers are asking why Black and Brown people are more likely to die of COVID-19. One medical study examined the pulse oximetry measurements of Black and White people in the hospital. If you've been to the hospital, you likely have had to put your finger into a little device that tells the medical professionals how much oxygen is in your blood. That's oximetry. The study's authors examined how often these measurements were accurate for White and Black patients.

They found that Black patients were three times more likely than White patients to have shortages of oxygen in the blood that the monitor didn't pick up. Because COVID-19 mainly attacks the lungs and reduces oxygen, the discrepancies in the measurements of this device may lead to more medical complications in Black patients (Sjoding et al. 2021, Wallis 2021). In addition, blood oxygenation levels are part of complex automated medical alerts. If the measurements are wrong, they do not trigger the alerts which notify medical professionals to respond. Therefore, the related levels of care are lower and less effective for Black patients.

Health Inequalities by Socioeconomic Status

The social location of wealth or poverty often influences health outcomes (Patel 2020). Marilyn Winkleby and her research associates (1992) state that "one of the strongest and most consistent predictors of a person's morbidity [incidence of disease] and mortality [death] experience is that person's socioeconomic status (SES). This finding persists across all diseases with few exceptions, continues throughout the entire lifespan, and extends across numerous risk factors for disease." In other words, having a lower SES makes you more likely to get sick or die of disease than people with a higher SES.

In Ijeoma Oluo's blog post, "Healthcare…can't live with it….can't live without it," the author describes her childhood experience in Japan. Feel free to read it for yourself if you'd like to. She explores how being poor changes a current healthcare crisis for her mother and her own ability to eat without pain. She writes that when you are poor, the only option you have when a tooth goes bad is to get it pulled. Even if you get richer as an adult, your mouth tells the story of your poverty because it is full of gaps (Oluo 2022). Although this post contains some strong language, feel free to read it to learn more.

Money is only part of the SES picture. Social class also influences how likely you are to have health insurance. Particularly in the United States, where healthcare is not universal, the poorer you are, the less likely you are to have quality health insurance. Suppose you have a full-time, beneficial managerial job in large multinational corporation. In that case, you will likely receive paid time off, excellent health insurance, long-term care insurance, and contributions to your retirement. This package of benefits helps you to prevent disease and stay healthy.

Conversely, suppose you have a low-wage seasonal job, particularly in a state that doesn't participate in the Affordable Care Act. In that case, neither your employer nor the government provides health care insurance for you. You pay for your health care out of your own pocket. Given the high cost of care, you will likely delay getting treatment, not have access to preventative care, or not be able to pay for complex treatment. In the US, economics, insurance, and health outcomes are linked in enormously inequitable ways.

But economics isn't the only driver of health outcomes. As we discussed in Chapter 6, class and education are related. Education is another variable that influences health outcomes. Phelan and Link (2003) note that many behavior-influenced diseases like lung cancer (from smoking), coronary artery disease (from poor eating and exercise habits), and HIV/AIDS initially were widespread across SES groups. However, once information linking habits to disease was shared, these diseases decreased in high SES groups and increased in low SES groups. This illustrates the important role of education initiatives regarding a given disease and possible inequalities in how those initiatives effectively reach different SES groups.

To find data on why people of low SES are more likely to contract and die from COVID-19, we look outside the United States to a study conducted in England. The study finds that people who are poor are more likely to live in overcrowded or substandard housing. These conditions make it challenging for the people who live there to quarantine effectively or maintain social distancing.

According to this study, people who are poor are more likely to be essential workers: servers, grocery clerks, delivery drivers, and other service workers. These essential workers have been required to keep their jobs and continue their interactions with many other people, increasing their risk of exposure to the virus. These essential workers are indeed heroes, but they had little choice because of their social location. If we wanted to recognize them, instead of just calling them “heroes,” we could raise wages.

Finally, because people with a lower socioeconomic status experience financial insecurity, they can be more stressed. This stress often translates into weakened immune systems, making it difficult to fight the virus. Finally, poorer people may delay going to the hospital because they have less access to quality healthcare. Because they have to wait until their health is in crisis to get medical attention, their symptoms are more severe, making it more difficult for them to recover.

Health Inequalities by Biological Sex

The Pandemic has finally opened our eyes to the fact that health is not driven just by biology, but by the social environment in which we all find ourselves and gender is a major part of that.

—Professor Sarah Hawkes, Co-Director of GH5050

In addition to race, ethnicity, and class, gender also influences health outcomes generally, and COVID-19 outcomes more specifically. During the pandemic, women are more likely to be caregivers for family members and work as frontline health workers than men, increasing their risk of exposure.

Over time, though, worldwide data is showing that women and men are getting infected with COVID-19 at near equal rates. Stereotypes regarding the types of occupations and tasks taken on by women that led them to get more serious COVID-19 infections did not hold up once the statistics started to come in. In fact, men are more likely to die from a COVID-19 infection than women.

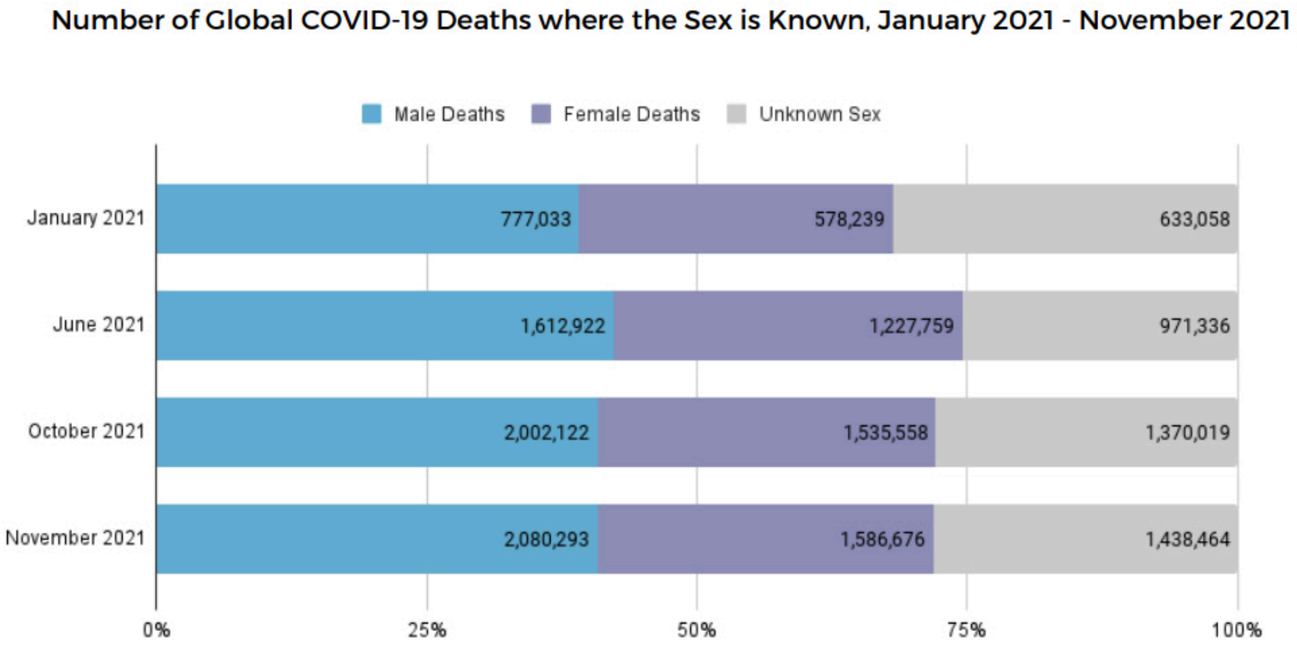


Figure 5: Number of Global COVID-19 Deaths Where Sex is Known, as of 2021. Men die more frequently. The Sex, Gender, and COVID-19

To understand why this is so, the social scientists from this project highlight both biological sex characteristics and socially constructed gender. They note that men have higher levels of an enzyme called ACE2. This enzyme allows viruses to enter cells more easily, which might tend to make men sicker than women. In addition to biological differences, the evidence highlights differences in behavior and social structures. In general, men tend to engage in more risky health behaviors such as drinking and smoking. These behaviors lead to poorer overall health and more risk of early death. Also, men tend to seek treatment later than women. The scientists write: However, experience and evidence thus far tell us that both sex and gender are important drivers of risk and response to infection and disease. For example, even in the case of ACE2 (the enzyme that helps the virus enter the body's cells), there are generally more ACE2 receptors in the heart cells of someone with pre-existing heart disease. And heart disease itself is associated with gender. In many societies today it is men who are more likely to suffer from heart disease and chronic lung disease as they are more frequently smokers, drinkers, or working in occupations that expose them to the risk of air pollution.

Other gender-based drivers of inequality may include men's generally lower use of health services, including preventive health services – which might mean that men are further along in their illness before they seek care, for example. (The Sex, Gender and COVID-19 Project 2022)

We are reacting to the COVID-19 pandemic and trying to understand complex links between the causes of pandemic sickness and death at the same time, so our scientific conclusions may change as we learn more. Even if the final analysis changes, gender is one dimension of difference that helps to explain unequal health outcomes during COVID-19.

Gender is also a key variable in understanding health with a wider lens. Women are affected adversely both by unequal access to and institutionalized sexism in the healthcare industry. According to a report from KFF, women experienced a decline in their ability to see needed specialists between 2001 and 2008. In 2008, one-quarter of women questioned the quality of their healthcare (Ranji & Salganico 2011). Quality is partially indicated by access and cost. In 2018, roughly one in four (26 percent) women—compared to one in five (19 percent) men—reported delaying healthcare or letting conditions go untreated due to cost. Because of costs, approximately one in five women postponed preventive care, skipped a recommended test or treatment, or reduced their use of medication due to cost (Ranji, Rosenzweig, and Salganicoff 2018).

In addition, many critics also point to the medicalization of women's issues as an example of institutionalized sexism. Medicalization refers to the process by which previously normal aspects of life are redefined as deviant and needing medical attention to remedy. Historically and contemporaneously, many aspects of women's lives have been medicalized, including premenstrual syndrome, menstruation, and menopause. The medicalization of pregnancy and childbirth has been particularly contentious in recent decades, with many women opting against the medical process and choosing natural childbirth.

Fox and Worts (1999) find that all women experience pain and anxiety during the birth process but that social support relieves both as effectively as medical support. In other words, medical interventions are no more effective than social ones at helping with the difficulties of pain and childbirth. Fox and Worts further found that women with supportive partners had less medical intervention and fewer cases of postpartum depression. Of course, access to quality reproductive health support outside the standard medical models may not be readily available to women of all social classes. It is also important to note that not all people with a uterus who may need this kind of healthcare identify as female and may face additional burdens finding reproductive healthcare.

Reproductive health is not limited to pregnancy and childbirth. It also includes the ability to choose when or whether to be pregnant. For centuries, women have controlled conception and pregnancy using plants and devices. As women's bodies became more medicalized, contraception and termination of pregnancy became managed by doctors. In some cases, this was useful. Doctors developed "the Pill" in the 1950s. It was widely available in the 1970s (Liao and Dolin 2012). By reliably preventing conception, women had more choices in when to get pregnant. Often, this gave them more freedom to work, make money, and gain economic power.

The technology to provide safe, effective terminations of pregnancy also evolved. Abortion is the spontaneous or voluntary termination of pregnancy. As women fought to control their reproduction, the right to choose abortion became a hotly contested debate.

On January 22, 1973, the Supreme Court affirmed the right to a woman's privacy in matters surrounding her pregnancy in a 7-2 decision, commonly known as Roe v. Wade. The decision reads in part: The Due Process Clause of the Fourteenth Amendment protects against state action the right to privacy, and a woman's right to choose to have an abortion falls within that right to privacy. A state law that broadly prohibits abortion without respect to the stage of pregnancy or other interests violates that right. Although the state has legitimate interests in protecting the health of pregnant women and the "potentiality of human life," the relative weight of each of these interests varies over the course of pregnancy, and the law must account for this variability (Oyez N.d.).

Since then, women have had access to abortion services in all US states. With access to safe and effective abortion, women's health outcomes improved. Maternal mortality decreased, and there was less infant mortality (World Health Organization 2021).

However, like many social problems, some people did not agree that this law was correct. The conflict in values is based on politics, religion, and power. If you look at the conflict based on political party, you see that the Republican party argues that the unborn child has a right to life that can- not be violated. The Democratic party argues that people have the right to choose whether to get pregnant or to terminate pregnancy and to have access to safe, legal, affordable contraception and abortion.

However, not all Republicans and Democrats support their own party's platform. Republicans who do support the platform are likely to be Protestant. 40% of them are White evangelical Christians (Lipka 2022). Republicans who don't support the right to life are much less likely to be religious. 80% percent of Democrats support the right to life. The 20% who don't are commonly White evangelical, Hispanic Catholic, or Black Protestant. The combination of race and religion appears to have a unique influence on beliefs about reproductive rights (Lipka 2022).

But differences in politics and religion mask a deeper divide: the debate over who controls women's bodies. Generally, men make the laws that control women and pregnant people's bodies.

We see the power of patriarchal systems in the challenges to Roe v. Wade. On June 24, 2022, access to abortion was removed as a federally protected right. Each state could decide whether abortions were legal or illegal. Many states limited the right to abortion. Other states protected the right to abortion.

The Supreme Court's decision to have states decide abortion rights has worsened health outcomes for women, particularly if they are poor or women of color. Women and people with uteruses may be arrested in some states if they have abortions. Doctors may face legal charges if they take action to terminate pregnancies, even when it is to save the mother's life. In mid-October 2022, a doctor was concerned about legal action in one case where the fetus would not survive at birth. The woman endured "a roughly six-hour ambulance ride to end her pregnancy in North Carolina, where she arrived with dangerously high blood pressure and signs of kidney failure"

(Kusisto 2022). Because poor women and women of color, who are disproportionately poor, can't afford to travel to states that protect abortion rights, they are even more at risk.

The medicalization of health, particularly regarding reproduction, encourages women and pregnant people to work for reproductive justice, a framework that centers on the human right to have children, not have children, and parent the children we have in safe and healthy environments.

Health Inequalities by Sexual Orientation and Gender Identity

Gender identity and sexual orientation may also impact how a person experiences health and illness. However, understanding these unequal experiences based on sociological data is challenging. Because it has been illegal to be queer or transgender until recently in the United States, many people do not disclose their unique identities. The agencies that sexual orientation gender identity and sexual orientation have only recently begun to re-tool their sexual orientations so that people can report their gender identity or sexual orientation. Despite these limitations, though, we notice inequality.

For example, when the Centers for Disease Control and Prevention (CDC) examined risk factors for COVID-19 illness or death, they found that gay, lesbian, and bisexual people had challenging underlying health conditions more often than straight people. The report points primarily to economic causes as a core cause of the difference, indicating that lesbian, gay, and bisexual people, particularly if they are Black or Brown, experience less economic stability (Heslin and Hall 2021).

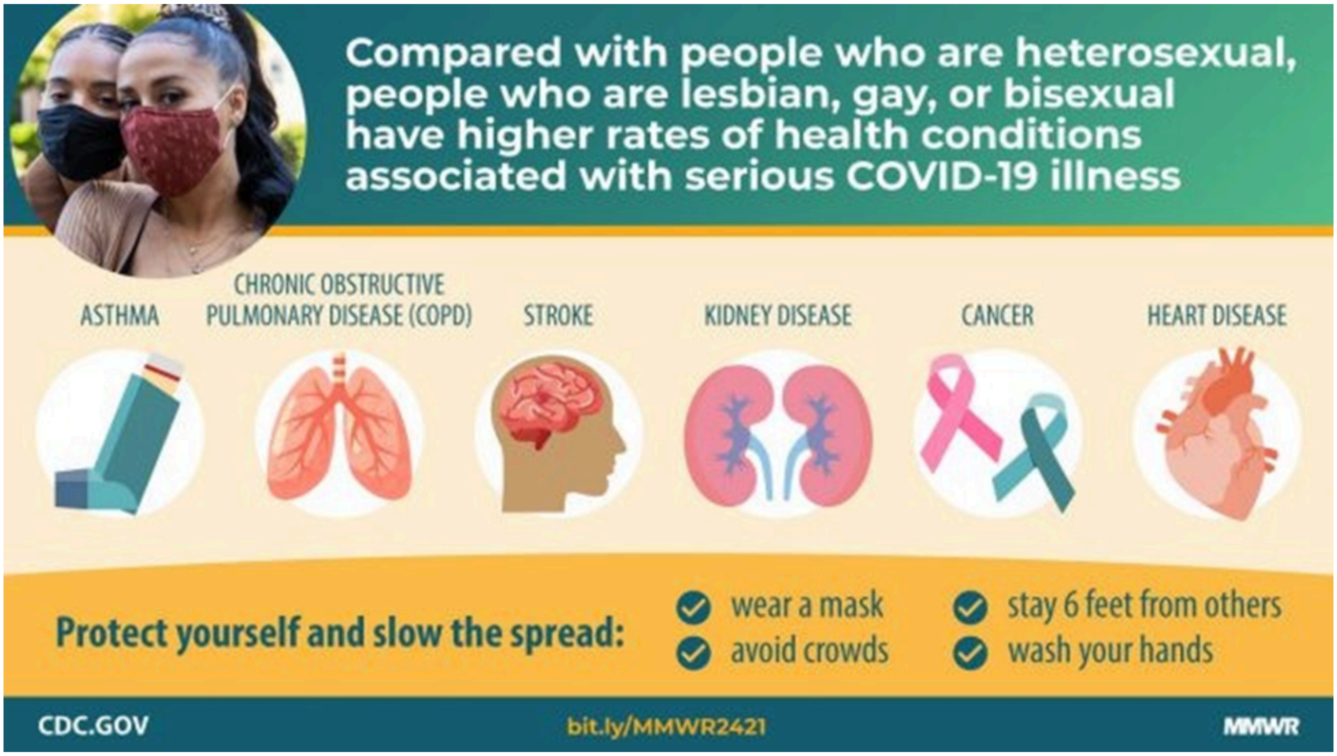


Figure 6: CDC Infographic COVID and LGBTQIA+ health (Heslin & Hall 2021)

When examining the overall health of lesbian, gay, bisexual, and transgender people, the American College of Physicians finds similar issues. They also highlight the connections between laws, discrimination, and rejection that result in poorer health outcomes for LGBTQIA+ people:

> These laws and policies, along with others that reinforce marginalization, discrimination, social stigma, or rejection of LGBT persons by their families or communities or that simply keep LGBT persons from accessing health care, have been associated with increased rates of anxiety, suicide, and substance or alcohol abuse. (Daniel 2015)

Transgender people have unique health concerns that are rarely addressed well by current practices. Although transgender people differ in their desires regarding medical support for their physical transitions, many of the procedures are not covered by insurance. When examining health outcomes for transgender people, the report states:

> Transgender persons are also at a higher lifetime risk for suicide attempt and show a higher incidence of social stressors, such as violence, discrimination, or childhood abuse, than non-transgender persons. A 2011 survey of transgender or gender nonconforming persons found that 41 [percent] reported having attempted suicide, with the highest rates among those who faced job loss, harassment, poverty, and physical or sexual assault (Daniel and Butkus 2015).

Perhaps this doesn't need to be said, but it is not the gender identity or sexual orientation per se that causes poorer health outcomes. Instead, it is the social structure embedded with stigma, discrimination, and violence that makes life riskier and shorter for LGBTQIA+ people.

Sociological Theories of Health

Like all social problems, the concepts of health and illness are socially constructed. The definition of the social construction of illness experience is based on the idea that there is no objective reality, only our own perceptions of social constructions and the social construction of health emphasize the social and cultural aspects of the discipline's approach to physical, objectively definable phenomena.

The Cultural Meaning of Illness

Most medical sociologists contend that illnesses have both a biological and an experiential components and that these components exist independently of each other. Dominant White culture influences the way we experience illness, dictating which illnesses are stigmatized, which are considered disabilities or impairments, and which are contestable illnesses (Conrad & Barker 2010).

Contested illnesses are those that are questioned or questionable by some medical professionals. Disorders like fibromyalgia or chronic fatigue syndrome are real physical experiences, but some medical professionals contest whether these ailments are definable in medical terms. This causes a problem for a patient with symptoms that might be explained by a contested illness—how to get the treatment and diagnosis they need in the face of a medical establishment that does not believe their symptoms are real.

We also see the social construction of health and illness when we try to measure and treat pain. Individual and cultural perceptions of pain can make it difficult for healthcare workers to treat illnesses since they cannot be measured using a device. A person's experience of pain is subjective, and a physician's response to treating pain is highly variable. In addition to individual and cultural differences in the response to pain, the medical system's response to pain varies by race. Minority women are less likely to receive adequate pain medication during childbirth (Lange, Rao, and Toledo 2017) and the postpartum period (Badreldin, Grobman, and Yee 2019).

Sick Role and Functionalist Perspective

Health is vital to the stability of the society, so illness is often seen as a form of deviance. The American sociologist Talcott Parsons studied the social system. He examined the functions of sickness and health in his book The Social System, published in 1951, exploring the roles of the sick person and the doctor. The sick role is defined as patterns of expectations that define appropriate behavior for the sick and those who take care of them.

Having a physician certify that the illness is genuine is an important symbolic step in taking on the sick role. It also reveals the strong power and authority differential between the physicians. An example of the power differential between a patient and the physician is if a physician calls the patient on the phone and leaves a voice message, the social norm is that the patient will call the physician back as soon as possible.

However, if the patient calls the physician, the expectation is that it may take several days for the call to be returned. In this example, the physician's priorities are different from that of the patient's. The patient has more social expectations to do what the physician says, and the physician has fewer social norms compelling them to respond to the patient. A long-term illness can make our world seem smaller, more defined by the illness than anything else. An illness can be a chance for discovery, for re-imaging a new self (Conrad and Barker 2007).

Social Disparities and the Conflict Perspective

According to conflict theory, the dominant group in society, those people with power and money, make decisions about how the healthcare system runs. Therefore, they ensure that they have access to quality healthcare. To ensure that subordinate groups stay subordinate, they restrict access to care. This creates significant healthcare and health disparities between the dominant and subordinate groups. These ideas come straight from the conflict perspective introduced in Healthcare institutions including thousands of doctors, staff, patients, and administrators. They are highly bureaucratic. They do not serve every- one equally, often because of structural racism, sexism, ageism, and heterosexism. When health is a commodity, marginalized people are more likely to experience illness caused by poor diet, and living and working in unhealthy environments.

Medicalization and the Symbolic Perspective

The term medicalization of deviance refers to the process that changes bad behavior into sick behavior. A related process is demedicalization, in which sick behavior is normalized again. Both of these concepts come from the symbolic perspective of sociology, which asserts that society is created by repeated interactions between individuals and groups. Medicalization and demedicalization affect who responds to the patient, how people respond to the patient, and how people view the personal responsibility of the patient (Conrad & Schneider 1992).

So far in this chapter, we have discussed medicalization as the process in which situations and behaviors are considered medical problems rather than social problems. In the case of the medicalization of deviance, the social problems that may be medicalized are deviant behaviors. Another important example of medicalization is the significant differences in who delivers babies worldwide. In Great Britain, midwives deliver half of all babies, including Kate Middleton's first two children, Prince George and Princess Charlotte. In Sweden, Norway, and France, midwives oversee most expectant and new mothers, enabling obstetricians to concentrate on high-risk births. In Canada and New Zealand, midwives are so highly valued that they're brought in to manage complex cases that need special attention.

The medicalization of childbirth in the US is so pervasive that most expectant mothers in the US give birth in hospitals, with fetal monitors, medications, and other medical interventions that are unnecessary for most healthy pregnancies. In fact, severe maternal complications in the US have more than doubled in the last 20 years.

Maternity care shortages have reached critical levels, with nearly half of all US counties without a practicing obstetrician-gynecologist. In rural areas, hospitals offering obstetric services have fallen more than 16 percent since 2004. Midwives are far less prevalent in the US than in other affluent countries, attending around 10 percent of births. The extent to which they can legally participate in patient care varies widely from one state to the next. At times, the cultural stigmas regarding medical practices can cause people to seek medical services that don't meet their needs. There are other aspects of the US healthcare system that rise as important social problems to be addressed.

Intersectional Theories of Health

When we consider the causes of poor health outcomes, a common theory about why People of Color have poor health outcomes is because they are disproportionately poor. They don't have the money or health insurance that they need to get the needed level of medical care. This theory is partially true. However, researcher Arline Geroniumus argues that racism itself can impact health outcomes. She coined the term weathering to describe the impact that social location can have on health. Weathering is the idea that chronic exposure to social and economic disadvantage leads to an accelerated decline in physical health outcomes (Geronimus 2023).

The Hispanic Paradox

Healthcare researchers also explore health outcomes for Hispanic people. They describe these outcomes as the "Hispanic Paradox." Hispanics make up the largest and fastest-growing minority group in the US (Funk and Lopez 2022). For decades, health services researchers have puzzled over a paradox among them. Hispanics live longer and have lower death rates from heart disease, and any other leading causes of death than non-Hispanic White people despite having social disadvantages, including lower incomes and worse access to health coverage.

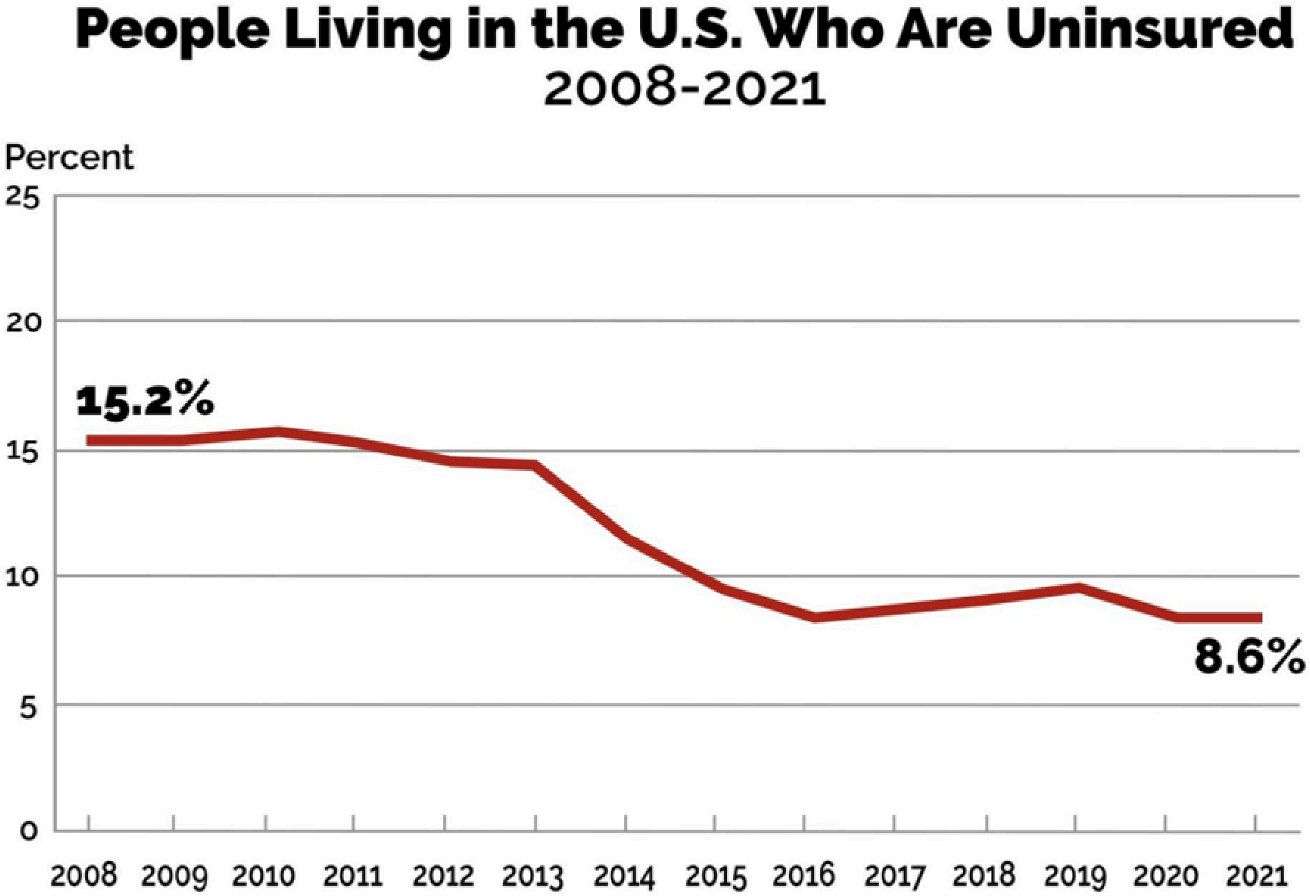
There are many theories about why this might happen. The possibilities include stronger social networks, healthier eating habits, and lower smoking rates among some Hispanic groups, particularly newer arrivals. However, focusing on national data can mask important differences. It also matters if people have health insurance, speak primarily Spanish or English, or grew up in the US or another country. The very heterogeneity of the Hispanic population— they were born here and they come from more than 20 countries, with widely differing experiences and social circumstances, including immigration status makes it hard to pinpoint problems, including high rates of diabetes, liver disease, and certain cancers and poor birth outcomes among some Hispanic groups. The same diversity challenges the validity of the Hispanic paradox. (Hostetter and Klein 2018).

Health Equity is Social Justice

As we examine the social structures of health and healthcare in the US and world the governments influence health outcomes. In this policymaking step of the social problems process, governments decide who gets insurance, how people have access to healthy water, or whether health initiatives related to reproductive health. We'll see how health laws, policies, and practices related to health care and health access affect the social problem of health.

Changing US Healthcare Policy

US healthcare coverage can broadly be divided into two main categories: public healthcare, which is funded by the government, and private healthcare, which a person buys from a private insurance company. The two main publicly funded healthcare programs are Medicare, which provides health services to people over sixty-five years old and people who meet other standards for disability, and Medicaid, which provides services to people with very low incomes who meet other eligibility requirements. Other government-funded programs include The Indian Health Service, which serves Native Americans; the Veterans Health Administration, which serves veterans; and the Children's Health Insurance Program (CHIP), which serves children. Private insurance is typically categorized as either employment-based insurance or direct purchase insurance. Employment-based insurance is health plan coverage provided in whole or in part by an employer or union. It covers just the employee or the employee and their family. Direct purchase insurance is coverage that an individual buys directly from a private company.



Notes: Insured includes employer, non-group, Medicaid, Medicare, and military insurance. Uninsured: Includes those without health insurance and those who have coverage under the Indian Health Service only.
Data source: Kaiser Family Foundation, Health Insurance Coverage of the Total Population:
https://www.kff.org/other/state-indicator/total-population/
and Health Insurance Coverage of the Total Population (CPS):
https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps/

Designed by Elizabeth Pearce and Michaela Willi Hooper,
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Figure 7: With the Affordable Healthcare Act, the percent of uninsured people dropped by nearly half. How do you think this could change healthcare costs and healthcare outcomes in the United States?

The number of uninsured people is far lower now than in previous decades, but that doesn't mean everyone has the healthcare they need. In 2013, and in many years preceding it, the number of uninsured people was in the 40 million range, or roughly 18 percent of the population.

The Patient Protection and Affordable Care Act (ACA), which was implemented in 2014, allowed more people to get affordable insurance (Patient Protection and Affordable Care Act – Glossary N.d.) The Affordable Care Act has been a savior for some and a target for others. As Congress and various state governments sought to have it overturned with laws or to have it diminished by the courts, supporters took to the streets to express its importance to them. The Affordable Care Act (ACA) was a landmark change in US healthcare. Passed in 2010 and fully implemented in 2014, it increased eligibility to programs like Medicaid, helped guarantee insurance coverage for people with pre-existing conditions, and established regulations to ensure insurance premiums collected by insurers and care providers went directly to medical care (as opposed to administrative costs). It also included an individual mandate, which required anyone filing for a tax return to either acquire insurance coverage by 2014 or pay a penalty of several hundred dollars. Other provisions, including government subsidies, are intended to make insurance coverage more affordable, reducing the number of underinsured or uninsured people.

The ACA remained contentious for several years. The Supreme Court ruled in the case of National Federation of Independent Businesses v. Sebelius in 2012, that states cannot be forced to participate in the ACA's Medicaid expansion. This ruling opened the door to further challenges to the ACA in Congress and the Federal courts, some state governments, conservative groups, and private businesses. The ACA has been a driving factor in elections and public opinion. In 2010 and 2014, the election of many Republicans to Congress came out of concerns about the ACA.

The uninsured number reached its lowest point in 2016, before beginning to climb again (Garfield, Orgera, and Damico 2019). People having some insurance may mask the fact that they could be underinsured; that is, people who pay at least 10 percent of their income on healthcare costs unencumbered by insurance or, for low-income adults, those medical expenses or deductibles are at least five percent of their income (Schoen et al. 2011).

However, once millions of previously uninsured people received coverage through the law, public sentiment and elections shifted dramatically. Healthcare was the top issue for voters going into the 2020 election cycle. The desire to preserve the law led to Democratic gains in the election (just a short time before COVID-19 began to spread globally). With its passage, response, subsequent changes, and new policies, the ACA demonstrates the interplay between policymaking, social problems work, and policy outcomes, the last steps of Best's claims-making process. Even with all these options, a sizable portion of the US population remains uninsured. In 2019, about 26 million people, or eight percent of US residents, had no health insurance. That number increased to 31 million in 2020 (Keith 2020). People don't have health insurance for many reasons. Many small businesses can't afford to provide insurance to their employees. Many employees are part-time, so they don't qualify for insurance benefits from their employers. Some people only have health insurance for part of a year (Keisler-Starkey and Bunch 2020). In addition, all states except for California and recently Oregon make it illegal for undocumented immigrants to receive Medicaid services through the ACA. Other states, such as Texas, are pushing to stop the spread of Medicaid to low-income citizens.

Changing Healthcare Policy Around the World

Clearly, healthcare in the United States has some areas for improvement. But how does it compare to healthcare in other countries? Many people in the United States believe that this country has the best healthcare in the world. While it is true that the United States has a higher quality of care available than many nations in the Global South, it is not necessarily the best in the world. In a report on how US healthcare compares to that of other countries, researchers found that the United States does "relatively well in some areas—such as cancer care—and less well in others—such as mortality from conditions amenable to prevention and treatment" (Docteur and Berenson 2009). This conflict between values and outcomes is another example of the conditions of a social problem: that values and outcomes do not match. Some consider the Patient Protection and Affordable Care Act (ACA) to be a slippery slope that could lead to socialized medicine, a term that for many people in the United States has negative connotations lingering from socialized medicine earlier. Under a socialized medicine system, all medical facilities and expenses are covered through a public insurance plan that is administered by the federal government. It employs doctors, nurses, and other socialized medicine run the hospitals (Klein 2009). The best example of socialized medicine is in Great Britain, where the National Health System (NHS) covers the cost of healthcare for all residents. Despite some US citizens' reactions to policy changes in socialized medicine, the United States Veterans Health Administration (VA) is administered in a similar way to socialized medicine in other countries.

It is important to distinguish between socialized medicine, in which the government owns the healthcare system, and universal healthcare, which is simply a system that guarantees healthcare coverage for everyone. Geruniversal health- care Canada all have universal healthcare. People often look to Canada's universal healthcare system, Medicare, as a model for the system. In Canada, healthcare is publicly funded and administered by separate provincial and territorial governments.

However, the care itself comes from private providers. This is the main difference between universal healthcare and socialized medicine. The Canada Health Act of 1970 required that all health insurance plans must be "available to all eligible Canadian residents, comprehensive in coverage, accessible, portable among provinces, and publicly administered" (Kaiser Family Foundation 2010).

Reproductive Justice is Social Justice

Access to health insurance is not the only urgent social problem related to health. Issues related to reproduction and pregnancy are also social problems of health. Women have been sharing information about health forever, but this work became more focused on the 1970s women's movement. A women's collective wrote Our Bodies Ourselves to share concrete practical information about women's health. In their work, they told each other stories about their first periods and how they learned about menstruation. Generally, information about periods had been shrouded in mystery and shame. The book challenges this mystery and shame related to women's health, offering women clear, accessible information about health, information that wasn't generally accessible at the time. This collective is still going strong today (Our Bodies Ourselves Today 2023).

Women's commitment to reproductive justice didn't stop with writing books and education. Feminists, including women, men, and nonreproductive justice work for reproductive justice. These efforts include supporting the 1973 Roe v Wade decision, which protected the right to have an abortion. More recently, this social movement generated several Women's Marches in Washington D.C., and protests related to reproductive rights. The song "I Can't Keep Quiet" became one of the anthems of recent women's marches. Feel free to listen if you'd like.

Beyond education, writing, and protesting, many organizations provide reproductive justice through healthcare services. Sister Song, the women of color reproductive justice coalition was formed in 1997 by 16 organizations of women of color. They write: Sister Song's mission is to strengthen and amplify the collective voices of Indigenous women and women of color to achieve reproductive justice by eradicating reproductive oppression and securing human rights (2023). They connect issues of gender, class, and race to create a national multi-ethnic movement to support reproductive justice, which includes not only access to safe abortion, but access to contraception, and freedom from forced sterilization. The organization collects funds and distributes them to birthing People of Color and queer or trans people who need birth support (Sister Song 2023).

Finally, midwives and birth doulas are offering options to ensure reproductive justice. Black Doulas, for example, help Black women and birthing people to have babies safely. This alternative is important to combat the racism in reproductive care, in which Black women are three times more likely to die than White women from pregnancy-related causes. A birth doula provides emotional and physical support to a pregnant person before, during, and after the birth. This culturally specific care improves outcomes for pregnant people: As doula care is a proven, cost-effective means of reducing racial disparities in maternal health and improving overall health outcomes, policy advocates, legislators, and other stakeholders should undertake efforts to increase Medicaid and private insurance coverage of doula services. (Robles-Fradet and Greenwald 2022). Reproductive Justice solutions include education, activism, and providing needed care. Reproductive Justice is social justice.

2.

TOPIC: PROBLEMS ASSOCIATED WITH DRUG USE

When we consider the social problem of problematic drug use, we enter a challenging space. Like many social problems, opinions are often extreme and heartfelt. In the 2020 optional-reading article, Don't Forget the Other Pandemic Killing Thousands of Americans, author Kate Briquelet writes, "Amid social distancing, authorities nationwide are reporting a surge in fatal opioid overdoses. Addiction and recovery advocates say the US is now battling two epidemics at once. From 1999 to 2018, opioid overdoses involving prescription and illicit drugs have killed nearly 450,000 Americans." We have not just one pandemic but two.

The COVID-19 pandemic has enabled us to see how social environments and conditions impact the consequences of drug use and addiction. For example, many experts are worried about the negative impacts of social isolation on those with substance use disorders. Isolation might increase depression, and the related self-medication will employ illegal substances. In addition, individuals who use opioids alone and overdose would have no one there to call 911 or administer Narcan, the overdose reversal medication. Beyond the individualized psychological view of drug use, a sociological perspective reveals the social conditions that can cause substance use, as well as make the consequences worse for certain structurally vulnerable groups.

Social scientists assert that people often seek to alter their consciousness deliberately. Sometimes, they choose prayer or meditation. Sometimes, they choose to dance or sing in a choir. Sometimes, they choose a pound of chocolate or a runner's high. Sometimes, they choose alcohol, cannabis, or other mind-altering substances. Many find this altered state without it becoming either a personal or a social problem.

As we look at the social problem of problematic drug use worsened by COVID-19, the following questions guide our curiosity:

- How can we describe drug use and misuse as a social problem?
- How does social location impact the experience of harmful drug use?
- How do the five models of addiction differ in how they explain the causes and consequences of harmful drug use?
- Which interdependent actions increase social justice related to problematic drug use?

The Social Problem of Drug Use and Misuse

There are many ways to construct drug use and addiction as a social problem. Addiction is a chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences (National Institute on Drug Abuse 2020). But it's not just the antisocial problem of drug use that is the social problem equal impact of drug use on families and communities the social prodrug users chapter will not discuss drug use as inherently bad. The opioid epidemic impacts everyone, from individuals to families, hospitals, workplaces, and governments. It goes beyond the experience of one individual.

Secondly, in our exploration of drug use and misuse, we see social construction at work. You may notice that throughout this chapter, we use the word cannabis to describe the drug that is commonly known as marijuana or weed. The common word for marijuana is racist. It reflects a racist past. More specifically, the United States experienced an increase in Mexican immigration after the 1910 Mexican War of Independence. Some immigrants used the herb marijuana for casual smoking. Although the immigrants were important in providing needed agricultural labor, the increase in immigration raised xenophobic fears.

Mexican immigrants were often blamed for property crimes and sexual misconduct. White people in power conveniently blamed the use of marijuana for this. "One Texas state legislator proclaimed on the senate floor: "All Mexicans are crazy and this stuff [cannabis] is what makes them crazy" (Ghelani 2020). In 1937, Harry Ainsliger, head of the Federal Bureau of Narcotics testified before Congress saying, "marihuana is an addictive drug which produces insanity, criminality, and death" (Ghelani 2020). Associating the use of cannabis with Mexican immigrants by manpower marijuana was a way to assert power and control over a particular ethnic group. This is using language as a social construction. To resist this oppression, we will use the word cannabis instead of the word marijuana in this chapter, except when we are quoting from other people. In addition, we remember that a social problem arises when groups of people experience inequality. This point is particularly important when we discuss drug use and harmful drug use. People of all races use drugs at the same rate. However, People of Color are likely to be arrested and jailed for drug offenses. White people are more likely to be seen as needing medical intervention, and therefore they are more likely to receive treatment. More specifically:

Although Black Americans are no more likely than Whites to use illicit drugs, they are 6–10 times more likely to be incarcerated for drug offenses. (Netherland and Hansen 2017)

This racialized response to harmful drug use is a deep source of inequality, a key component of a social problem. Finally, we recall that social problems must be addressed interdependently, using both individual agency and collective action. In this case, citizens, lawmakers, health care workers, community advocates, and the individuals themselves must act to address the social problem. We'll look at various solutions in more detail in Recovery is Social Justice.

Drug Use

Drug use can be a problem for anyone, but it is people's different social locations that determine how harmful the drug use will be for themselves and for their family, friends, and community. Harmful drug use occurs when it negatively impacts a person's health, livelihood, family, freedom, or other important aspects of their life.

One of the dominant approaches to understanding addiction involves looking solely at how a person's brain is affected by drug use. Another popular approach focuses on the psychology of the user and the chemical traits of the substance. Both approaches ignore social issues such as poverty, racism, and sexism that increase the harmfulness of drug use for certain individuals, populations, and neighborhoods. Incarceration, disease (such as HIV), other negative health impacts, job loss, and family disruption are examples of harms associated with drug use that are more or less likely to occur depending on one's social location.

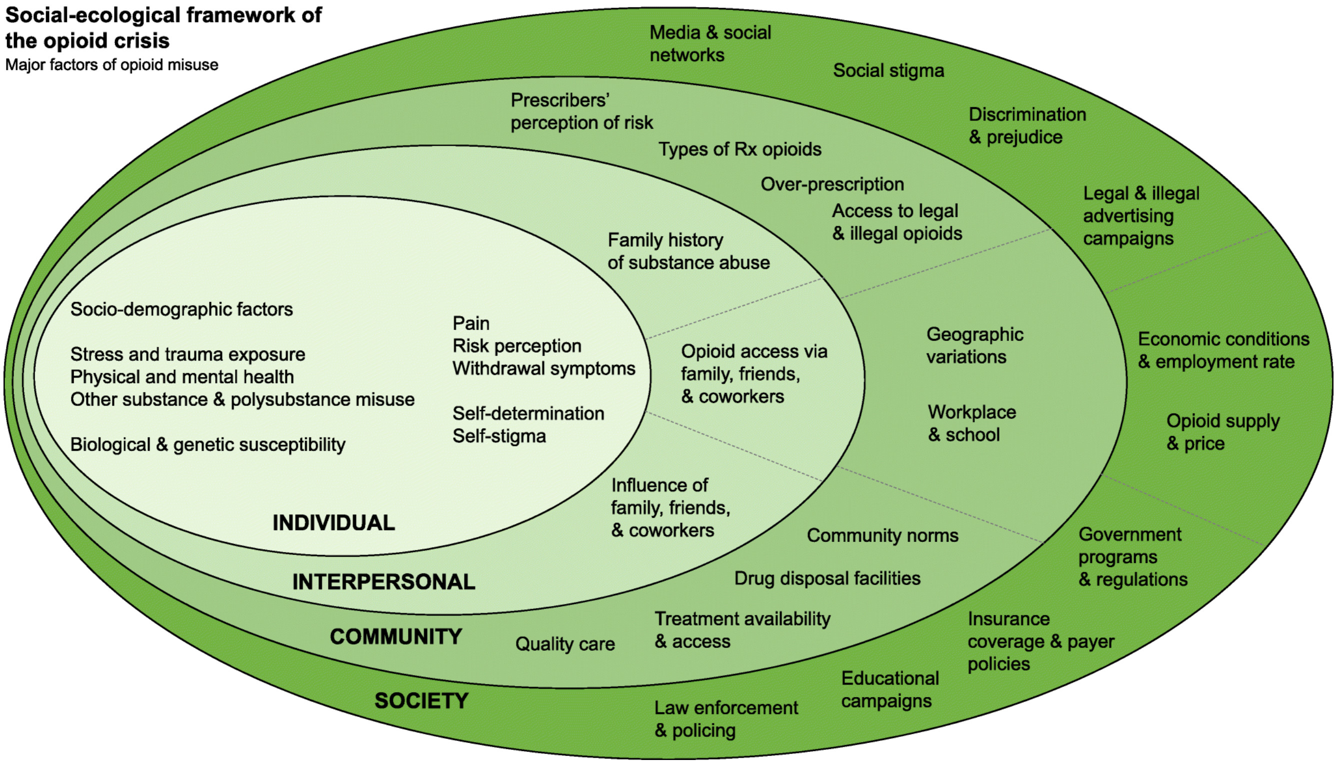


Figure 8: The Social Ecological Framework of the Opioid Crisis: This social-ecological model framework of the opioid crisis is a complex model which examines individual, interpersonal, community, and societal factors for the opioid crisis. We can use this model to examine harmful drug use in general. Sociologists look at the problem of harmful drug use at all levels, particularly focusing on how social location, social determinants of health, laws, policies, and practices influence drug use, misuse, and related health outcomes. Image description link.

Problematic Drug Use

Social scientists point out that a person's socioeconomic class may impact whether they can continue to work or go to school while using substances (Zinberg 1984; Singer and Page 2014; Friedman 2002). For example, White middle-class users of opioids, like heroin, are less likely to get arrested or go to jail. Therefore, they can more often keep their jobs and still earn money.

Racism in our society creates differences in how White people and People of Color are treated when they use drugs. White people are more likely to be seen as people experiencing a medical condition. Therefore, they need drug treatment to recover. Black, Brown, and Indigenous people are more likely to be seen as criminals. They are more likely to be arrested and put in jail than receive treatment This chapter will discuss how racist social structures shape the experiences of problematic drug use.

A problem in deciding how to think about and deal with drugs is the distinction between legal drugs and illegal drugs. It makes sense to assume that illegal drugs should be the ones that are the most dangerous and cause the most physical and social harm, but research shows this is not the case.

Rather, alcohol and tobacco cause the most harm even though they are legal. As Kleiman and his research team note about alcohol: When we read that one in twelve adults suffers from a substance abuse disorder or that 8 million children are living with an addicted parent, it is important to remember that alcohol abuse drives those numbers to a much greater extent than does dependence on illegal drugs. (2011). According to the CDC, cigarette smoking kills 480,000 people due to complications from smoking or secondhand smoke (CDC 2022). Alcohol use prematurely kills 140,000 people per year in the US. These deaths are caused by physical damage related to long-term use. They are also caused by drinking too much alcohol in a short period of time. DUI fatalities are one example of this premature death. The rate of premature death is much higher for legal drugs than illegal ones.

Dependence

Substances that we consider drugs interact with our bodies in different ways. Drugs are often grouped by the kinds of physical effects they have. Some drugs, called depressants, slow down the central nervous system. Hallucinogens cause people to hallucinate, to see, hear, or experience things that are not physically real. Narcotics, derived from natural or synthetic ingredients, are effective at relieving pain, but they depress the nervous system. They are also highly physically addictive. Stimulants speed up the nervous system, potentially causing alertness, euphoria, or anxiety. Finally, cannabis may create euphoria, hunger, and relaxation and dull the sense of time and space.

Important distinctions exist between addiction, physical dependence, and drug use. These three are not mutually exclusive, but they differ from each other in significant ways. Addiction is often associated with a mental health diagnosis such as substance use disorder. Rather than using the diagnosis of addiction, health professionals now use the language of substance use disorder

(SUD), which is a condition in which there is uncontrolled use of a substance despite harmful consequences. People with SUD have an intense focus on using a certain substance(s), such as alcohol, tobacco, or illicit drugs, to the point where the person's ability to function in day-to-day life becomes impaired (Saxon 2023). Physical dependence means that the body has built up a tolerance to the drug and that one must take the substance to not feel ill. Drug use is just the intake of a substance that produces a change in your body. This can happen with or without addiction or physical dependence.

Harmful Drug Use: Exploring Unequal Outcomes

By 1994, the deindustrialization of the US economy produced by global economic shifts, was having a deleterious impact on working-class Black communities. The massive loss of jobs in the manufacturing sector, especially in cities like Detroit, Philadelphia, Chicago, New York, and Los Angeles, had the result, according to Joe Willam Trotter, that "the black urban working class nearly disappeared by the early 1990s." Combined with the disestablishment of welfare state benefits, these economic shifts caused vast numbers of black people to seek other—sometimes "illegal"—means of survival. It is not accidental that the full force of the crack epidemic was felt during the early 1980s and 1990s (Davis 2021).

The massive expenditures on the curtailment of the drug epidemic also shifted our views on drug use. The United States became much more punitive towards drugs. The courts treated harmful drug use as a criminal justice issue rather than as a substance dependence issue. The War on Drugs created tougher sanctions on drug use in America. The Drug Enforcement Agency was created in 1973 to provide another arm of the government to tackle the specific issue of drugs. By the 1980s, lengthy sentences for drug possession were also in place. One to five-year sentences for possession were increased to more than 25 years.

The War on Drugs and its associated policies also drove massive increases in prison populations. Between 1980 and 2010, the US prison population quintupled. The population only began to decline slightly in the early 2010s. As of 2019, the United States still imprisoned more than 2 million people in prisons and jails. Mass incarceration refers to the overwhelming size and scale of the US prison population. The United States has the largest prison population in the world, but how did this come to be the case?

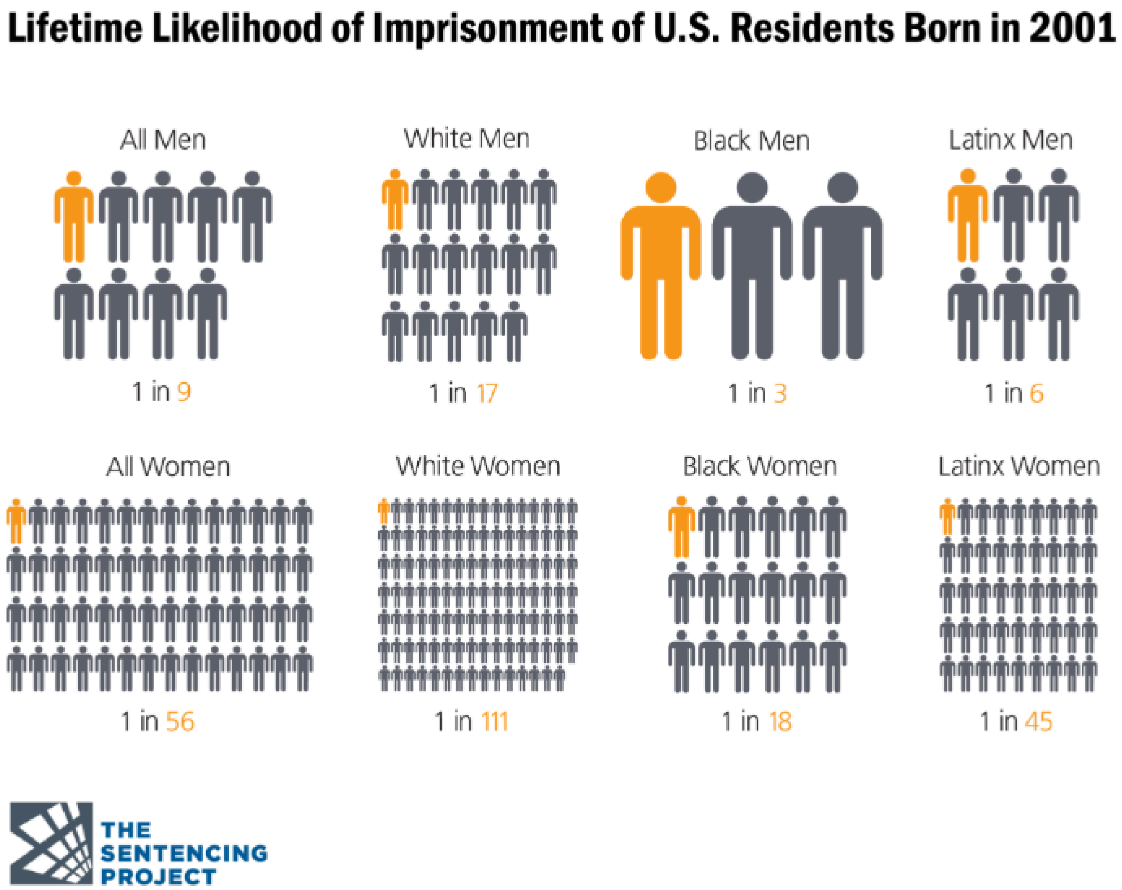


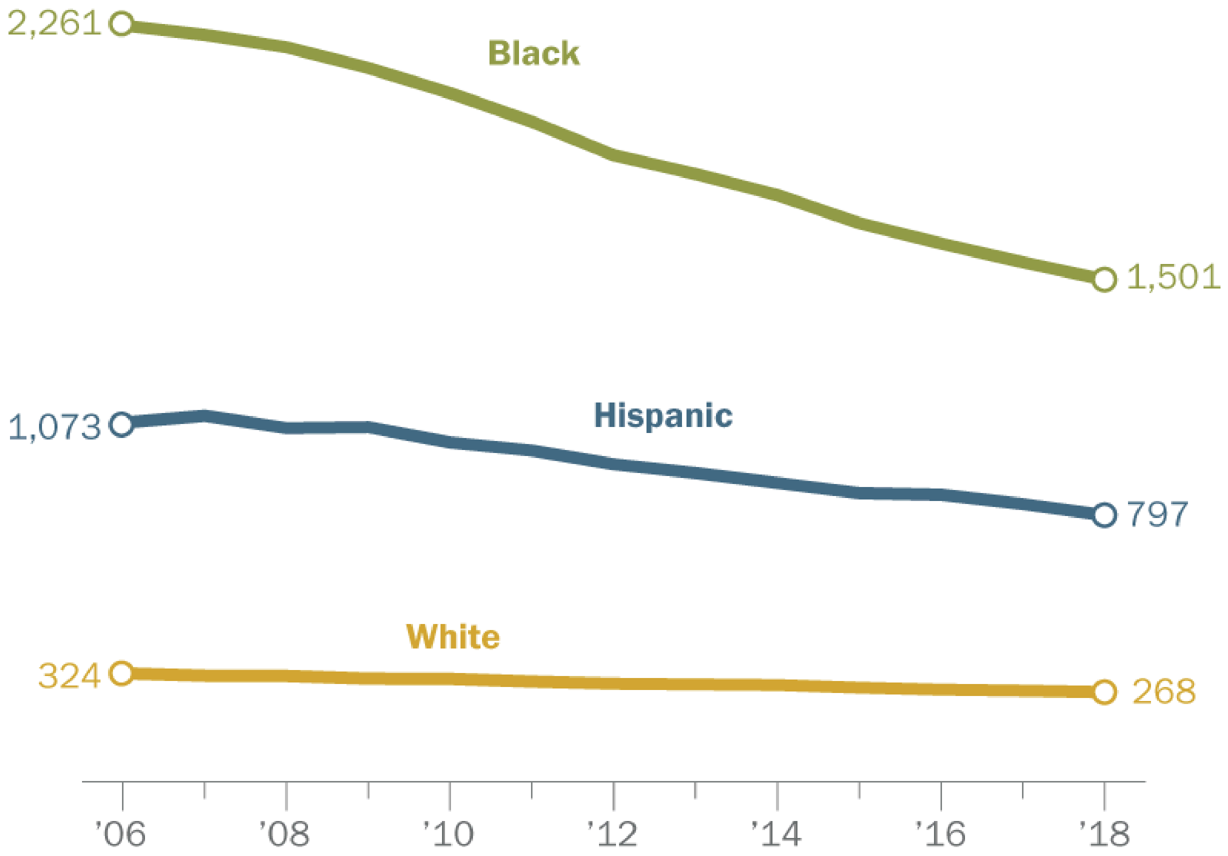
Figure 9: This chart shows the lifetime likelihood of imprisonment for men and women, by race and ethnicity. You are most likely to be imprisoned if you are a Black man and least likely to be imprisoned if you are a White woman.

The War on Drugs is one of the major drivers of the prison population in the United States. In 1971, President Richard Nixon declared a War on Drugs, dedicating increased federal funding and resources to quelling the supply of drugs in the United States. This war continued to ramp up through the 1980s and 1990s, especially as crack cocaine became a growing concern in the media and public sphere. Crack cocaine was publicly portrayed as a highly addictive drug sweeping its way through America, allowing politicians to capitalize on this hysteria and pass policies that rapidly increased the prison population. Even so, the vast majority of arrests and enforcement were not of high-level, violent dealers. More often, police arrested small-time dealers or people struggling with addiction. In fact, during the 1990s, the period of the largest increase in the US prison population, the vast majority of prison growth came from cannabis arrests (King and Mauer 2006).

The 1980s and 1990s were also an era where states turned to partnerships with private companies to meet the booming demand for facilities, leading to the rise of private prisons. Private prisons are for-profit incarceration facilities run by private companies that contract with local, state, and federal private prisons. The business model of private prisons incentivizes them to keep their prisons as full as possible while spending as little as private prisons care for inmates. Down 16 percent from its peak in 2012, private prisons still held 8 percent of all people incarcerated at the state and federal level as of 2019 (The Sentencing Project 2022). This general statistic hides state-to-state differences, though. For instance, Oregon has private prison facilities in the state, while Texas has the highest number of people incarcerated in private prisons.

Imprisonment rates have declined across racial and ethnic groups – especially among black Americans

Prisoners per 100,000 adults ages 18 and older in each group



Notes: Blacks and whites include those who report being only one race and are non-Hispanic. Hispanics are of any race. Prisoners are those sentenced to more than a year in state or federal prison.
Source: Bureau of Justice Statistics.

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Figure 10: As of 2018, even though rates of imprisonment are declining for people of all races and the racial gap is closing, disproportionately more People of Color are still imprisoned.

Even as the racial gap in incarceration has narrowed in recent years, the US disproportionately incarcerates Black Americans. While Black Americans make up 12 percent of the population, they make up over 33 percent of incarcerated individuals (Gramlich 2019). Similar trends exist among Latino Americans: while Latinos comprise 16% of the US population, they account for 23% of incarcerated individuals (Gramlich 2019). In contrast, while White Americans comprise 63% of the population, they only make up 30% of those incarcerated (Gramlich 2019).

This network of policies and unequal institutional practices led to what scholar Michelle Alexander terms The New Jim Crow. The New Jim Crow refers to the network of laws and practices that disproportionately funnel Black Americans into the criminal justice system, stripping them of their constitutional rights as a punishment for their offenses in the same way that Jim Crow laws did in previous eras. Because of these new mass incarceration policies, a new iteration of the racial caste system has emerged: one where Black Americans can legally be denied public benefits, housing, the right to vote, and participation on juries because of a criminal conviction.

Nearly three-quarters of the people in federal prison are nonviolent offenders with no history of violence. Black men are disproportionately arrested and imprisoned. These statements are all true, but what do they actually mean? Sociologists look at patterns of difference or change over time to measure inequality between groups and to explain it. Social problems sociologists often explore the efficacy of possible interventions. Because we want to take effective action, we must examine the information we use to make decisions very carefully.

We see deep inequalities in our criminal justice system. However, we also see competing claims about what is true. How, for example, can the first two statements be true at the same time? The issue lies in combining two populations in the first statement—people who commit violent crimes and people who have a prior criminal record. Getting a prior criminal record might include being arrested for being at a protest, even if you weren't convicted. It could include failure to pay child support. It could also include having a few grams of cannabis in Oregon prior to 2015 when the related law changed. Many people have a criminal record, but they are not actually dangerous to society.

When you examine the second statement, it only includes one group of people: people who are in prison for non-violent offenses. Many of these offenses are related to drug possession, and some of them are related to drug distribution. Although harmful drug use causes harm, these offenses are non-violent. By looking at the numbers in this way, we open the door to considering options for social justice that are effective rather than carceral.

Harmful Drug Use: Exploring Unequal Outcomes

Disproportionality is the overrepresentation or underrepresentation of a racial or ethnic group compared with its percentage in the total population. We can see disproportionality across group disproportionality locations. Racial disproportionality is commonly related to harmful drug use and the criminal justice system. White people make up 60% of the overall population of the United States, but they make up only 38% of people who are incarcerated. Black people make up 13% of the overall population of the United States, but they are also 38% of the incarcerated population. Hispanic people are 18% of the total population and 21% of people in prison or jail. Finally, Native Americans have disproportionality, and 2% of those in jail. In every case, we see disproportionality.

However, the measure of disproportionality doesn't tell us why the difference exists or what to do about it. If you consider the infographic The Social Ecological Framework of the Opioid Crisis, you see many causes of inequality. The causes of disproportionality are often disparity. Disparity is the unequal outcomes of one racial or ethnic group compared with outcomes for another racial or ethnic group (Child Welfare Information Gateway 2021). Disparity can be used to compare any groups with different social locations.

However, as we consider the War on Drugs as an example, we see that systems, laws, policies, and practices privilege White people over People of Color. In one example, the sentencing for crack cocaine and powder cocaine are significantly different. Distributing 5 grams of crack cocaine has a 5-year mandatory minimum federal prison sentence. Distributing 500 grams of powder cocaine has the same sentence. More than 80% of the crack cocaine defendants in 2002 were Black, even though two-thirds of the crack cocaine users were White or Hispanic (The Sentencing Project 2004). Powder cocaine is more likely to be used by wealthier people, who are disproportionately White (Vagins and McCurdy 2006).

Even when judges have more discretion in what sentences they impose, racial disparities exist: Racialized assumptions by key justice system decision-makers unfairly influence outcomes for people who encounter the system. In research on presentence reports, for example, scholars have found that People of Color are frequently given harsher sanctions because they are perceived as imposing a greater threat to public safety and are therefore deserving of greater social control and punishment. (Nellis 2021).

These biases are both conscious and unconscious, and they occur at every level of the criminal justice system, from police to lawyers, to judges, to the politicians who make the laws in the first place. Structural racism and individual racist ideas result in racial disparity in the criminal justice system.

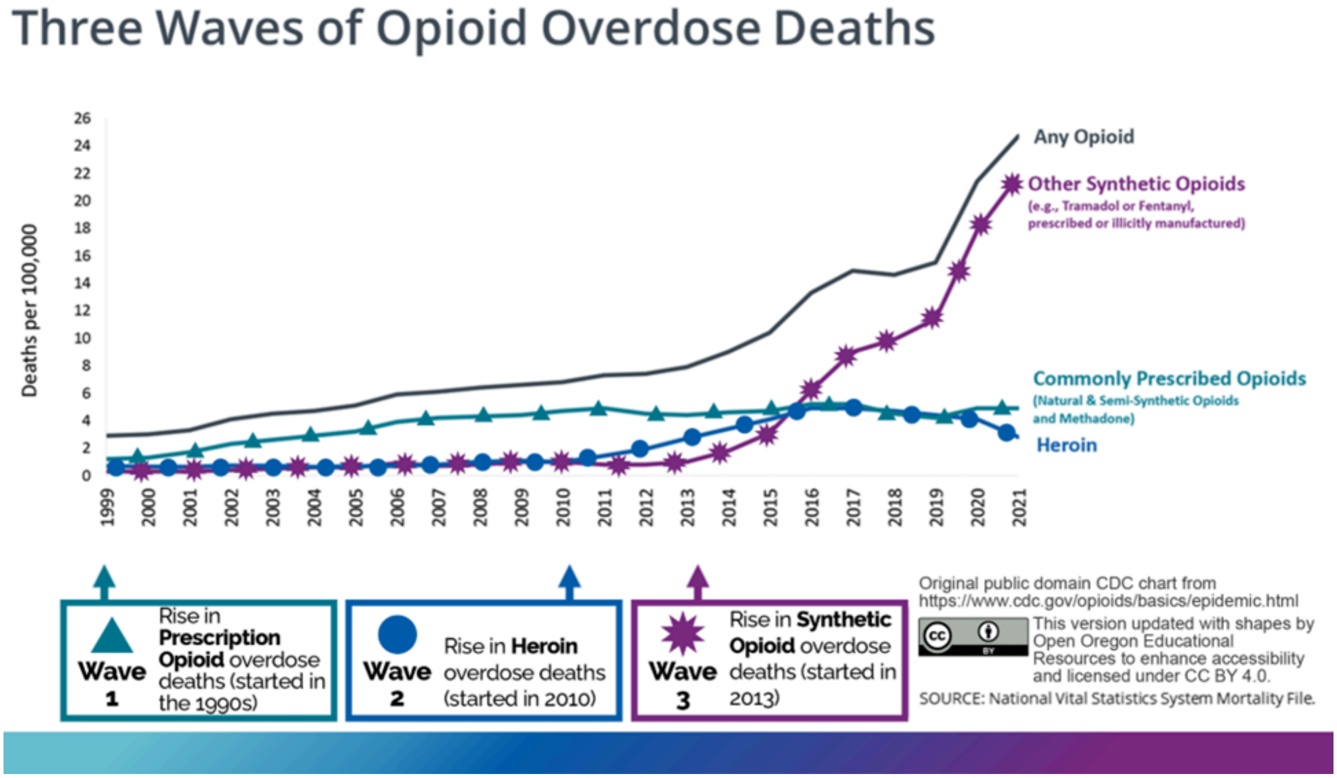
The Opioid Crisis: Medical Intervention, not Crime

Another way to notice racism at work in response to harmful drug use is to examine the opioid crisis. The opioid crisis refers to the surge in fatal overdoses linked to opioid use (DeWeerdt 2019). The overdose fatality rate rose by 345% between 2001 and 2016 (Jalali et al. 2020). Opioids are a class of drugs that cause euphoria. Opioids include heroin, morphine, codeine, hydrocodone, OxyContin®, and fentanyl (Johns Hopkins Medicine 2023). Heroin is an illegal drug. The others are prescription drugs that doctors prescribe for pain relief.

Nearly 75% of drug overdoses in 2020 involved a legal or illegal opioid (Centers for Disease Control

2022). The CDC describes the crisis using three waves. The first wave started in the 1990s. In this wave, the deaths were primarily due to overdoses on prescription opioids, like OxyContin® and Vicodin®. This wave was a result of the over-prescription of opioid-based painkillers, causing some individuals to become physically dependent. The second wave started in 2010.

The second wave was due to overdoses related to using heroin. This use of heroin partially resulted from a decrease in the amount of legally available prescription painkillers. The third wave started in 2013. This wave marked an increase in overdose deaths from synthetic opioids like fentanyl and tramadol. While fentanyl can be prescribed, this wave was driven by illegally manufactured substances.



Original public domain CDC chart from https://www.cdc.gov/opioids/basics/epidemic.html

This version updated with shapes by Open Oregon Educational Resources to enhance accessibility and licensed under CC BY 4.0.

SOURCE: National Vital Statistics System Mortality File.

Figure 11: Three Waves of Opioid Overdose Deaths. Each wave was caused by a different opioid substance. Each wave also had different racist responses.

The response to heroin use and misuse was carceral. Race was at the core of drug policy that emerged from an increase in heroin use in urban centers in the 1960s. According to media accounts, the face of the heroin user at that time was "black, destitute and engaged in repetitive petty crimes to feed his or her habit" (Hart and Hart 2019:7). A popular solution to this racialized drug scare was to incarcerate Black users of heroin and offer methadone treatment to White users.

New York state was a forerunner in creating harsh drug laws to address heroin use in cities. The infamous Rockefeller drug laws of 1973 created mandatory minimum prison sentences of 15 years to life for possession of small amounts of heroin and other drugs (Hart and Hart 2019). 90% of those convicted under the Rockefeller drug laws were Black and Latinx, though they represent a smaller proportion of people who use drugs in the population (Drucker 2002).

The societal response to opioid use and dependence among White people during this crisis has been gentler, relying more on treatment than the criminal justice system (Hart and Hart 2019; James & Jordan 2018). According to statistics from the Bureau of Justice, 80% of arrests for heroin trafficking are among Black and Latinx people, even though White people use heroin at higher rates and are known to purchase drugs within their own racial community (James & Jordan 2018).

As we examine the response to the over prescription of opioids and the harmful use of fentanyl, we see a stark difference in public response. We see a focus on monitoring doctors so that they don't overprescribe opioids. We see a focus on the overuse of opioids as a medical disease needing treatment rather than criminalizing the user of the drug. Our response to drug overuse in the opioid crisis is racialized. Researchers Netherland and Hansen summarize the unequal response this way:

> The public response to White opioids looked markedly different from the response to illicit drug use in inner-city Black and Brown neighborhoods, with policy differentials analogous to the gap between legal penalties for crack as opposed to powder cocaine. This less examined 'White drug war' has carved out a less punitive, clinical realm for Whites where their drug use is decriminalized, treated primarily as a biomedical disease, and where White social privilege is pre- served… in the case of opioids, addiction treatment itself is being selectively pharmaceutical in ways that preserve a protected space for White opioid users, while leaving intact a punitive, carceral system as the appropriate response for Black and Brown drug use. (Netherland and Hansen 2017)

We can see a racialized response in the differential access to treatment options for the harmful use of opioids White people who use opioids have been given more access to the preferred addiction treatment medication, buprenorphine. Treatment with buprenorphine is less stigmatized because it is dispensed like any other pharmaceutical medication at a private doctor's office. Another treatment option is methadone. This method requires frequent visits to a methadone clinic. Often BIPOC receive treatment at the less- preferred methadone clinics (Hansen 2015). Politicians legalized Buprenorphine treatments for opioid use disorder, supporting the privileged lives of middle-class White addicts (Netherland & Hansen, 2017).

These characteristics of the social landscape contribute to increased health harms, such as contracting HIV or hepatitis C, for Black people who use drugs. Health harms caused by substance use are higher among Black people who use drugs, not because they participate in riskier drug use behavior, but because they reside in under-resourced communities that hinder access to health-promoting services and materials (Cooper et al. 2011). Accordingly, opioid overdose rates for Black people have historically been higher than those for White people in some states. Recently this rate has been increasing more rapidly, though the media attention surrounding the opioid crisis mostly focuses on drug use by White people (James & Jordan 2018). We also see differences in the harm caused by harmful drug use because of the lack of treatment centers in rural areas. The lack of treatment centers harms White people who live in these areas and People of Color.

Five Models of Addiction

In this section, we explain the five models of addiction that are dominant in US society: the moral view, the disease model, a public health perspective, a sociological approach, and an intersectional approach. We will discuss these five views or models, as well as where this society can be found in action within society.

Moral View

The moral view depicts the use of illicit substances and the state of addiction as wrong or bad. Illicit drug use is understood as a sin or personal failing. Faith-based drug rehabilitation programs are one location where we see the moral model in use. Through qualitative interviews with individuals who had attended such a facility, Gowan and Atmore (2012) found that within the teachings of evangelical conversion-based rehab, substance use is thought to be rooted in immorality. This requires the user to convert and submit to religious authority to recover. Gowan and Atmore (2012) found that addiction implied that the root of addiction was in secular or nonreligious life. The rigid structure of faith-based drug treatment programs can be helpful for some people in recovery. Some people also find that faith-based community programs like twelve step programs are effective.

Table 1: The Federal Drug Schedule. Which drugs that impact human behavior are on this list? Which ones are missing?

Schedule	Definition	Examples
Schedule I	No currently accepted medical use and a high potential for abuse.	Heroin, LSD, and cannabis
Schedule II	High potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous.	Vicodin, cocaine, methamphetamine, etc.
Schedule III	Moderate to low potential for physical and psychological dependence. Abuse potential is less than Schedule I and Schedule II drugs but more than Schedule IV.	Tylenol with codeine, ketamine, etc.
Schedule IV	Low potential for abuse and low risk of dependence.	Xanax, Soma, Valium, etc.
Schedule V	Lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics.	Robitussin AC with codeine, Lomotil, etc.

The moral view toward drug use can also be seen in our criminal justice system and the criminalization of drug use. Criminalization is the act of making something illegal (Definition of Criminalize 2023). The 1970 Comprehensive Drug Abuse and Control Act (US House 1970) created drug categorizations, called schedules, based on the drug's potential for abuse and dependency and its accepted medical use. This new system of categorization acknowledged the medical use criminalization while heightening the criminalization of other drugs. Drug policy in the United States is guided by the moral view of drug use. It calls for those who use substances to be punished, whether it is through fines, some form of home arrest, or incarceration.

Disease Model

Understanding drug use and particularly addiction to mind-altering substances as a disease is another dominant model found within US society and its social institutions. The idea of considering substance use a disease is at least 200 years old. Researching the history of the disease concept of addiction, sociologist Harry Levine (1978) found that habitual drinking during the eighteenth century was not considered a problematic behavior. The emergence of the temperance movement in the nineteenth century shifted American thought toward understanding addiction as a progressive disease. In this idea of disease, a person loses their will to control the consumption of a substance. In the 1940s, the National Council of Alcoholism was founded by E.M. Jellinek, a professor of applied physiology at Yale. The purpose of this council was to popularize the disease model of addiction by putting it on scientific footing by conducting research studies on drug use. Science promoted the disease model. It did not create it (Reinarman 2005).

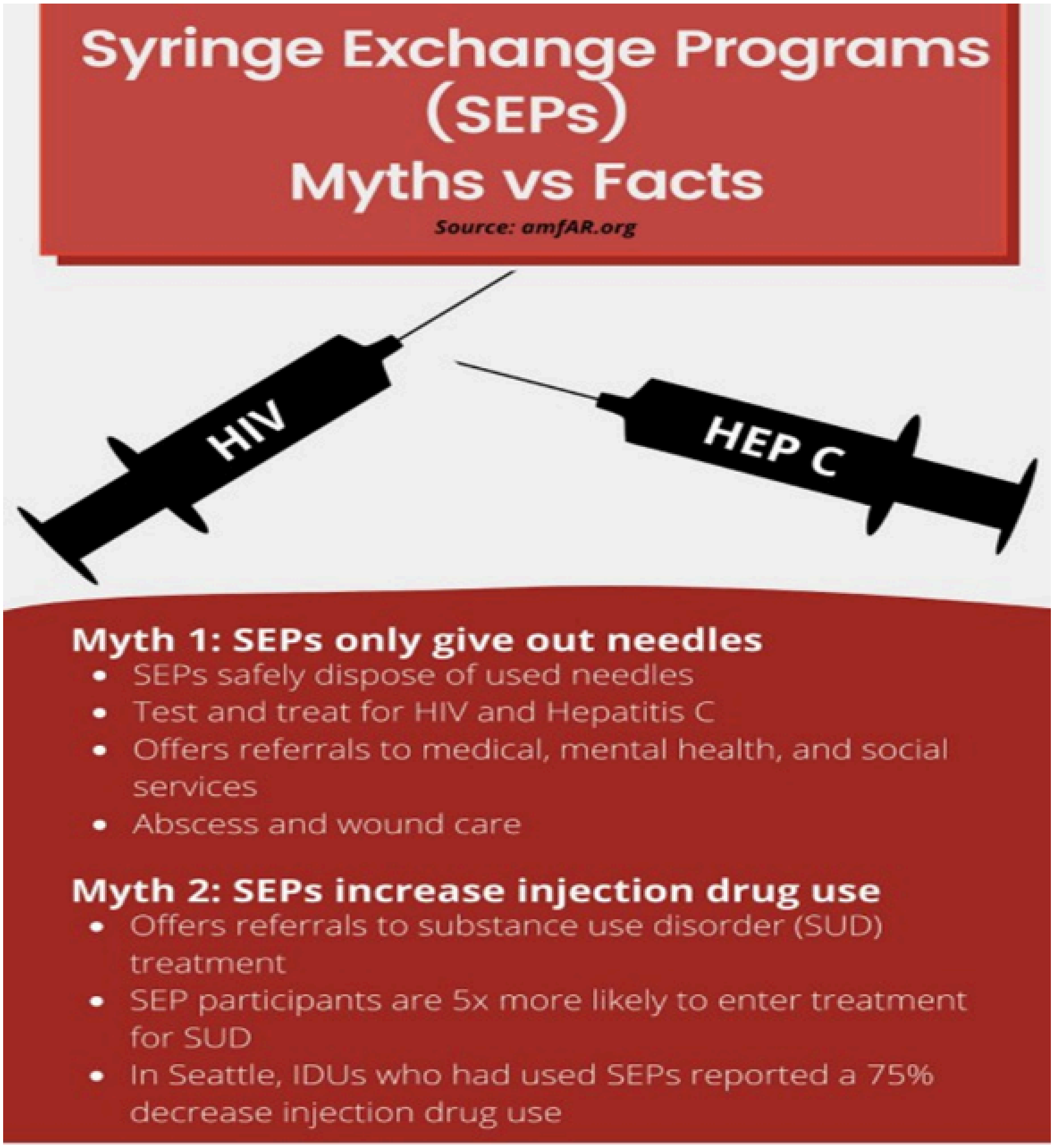
The disease model of addiction also involves the use of pharmaceuticals, such as methadone, to treat physical and psychological dependence on opiates. Physicians Vincent Dole and Marie Nyswander successfully researched the use of methadone to stabilize a group of 22 patients previously addicted to heroin. Dole and Nyswander (1965) found that with the medication and a comprehensive program of rehabilitation, the patients showed marked improvements. They returned to school, obtained jobs, and reconnected with their families. The researchers found that the medication produced no euphoria or sedation and removed opiate withdrawal symptoms.

The legitimacy of the disease model of addiction was reinforced by the clinical research findings of Dole and Nyswander, which showed that a pharmaceutical (i.e., methadone) could be used to treat addiction. Dole and Nyswander (1965) wrote: “Maintenance of patients with methadone is no more difficult than maintaining diabetics with oral hypoglycemic agents, and in both cases, the patient should be able to live a normal life.” Those who support the disease model of addiction often compare addiction to diabetes. The analogy demonstrates the similarity of addiction to other diseases.

Since the 1990s, addiction has been understood as a neurobiological disease and referred to as a chronic relapsing brain disease or disorder. Using brain imaging technology, scientists and researchers came to find that addictive long-term use of substances changed the structure and function of the brain and had long-lasting neurological and biological effects. Social scientists have questioned the sole use of the disease model to understand addiction, asserting that addiction also involves a social component. They point out that the disease of addiction is not diagnosed through brain scans. Rather, it is often identified when one is breaking cultural and social norms around productivity and compulsion (Kaye 2012).

Public Health Perspective

A public health perspective toward substance use incorporates a sociological understanding of drug use but focuses on maintaining the health of people who use drugs. Often this approach is labeled harm reduction. Harm reduction is a set of strategies and ideas aimed at reducing negative consequences associated with drug use (Harm Reduction Principles N.d.). Harm reduction is also a practical movement for social justice built on a belief in, and respect for, the rights of people who use drugs. It focuses on providing people who use drugs with the information and material tools to reduce their risks while using drugs. This perspective focuses on reducing the harm of substance use rather than requiring harm reduction all drug use. Similar harm reduction strategies are wearing seat belts or providing adolescents with condoms.



Syringe Exchange Programs (SEPs)
Myths vs Facts

Source: amfAR.org

Myth 1: SEPs only give out needles
- SEPs safely dispose of used needles
- Test and treat for HIV and Hepatitis C
- Offers referrals to medical, mental health, and social services
- Abscess and wound care

Myth 2: SEPs increase injection drug use
- Offers referrals to substance use disorder (SUD) treatment
- SEP participants are 5x more likely to enter treatment for SUD
- In Seattle, IDUs who had used SEPs reported a 75% decrease injection drug use

Figure 12: In this infographic, we see myths about syringe exchange programs and the facts that dispel the myths. Syringe exchange programs reduce harm.

One of the most well-known harm reduction practices is syringe exchange. This became legal during the HIV epidemic of the 1980s and ’90s to help people who inject drugs avoid infection with the then-deadly virus. Currently, harm reduction is also associated with the distribution of the opioid overdose reversal antidote—Narcan or Naloxone. This harmless medication can almost instantaneously reverse an opioid overdose, saving a person’s life. The public health or harm-reduction perspective toward drug use can be controversial because some believe that it enables drug use. There is no scientific evidence to support this idea. Instead, scientific evidence shows that syringe exchange reduces HIV and hepatitis C rates, and the distribution of Narcan lowers drug overdose mortality rates (Platt et al. 2018; Fernandes et al. 2017; Chimbar & Moleta 2018).

Sociological Model

The sociological model of drug use and addiction examines how social structures, institutions, and phenomena may lead individuals to use mind-altering substances to cope with difficulty and distress. A sociological view also examines how social inequalities can make the impacts of drug use worse for some social groups than others. Within the sociological model, a socio-pharmacological approach looks at how social, economic, and health policy might exacerbate harm to people using substances. Socio pharmacology is a sociological theory of drug use developed by long-time drug use researcher Samuel R. Friedman. Friedman (2002) writes that approaches toward understanding drug use that focus on the psychological traits of the people using the drugs and the chemical traits of the drugs ignore socioeconomic and other social issues that make individuals, neighborhoods, and population groups vulnerable to harmful drug use.

To consider how the socio-pharmacological approach plays out in everyday life, consider how drug policy prohibits the use of heroin and results in several harmful effects. New syringes can be hard to find. People will inject in unclean and rushed circumstances, which may negatively impact their health by putting them at risk of contracting HIV or life-threatening bacterial infections. This type of analysis is also thought of using the analytic concept of risk environments developed by Tim Rhodes. A risk environment is a social or physical space where a variety of things interact to increase the chances of a drug-related risk environment. An analysis of the risk environment looks at how the relationship between the individual and the environment impacts the production or reduction of drug harm.

In his socio-pharmacology theory, Friedman also notes that the social order might cause misery for some social groups, which might cause people to self-medicate with drugs. People who experience class, gender, or racial oppression suffer harm. As a way to deal with that harm, they may choose to self-medicate with drugs or alcohol. For example, working a low-paying service job where you deal with unhappy customers and mis- treatment from your boss may lead you to blow off steam by using substances. Individualistic theories of drug use stigmatize and demonize individuals who use drugs as being weak or criminal. According to the socio-pharmacological approach, if anything should be demonized, it should be the social order—not the individual who uses drugs (Friedman 2002).

Looking at the social determinants of the opioid crisis provides a way to discuss a sociological approach to studying drug use. opioid crises to understand the opioid crisis focus on the supply of opioids in the US and whether they were pharmaceutical or illicit. This approach misunderstands the reasons individuals use opioids. The label deaths of despair has been used to describe three types of mortality that are on the rise in the US. Deaths of despair have caused a decline in the average lifespan among Americans. These three deaths occur from drug overdose, alcohol-related disease, and suicide. Death from these conditions has risen sharply since 1999, especially among middle-aged White people without a college degree (Dasgupta, Beletsky, and Ciccarone 2018).

Researchers are examining how economic opportunities impact opioid use and overdose rates. In a study focused on the Midwest, Appalachia, and New England, areas that are predominantly White, researchers found that mortality rates from deaths of despair increased as county economic distress worsened. In rural counties with higher overdose rates, economic struggle was found to be more associated with overdose than opioid supply (Monnat 2019). Analysis of the social and economic determinants of the opioid crisis notes that the jobs available in poor communities, which are often in manufacturing or service, present physical hazards and cause long-term wear and tear on the worker's body (Dasgupta et al. 2018). An on-the-job injury can lead to chronic pain, which may disable a person. The disability may cause them to seek pain relief through opioids. The resulting addiction pushes them into poverty and despair.

A 2017 report from the National Academy of Sciences used a sociological view of drug use when it commented on the cause of the opioid crisis. The report states: Overprescribing was not the sole cause of the problem. While increased opioid pre- scribing for chronic pain has been a vector of the opioid epidemic, researchers agree that such structural factors as lack of economic opportunities, poor working conditions, and eroded social capital in depressed communities, accompanied by hopelessness and despair, are root causes of the misuse of opioids and other substances. (Zoorob and Salemi 2017)

However, this research into deaths of despair focused on the increased opioid-related deaths due to overprescription in the first wave of the opioid crisis. Although the researchers don't name it specifically, they were looking at patterns of drug use and abuse by White people. The researchers demonstrate implicit bias. As the crisis continues, researchers are examining of the second and third waves of the crisis. According to a study from Marjorie C. Gondré-Lewis, Tomilowo Abijo, and Timothy A. Gondré-Lewis: Categorically, from 2015 to 2017, African Americans experienced the highest OOD increase of all races analyzed; 103% for opiates and 361% for synthetic opioids in large central metropolitan cities, and respectively 100% and 332% in large fringe metros Illicitly manufactured fentanyl accounts for increased overdose deaths more than any other opioid across the USA. (2022)

The opioid crisis is now impacting urban, Black people disproportionately. Despite the research biases we notice here, a sociological view of drug use helps us to understand the social contexts that can lead to drug use and cause it to be harmful or deadly. Without a sociological analysis, we'd only be looking at individual people and drugs. We would miss the entire social environment which influences both drug use and the consequences of drug use. A sociological analysis notices widespread social structural elements that might increase drug use: racism, economic despair, and hopelessness. This analysis can help us create policies and programs that can be beneficial for large numbers of people. From the sociological perspective, we see that, like other social problems, differences in social location create unequal outcomes.

Intersectional Model: Colonization and Drug Use

Indigenous people report the second highest rate of illicit drug use disorder between 2015 and 2019, at 4.8%. The highest percentage is among people who identify as two or more races or ethnicities. Indigenous people are also the highest percentage of people who sought treatment for illicit drug use disorders and received it (Center for Behavioral Health Statistics and Quality 2021).

The work of researcher and professor Maria Yellow Horse Brave Heart, explains how the historically-based trauma experienced by Indigenous communities in the United States may impact substance use. She emphasizes that the traumatic losses suffered across generations by the North American Indigenous populations meet the definition of genocide. She lists massive traumatic group experience trauma as part of the intergenerational trauma experienced by this community, which may contribute to substance use (2003).

This list includes traumas such as massacres; prisoner of war experiences; starvation; displacement; separation of children from families and placement in compulsory and often abusive boarding schools; disease epidemics; forced assimilation; and the loss of language, culture, and spirituality. All of this contributes to the breakdown of family kinship networks.

Brave Heart points to an 1881 US policy outlawing the practice of Native ceremonies, which prohibited traditional mourning practices. This undermined practices of healing and resolution that might improve wellness and potentially lower problematic substance use levels. Urban Indigenous people who use alcohol and/or other illicit substances reported symptoms of historical trauma (Wiechelt et al. 2012). Brave Heart (2003) points out that alcohol was not part of Indigenous culture except for specific ceremonies before colonial contact.

Researchers suggest that treatments for substance use disorder among Indigenous peoples should coincide with decolonizing practices. This means that Indigenous communities should be supported in making attempts and achieve control of land and services. Nutton and Fast report that:

> …communities that have made attempts to regain control of land and services have been found to have lower suicide rates, reduced reliance on social assistance, reduced unemployment, the emergence of diverse and viable economic enterprises on reservation lands, more effective management of social services and programs, including language and cultural components, and improved management of natural resources. (2015).

Identity formation can also be a helpful part of drug treatment for Indigenous individuals. Research indicates that increased participation of Indigenous peoples in their culture of origin can decrease the prevalence of substance use disorder. (Nutton & Fast 2015). Finally, all drug treatment interventions should be culturally adapted for Indigenous communities. For example, among Indigenous people inhabiting the Great Plains, the Sun Dance was performed in thanksgiving for a bountiful year and a request for another year of food, health, and success. Today community members pledge to do the Sun Dance to maintain their sobriety from alcohol or drugs.

Recovery is Social Justice

Though the continued opioid (and now fentanyl) crisis may be a reason to despair, there are many individuals, social movements, and other organizations who are working to address problems associated with substance use. Social science, public health, biomedical, and legal scholars and researchers are diligently producing more evidence-based knowledge to guide societal efforts toward more humane and pragmatic responses to substance use. Reducing harmful drug use is social justice.

Harm-Reduction Movement

Harm reduction offers a lens through which we can understand and address issues associated with substance use. Harm reduction can be understood as a set of practices. It can also be understood as a social justice movement. The philosophy behind harm reduction revolutionizes the way we respond to human problems, namely addiction, drug overdose, and HIV. Harm reduction uses a grassroots approach based on advocacy from and for people who use drugs and accept alternatives to abstinence that reduce harm (Marlatt 1996). According to the Harm Reduction Coalition, the central harm reduction organization in the US, a core principle of harm reduction philosophy “accepts for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.”

Syringe exchange programs, or their more current name—syringe service programs—were one of the early harm reduction efforts made to address the AIDS crisis of the 1980s and ’90s. The Harm Reduction Coalition states that “Syringe service programs (SSPs) distribute sterile syringes, safer drug use supplies, and education to people who inject drugs.” The current opioid crisis in the United States is causing a dramatic increase in infectious diseases associated with injection drug use, such as HIV or hepatitis C. Syringe service programs are known to reduce HIV and hepatitis C infection rates by an estimated 50% (Platt et al. 2017). When paired with medication-assisted treatment to treat opioid dependence, syringe service programs can reduce HIV and hepatitis C transmission by over two-thirds (Platt et al. 2017; Fernandes et al. 2017). Sometimes people oppose syringe service programs because they think it might enable drug use.

Research shows the opposite. According to the US Centers for Disease Control and Prevention (2019), new users of syringe service programs are “five times more likely to enter drug treatment and three times more likely to stop using drugs than those who don't use the programs." Syringe service programs can also prevent opioid overdoses by educating people who use drugs about ways to prevent overdose. Syringe service programs provide training on how to recognize an overdose and how to use naloxone or Narcan, a harmless medication that reverses opioid overdoses. Often syringe service programs will distribute overdose prevention kits that include naloxone (CDC 2019).

Decriminalize Low-Level Drug Offenses

National social justice advocates recommend decriminalizing low-level drug offenses as a way to decrease oppression in our criminal justice system. Decriminalization is the act of reducing penalties for possession/use of small amounts from criminal sanctions to fines or civil penalties (Galvin 2014). For example, in order to address the racial and ethnic disparities in criminal justice systems, Ashley Nellis from the Sentencing Project recommends that we: discontinue arrest and prosecutions for low-level drug offenses which often lead to the accumulation of prior convictions which accumulate disproportionately in communities of color. These convictions generally drive further and deeper involvement in the criminal legal system. (Nellis 2021)

Decreasing criminal involvement in the first place related to harmful drug use is a step in treating harmful drug use like a medical condition that needs treatment rather than a criminal condition that needs punishment.

Legalization of Cannabis

Social movements, as well as individuals who sought to decriminalize and legalize cannabis, were often motivated by the United States's long history of systemic racism and the war on drugs. Legalization means to make the possession and use of a drug legal (Galvin 2014a). Since 2012, 24 states and Washington, D.C., have legalized cannabis for adults over the age of 21. Legalizing cannabis has meant fewer arrests and jail time. In Oregon, the number of cannabis arrests decreased by 96 percent from 2013–2016, the year cannabis was legalized for adult recreational use Drug Policy Alliance 2022).

The Drug Policy Alliance, a nonprofit organization that advocates for the decriminalization of drugs, examined rates of youth cannabis use. They found that since the legalization of cannabis use in some states, youth use rates have remained stable and, in some cases, legalization has also found that legalization has not made roadways less safe due to driving under the influence of cannabis. Finally, they show that states are using the money generated through taxes on legal cannabis for social good (The Drug Policy Alliance 2022). In Oregon, 40% of the cannabis tax revenue goes to the state school fund, and 20% goes to alcohol and drug treatment.

However, health researchers remain concerned about the impacts of cannabis legalization on adolescent cannabis use. Increasing amounts of research reveal correlations between adolescent cannabis use and short and potentially long-term impairments on cognition, worse academic/ vocational outcomes, and increased prevalence of psychotic, mood, and addictive disorders (Hammond et al. 2020). Though cannabis use rates among adolescents are higher in states that have legalized the substance, those rates were higher even before legalization (Choo et al. 2014; Wall et al. 2011; Ammerman et al. 2015). Legalization itself did not cause higher usage rates.

Other negative impacts of cannabis use have risen in states where cannabis is legalized. Motor vehicle accidents and deaths where cannabis was involved have increased. Young children and pets accidentally overdose more often. Finally, emergency rooms see more patients and hospitalize them more often due to potent cannabis causing psychosis, depression, and anxiety (Committee on Substance Abuse & Committee on Substance Abuse Committee 2015, as cited in Hammond et al. 2020).

When considering whether cannabis should be legal, Hammond et al. (2020) point out that we must balance the negative impacts (discussed above) with the positive effect of decriminalization, reducing youth juvenile justice involvement. Youth involvement in the juvenile justice system can have long-lasting negative impacts on the life outcomes of youth. For example, involvement in the juvenile justice system may disrupt education or cause long-lasting mental health problems. We must consider the reduction of these types of issues alongside the known negative impacts of youth cannabis use. Another equity issue arises with the legalization of cannabis and the rise of a money-making industry. A drug-related felony on an individual's record may be a barrier to gaining a license to sell cannabis through a dispensary. As we've discussed in this chapter, due to systemic racism within drug policy enforcement, those with drug-related felonies on their record are disproportionately Black. This means that Black entrepreneurs may be disproportionately blocked from entering the cannabis industry. Several cities have implemented equity programs to address this issue. In California, a prior drug felony cannot be the sole basis for denying a cannabis license. In Portland, Oregon a portion of cannabis sales tax revenue is spent on funding women-owned and minority-owned cannabis businesses (DPA).

Decriminalizing Personal Possession of Illegal Drugs in Oregon

On November 3, 2020, Oregon became the first state in the United States to decriminalize the personal possession of illegal drugs. By approving Measure 110, Oregon voters significantly changed the way drug possession violations are addressed. People found with smaller amounts of controlled substances (such as heroin, cocaine, or methamphetamine) are issued a Class E violation, which is punishable by a $100 fine. Alternatively, people in violation can have the fine waived if they complete a health assessment at an addiction recovery center. Measure 110 also created a new drug addiction treatment and recovery grant program funded by the anticipated savings due to reduced enforcement of criminal drug possession penalties, as well as cannabis sales tax revenues (Lantz and Neiubuurt 2020). Advocates for Measure 110 saw it as a way to eliminate drug policies that were having a disproportionately negative impact on Black and Indigenous People of Color. This law also shifted the societal response to drug use from a punitive, moralistic approach to one that involved treatment and compassion.

During the same election vote in 2020, Oregonians also approved Measure 109, which directs the Oregon Health Authority to license and regulate the manufacturing, transportation, delivery, sale, and purchase of psilocybin products and the provision of psilocybin services (Oregon Health Authority N.d.). Psilocybin is the main psychoactive component of magic mushrooms (Figure 11.18). This substance has been utilized for thousands of years in spiritual ceremonies in Indigenous cultures (Lowe et al. 2021). Psilocybin is considered a psychedelic hallucinogenic drug that produces both mind-altering and reality-distorting effects.

Following negative stigmatization of the substance due to its use within the hippie counter culture movement, in 1970, the federal government changed the classification of psychedelics (including psilocybin) to Schedule 1 drug, which ended all scientific research on psychedelics. Research interest in the therapeutic uses of psychedelics resumed in a 2004 pilot study from the University of California, Los Angeles, which investigated the use of psilocybin treatment in patients with advanced-stage cancer (Grob et al 2010).

Since then, significant amounts of research into the use of psilocybin to treat an array of health concerns, from anxiety to cluster headaches, have taken place. Measure 109 in Oregon required a comprehensive review of the scientific literature on psilocybin's therapeutic uses. This review found research that suggests that psilocybin can reduce depression and anxiety. The FDA has designated psilocybin as a "breakthrough therapy" for the treatment of depression, which means that psilocybin treatment may be a significant improvement over existing therapies to treat depression Psilocybin therapy involves the administration of the substance in the context of counseling support in the weeks before and after dosing (Abbas et al. 2021). Though Oregon's regulated psilocybin treatment programs will not be up and running until 2023, they offer hope to those suffering from mental health disorders for whom other treatments do not work. Oregon's decriminalization of low-level drug offenses is revolutionary, but it follows the advice of national social justice advocates, who recommend this action to address systemic inequalities related to harmful drug use.

Community Collaboration for Drug Treatment

A final way to address the social problem of harmful drug use is to expand access to effective drug treatment. Expanding options takes collaboration by federal, state, and community partners to make a difference.

The Intersectionality of Drug Treatment

Socioeconomic status and race impact access to drug treatment. Most elective drug treatment programs require some form of payment for services. Those without insurance and without the financial means to pay will be unable to receive treatment. Researchers have also found that racial discrimination has prevented entry for Black and Indigenous People of Color into more desirable forms of drug treatment (Hansen 2015).

While some may actively seek drug treatment, others may be forcefully mandated to attend strong-arm or faith-based rehabilitation pro- grams. Sociologist Teresa Gowan asserts that these types of mandated rehab programs are used by the state to manage the poor. Poor individuals with a drug violation may be mandated to undertake forms of treatment that are designed to "transform basic behavioral dispositions and instill a new moral compass" (Gowan 2012).

At strong-arm rehab centers, all DWI (driving while intoxicated) and many low-level drug offenders are encouraged to define themselves as addicts, even if they may not actually have a substance use disorder. They are also punished for relapse and rewarded for a "cure." Gowan found that cultural styles and tastes that were not middle-class were brought into the so-called therapeutic habilitation process and considered to be in need of reform. Bringing up the role of poverty or racism in one's life is thought to be immature and evidence of the addict's ego (Gowan 2012).

Race and class also play a role in determining which type of opioid use disorder treatment one will receive. Hansen (2015) found that BIPOC was often only offered the option of the less desirable methadone treatment, which requires near-daily visits to a clinic and a demeaning and constricting practice of surveillance (Bourgois 2000). In contrast, White middle-class individuals were more likely to be given the opportunity to receive buprenorphine treatment for their opioid use disorder. This type of treatment is more private and requires significantly fewer medical interactions. Hansen (2015) sees this systemic discrimination as working to maintain the race and class privilege of White middle-class individuals.

Increasing Drug Treatment Options in Local Communities

Drug treatment in Oregon is particularly lacking. Oregon ranks 47th among the 50 US states in access to treatment for substance use disorders. Treatment needs are significantly unmet. In fact, only 8.5% of teens and adults in Oregon who needed treatment received it (Substance Abuse and Mental Health Administration 2020). How might increasing treatment options impact the social problem of harmful drug use? Higher levels of social capital within a community might protect it from higher overdose rates. Social capital is defined as the social networks or connections that an individual has available to them due to group me social capital researchers measured social capital by looking at voting rates, the number of non-profit and civic organizations in a community, and response rates to the census (Zoorob and Salemi 2017). These are all indicative of one's engagement with their community, as well as increased social linkages between people through community organizations.

Community connections can also decrease drug use. Research documents the relationship between experiences with racism and illicit drug use among Black women (Ehrmin 2002). This research shows that while socioeconomic class was a factor, it was not the sole determinant of drug use (Stevens-Watkins et al.2012). Instead, Black women used drugs less if they had a strong ethnic identity and were connected to their communities (Maclin-Akinyemi et al. 2019).

Increasing funding for drug treatment, including drug treatment facilities, harm reduction programs, and community-based drug treatment pro-rams can expand social justice for drug users. Community-based drug treatment programs serve over 53% of people in recovery (Bowser 1998). They include Twelve Step programs and other peer-led recovery groups. These community-based organizations may serve people with specific social identities, such as recovery groups for firefighters, queer people, or women, as examples. In addition, a recent study found that even when harm reduction or drug treatment services were available, they wouldn't offer enough wrap-around services to their clients. For example, even though many clients were unhoused, most programs didn't offer housing. Even when clients were parenting, the programs had no funding for childcare services (Krawczyk et al 2022).

One way to increase funding for drug treatment is through local ballot measures. Measure 110, which decriminalizes possession of small amounts of illicit drugs, was passed in the 2020 election in Oregon. This law increases state funding for drug treatment services.

3.

TOPIC: THE SOCIAL PROBLEM OF MENTAL HEALTH

We examine the social problems of mental health, mental illness, and mental well-being. Our human lives contain sadness, loss, excitement, joy, and, especially in the United States, feeling like you are not enough. But what are the boundaries between having a tough week and mental illness? To begin, we'll read my story about my interactions in a mental hospital.

At first blush, mental health appears to be a uniquely personal phenomenon: mental health, mental well-being, and mental illness seem to be intensely private experiences outside the realm of sociological analysis. After all, who but psychologists and psychiatrists are truly equipped to understand mental health and illness? In this chapter, we aim not only to understand the role of sociology in the study of mental health but to gain a deeper understanding of the effects of social life on our mental well-being. You will be introduced to the major concepts and techniques of understanding mental health and illness from a sociological perspective.

This topic is interdisciplinary. It includes material from many fields. But there is a coherent organizing theme: the need to understand mental illness in a broad social context. Too often, scientists and psychologists study people who have diseases of the mind without regard to their social origins and the institutions of social control involved in mental illness. We examine how history, institutions, and culture shape our conceptions of mental illness and people with mental health challenges. Mental health and mental illness become a social problem because of the conflict in how people disagree about these ideas. We will consider the social factors contributing to the rates and the experiences of mental illness. By this point in our exploration, you will not find it surprising that social location impacts the social problem of "Who is OK?"

We examine the epidemiology of mental health and mental illness to discover how race, class, gender, and other social locations impact how people are diagnosed and treated. We explore how sociologists explain this difference, using concepts such as stigma. Finally, we consider the interdependent nature of mental health and mental illness. These conditions impact individuals, but they also affect families and society. The questions that focus our curiosity are:

- What is the difference between mental health, mental illness, and mental well-being?
- How can we understand mental health as a social problem?
- Why do people experience different mental health issues, diagnoses, and treatments based on gender, race, class, and other social locations?

- How does the social construction of the mixed-race identity explain social inequality, particularly in relation to mental health?
- How are mental health and mental illness underlying factors in other social problems?
- How does the structural oppression of patriarchy impact social problems, particularly related to women, queer, transgender, and non-binary people?
- How do sociological explanations of mental health and mental illness differ from primarily medical or psychological models?
- What creative solutions to providing mental health services combine individual agency and collective action to expand social justice?

In our everyday lives, we might say someone is crazy. Or we might say that we feel out of it. These terms are commonly used, but social scientists must be more precise in their language. Once we have defined our terms, we explore why mental health and mental illness are social problems, not just individual ones.

Mental health is a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life (American Psychological Association 2023). It includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices.

Mental health includes subjective well-being, autonomy, and competence. It is the ability to fulfill your intellectual and emotional potential. Mental health is how you enjoy life and create a balance between activities. Cultural differences, your evaluation of yourself, and competing professional theories all affect how one defines mental health. Mental health is important in every stage of life, from childhood and adolescence through adulthood. When sociologists study mental health, they look at trends across groups. They look at how mental health varies between all genders, different racial and ethnic groups, different age groups, and people with different life experiences, including socioeconomic status. In addition to this, though, they also explore the factors that maintain or distract from mental health, such as stress, resilience, and coping factors, the social roles we hold, and the strength of our social networks as a source of support.

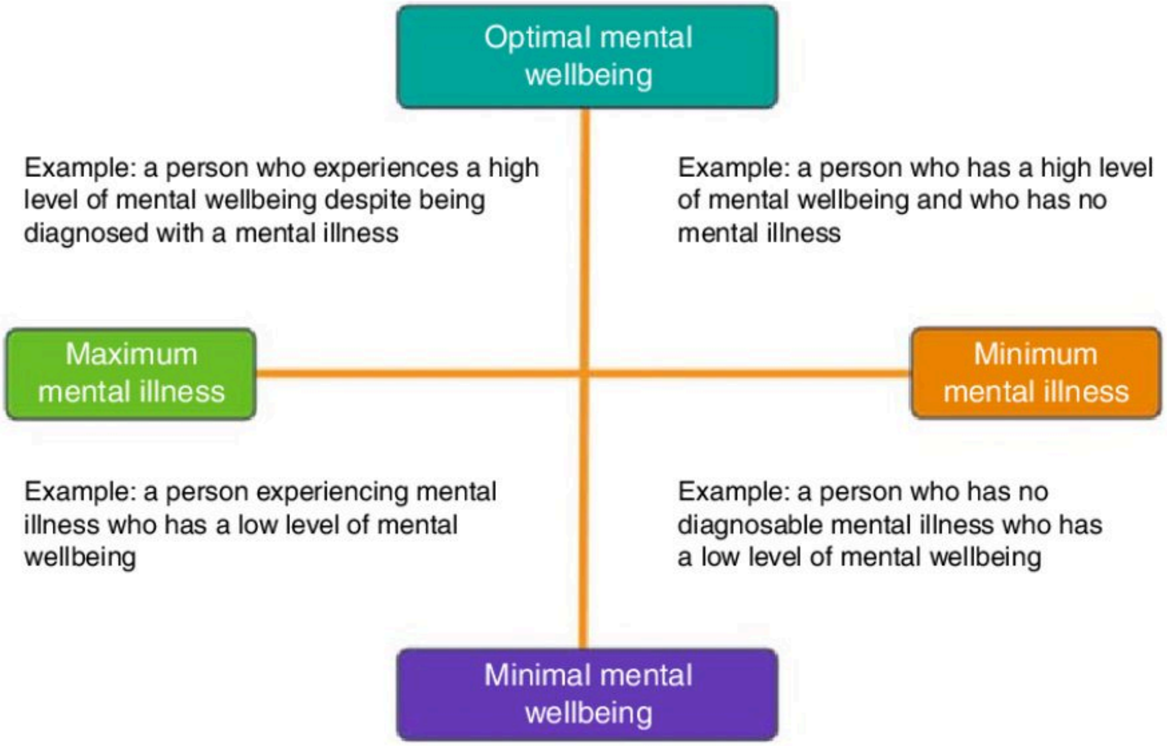
The term mental health doesn't necessarily imply good or bad mental health. At some times in your life, you will feel really good and have good coping skills, strong social networks, a fulfilling career, and a healthy personal and family life. At other times, things may not be going so well for you. You may have work or family conflicts, you find your- self engaging in poor coping skills, not contacting your social network for support. Both times, you are dealing with mental health. In the next section, we will explore the concept of mental illness, which, contrary to common belief, is not the opposite of mental health. Rather, it is one type of experience a person can have with their mental health.

Throughout your life, if you experience mental health problems, you're thinking, mood, and behavior could be affected. Some early signs related to mental health problems are sleep difficulties, lack of energy, and thinking of harming yourself or others. Many factors contribute to mental health problems, including:

- biological factors, such as genes or brain chemistry
- life experiences, such as trauma or abuse
- family history of mental health problems

All of us will experience mental health challenges throughout our lives—times when we're not sleeping, eating, or socializing as well as we know we could be. We may have times when we feel mildly depressed for a matter of days or just don't feel like doing much. These experiences are common and do not mean you have a mental illness. Mental illness, also called mental health disorders, refers to a wide range of mental health conditions and disorders that affect your mood, thinking, and behavior. Examples of mental illness include depression and other mood disorders like bipolar disorder, anxiety disorders, schizophrenia, eating disorders, and addictive behaviors (Mayo Clinic Staff 2022). When substance use disorders co-occur with other mental health disorders, it is known as dual diagnosis. Having a dual diagnosis increases symptoms and decreases responsiveness to treatment. Drug use can precipitate overdoses on drugs such as methamphetamines, cocaine, and cannabis and can also worsen diagnoses such as bipolar disorder and schizophrenia.

Unlike mental health, mental illness has a very specific definition. Psychiatrists, psychologists, and even your primary care doctor use a manual called the Diagnostic and Statistical Manual of Mental Disorders (DSM), which lists every recognized mental illness. The DSM lays out each condition—297 in the most recent iteration— that professionals recognize as a mental illness (American Psychiatric Association 2013). Each mental illness listed in the DSM has a list of diagnostic criteria that a person must meet to be considered to have that particular mental illness. For example, to get an official diagnosis of major depressive disorder, a person must meet five out of eight symptoms, such as severe fatigue, feeling hopeless or worthless, or much less interest in activities they used to enjoy, for at least two weeks to be considered clinically depressed.



Source: Adapted from Keyes (2002)

Figure 13: The Mental Health and Well-being Continuum. Have you ever considered that mental illness and well-being might differ?

In addition to the definitions of mental health and mental illness that we commonly use to discuss diagnosis or lack thereof, some people are starting to use the description of mental well-being. Mental wellness is an internal resource that helps us think, feel, connect, and function; it is an active process that helps us to build resilience, grow, and flourish (McGroarty 2021). While people can support their mental well-being with self-care activities and connecting with family and friends, the core concept is more profound. It comprises the activities and attitudes that all of us can cultivate to ensure our resilience, whether we have a mental health diagnosis or not. The community activists and researchers who created the phrase mental well-being use it for two reasons. First, by separating a mental health diagnosis from the quality of mental well-being, we have a model that helps us understand that mental illness can be like a chronic disease. Some days, weeks, or even years, the illness is very well managed, and the person leads a productive, happy, and fulfilling life. On other days, the illness is not well managed, and the person needs more support. On the other axis, some people may experience a life event that makes them deeply sad or feel powerless. They don't have a mental health diagnosis but may need mental health treatment or support anyway.

Second, some people and communities stigmatize people who have mental illnesses or need mental health treatment. In those cases, using the language of mental well-being avoids stigma.

The National Alliance on Mental Illness (NAMI) hosts these sites, which you can explore if it interests you: Sharing Hope: Mental Wellness in the Black Community and Compartiendo Esperanza: Mental Wellness in the Latinx Community. Both sites have excellent videos exploring issues relating to mental wellness and resilience, mental health, and mental illness in these specific communities.

Mental Health and Mental Illness Go Beyond Individual Experience

Mental illnesses are common in the United States. Nearly one in five US adults live with a mental illness (57.8 million in 2021) (National Institute of Mental Health 2023). Mental illnesses include many different conditions that vary in degree of severity, ranging from mild to moderate to severe. Two broad categories can be used to describe these conditions: Any Mental Illness (AMI) and Serious Mental Illness (SMI). AMI encompasses all recognized mental illnesses. SMI is a smaller and more severe subset of AMI. Below it shows the prevalence of AMI and SMI among adults in 2020, and the bottom chart shows the rates of mental illness in adolescents. Some group-level differences in this data are important to notice. The prevalence of AMI among women is much higher than that of men. There is a 10% gap between the two groups. Why might this be?

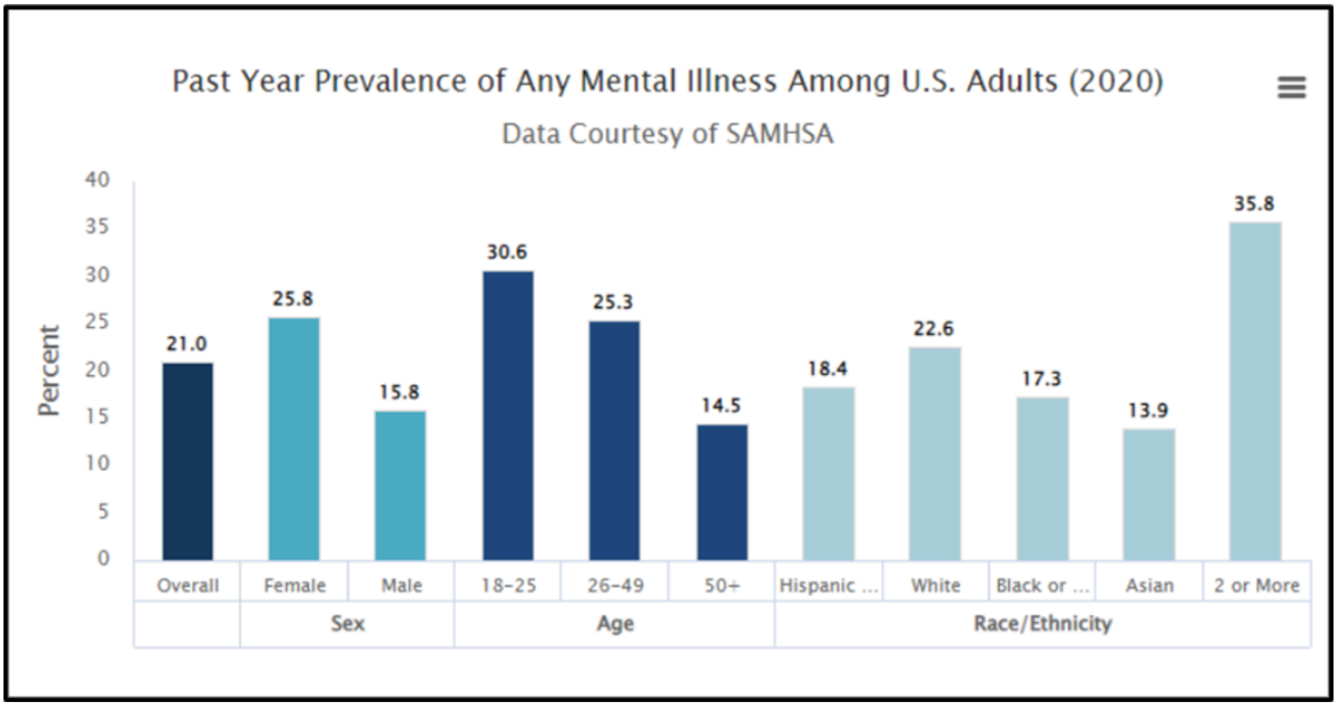


Figure 14: Prevalence of Any Mental Illness (AMI). What differences do you see?

We see several differences between groups of people. For now, we will focus on just one of the bars on this image: the 35.8% of people who experience any mental illness and report as two or more races. We'll look at two factors that might influence the mental health of multiracial people: legal history and double discrimination, although there are many more contributing factors.

Mental Health and Mental Illness as a Social Problem

We see how America has changed," describes several demographic trends of "mixing" occurring recently in the United States. People from different races have always had relationships with each other. Sometimes, in the cases of slavery, these relationships were non-consensual sexual violence. The laws against miscegenation, or the mixing of two races, were only overturned at the federal level in the United States in 1967, less than 50 years ago. (Greig 2013). In fact, "the 2000 Census was the first time that citizens of the United States could select multiple racial categories for self-identification apart from Hispanic ethnicity in a census" (Whaley and Francis 2006). The lack of legal, governmental, and systems recognition of multiracial identity is an additional stress for multiracial people.

A second contributing factor to mental health risks for multiracial people is double-discrimination, the concept that you experience discrimination from both of your communities. This popular media article about Kamala Harris quotes Diana Sanchez, a professor who studies multiracial identity: Sanchez says that multiracial people can face what she refers to as double discrimination, where they experience discrimination from both communities they are members of. In Harris's case, that leads to South Asians saying she's not South Asian enough and Black people saying she might not be Black enough. "So there's all these different sources of discrimination that are affecting the development of your multiracial identity and your experience with it, and that can make it hard to navigate," Sanchez said. (Chittal 2021)

Social Location and Mental Illness Prevalence

Studies show that your social location—your race, class, gender, and sexuality—influences whether or not you develop a mental illness. Our social environments—the way we were socialized as children to be men or women, and the privileges and disadvantages granted by our race, class, and birth sex—all contribute to rates of mental illness. This does not mean that a particular person is more or less likely to get a mental illness but that the rate of mental illness in a particular social group is influenced by that group's location in the social structure.

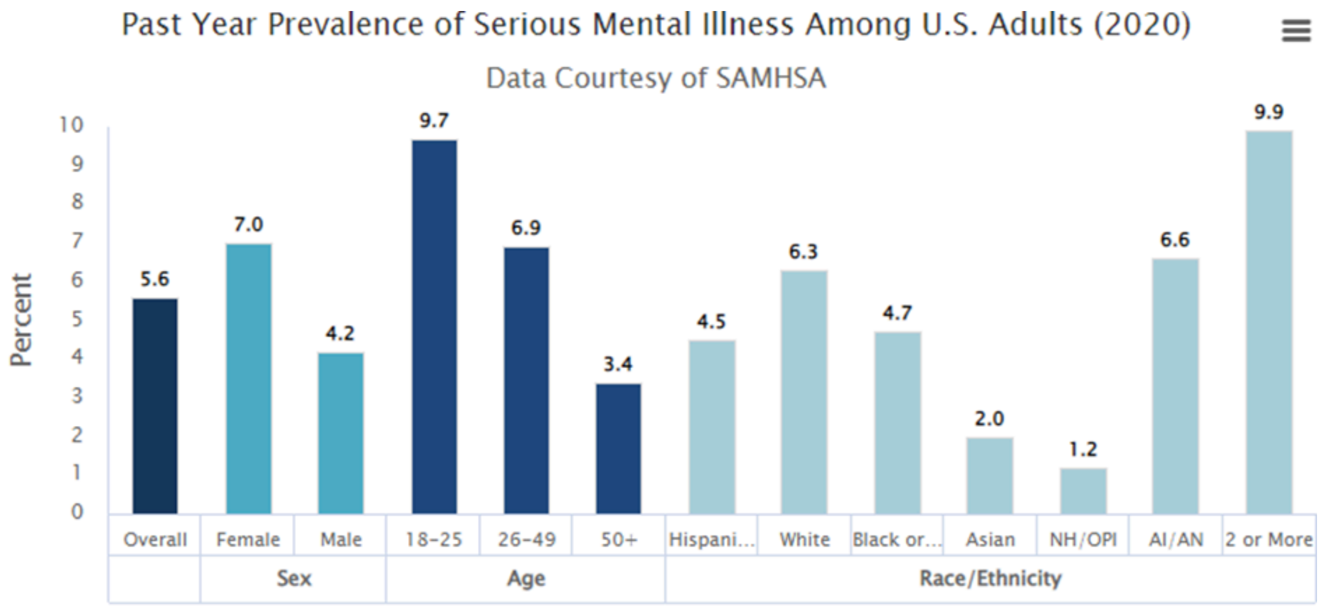


Figure 15: Prevalence of Serious Mental Illness 2020. Mixed Race Adults have the highest prevalence followed by young people ages 18-25.

We will focus on the different prevalence of serious mental illness between women and men. Worldwide, women are more likely than men to experience mental health issues (Andermann 2010). In the past, social scientists commonly concluded that women are more emotional than men. Today, we consider other factors. In the optional article, Culture and the Social Construction of Gender: Mapping the Intersection with Mental Health, psychiatrist Lisa Andermann calls us to look beyond individual explanations of women's mental health and explore structural factors:

Identifying the psychosocial factors in women's lives linked to mental distress, and even starting to take steps to correct them, may not be enough to reduce rates of mental illness or improve well-the well-being of women around the world. More studies that take into account the interaction between biological and psychosocial factors are needed to explore the perpetuating factors in women's mental health, explain why these problems continue to persist over time, and suggest strategies for change. And for these changes to occur, health system inadequacies related to gender must be addressed. (Andermann 2010).

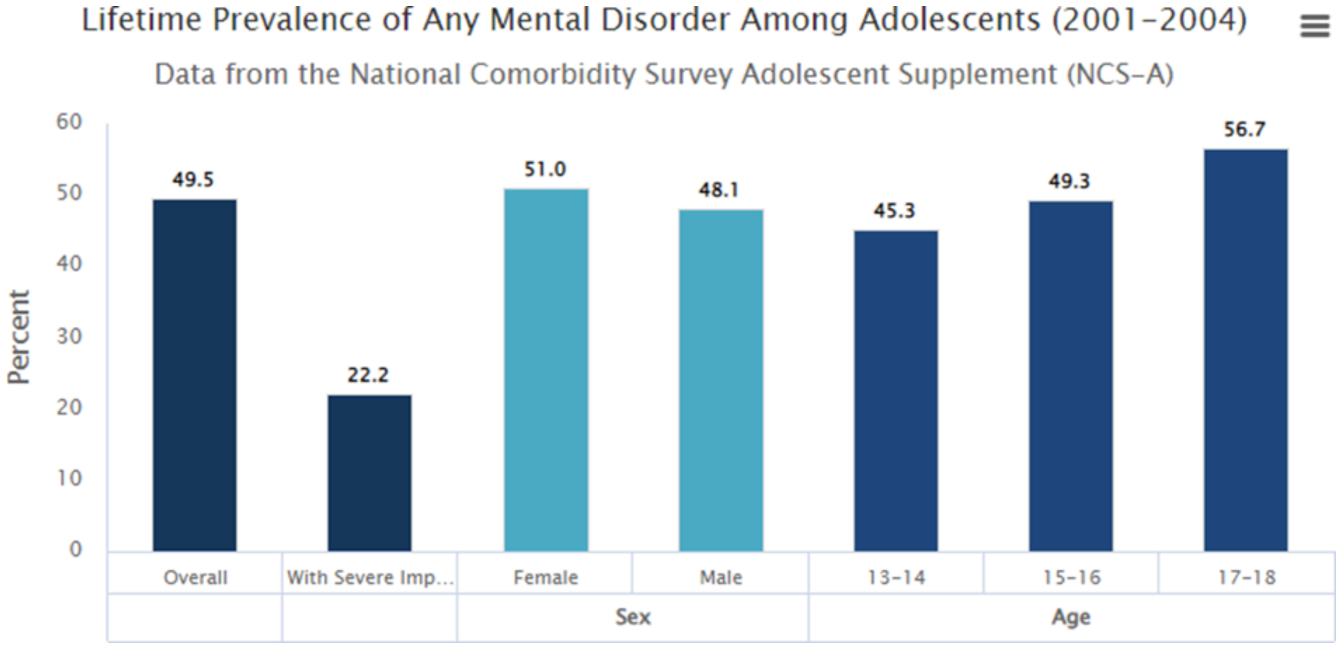


Figure 3.4: Prevalence of Any Mental Disorders Among Adolescents. Almost half of all teenagers report a mental disorder.

When 21% of all adults have a mental illness, and almost half of all teenagers have mental disorders, the condition goes beyond being a personal trouble and enters the realm of a public issue. Biology: Scientists are mapping changes in the brain in much more detailed ways. During adolescence, the brain adds new connections, particularly connections related to executive planning and regulation. Half of adults with mental disorders experience the onset of the disorder by age 14, and 75% of adults experience the onset by age 24 (Kessler 207). Remembering that the human brain is in formation until age 25, these data suggest that experiences during adolescence shape mental health outcomes.

Scientists are mapping brain development in new ways that reveal the importance of the neural networks that are being created in adolescence. An adolescent brain is creating new connections, particularly connections related to planning and regulation. These connections help to stabilize a person's mental health. Further, if a person's experience or biology does not map new connections in essential pathways, a person's mental health may be less stable. Because adolescent brains not only respond to the same experiences as adult brains but develop faster and more extensively, experiences in adolescence may shape the brain's functioning more powerfully than those experiences in adulthood. Experiences that negatively impact brain development include child and adolescent illness, hormonal shifts, exposures to toxins such as drugs and alcohol, food insecurity, trauma history, and emotional and physical abuse. As we learned, ACEs predict health outcomes. Impact on brain development is one of how childhood trauma impacts adult health outcomes. Specifically, trauma and stress factors negatively impact normal brain development and increase vulnerability to mental or emotional illness.

Other researchers suggest that part of the difference between the two age groups has to do with being able to contact people. Many youths are still connected with school and family, even if they are experiencing mental health issues. Most mental health surveys don't contact people in residential living, including assisted living, group homes, prisons, or jails. Also, they do not contact houseless people. Because of this, mental health issues in adult and senior populations may be significantly under-reported (Kessler and Wang 2008). More stress, less stigma: Also, researchers are exploring whether the increase in reporting of mental health issues for teens and young adults is due to experiencing more stressors or experiencing less stigma around reporting mental health concerns.

Conflict in Values

One major conflict in values we see in the social problem of mental health and mental illness is the value of community care versus the efficacy of psychiatric care. Historically, many people with mental illnesses were institutionalized. Many state hospitals provided essential care. People were isolated from their families and communities and significantly stigmatized. Also, because these facilities were often locked, outside oversight was often limited. In 1955, over half a million people were hospitalized (Talbott 2004). Since this high, the institutionalized population has decreased by almost 60% (Yohanna 2013). Some of that decrease is due to a change in values. Talbott writes, “The impact of the community mental health philosophy is that it is better to treat the mentally ill nearer to their families, jobs, and communities” (2004). This perspective humanizes people with this condition. Unfortunately, government funding for community mental health services and other social supports is insufficient to meet the need. Instead of finding wrap-around support, many people who were deinstitutionalized became homeless instead (Pierson 2019).

Socially Constructed but Real in Consequences

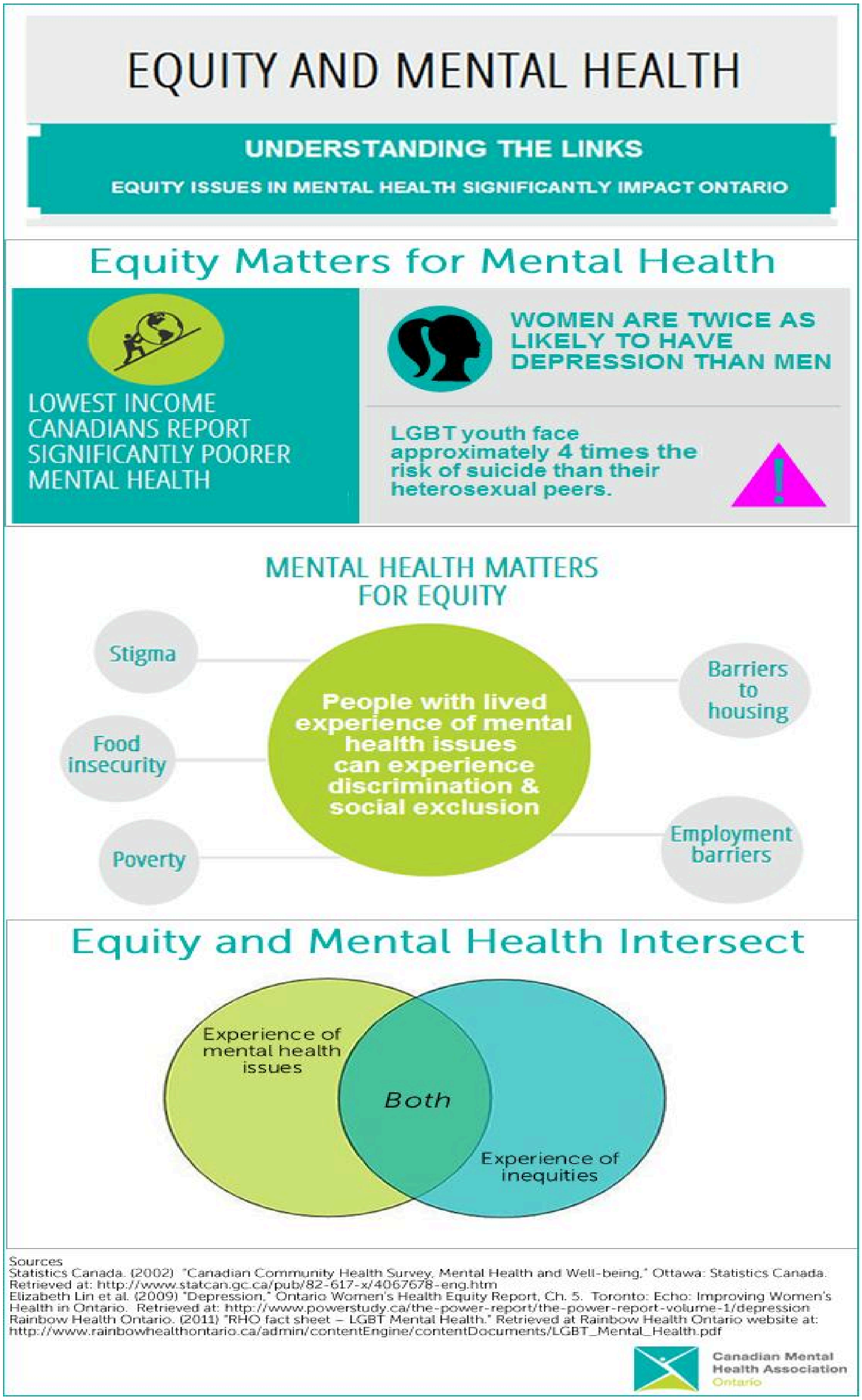
Scholars disagree over whether mental illness is real or a social construction. The predominant view in psychiatry, of course, is that people have actual mental and emotional functioning problems. These problems are best characterized as mental illnesses or mental disorders and should be treated by medical professionals (Kring and Sloan 2009). But other scholars, adopting a labeling approach, say that mental illness is a social construct (Szasz 2008). In their view, all kinds of people sometimes act oddly, but only a few are labeled as mentally ill. If someone says they hear the voice of an angel, we attribute their perceptions to their religious views and consider them religious, not mentally ill. Instead, if someone insists that men from Mars have been in touch, we are more apt to think there is something mentally wrong with that person. We socially construct our concepts of mental illness, labeling some people but not others. This intellectual debate notwithstanding, many people suffer serious mental and emotional problems, such as severe mood swings and depression, that interfere with their everyday functioning and social interaction. Other symptoms of mental illnesses include psychosis, which is the loss of contact with reality; hallucinations, which are seeing or hearing things that others cannot; and delusions, which are believing things that are not actually true. Sociologists and other researchers have investigated the social epidemiology of these problems. As usual, they find social inequality (Cockerham 2011).

Unequal Outcomes

Sociologists see unequal outcomes when they examine the prevalence and outcomes of mental illness. First, social class affects the incidence of mental illness. To be more specific, poor people exhibit more mental health problems than rich people. They have higher rates of severe mental illnesses such as schizophrenia, serious depression, and other problems (Mossakowski 2008). However, sociologists are careful not to confuse correlation with causation. Some sociologists believe that the stress of poverty can contribute to having a mental illness. Others think that having a mental illness may increase the chances that the person might be poor. Although there is evidence that both cause poverty, most scholars believe that poverty contributes to mental illness more than the reverse (Warren 2009).

Second, gender is related to mental illness in complex ways. The nature of this relationship depends on the type of mental disorder. Women have higher rates of eating disorders and PTSD than men and are more likely to be seriously depressed. Still, men have higher rates of antisocial personality (a lack of empathy, or psychopathy), disorders, and substance use disorders that lead them to be a threat to others (Christiansen, McCarthy, and Seeman 2022). Although some medical researchers trace these differences to sex-linked biological differences, sociologists attribute them to differences in gender socialization that lead women to keep problems inside themselves while encouraging men to express their problems outwardly through violence (Kessler and Wang, 2008). Women are socialized to talk about their feelings more than men, who tend to be less connected to their feelings. To the extent that women have higher levels of depression and other mental health problems, the factors that account for their poorer physical health, including their higher rates of poverty, stress, and rates of everyday discrimination, are thought to also account for their poorer mental health (Read and Gorman 2010). Mental health is a social problem, although people rarely take to the streets to protest about mental illness.

Social Location and Mental Health



EQUITY AND MENTAL HEALTH

UNDERSTANDING THE LINKS

EQUITY ISSUES IN MENTAL HEALTH SIGNIFICANTLY IMPACT ONTARIO

Equity Matters for Mental Health

LOWEST INCOME CANADIANS REPORT SIGNIFICANTLY POORER MENTAL HEALTH

WOMEN ARE TWICE AS LIKELY TO HAVE DEPRESSION THAN MEN

LGBT youth face approximately 4 times the risk of suicide than their heterosexual peers.

MENTAL HEALTH MATTERS FOR EQUITY

People with lived experience of mental health issues can experience discrimination & social exclusion

Equity and Mental Health Intersect

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Canadian Mental Health Association Ontario

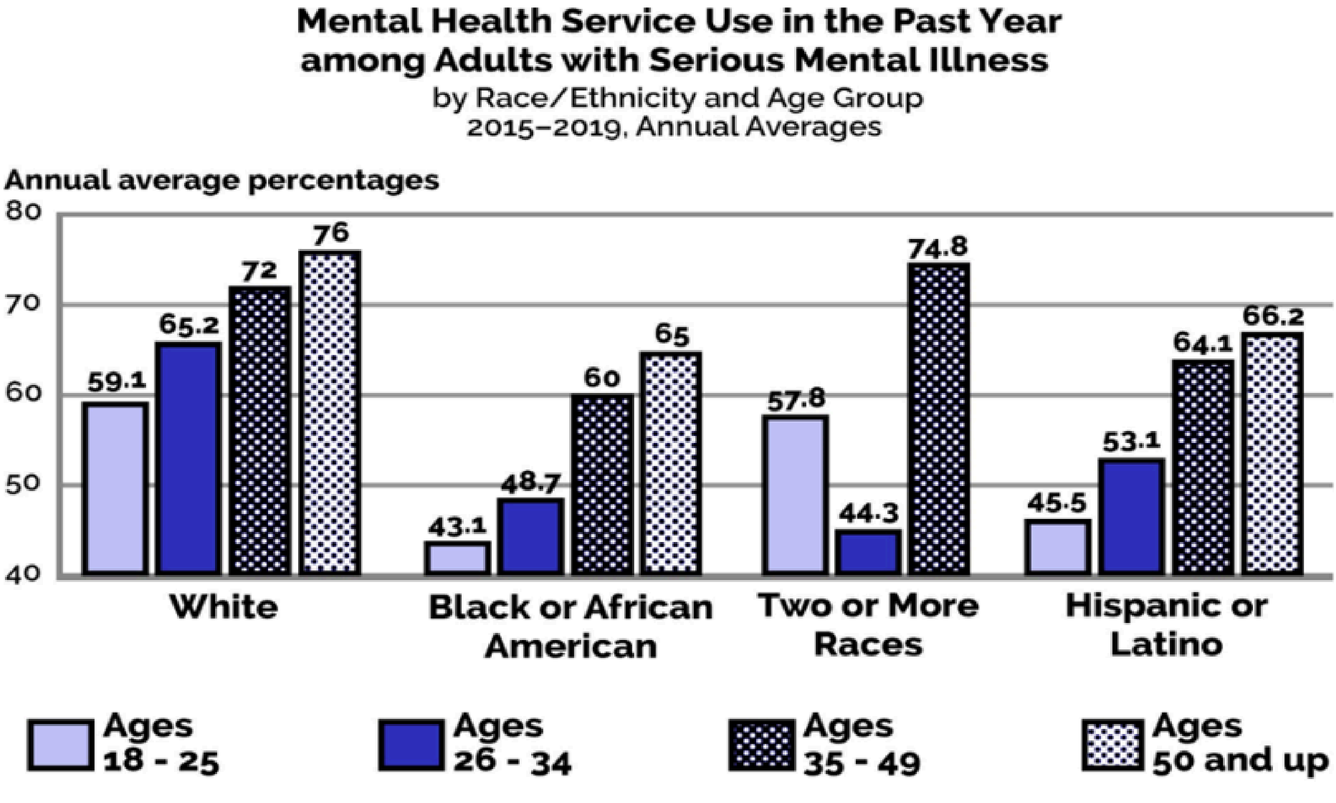
Figure 16: Equity Matters to Mental Health: Equity and Mental Health impact each other. Image Description.

Figure 16 “Equity Matters to Mental Health” highlights the intersectional nature of social location and mental health. In the related report, the Canadian Mental Health Association-Ontario detrimental relationship between equity, mental health, and intersectionality:

1. Equity matters for mental health. Due to decreased access to the social determinants of health, inequities negatively impact the mental health of people who live in Ontario. Marginalized groups are more likely to experience poor mental health. In addition, marginalized social determinants of health to the social determinants of health essential to recovery and positive mental health.
2. Mental health matters for equity. Poor mental health has a negative impact on equity. While mental health is a key resource for accessing the social determinants of health, historical and ongoing stigma has resulted in discrimination and social exclusion of people with lived experience of mental health issues or conditions.
3. Equity and mental health intersect. People often experience both mental health issues and additional inequities (such as poverty, racialization, or homophobia) simultaneously.

Intersectionality creates unique experiences of inequity and mental health that pose added challenges at the individual, community, and health systems levels (Canadian Mental Health Association 2014). Mental health status itself can influence your ability to stay in school, hold a job, or raise a family. And the reverse is also true if you are struggling to put food on the table, keep your kids stable, or stay safe in your neighborhood, you are more likely to have poor mental health.

Race and Ethnicity



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015–2019. See figure 5.4 in *Racial/Ethnic Differences in Mental Health Service Use among Adults and Adolescents (2015-2019)* for confidence intervals: https://www.samhsa.gov/data/sites/default/files/reports/rpt35327/2021NSDUHMHChartbook.pdf

Figure 17: Mental Health Service Use in the Past Year among Adults with Serious Mental Illness, by Race/Ethnicity and Age Group: 2015–2019, Annual Averages.

We can also examine the number of unmet needs for mental health services according to race and ethnicity. When we do this, we see that People of Color have more unmet needs than non-Hispanic White people. Black and Brown people have a harder time accessing quality mental health services. When they do receive services, they are more likely to have a negative experience. Some cultures have more stigma around mental health issues than White Americans generally have. This can be a barrier for some immigrants and first- and second-generation Americans to seek services.

For immigrants, mental health providers often lack language and cultural competency skills, which makes the treatment much less effective. Finally, People of Color are profoundly underrepresented in research and clinical trials for new treatments. Mental health researchers often don’t consider the unique experiences of People of Color when they develop new treatment options or medications.

Class Issues in Mental Health Treatment

One of the most consistent findings across studies is that lower socioeconomic groups have greater amounts of mental illness. One of the earliest studies of the sociology of mental health came from the University of Chicago in the 1930s. Sociologists explored whether mental illness caused poverty or whether poverty caused mental illness. The two researchers who led this project—Faris & Dunham—looked at psychiatric admissions to Chicago hospitals by neighborhood. What they found was rather shocking—there was a nine times increased rate of schizophrenia from people who came from poorer neighborhoods, than from more middle-class neighborhoods. The researchers tried to figure out why.

One idea was social selection, the idea that lower-class position is a consequence of mental illness. Mentally ill people would drift downward into lower-income groups or poorer neighborhoods because they couldn’t keep jobs. In addition to considering social selection, they considered social causation, also. In this model, which Faris & Dunham later refuted, the lower class position was a cause of mental illness. The results of this early study came back mixed. At first, Faris & Dunham said that the isolation and poverty of living in the central city created schizophrenia cause. But then, they changed their minds and said people with schizophrenia have a downward drift and move to the central, poorer part of town after developing schizophrenia. Later studies have found that Faris & Dunham’s study was actually trying to tell us that it’s both—cause and effect. Social selection theories and social causation theories can be used to account for the relationship between schizophrenia and poverty.

As our infographic on equity and mental health shows, people with mental health issues can struggle with educational and economic stability because sufficient social support is not in place to support them. Poverty itself can be a risk factor for poor mental health.

Gender

Gender has often been an explanation for the occurrence of mental health and mental illness. While traditional explanations focus on women, as explored in the previous section, newer research focuses on the interactions of nonbinary and gender fluid folx (a deliberately non-binary word) and their mental health.

Unpacking Oppression, Embodying Justice: Patriarchy

Traditionally, sociologists defined gender as the attitudes, behaviors, norms, and roles that a society or culture associated with an individual’s biological sex. Gender describes the social differences between females and males or the meanings attached to being feminine or masculine. This definition is somewhat outdated because it labels gender as only female or male rather than seeing gender expression and gender identity as a continuum.

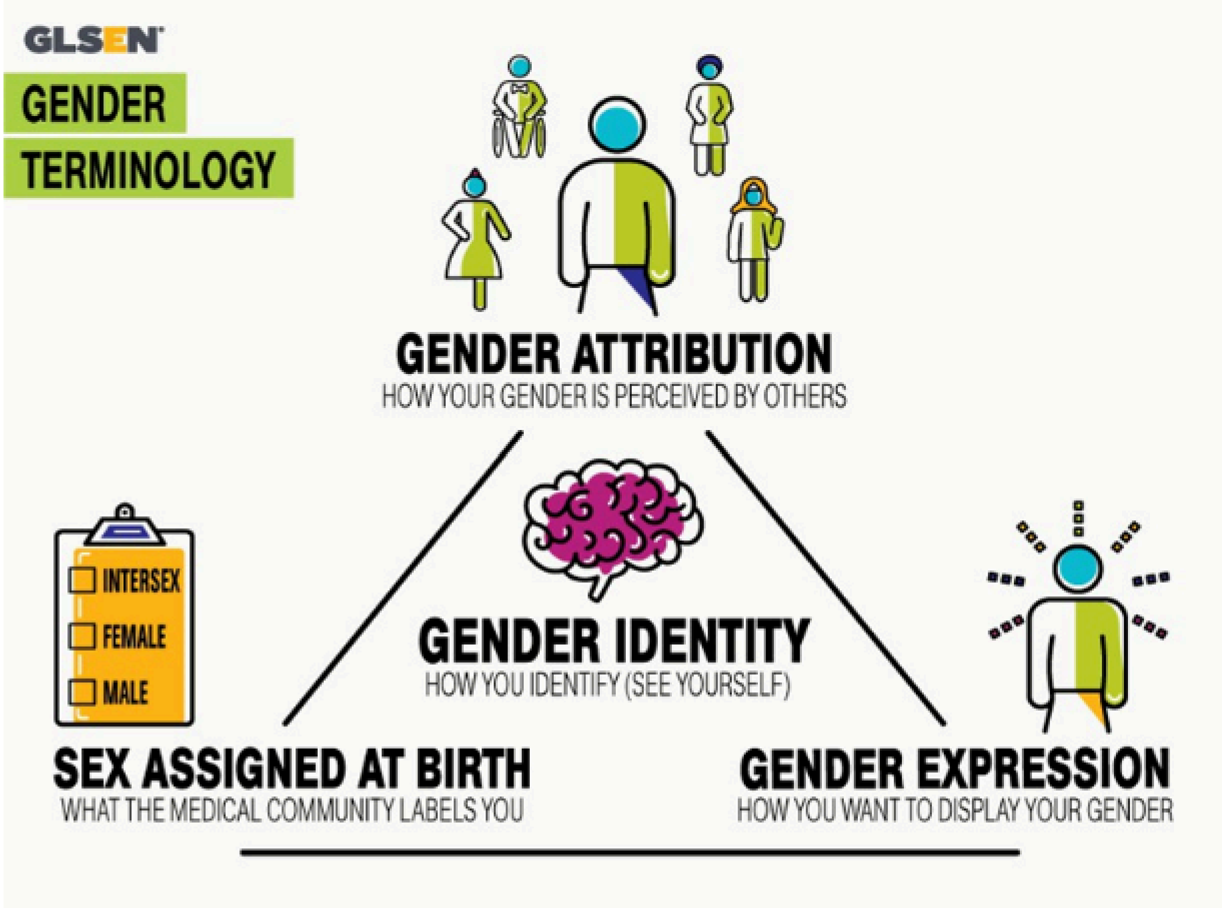


Figure 18: Gender terminology from GLSEN shows the relationship between sex and gender and the different ways gender identity interacts with gender expression and attribution.

The Human Rights Campaign Foundation (HRC) defines gender identity as one’s innermost concept of self as male, female, or a blend of both or neither—how individuals perceive themselves and what they call themselves (Human Rights Campaign 2023). One’s gender identity can be the same or different from the sex assigned at birth. For example, you may know yourself as female, even if your physical body has a penis. Alternatively, you may feel like female or male gender labels don’t fit you at all. HRC further defines gender expression as the external appearance of one’s gender identity, usually expressed through behavior, clothing, body characteristics, or voice, and which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine (Human Rights Campaign 2023).

Often, your identity and your expression match. Sometimes, you may choose to wear skirts, glitter, and paint your nails, even if your gender identity is male. Gender, then, is a complex construct. Gender develops throughout life. We may change our gender identity as we age.

Social Location and Mental Health

How sociologists understand gender changes as we listen carefully to people who don't fit in traditional gender boxes. How each of us "does" gender changes as we become more authentically ourselves throughout our lives. Even though our concept of gender is fluid, our social structures consistently privilege people with a male gender and marginalize people of a female or nonbinary gender.

Patriarchy is a form of mental, social, spiritual, economic, and political organization/ structuring of society produced by the gradual institutionalization of sex-based political relations created, maintained, and reinforced by different institutions linked closely together to achieve consensus on the lesser value of women and their roles. This is a powerful definition, but it is complicated to understand. Think of it this way. Put simply, feminism is the radical idea that women are people. Patriarchy is the social structure and related behaviors that give men power, and oppression women and people of non-traditional gender. As social problems scholars, we want to understand how patriarchy works in a much deeper way.

Leadership is a male role and a source of male power. The third principle, male identification, locates men at the center of what is right and good. We see this principle in action when we use words like all mankind when we mean all people. The fourth and final principle is male-centeredness. In this principle, we focus on and value the activities of men and boys, rather than women, girls, and nonbinary gendered people.

Combining many of these principles in action, the US Soccer Federation only agreed that female and male soccer players should earn equal pay in 2022. For more on this landmark victory, feel free to read The US National Women's Soccer Team Wins $24 million in equal pay settlement.

Models and Treatments

We will explore the different models of mental health and mental illness. These models come to us from different academic disciplines—psychology, psychiatry, and sociology. All three have something to offer to mental illness and mental health and mental illness.

The dominant models of mental illness are biological, medical, and psychological, and so are important to learn about even in a sociology course! Cultural views and beliefs about mental illness have varied enormously throughout his- tory. For example, ancient humans once believed that mental illness was caused by the influence of evil spirits over the afflicted person. Accordingly, treatments back then involved removing part of the patient's skull to allow the demon to escape.

Later, during the Middle Ages, mental illness was thought to be connected to the moon (hence the term lunacy). Another common belief was that a person with mental illness was being punished by God.

Fortunately, we've come a long way since then. However, scientists are still struggling to pinpoint exactly what causes mental illness. Most people, however, agree that mental illness can be influenced by a variety of things, including biological factors, personal history and upbringing, and lifestyle. To help provide a framework for understanding these potential causes, experts have developed several different models, which we'll explore here.

Biological model

The biological model of mental illness approaches mental health in much the same way a doctor would approach a sick or injured patient. They look for problems or irregularities in the body that are causing the symptoms. Adherents of the medical model believe that mental illness is primarily caused by biological factors such as abnormal brain chemistry or genetic predisposition (McLeod 2023).

Medical model

The medical model of mental illness has proven to be true in many cases. For example, depression has long been linked to deficiencies in certain neurotransmitters (a chemical substance that is released at the end of a nerve fiber), and schizophrenia has been shown to run in families. Science like this forms the basis of psychopharmacology, which is the treatment of mental illness with medication that adjusts the level of neurotransmitters present in the brain. Researchers still do not know what turns on or off the brain/chromosome structures. The result is an impairment of a person's overall level of functioning. However, critics of the medical model believe that it is too simple because it ignores important social factors in a person's life.

Psychological model

As you might expect, in the psychological model of mental illness, psychologists look at psychological factors to explain and treat mental illness. For example, they look at attachment theory, which is a theory that examines how you relate to other people. There are over 500 different psychological models of therapy there is a right model for everybody, and a psychologist's or therapist's job is to figure out which of those models works for which patient. Of course, psychologists have preferences, and skill sets no psychologist can practice 500 forms of psychotherapy.

Sociological Approaches to Mental Illness

The previous models focus on biology, medicine, and psychology. However, as sociologists, we know that social factors matter. They apply also to mental health. The social determinants of health help us to explain why mental illness a social problem is also. Let's look more deeply at sociological theories of mental health.

Functionalist

Functionalist sociologists begin to layer social approaches to medical and psychological models. Functionalists look at the function that mental illness and mental health play in society. They look at how mental health functions in a person's life. To this end, they developed psychosocial and biopsychosocial models of mental illness. One functionalist model of mental illness is called the psychosocial model of mental illness. The psychosocial approach focuses on how individuals interact with and adapt to their environment. Specific factors of interest might include a person's relationships, past trauma, economic situation, outlook on life, and religious beliefs.

For example, stress both good and bad can affect your mental health. Social scientists pay attention to where these stressful areas are. Starting a new job is in the top three stressful things but most people are happy to start new jobs. Happiness aside, the new expectations, roles, and attitudes you find at your new workplace cause stress. Of course, negative things can also cause stress, and psychologists help people develop resilience against this sort of stress so they can successfully navigate the stressful situation.

Another thing psychologists consider is your social roles. Having conflicting social roles—such as being a parent during COVID-19 and having a full-time job, is a role conflict that can cause stress. There are several kinds of role strain, when one role takes up too much of the time you need to dedicate to other roles or when two different roles compete with each other.

As the name implies, the psychosocial model focuses on the importance of psychological and social factors in informing a person's mental health. Rather than looking to a person's brain for clues, a proponent of the psychosocial model of mental illness might look to a patient's personal history, attitude, beliefs, and life circumstances to better understand their mental illness.

However, the psychosocial model is also limited because it doesn't take biological or genetic factors into account. To address this, sociologists, psychologists, and psychiatrists have developed the biopsychosocial model of mental illness, which addresses the idea that mental health problems are caused by a combination of biological, sociological, and psychological features.

For example, it can be true that a patient has a biological disposition to mental illness and has experienced trauma that is causing or exacerbating their symptoms. Similarly, many patients have discovered that a combination of psychotropic medication and talk therapy helps address their mental health issues. In fact, many mental health care providers integrate both approaches into a more holistic framework called the biopsychosocial model.

Symbolic Interactionist

Mental illness impacts individuals, so why do sociologists, who study groups, research it? Michaels MacDonald, historian of psychiatry, observed, "is the most solitary of afflictions to the people who experience it; but it is the most social of maladies to those who observe its effects" (1981:1). Mental illness has social and cultural dimensions which compel sociological interest.

Psychiatry generally focuses on the suffering individual while sociologists study the social aspects and implications of an individual's mental disturbance on friends, family, community, and society. Sociologists ask questions like:

- How can we define and draw boundaries around mental illness and distinguish it from eccentricity or mere idiosyncrasy?
- Who determines what is "normal" difference and what is pathological?
- Who has the privilege to make such decisions? Why? Do such things vary across time and cross-culturally?
- How have societies responded to the presence of those who do not seem to share our common sense notions of reality?

As part of the answer to these questions, the social construction theory of mental illness states that mental illnesses, mental health, normality, and abnormality are all social constructions and are not based on biological reality. One socially constructed concept is the idea of what is normal. People in power say that normal is being happy and productive. If you are not these things, you are deemed "abnormal" or "sick." The National Alliance for Mental Illness, or NAMI, challenges this idea and argues that people with mental illnesses are indeed "normal," although they may be different. Differences are to be celebrated, not labeled as dangerous or damaged.

At the same time, mental illness has profoundly disruptive effects on individual lives and on the social order we all take for granted. Mid-twentieth century writings still constitute some of the most provocative and profound sociological meditations on the subject, is perhaps best known for his searing critique of mental hospitals as total institutions. From the late nineteen-sixties through the nineteen-eighties, the intellectual distance and even hostility between sociologists and psychiatrists often seemed to be growing. Within five years of the appearance of Goffman's groundbreaking book Asylums, the California sociologist Thomas Scheff had authored a more radical assault on psychiatry. Scheff dismissed the medical model of mental illness altogether and attempted to replace it with a societal reaction model, where mental patients were portrayed as victims—victims, most obviously, of psychiatrists (Scheff 1966).

Noting that despite centuries of effort, "there is no rigorous knowledge of the cause, cure, or even the symptoms of functional mental disorders," argued that we would be better off adopting "a [sociological] theory of mental disorder in which psychiatric symptoms are considered to be labeled violations of social norms, and stable 'mental illness' to be a social role." And "societal reaction [not internal pathology] is usually the most important determinant of entry into that role" (Scheff 1966:25).

During the 1960s and 1970s, the societal reaction theory of deviance enjoyed broad popularity and acceptance among many sociologists. Scheff's was one of the principal works in that tradition. In the face of an avalanche of well-founded objections, Scheff was eventually forced to back away from many of his more extreme positions. By the time the third edition of his book appeared (Scheff 1999), most of its bolder ideas had been quietly abandoned. Labeling and stigmatization of the mentally ill have remained important subjects for sociologists. This stigmatization of illness is when shame or disgrace is aimed at a person with a physical or mental illness or condition. The idea of stigmatization is powerful, even if few would now argue that they have the significance once attributed to them.

Though the labeling theorists' skeptical claims have been sharply curtailed, much of the sociological work on mental illness has retained its critical edge. Four major inter-related changes have occurred in the psychiatric sector in the past half-century. The first change is the progressive abandonment of the prior commitment to hospitalization for patients for life when they have serious mental illness. The second change is the rundown of the state hospital sector.

Deinstitutionalization, for example, was initially presented as a grand reform, ironically just as the mental hospital had originally been. From the mid-1970s, however, a more skeptical set of perspectives emerged. Psychiatrists had assumed that the new generation of antipsychotic drugs had been the main drivers of the expulsion of state hospital patients. In reality, it was a political and economic decision by the federal government to close mental hospitals because they were expensive and overcrowded. Also, there was a move toward community mental health, which provides a patient-centered approach, but these services were not sufficiently funded. Also, there are not enough beds in current hospitals and psychiatric wards for the people who need them.

Unfortunately, deinstitutionalization had several unintended consequences, including a rise in homelessness (Mechanic and Rochfort 1990). Another unintended consequence is that the prison system became a de facto asylum system. Approximately half of current prison and jail inmates experience a mental illness. However, treatment there is irregular and insufficient (Bronson and Berzofsky 2017).

In addition, the hegemony, or dominance, of the Diagnostic and Statistical Manual (DSM) began to attract attention, with critics examining both the processes by which the successive editions had been produced and the intended and unintended effects of its widespread use. The sources and the impact of the psychopharmacological revolution drew increased interest, with attention paid to both the role of the pharmaceutical industry and changes in the intellectual orientation of the psychiatric profession.

Mental Health Is Social Justice

As the title of this topic suggests, “It’s Okay not to be Okay.” This was one of the themes of the media response to COVID-19 and the related mental health problems people experienced due to the isolation and fear brought on by the pandemic. For example, the 2020 song OK Not to Be OK by Marshmello and Demi Lovato deals with this topic head-on. By the winter of 2020, the CDC reported that up to 40% of Americans reported mental health problems due to the pandemic (Kostic 2020). In conjunction with the White House, the CDC, and Health and Human Services, the Ad Council created a new advertising campaign that discussed coping skills for dealing with the pandemic. Feel free to watch the ad campaign Coping-19.

To explore alternative approaches to addressing this problem, let us examine two programs that increase mental health access to treatment in non-traditional manners. The Crisis Assistance Helping Out On The Streets (CAHOOTS) program in Eugene, Oregon, addresses mental health and drug-related issues integrated into the police and 911 emergency access services system operated jointly by Policeite Bird Clinic and the Eugene police. CAHOOTSs began as an offshoot of the counter-culture movement in Eugene. The organization provided volunteer-operated mental health services to the community. It also presented periodic role-playing seminars to the Eugene police related to managing and defusing mental health-related situations in policing. In the 1980s, the police department began taking advantage of this community initiative, informally referring mental health cases to the CAHOOTS organization to reduce the direct involvement of police in non-crime-related scenarios. CAHOOTS volunteers still offer crisis response services and access to other community services to persons experiencing mental health or drug-related issues.

Following a 2015 lawsuit against the city for excessive use of force and racial discrimination in a fatal shooting of a veteran with PTSD by the Eugene police, the incidents helped focus public attention on Eugene’s response to a mental health crisis. In response, the Eugene city council committed $225,000 of the city police budget to fund the 24/7 availability of the CAHOOTS services and access to the 911 dispatch system. As the CAHOOTS organization began to respond to calls, the delays in responding to issues decreased significantly, to a level of about double the time required for a response by the police. CAHOOTS estimates that in 2021, roughly 17 percent of the calls to 911 in Eugene resulted in a dispatch of a CAHOOTS team reducing the involvement of the official police significantly. Chris Skinner, the Eugene chief of police, commented before the pandemic hit that increasing the number of CAHOOTS teams is a benefit of probability “The less time I put police officers in conflict with people, the less time those conflicts go bad.”

In 2019, Eugene voters approved a payroll tax to bring in $23 million for additional community safety positions. In the initial proposal, two-thirds of this money was intended to go to the police department for additional positions. Reacting to the Black Lives Matter protests, the city council instead redirected that money to community organizations. CAHOOTS received some of that money and benefited from county use of federal CARES Act funding to open a 250-bed homeless shelter in buildings on the Lane County Fairgrounds. The federal funding expired in June of 2021, but talks are in place to expand the use of some police funds to maintain the program, roughly $1 out of every $50 committed to the police budget.

A different approach by the Loveland Foundation addresses resources to communities of color in a number of locations nationwide, including Texas, Georgia, California, Ohio, and New York. The Loveland Foundation was established in 2018 by Rache Cargle in response to a fundraiser for therapy support for Black women and girls. The organization partners with organizations providing culturally competent therapy resources for Black women and girls in the areas where they operate. The organization funds all or part of the costs of access to therapy. Additionally, the organization operates workshops for therapy providers to educate about eating disorders in Black women and girls in partnership with the Renfrew Center for Eating Disorders. The workshops are a six-part series focusing on providing the historical context, etiology, intergenerational trauma, and its impact on body image, assessment, and treatment.

One unusual feature is their approach to building future therapy support resources for specifically People of Color. According to the American Psychological Association, only 17 percent of therapists in the US identify as People of Color, and only 3 percent identify as Black or African American. The Loveland Foundation is investing significant scholarship funding in enabling undergraduate and graduate education for BIPOC to offer therapy to the BIPOC community, including addressing the use of unpaid internships and the lack of dependable mentors to provide support resources to students wishing to address this need. If you would like to learn more about the services of the Loveland Foundation, you can check out their site, The Loveland Foundation.

When we consider mental health, mental illness, and mental well-being, we notice interdependent solutions supporting social justice. Each of us has agency in our mental health and the mental health of our friends and families. We can care for ourselves and each other. At the same time, we experience different rates of trauma, prejudice, and mental illness. We need equity in mental health resources and treatment options. Organizations like NAMI, CAHOOTS, and the Loveland Foundation work to address the systemic inequities in mental health experiences. Working together we can weave interdependent social justice mental resilience and social justice.

Chapter adapted from: "Inequality and Interdependence: Social Problems and Social Justice (Kimberly Puttman et al.)" by LibreTexts is licensed under CC BY.

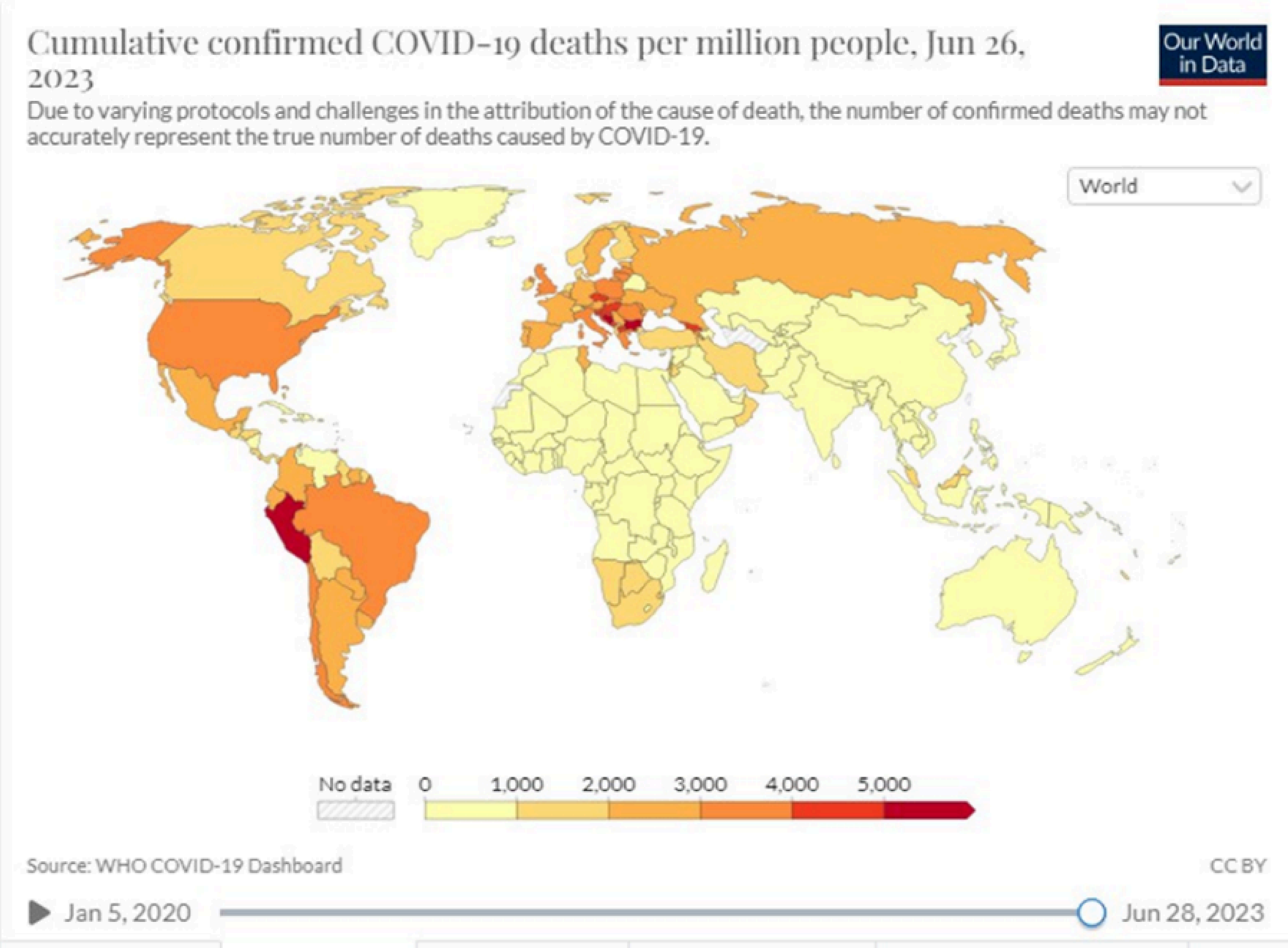
4.

TOPIC: DEATH AND DYING AS A SOCIAL PROBLEM

We will be exploring the social problems of death and dying. Some of us have lived with a lot of death in our lives. The experience is familiar, even though every death is painful. Some of us have never even thought about death. Please remember to practice good self-care as you walk with us through this material. And, as much as we once knew about the process of dying and death itself, dealing with death during the COVID-19 pandemic brings its own set of challenges.

To put this story in a wider context, over 767 million people contracted COVID-19 worldwide as of August 2023. Nearly 7 million people worldwide died from COVID-19. (World Health Organization 2023). That's about half the population of the Pacific Northwest or just under twice the population of Los Angeles. Although some people would have died anyway, many of these deaths were unexpected. Sociologists call this pattern excess death, the difference between the observed numbers of deaths in a particular period and the expected deaths for that same period (CDC 2023).

The level of illness worldwide overwhelmed our healthcare system. The amount of unexpected death overwhelmed our end-of-life systems as well. Hospitals in New York and elsewhere needed to park morgue trucks in their parking lots to handle the number of bodies. Spiritual care staff, including chaplains, pastors, ministers, rabbis, and other religious leaders, performed funerals on Zoom and prayed over burials in uncountable numbers. Every country has been impacted by unexpected deaths due to COVID-19. You can see the cumulative death per million people on the map.



Cumulative confirmed COVID-19 deaths per million people, Jun 26, 2023

Due to varying protocols and challenges in the attribution of the cause of death, the number of confirmed deaths may not accurately represent the true number of deaths caused by COVID-19.

Source: WHO COVID-19 Dashboard

Figure 19: Global cumulative deaths from COVID-19, per million people, as of June 26, 2023. The country in which you live partially determines how likely you are to die from COVID-19.

As we consider what may be the most personal of all human experiences, death, we also see that death is a social problem. We notice that where you live, and by country, changes the likelihood that you will die of COVID-19. Even by this simple measure, death is also a social problem.

Death and Dying as a Social Problem

“Nothing is certain but death and taxes.” This phrase summarizes some of the wisdom of living in a modern economy. If we think back to the sociological imagination, we know that of course, death is personal. It happens to each of us diversely and individually. However, death is also a social event. Our families, friends, and communities walk through the process with us. We depend on the social institutions of hospitals and hospices and the businesses of more deaths and funeral homes to care for deaths. Even the government must issue death certificates for deaths to be considered valid. In this sense, death is also a social problem.

Beyond the Experience of the Individual

Death is one of the most intimate and personal issues a person will ever confront. What happens to an individual is affected by the social context within which it takes place, but death also has broader social implications. At a micro level of analysis, death, and the dying process involves the loss of social roles and a shift in existing roles. For instance, when a parent dies, you lose someone in the parental role. Older siblings, grandparents, or family friends may need to step in and take on parenting responsibilities. Social relationships are also altered. The loss of a member of our social circle affects all who are part of that social network. As a result of a death, the group dynamics and relationships may need to be renegotiated, and a new shared meaning developed.

At a social institutional level, death and the resulting loss of a worker, a teacher, or a community leader affect institutional processes and shift institutional resources to fill vacated roles. While a single death may have one type of impact, numerous deaths may have a more immediate and significant societal impact. The COVID-19-related workforce issues disrupted the flow of goods and services worldwide.

Conflict in Values: Right to Die

All human societies must answer the profound questions of who lives and dies. We discussed the conflict in values related to who lives when we discussed reproductive justice. We also see a conflict in values in talking about who dies. Who gets to decide who dies? What criteria or values do people use to make this decision? This conflict in values is expressed in right-to-die laws. These right-to-die laws are the laws that allow a person who suffers from a terminal disease and meets the required criteria to choose to end their life on their terms. They provide an option for eligible individuals to legally request and obtain medications from a physician to end their lives in a peaceful, humane, and dignified manner. As of 2023, only 10 states and the District of Columbia have a Death with Dignity law.

In recent decades there has been a growing movement to ensure that individuals have the autonomy and agency to control their own end-of-life decisions, including the right to die. With medical professionals' advice, the government sets standards, accepted practices, and legal statutes concerning end-of-life options. These regulations and standards may conflict with the personal preferences of those who are in the dying process.

This highlights a fundamental question, "Who has the ultimate right to decide how and when an individual's life ends?" Those working for the passage of so-called "right-to-die" legislation (also referred to as physician-assisted suicide or physician-assisted death) assert that individuals should be able to decide how much pain, suffering, and debilitating symptoms at end-of-life they should endure.

The first right-to-die law in the United States was enacted in Oregon in 1997. Oregon's Death with Dignity Act (DWDA) allows a terminally ill individual to end their own life with a self-administered lethal dose of medication prescribed by a physician for that purpose (Oregon Health Authority 2022). The Oregon law sets out a very structured procedure with specific requirements and criteria that must be met for an individual to utilize this option. Generally, you must be able to make decisions for yourself, and two physicians must agree. Those who oppose this type of legislation express fear over a lack of oversight. They cite concerns that the final decision to end one's own life will be made by others on behalf of those who may be too ill to speak on their behalf. Some fear the normalization of physician-assisted death to the point that patients will feel responsible for relieving the burden their care places on their loved ones. And many believe it is the job of physicians to alleviate suffering, not the role of the patient to decide.

Beliefs grounded in a sanctity of life orientation strongly emphasize the basic duty to preserve life. This perspective is often grounded in cultural and religious tenets that explain life as being a sacred gift granted to humans accompanied by a requisite responsibility to care for the body. Such an orientation may lead to a preference for using all available medical options to live as long as possible.

Alternatively, others may focus more on the quality of a person's life. A quality-of-life perspective argues that when life is no longer meaningful, the obligation to preserve life no longer exists. Although medical technology may be able to extend life, the human experience of living is more important than simply keeping the body medically functioning. From this orientation toward life, the emphasis is placed on the ability to live with dignity and purpose. Decisions concerning the use of end-of-life medical interventions are shaped by the intentional consideration of the distinction between the quantity of life and the quality of that life.

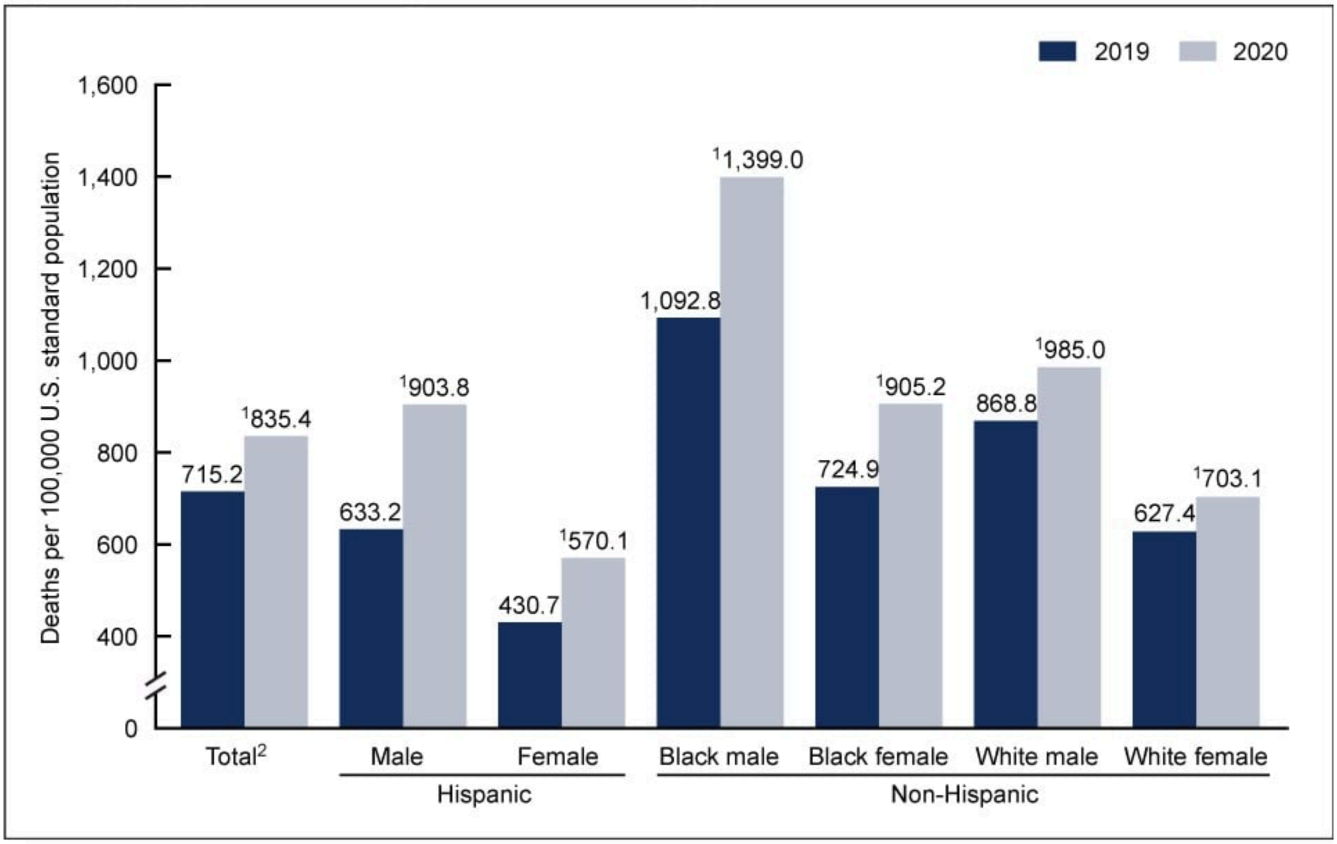
Inequality in Life Expectancy

Although death is an inevitability of the human condition, mortality rates vary based on social location. When and how a person dies is more than just the outcome of individual genetics and human physiology. Life expectancy and cause of death are also affected by the social determinants of health, such as access to healthcare, quality of life indicators, geographic location, and socioeconomic variables. Differential patterns in life expectancy and death rates based on gender and race/ethnicity are affected by broader social issues and systemic inequalities.

Social institutional features involving work, family, social class, healthcare, and social construction of gender role expectations contribute to the ongoing differential life expectancy, the number of years a person can expect to live, based on an estimate of the average age that members of a particular population group will be when they die (Ortiz-Ospina 2017). When we look at life expectancy based on gender, we see a difference. Males are predicted to live only 76.3 years on average, while females are expected to live 81.4 years on average (National Center for Health Statistics 2021).

Comparative death rates based on race and ethnicity also reflect systemic inequalities in social systems and people's social experiences.

Figure 2. Age-adjusted death rates, by sex and race and ethnicity: United States, 2019 and 2020



[1] Statistically significant increase in age-adjusted death rate from 2019 to 2020 ($p < 0.05$).

[2] Includes races and origins not shown separately.

NOTES: Race groups are single race. Data table for Figure 2 includes the number of deaths. Access data table for Figure 2 at: https://www.cdc.gov/nchs/data/databriefs/db427-tables.pdf#2.

SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Figure 20: Age-Adjusted Death Rates by Sex and by Race/Ethnicity United States 2019 and 2020. Black males experience the highest rate of death. Part of the difference in rates of death in 2020 was due to COVID-19

The impact of social inequalities is also evident during significant catastrophic events that challenge society, such as the COVID-19 pandemic. With the emergence of a new virus, this medical crisis strained social institutions and fundamentally interrupted previous patterns of social activity. Any one of us could get COVID-19, but the probability of contracting the virus and the likelihood of death from the infection are affected by social factors. Many of these social risk factors disproportionately impact people based on social location indicators such as race, ethnicity, and social class.

Table 2: This chart shows the number of COVID-19 cases and deaths by race and ethnicity in California as of May 9, 2023.

Race/ Ethnicity	Number of Cases	Percent of Cases	Number of Deaths	Percent of Deaths	Percent of CA Population
Latino	3,171,021	42.5%	42,360	41.9%	36.3%
White	2,042,907	27.4%	35,688	35.3%	36.8%
Black	313,576	4.2%	6,919	6.8%	6.5%
Asian	1,122,993	15.1%	15,105	14.9%	15.4%
Other	339,452	4.6%	4,525	4.5%	4.7%
Total	**7,453,970**	**100.0%**	**101,212**	**100.0%**	**100.0%**

As you look at this table, you may want to start at the last column. This column reflects the percent of California's total population for a particular group's race and ethnicity. If race and ethnicity did not influence the rate of catching COVID-19 or dying from COVID-19, you would expect that columns Cases (column 2) and Deaths (column 4) would match the last column. They do not. Instead, we see that White, Asian, and multi-ethnic people have a slightly lower-than-expected death rate. People of all other races and ethnicities have a slightly higher death rate. When you consider what you learned about why this is true for health, you can apply those learnings to understanding the consequences of social location on death.

The Social Construction of Death

Determining when a death takes place seems straightforward and obvious. When a person's body ceases to function, death has occurred. But as one delves deeper into the details and specifics, that task becomes far more complex. Historically, there have long been accounts of people who were determined to be dead when, in fact, they were still very much alive. Although not common, such instances were often a result of shallow breathing or faint heartbeats that went undetected. Advancements in medical technology address this possible problem. At the same time, they introduce new challenges in determining when death occurs. Modern medicine's ability to artificially keep people alive raises new and difficult questions in determining when death occurs. Therefore, society found a need to clearly define what determines death, delineate the criteria to be used to establish that death has occurred and develop a process to socially recognize and certify death.

Clinical Death

The customary method of determining death has centered on the cessation of basic vital signs of life – the absence of breathing and a heartbeat. However, advancements in new technology have raised new issues and challenges in using these conventional methods for establishing death. The use of advanced life support systems, such as ventilators, respirators, and various methods of cardio-pulmonary support, can now artificially support life for long periods of time. In these cases, a person can be kept "alive" through mechanical means for days, months, and in some cases, years. While in this state, do we say that the person is alive, or that the person is dead?

With the ability to keep a person breathing and the heart beating through artificial means for long periods of time, the medical community turned to the concept of brain death to determine death. Based on the work of the 1968 Harvabrain Death School Ad Hoc Committee, brain death, or what became known as the "whole-brain" definition of death, involved the following criteria: the absence of spontaneous muscle movement (including breathing), lack of brain-stem reflexes, the absence of brain act brain death the lack of response to external stimuli. This criterion for brain death is used to augment the customary use of vital signs when they may be ambiguous.

Legal Death

The definition of death affects many aspects of our daily lives. The death of an individual often triggers government laws that regulate issues directly related to how the body of the deceased is handled and the options for the final disposal of the corpse. Issues arising after death may also require some type of official government documentation verifying a death has occurred. A government-issued death certificate with verified information as to the date, place, and in some cases, the cause of death is needed to execute wills and inheritances, file necessary taxes, assess any civil and criminal liabilities, and a host of other legal issues regulated by the government. With the broad-based acceptance of the medical criteria for death, legislative discussion ensued to develop a standardized, legal means for determining that a death has occurred. Efforts focused on updating the legal standards used to determine death that closely aligned with the criteria being used by the medical community.

Social Death

Social death involves the loss of social identity, loss of social connectedness, and loss associated with the disintegration of the body (Králová 2015). This can be marked by a specific event, such as biological death. But it can also involve a series of changes, such as the loss of the ability to take part in daily activities, the loss of social identities, and/or the loss of social identity during end-of-life and the dying process. When there is a social determination of death, a person's place in society changes. There is a shift in their social status that denotes a separation from society and community. Establishing when social death occurs signals others as to the expected adjustments in social interactions.

Social death can change social role expectations, social status, and social interactions. When a person is dying, they may no longer be able to fulfill their social roles. For instance, a mother or father may no longer be able to care for the children. The children may need to become care providers for the parents. Adult children may become the care provider for an aging parent. The meaning of friendship expectations changes and social interaction within community or work settings is altered or severed.

After biological death, the status transition of the deceased from the world of the living to the spiritual realm or the world of their ancestors is often denoted by funeral rituals. Socio-cultural beliefs, values, and norms form the basis for the determination and meaning of social death. In the US dominant culture, the meaning of social death may be directly linked to the absence of medical/ biological indicators such as breathing, heartbeat, brain-based reflexes, and processes that then lead to various funerary rituals.

In other cultural belief systems, biological death is only one aspect of determining social death. For the Toraja people of Indonesia, social death does not come until the body leaves the home. They often keep the body of the biologically deceased in the home as an ongoing social member of the family and community for weeks, months, or even years. During this time, the person is perceived as being sick or in a prolonged sleep. They are fed and bathed, and their clothes are periodically changed. They are talked to, hugged, caressed, and moved to various settings to ensure they are included in family and community activities. The removal of the body from the home and completion of funerary rituals denotes the change in social status and social determination of death (Arora 2023; Seiber 2017).

Interdependent Solutions

The final characteristic of a social problem is that it requires both individual agency and collective action to create social justice. When we apply this characteristic to the experience of death and dying, we can change both the individual willingness to talk about death. We can also create communities that collectively support the experience of dying. Many of us are afraid to even talk about dying. However, this isn't the only way to approach death. Instead, we can be open to learning about death and talking about it. We can be death-positive. Death positive doesn't mean that we want to die now. Death positivity means that we are open to honest conversations about death and dying. It is the foundation of a social movement that challenges us to reimagine all things tied to death and dying (Lewis 2022).

One of the ways to have individual agency is to have "the conversation." In this conversation, you can talk to your parents, your children, your partner, or your friends. You can talk about what you want at the end of life, what you think will happen when you die, how you want your funeral to be, or what gives meaning and value to your life. By having these conversations now, you begin to prepare for the end of your life or the end of life for those you care about.

You can also participate in a Death Cafe. A Death Cafe is a social gathering, usually with tea and cake, where people talk about death. The question may range from, "What do you want to be remembered for?” to “What is the best funeral you ever attended?” Because people talk about death, they support each other and are more prepared to deal with it when it happens (Death Cafe N.d.). Having the conversation and attending a death cafe are acting at an individual and community level. However, death positivity is also a social movement. Rather than marching with signs, activists are creating compassionate communities. People are forming communities that care for each other, whether physically living together, meeting regularly, or connecting online. Hospice Palliative Care Ontario describes it this way, “A Compassionate Community is a community of people who feel empowered to engage with and increase their understanding about the experiences of those living with a serious illness, care” (Hospice Palliative Care Ontario 2019). At these individual, community, and institutional levels, we see action creating social justice. We’ll examine many more interdependent solutions as the chapter continues.

Inequality in End of Life and Death

We will explore three ways to understand inequality in the social problem of death and dying. First, we examine the sociological concept of life course, which helps us understand the expected paths of our lives and the differences in power and privilege that occur at each stage. Then, we look more deeply at inequalities based on cultural death in a White US culture “does” death in culturally specific ways. People from Latinx, Black death Indigenous cultures have other ways of understanding end-of-life, death, and life after death. When cultures collide, we see inequality. Finally, we look at end-of-life. In this section, we specifically highlight the challenging social location of being rural. Ruralness itself contributes to shorter life expectancy. We’ll look at why that is. First, let’s find out more about the relationship between power and age.

Unpacking Oppression, Living Justice

Sociologists and other social scientists study the human life course or life cycle to make sense of these questions and many more. As human beings grow older, they go through different phases or stages of life. It is helpful to understand aging in the context of these phases. A life course is the period from birth to death, including a sequence of predictable life events such as physical maturation. Each phase comes with different responsibilities and expectations, which of course, vary by individual and culture.

Inequality in End of Life and Death

Figure 21: The Western model of the life course or life stages.

The life course in Western societies often includes preconception and pregnancy, infancy, childhood, adolescence, adulthood, and old age. Children love to play and learn, looking forward to becoming teenagers. Teenagers, or adolescents, explore their independence. Adults focus on creating families, building careers, and experiencing the world as independent people.

Finally, many adults look forward to old age as a wonderful time to enjoy life without as much pressure from work and family life. In old age, grandparenthood can provide many of the joys of parenthood without all the hard work that parenthood entails. For others, aging is something to dread. They avoid it by seeking medical and cosmetic fixes. These differing views on the life course are the result of the cultural values and norms into which people are socialized. In most cultures, age is a master status influencing self-concept, as well as social roles and interactions.

You may also experience changes in power and privilege as you move through life stages. Young children, as you might expect, have little power. They depend on others to care for them. When a person turns 18 in the United States, they can vote, which is a level of power and privilege. As people move from adulthood to senior citizens, they may experience more frequent ageism, which is discrimination based on age.

Often, your power and privilege decline as you age. For example, sometimes older workers are laid off first, right before they reach retirement age so that companies don't have to pay full retirement benefits. Older people aren't hired for jobs because hiring managers assume that they don't understand technology or won't be able to keep up with the demands of the job. In an intersectional example, Black elders often can't retire or can't retire well because of the Black wealth gap. Because of racism in employment and housing Black families (and other families' wealth) cannot accrue generational wealth at the same rate as White families (National Partnership for Women and Families 2021). Therefore, they have less to fall back on when it comes to getting the care that they need during retirement, end of life, and dying.

Also, sociologists see a connection between ageism and death and dying. When people fear death and dying, they don't want to interact with people who are aging or at the end of life. When they worry about dying, they are more likely to be ageist (Banerjee, Brassolotto, and Chivers 2021), discriminating against people as they age or enter their end of life. For example, a doctor or caregiver might assume that an older person can't make their end of life decisions based on their chronological age. However, age is only part of the picture. Physical health, mental health, and cognitive capacity all play a role in whether a person is capable of making decisions for themselves (Kotzé and Roos 2022).

As we look at the life course, related more specifically to death and dying, professionals use this model in two ways. The first way helps us understand what constitutes a good death good medicine defines a good death as one that is free from avoidable death and suffering for patients, families, and caregivers in general, according to the patients' and families' wishes (Gustafson 2007). Albert Albert McLeod is a Status Indian with ancestry from Nisichawayasihk Cree Nation and the Metis community of Norway House in northern Manitoba. He is an activist and Two-Spirit leader.

When children die, for example, grief is particularly challenging in part because their death is unanticipated and not part of the normal life course. When people who are poor die of diabetes or heart disease as young adults, this is also not a good death because these deaths could have been prevented. Medical professionals also integrate this idea of a good death into their models of health and illness. This infographic is intended for doctors, so it is very complicated. However, if you examine it piece by piece, you will find that we have covered most of these ideas in this book. The infographic helps to synthesize our knowledge.

The circles on the left side represent the social ecology model. A person's health is impacted at the micro level of individual interactions to the macro level of the laws and policies that create or change structural inequality. People who talk about racial environmental justice might notice how neighborhood exposure to oil or coal burning would impact health outcomes.

The Exposome is the equivalent of Adverse Childhood Effects (ACEs) or the protective factors. The chart maps resilient heath to less health during the aging process. It also shows how the likelihood of illness or death changes depending on social factors. Finally, the chart displays how health and illness may unfold over the life course, depending on social and individual factors. The concept of life course helps sociologists understand how a "good life" and a "good death" unfold for people from a particular culture. When a life or a death does not unfold that way, sociologists can explain why. Social problems scientists can then propose action. Activists, community members, and governments can act or choose not to act to support good living and good dying for everyone.

Cultural Differences in Death and Dying

One of the ways we can think about inequality in death and dying is to consider cultural differences. Think for a minute about the last funeral you attended. For some of you, this may have been a recent experience. Others of you may never have attended a funeral. However, when we examine how people from different cultures think about and do death and dying, we notice many differences.

In dominant White culture, there is often a funeral. People come together to pay their respects to the dead person. The body of the dead person may be present in a casket, or a cremation may occur. People may also attend a viewing or wake, where they can sit with the family and the body to pray or say goodbye. There may be a burial of the body or placement of the cremated remains in a columbarium. Finally, the process may end with a memorial service or a celebration of life, depending on the wishes and beliefs of the person or their family.

This pattern is very common. We also notice three themes related to death and dying in dominant White culture. The first is the denial of death. We don't often talk about death, prepare for death, or talk about a person who died (Hughes 2014). Although the denial of death is not unique to US culture, the dominant US cultural norm is that being young and beautiful is the right standard. We live as if we will stay young and healthy forever.

The second element of death and dying in the dominant culture is that death and dying is a big business. It costs money for the casket, for embalming the body, the cremation, the rituals, the burial plot, the mausoleum, or columbarium, the flowers, the food, and all of the things associated with the funeral rites. Journalist Jessica Mitford drew attention to this problem. She wrote an article in "The Undertaker's Racket" for the Atlantic Monthly magazine in 1963. In it, she details all of the people and all of the costs of a traditional US death. At the time of the article, she estimated that the funeral business was a 2-billion-dollar industry in the US (Mitford 1963:56). As of 2023, the funeral industry makes over 20 billion dollars annually (Marsden-Ille 2023). Dying is a big business.

Finally, the dominant White culture leaves very little space for grief. Although bereavement leave exists, it is often short and unpaid. In dominant White culture, people often talk about "getting over" someone's death as if the grief will go away at some point. It is not common to sit in prayer for several days or to restrict your activities to allow space for grief. However, this way of dying, death, and grieving isn't the only way. We'll illuminate inequalities in death and dying by exploring the Day of the Dead/Dia de los Muertos in Mexican and Mexican American culture, RIP T-shirts from the Black community, and current practices in two Indigenous communities. We will use qualitative data, or stories, to do this exploration.

Because we are using stories, we don't have numbers to demonstrate the inequality present between dominant and non-dominant cultures. However, doing death differently than traditional White culture requires explaining what you need and insisting that you get it activities of resistance that take energy and focus. This additional load is an example of inequality in action.

Before we begin, let's look at another social location: religion. As you might expect, religion has a lot to do with how we go about death and dying.

Unpacking Oppression, Believing Justice

How people deal with death and dying is often related to their religions and spiritual beliefs. Religion is a personal or institutional system of beliefs, practices, and values relating to the cosmos and supernatural. This definition has two key components. First, people experience religion as a personal set of beliefs and practices. Second, religion is a social institution, a structure of power with hierarchies, doctrines, practices, and beliefs. The religion you belong to is often included when sociologists discuss power and privilege. In the United States, the dominant religion is Christianity. About 64% of Americans are Christian, and the number is dropping (Pew Research 2022). However, Christian privilege is embedded in our society in other ways. For example, our Pledge of Allegiance contains the words, "One nation under God." Our national holidays include Christmas, a holiday that is only celebrated in Christianity. We most often swear oaths for public service or juries on the Bible, the holy book of Christianity. Recognized churches that closely match the Christian pattern get tax breaks. What other examples can you think of?

Other religions and spiritualities are non-dominant, even though the number of people who are not Christian is rising. Except for Judaism, non-Christian religions like Hinduism, Buddhism, Islam, and others are growing. Additionally, people who identify as "None" or have no religious affiliation will be many people in the US by 2070 (Pew Research 2022). While estimates that far in the future are somewhat unreliable, the number of "Nones" is growing. These differences in religious power and privilege drive inequality in death and dying. Differences in religious practices around death and dying also create conflict. In some religions, for example, it is essential to cremate the body. In others, only burial will work.

Cultural Differences – RIP T-Shirts and Social Justice

When we consider grief and social justice, one of the privileges that wealthy, White people have is time to grieve and resources to have an expensive funeral. In Black communities, on the other hand, grief is disenfranchised. This disenfranchised grief is “grief that is unacknowledged and unsupported both within their sub-culture and within the larger society” (Bordere 2016). Bordere describes this grief: African American youth, for instance, who reside in urban areas are often disenfranchised grievers. Many African American youth cope with numerous profound death losses related to gun violence and non-death losses, including the loss of safety…[these youth are often inappropriately described as desensitized. Consequently, these losses are dealt with in the absence of recognition or support for their bereavement experience in primary social institutions, including educational settings, where they are expected to continue in math and writing as if a loss has not occurred (Bordere 2016).

As a partial response to disenfranchised grief, RIP (Rest in Peace) T-shirts have become part of the funeral rites in Black communities. Dr. Kami Fletcher is the aunt of an African American man who was murdered. Further still, RIP T-shirts allow room for healing by metaphorically filling the void of the loved one’s absence, serving as a second skin to keep him close, and even allowing mourners to fill out the imprint he left, with our own image, (Fletcher 2020). These shirts are also worn after the funeral itself, bringing the presence of the loved one to birthday parties or other family events.

They also become a call for justice because they remind people of the importance of the person’s life. They call out White supremacist violence by both naming and picturing the person who was murdered: From Mike Brown and Sandra Bland to Willie Oglesby, Jr., and Breonna Taylor, and George Floyd, Black bereaved family members politicize their grief in ways that highlight what caused the death as well as use it as a tool to fight for justice. As a walking memorial, the RIP T-shirt is a reminder of the life cut short by injustice. It is a reminder that we have not forgotten and that we won’t forget. (Fletcher 2020).

Wearing RIP T-Shirts becomes another way to “say their name”, to make their name visible, ensuring that the consequences of racial violence are obvious. If you would like to learn more about this memorial proactively, you can read Fresh to Death: African Americans and RIP T-Shirts.

Rural Challenges

What does it mean to be at the end of your life? Common sense would say that the end of life is the period before you die. However, none of us know when we will die. How, then, can we understand when the end of life happens? Researchers depend on two definitions. First, end-of-life is defined by Medicare and Medicaid as a person who is in a six-month or less period before their death. The government uses this definition to decide who qualifies for hospice, particularly when the government is paying for the care.

A second definition focuses on the end of life as a physical process. End of life is the period preceding an individual’s natural death from a process that is unlikely to be arrested by medical care (Hui et al. 2014). The end of life is a fertile ground for social problems. End-of-life decisions raise issues of culture, choice, and values. End-of-life options also vary depending on where you live or how much money you have. Let's look at the case of rural living.

We introduce the social location of being rural. Social locations such as age, gender, socioeconomic status, and geographic locality affect all aspects of a person's life. The variability in access to resources and services based on these factors has a significant impact on the dying experience. One social location that matters is geography. People in urban areas and cities tend to have access to more services. To be rural means to live in areas that are sparsely populated, have low housing density, and are far from urban centers (US Census Bureau 2017). US rural populations tend to be older, have higher mortality rates, be more likely to suffer from chronic diseases, and be disproportionately poorer than urban populations (Rural Health Information Hub 2022).

Palliative Care

Death is an unavoidable event in the life course. We are born. Eventually, we will all die. But with the advancements in modern medicine and its ability to manage disease and prolong life, dying has increasingly become an elongated process rather than a sudden specific event. The dying process is now often the result of chronic disease and/or age-related physical decline that can be accompanied by pain and distressful symptoms. Palliative care is often used to improve the quality of life and relieve pain and suffering during end-of-life care. As a treatment strategy, palliative care is specialized medical care for people living with serious illnesses and medical conditions (Definition of Palliative Care N.D.). The focus is on anticipating, preventing, and treating physical, psychological, and emotional pain and relieving symptoms. Rural populations are generally older and poorer than urban palliative career palliative care for palliative care, but they have less access to palliative care (Rural Health Information Hub 2021). Data also indicates that caregivers for the medically fragile who live in rural areas often spend more time providing care and are more likely palliative care of people than in urban or suburban areas. This is especially concerning considering the role palliative care programs can play in supporting those who provide daily caregiving and support for loved ones (Center to Advance Palliative Care 2019).

Readily available access to palliative care has advantages for the patient, those who provide daily care, and the healthcare system. Community-based palliative care programs lower healthcare costs and reduce the need for hospitalization (Weng, Shearer, and Grangaard Johnson 2022). Early diagnosis of care needs and promptly addressing medical needs before hospital care is needed provide obvious benefits for the patient. The availability and accessibility of support services for care providers are also critical to the overall well-being of the patient and the caretakers. In addition, minimizing hospital visits helps bring down overall medical costs and conserves system-wide medical resources at a time when the healthcare system is struggling to control escalating costs.

Rural areas face disproportionate barriers in providing palliative care options. Financially, the sheer volume of patients in urban areas is better able to support the resource allocation needed for hospital and community palliative care programs. Larger patient numbers can financially support the viability of healthcare teams specifically designated and trained to provide palliative care. However, rural areas lack sufficient patient numbers and the necessary medical resources to maintain palliative care programs. These areas are hindered by geographically dispersed patients, significant travel and driving time, the lack of rural hospitals and medical specialists, and the difficulty in recruiting and retaining trained healthcare providers (Weng et al. 2022).

Nursing Care and Home Health Care

The scarcity of nursing care facilities and hospice services in rural areas poses barriers to accessing end-of-life care assistance with medical and personal needs. Nursing care facilities (sometimes referred to as nursing homes) are residential centers designed to provide health and personal care services for those who can no longer care for themselves. These facilities provide a broad array of services dependent upon the specific focus of a facility. Levels of service can range from assisted living settings where residents may need assistance with meals, help with medication, and housekeeping to skilled nursing care facilities where the focus is more on medical care, including rehabilitative services (e.g., physical, occupational, and speech therapy), and complete support with daily activities. These facilities can be essential end-of-life options, but for rural residents, they are often not available. Rural nursing care facilities face many of the same challenges as rural palliative care programs. Rising operational costs due in part to the lower number of patients, distance to resources, and difficulty in finding and retaining trained staff have resulted in a high rate of nursing facility closures across rural America. Rural residents who must often leave their community, family, and friends to access these services face the stress of relocation and isolation because of less contact with loved ones.

When end-of-life health care can be delivered to a patient’s home, it can be less expensive, more convenient, and just as effective as services provided in hospitals or nursing care facilities. However, there is limited access to these services in rural areas, where the service may be based out of cities 50-100 miles away and have limited openings or long waiting lists to enroll. In many instances, there are no options available for specialized medical needs, occupational or physical therapy, or mental health support. To help fill this service gap, telemedicine is increasingly feasible. Research indicates that the use of telemedicine can improve access to healthcare professionals for patients at home. Its visual features allow genuine relationships with healthcare providers (Steindal et al. 2020). However, for rural residents, limited cellular coverage and internet access are barriers. Any cost savings to the patient and the health care system may be far less than what is needed for investment in extending the needed technological infrastructure.

Hospice

Hospice programs provide an important option for end-of-life care. Hospice is specialized healthcare for those approaching end-of-life. Hospice focuses on the quality of life and comfort of the patient and supports the patient's family. The focus of hospice care is not to cure disease or medical conditions. Instead, the goal is to support the patient and their loved ones while facilitating the highest quality of life possible for whatever time the patient has left. To qualify for hospice services, a physician or primary healthcare provider must verify that the patient is terminally ill with 6 months or less to live. A patient's enrollment can be extended as many times as necessary to support a patient until the end of life. A patient can disenroll whenever they choose or request re-enrollment at any time. The focus within hospice programs is on reducing pain and keeping the patient as comfortable as possible.

The broad-based approach to addressing overall well-being during end-of-life includes attention to physical, psychological, social, and spiritual needs. To address these needs, a hospice team can involve doctors, nurses, and other health care providers as needed, as well as social workers, counselors, and volunteers. Depending upon patient preference, hospice programs may include access to options such as aromatherapy, touch and massage, art therapy, music therapy, and pet therapy. These complementary services can help with pain management and psychological well-being and contribute to the patient's comfort and quality of life (Hospice Alliance N.d.).

Although hospice programs are increasingly available nationwide, less than 20% of hospices operate in rural areas. Rural hospice programs face many of the same barriers as the other end-of-life care options discussed above. Due to lower patient numbers, staffing shortages, high staff turnover, and long driving distances and time, they are financially vulnerable and have limited services. This is further complicated by a common lack of available family member caregivers, which is essential to the home-based hospice option. Adult children or other caregivers often live far away, making it difficult for the dying patient to be cared for by a family member and live out their life in their home. Although quality end-of-life care can take many forms, rural residents have less access to needed services during the process of death and dying. The social location of rural is a unique location of oppression.

Dying Well is Social Justice

As we look at the complex issues related to death and dying, we see that the question of who dies when is complicated by privilege, oppression, and difference. At the same time, we can take interdependent action to increase social justice for people who are dying and their families. We already talked about the community actions of death cafes and conscious communities. We discussed changes in the laws related to the end of life and the right to life. In this section, we learn about three additional ways that people are taking interdependent action: POLSTs and Advance Directives, Green Burials, and Last Words.

Table 3: The table describes the differences between a POLST and an Advance Care Directive.

POLST	Advance Directive
Medical Order to a doctor	Legal document
A health care professional completes the form	An individual completes the form
Is a specific Medical Order	Contains general wishes about treatment
A copy is in the patient's medical record	May not be in the patient's medical record
Was created in 1990 by Oregon Health and Sciences University	Began in 1967, as part of a living will
Oregon POLST	Sample Advance Directive

The state of Oregon is once again an innovator. In the early 1990s, healthcare professionals and the state legislature created the POLST or Portable Orders for Life-Sustaining Treatment®. The POLST allows patients to describe what measures they want doctors to use to sustain their lives. These orders are useful when patients are too sick to speak for themselves. The POLST form is in addition to an advanced directive, a legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions because of a serious illness or injury. An advance directive may also give a person (such as a spouse, relative, or friend) the authority to make medical decisions for another person when that person can no longer make decisions. Unlike an advance directive, the POLST focuses on what a doctor can or cannot do for the patient, including providing CPR or assistance with breathing. The POLST process is now widely used in all US states, although state regulations vary (National POLST N.d.).

Green Burial

In the United States, until the 1930s, most people died at home. Their loved ones took care of their body. They were buried in-home or city-owned cemeteries. After this time, however, many states required trained morticians to report the deaths, embalm the bodies, and bury them in cemeteries with caskets. Often, these caskets were covered in cement, preventing the normal decay of the body. This style of burial adds toxic chemicals to the environment, risking the health of funeral workers. It also contributes toxins to the cemeteries. As an alternative, eco-death activists agitate for green burials. A green burial is a way of caring for the dead with minimal environmental impact (Green Burial Council. N.d.). This aids in the conservation of natural resources, reduction of carbon emissions, protection of worker health, and the restoration and or preservation of habitat. If a body is buried without these chemicals in a wooden box, the decomposing body can eventually nurture plants.

Last Words Project: Art as Activism

In addition to implementing new laws and policies related to end-of-life, and new options for funerals and burials, one woman is creating new alternatives for expressing grief. Crystal Akins is an arts activist, musician, spiritual director, and death doula. In the Last Words Project, she united people with words and music to create support for the dying and celebrate the dead. In these interdependent actions changing laws and policies, providing new ways to deal with bodies, and using art and song to create change we expand the possibilities for social justice for people who are dying, their families, the dead, and our ancestors.

5.

TOPIC: PUBLIC HEALTH ETHICS

Introduction

Introducing public health ethics poses two special challenges. First, it is a relatively new field that combines public health and practical ethics. Its unfamiliarity requires considerable explanation, yet its scope and emergent qualities make delineation difficult. Moreover, while the early development of public health ethics occurred in a Western context, its reach, like public health itself, has become global. A second challenge, then, is to articulate an approach specific enough to provide clear guidance yet sufficiently flexible and encompassing to adapt to global contexts. Broadly speaking, public health ethics helps guide practical decisions affecting population or community health based on scientific evidence and by accepted values and standards of right and wrong. In these ways, public health ethics builds on its parent disciplines of public health and ethics. This dual inheritance plays out in the definition the U.S. Centers for Disease Control and Prevention (CDC) offers of public health ethics: "A systematic process to clarify, prioritize, and justify possible courses of public health action based on ethical principles, values and beliefs of stakeholders, and scientific and other information" (CDC *2011*). Public health ethics shares with other fields of practical and professional ethics both the general theories of ethics and a common store of ethical principles, values, and beliefs. It differs from these other fields largely in the challenges that public health officials typically encounter and in the ethical frameworks it employs to address these challenges. Frameworks provide methodical approaches or procedures that tailor general ethical theories, principles, values, and beliefs to the specific ethical challenges that arise in a particular field. Although no framework is definitive, many are useful, and some are especially effective in particular contexts.

We learn new things more readily when we can relate them to familiar things, and we understand complex things by breaking them into their components. We will relate public health ethics to more familiar concepts and better-known related fields, while the immediately following we will explore the components of public health ethics that derive from its parent disciplines of public health and ethics. After describing public health's core activities, goals, and values, we will explain why ethical concepts like the right to health, social justice, and health equity directly follow as central concerns of public health. After defining ethics broadly in everyday terms, we will examine the complementary roles facts and values play in public health. This examination is important because the respective bases of the two parent disciplines differ considerably: public health science rests on the logic of scientific discovery, whereas ethics rests on the logic of right action and good decision-making. We will then contrast the more familiar, everyday understanding of morality with the formal discipline of ethics as a prelude to considering three well-known ethical theories relevant to public health. Because both laws and ethical rules establish parameters for public health practice, their similarity and differences need to be clarified. This extended account, first of parent disciplines, then of kindred concepts, and finally of family resemblances between the related fields of clinical ethics, bioethics, and research ethics, will culminate to characterize what is distinctive about public health ethics.

Public Health

There are many definitions of public health. They often begin as descriptions of current practice but once established become prescriptions for subsequent practice. It is important, then, to consider definitions, because they shape not only public health practice but also how we conceive of public health ethics (Dawson and Verweij *2007*). The same logic applies to how we think about the individual concepts of health and the public. Defining health as the absence of disease or symptoms, for example, more readily fits allopathic medicine, which focuses on negating symptoms to treat disease. But it hardly fits public health's emphasis on preventive measures that address root causes rather than symptoms. Nor does it cover public health's promotion of health and well-being across a range of interventions. In this regard, the World Health Organization (WHO) defines health more suitable to public health: "A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO *2006*). But even this more holistic definition does not sufficiently clarify the meaning of "public" in public health. Dawson and Verweij (*2007*) identify two primary meanings of "public" in public health, each of which they break down into three senses. Public can mean population-wide and refer to (1) the epidemiologically measured health of a population or group, (2) the distribution of health in a population, or (3) the underlying social and environmental conditions impacting everyone's health. Public also can mean collectively accomplished and requiring (1) the concerted actions of many people and institutions whether governmental or nongovernmental; (2) the cooperation or involvement of the public, or (3) the public's joint participation to realize the health improvement.

In a practical field like public health, the definition often takes the form of enumerating key activities, such as surveillance, sanitation, maintaining food and workplace safety, disease prevention and control, and promoting healthy behavior. The identification of the ten essential services of public health illustrates this enumerative approach (Public Health Functions Steering Committee *1994*). These services fall under three overarching functions of assessment, policy development, and assurance that constitute an integrated cyclic process. The delivery of these services in local, regional, or national public health agencies accordingly defines public health practice. In this schema, research is a distinct practical service but also integral to all public health activities, providing insights and innovative solutions at every point. Public health ethics addresses the entire spectrum of ethical issues that arise in any area of public health practice, especially in those areas where no specific guidelines govern practice.

The U.S. Institute of Medicine (IOM) defines public health as “what we, as a society, do collectively to assure the conditions for people to be healthy” (IOM *1988*). These two definitions highlight the importance of collective action to address the health needs of populations. Public health’s population focus distinguishes it from clinical medicine’s focus on individual patients, though examples like vaccination indicate that the two fields can overlap. Epidemiologists statistically aggregate the health data of individuals to provide a picture of population health, but populations ultimately originate from communities of individuals who constitute social wholes. Individuals in society stand in complex relations of interdependence, competition, and solidarity that can impact health in ways that transcend the individual. Thus, in addition to aggregating individual medical data, epidemiologists need to measure the impact of various social factors on health. To tackle the complex, often competing health needs of social groups, public health practitioners need to dialogue and partner with their communities. At a higher administrative level, public health officials need to manage intersectoral collaborations, navigate political processes, and formulate public health laws. Four distinguishing features of public health practice —the pursuit of the collective good, a focus on prevention, the use of government or collective action, and an emphasis on an outcome-based (utilitarian) approach—generate most of the ethical challenges public health practitioners typically face (Faden and Shebaya *2010*).

Core Values

People value many things such as friends and family, material goods and resources, knowledge, and art. Some things people value are ethical virtues like courage or honesty, whereas others are ethical principles like justice and equality. People generally value what they consider important, what matters to them, and what gives their lives meaning. Public health’s primary goals and commitments reflect its core values, which are rooted in health, science, and the community (Public Health Leadership Society *2002*). Everyone recognizes the value of health, but public health approaches health about science and the community in its endeavor to prevent disease and injury, protect the public from harm, and promote health and well-being. But seeing how science and community represent values requires a word of explanation.

The commitment to science as a value stance often becomes apparent only in people who distrust science or prioritize other value commitments such as economic interests or religion. Public health values science by endeavoring to base interventions and policies on the best available data and evidence-based practices. That endeavor entails a commitment to conduct surveillance and research because only by understanding the social burden of disease and its underlying or structural causes can public health impact the health of the entire population. The qualifier “best available” is a reminder of the need to continuously improve practice and not rely on tradition or current practices. It also reminds us that during emergencies, time and resource constraints limit the ability to gather evidence.

Public health values community in two obvious senses. First, it recognizes that the success of most health interventions depends on a community's acceptance, cooperation, or participation. Second, it recognizes that to be successful, public health must respect the community's values and gain the trust of its members. Yet there is a third, deeper sense in which community represents a value. A community is, to emphasize again, neither a statistical abstraction nor a mere aggregate of individuals but rather a network of relationships and emotional bonds between people sharing a life in common organized through a political and moral order (Jennings *2007*). The value that best reflects this fundamental, relational character of social life is solidarity. Solidarity can remain unspoken yet operative because it forms the basis of social life and collective action. Just as communities are not mere aggregates of individuals, neither are the agencies or organizations that make the collective decisions that affect the community. Personal interests, to be sure, can motivate individuals, but the felt recognition of a common plight, that we are all in it together, underlies the collective decisions society and public health must make to solve collective problems. To say that public health values community means that it values solidarity, even when solidarity remains unacknowledged as is often the case (Dawson and Jennings *2012*).

Health Equity, Social Justice, and Social Determinants of Health

As the foregoing goals, definitions, core values, and commitments of public health clearly suggest, the right to health and health equity are central, not peripheral, to public health's mission. International collaboration will examine some practical challenges in addressing the right to health and social determinants of health, so the emphasis here will be on the rationale for achieving health equity as a matter of social justice.

Despite greater individual access to health care and advances in public health, high burdens of disease remain across much of the globe. Some differences in disease burden result from genetics and some from variable risks of exposure to infectious agents and other threats, but most of the differential burden arises from social, economic, and political conditions. These conditions include poverty, lack of education, and discrimination against particular social groups and often reflect historical injustices or long-standing systemic, structural deficiencies. Collectively, these conditions have come to be known as social determinants of health (Blane *1999*). Greater access to individual health care can mitigate their effect, but an adequate response to them requires concerted public action to address their underlying causes.

Whether comparing countries or groups within countries, social stratification by social determinants correlates with differences in health status (Marmot *2007*). These health differences have aroused widespread concern, but how one defines them significantly affects public health practice (Braveman *2006*). Distinguishing health disparity from health inequity is critical. As a comparative indicator of health status, health disparity is a neutral, epidemiologic term that need not imply an ethical obligation to remedy. Health disparities, however, can and frequently do reflect underlying inequities. WHO defines health inequities as health differences that are "socially produced; systematic in their distribution across the population; and unfair" (WHO *2007*). Terms like "inequity" and "unfair" are ethical terms that imply an obligation to redress an injustice. Justice has a range of meanings that include giving people what they deserve or are owed and distributing goods and services fairly. Justice in a medical context often involves the individual's access to health services. In public health, discussions of health equity usually involve questions of how to distribute health benefits fairly or how to achieve better health outcomes among communities or groups that suffer health inequities. Attaining greater equity might involve the politically controversial strategy of disproportionally distributing resources within a population, by, for example, distributing more to those most in need. A less controversial strategy is to improve health outcomes for all, even while devoting special efforts to those most in need. WHO defines health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically" (WHO *2007*).

Achieving health equity is most urgent for groups who have experienced histories of marginalization and discrimination and who continue to experience higher rates of illness and premature deaths than members of the mainstream population. Especially for these groups, "social injustice is killing people on a grand scale" (WHO *2008*). Realizing the goal of social justice concerning health means achieving health equity. Doing so requires not only a fair distribution of health outcomes, it also means that "ideally everyone should have a fair opportunity to attain their full health potential" and that "no one should be disadvantaged from achieving this potential if it can be avoided" (Whitehead *1992*). For many, these goals imply that social justice obligates public health to improve any social condition that prevents people from maintaining a standard of life adequate to maintain health (Powers and Faden *2006*). Although some believe that improving social conditions that affect health overextends public health's mandate, such a broad mandate is arguably consistent with both Winslow's and IOM's definitions of public health. Moreover, such a broad mandate has both nineteenth-century precursors in the social medicine movement and more recent precedents in the "Health for All" strategy that emphasizes health promotion and the "Health in All Policies" strategy (Kickbusch *2003*; Freiler et al. *2013*). However, a major milestone was reached with the 2008 report of the WHO Commission on Social Determinants of Health that sought to "marshal the evidence on what can be done to promote health equity, and to foster a global movement to achieve it" (WHO *2008*). and essential services, establish policies that provide an equitable basis for health improvement, and gather and monitor data on health equity, achieving equity ultimately will depend on the cooperation of government and civil society (Blas et al. *2008*).

Ethics

People strive to be "good," to do the "right" thing, and to lead a "good life," but where do such basic, familiar moral values as good and right originate? Throughout history, religious people have explained these ideas as revelations of divine command. Anthropologists, however, view morals as customs that govern social interactions, and because all cultures display such customs, interpret moral practices in terms of a survival function rooted in human nature. By contrast, many social and political thinkers emphasize that moral concepts result from social conventions or agreements that are subject to deliberation and change. Governments today often consult social scientists and health experts who empirically investigate what fosters or improves human life, health, and happiness. Where science informs law and policy, it helps define in a conventional sense what we mean by good and right. In particular, public health science helps establish what is considered good for the health of populations and communities. Further below we will examine three ethical theories prominent in public health ethics that offer contrasting perspectives on the nature and basis of morality. In the meantime, we will address three general questions that a public health practitioner first approaches the study of ethics might well ask: how does science relate to ethics, what is the difference between ethics and morality, and what sort of things count as principles or basic concepts in ethics?

Scientific Facts and Ethical Values

Public health practice increasingly requires an appreciation of the complementary roles facts and values play in making and justifying decisions. Observation reveals facts, while scientific research controls and manipulates the experimental context to discover causation or correlation. Data on disease burden, research on intervention effectiveness, and estimates of the resultant health benefits for the population generally inform public health interventions. Health messaging can often inform the public about the scientific rationale underlying public health interventions. Nevertheless, in the mind of the public, scientific evidence does not always invalidate or outweigh other sources of evidence or appeals to emotions, interests, and values. While public health practitioners give more weight to community health and scientific evidence, they also need to consider how the public will respond to an intervention. Successfully implementing public health actions, then, will often entail weighing the public's attitudes, interests, and values about public health's core values.

Two mundane features of public health practice often serve to conceal value assumptions: shared core values and standard practice. First, sharing values can render them invisible as assumptions, until they unexpectedly become contested. Unwelcome surprises occur when interventions that presuppose core values affect stakeholders who do not share those values, as when parents refuse to have children vaccinated based on media hearsay or individuals reject a highly effective program as a governmental intrusion. Avoiding such surprises begins with becoming aware of one's value presuppositions about those of other stakeholders and community members. Second, routine use of evidence-based standards can conceal underlying value assumptions. If developed and tested to address a known health problem, as is common, an intervention's purpose and effectiveness are taken for granted. Standard interventions, then, generally require no more justification than noting their standard status or seeing that “the facts dictated” their use. “Dictating” facts are indicators that trigger the use of a standard intervention (e.g., meeting the criteria of a case definition or documenting exposure to a dangerous level of a contaminant).

Such "dictating facts," more properly speaking, only indicate the appropriate intervention but cannot dictate that anything be done. What in the end dictate actions are the values, goals, and obligations that the standard intervention presupposes and that practitioners tacitly ratify each time they apply the standard. In other words, values, goals, and obligations, even when tacit, form a necessary bridge between knowledge and action.

Though standard practices tacitly incorporate ethical principles, they seldom raise ethical challenges. Challenges more typically arise in unusual or extreme situations where standards are not yet in place, are changing, or are competing. These situations include emergency operations, foreign cultural settings, emergent fields with innovative interventions, or periods of severe budget constraints that force prioritization of programs. In such challenging situations where no value consensus exists or where evidence does not point to a single course of action, public health ethics provides a process to determine and justify a course of action. That justification can incorporate several factors: the evidence bases for the intervention, cost-effectiveness, analysis of relevant ethical rules and stakeholder values, a creative design of options or alternatives that embody these values, and a fair and transparent decision-making process that incorporates stakeholder contributions.

Recognizing one's value assumptions about those of the public will be critical for implementing new interventions wherever success depends on public acceptance. The public will not embrace interventions that embody or presuppose values that clash with community values or whose relative importance is low compared to other community values. Members of the public generally are more committed to their political views, ethical and religious values, and an intervention's impact on them personally than to scientific evidence or community impact. Public health practitioners need to recognize that no matter how compelling to them, community impact and scientific rationale seldom resonate as deeply with the public. Consequently, in communicating, public health practitioners need to supplement scientific messaging with dialogue, an appeal to common values, or enlistment of spokespersons who share the value orientation of the relevant stakeholders or community. Regarding some controversial matters, ultimate success in implementing an intervention may require building a social consensus (Ortmann and Iskander *2013*).

In certain situations, untangling factual claims based on science from value judgments is critical for success. For example, suppose independent investigators have scientifically verified the level of worker exposure to a toxic chemical used in industry. Determining what level of exposure would be safe, however, remains a value judgment that depends on the degree of concern that people have about safety. Placing a higher value on safety might result in stricter controls that decrease risk for workers, but the financial costs of decreasing risks could cut industry profits or jobs, even as health costs fall. Stakeholders representing industry, workers, or public health practitioners might have different positions regarding a safe level of exposure. To make a good decision about a safe exposure level, the value of safety might have to be discussed and weighed about business, employment, and health considerations. However, these varying positions regarding safety need not imply disregard for safety or disagreement on the underlying facts. Rather, they illustrate that conflicting value judgments can coexist despite a consensus on both the underlying facts and the importance of a particular value such as safety.

Directly addressing the value conflicts in such situations through ethical deliberation makes more sense than calling into question the underlying facts and can lead to better, fairer, and more transparent decisions. It is also important to recognize that doubting science often represents an underlying value dispute masquerading as a scientific dispute (Brunk et al. *1991*). Sowing doubt on scientific assessments merely as a tactic to oppose an evidence-based policy or recommendation undermines science. This doubt can exert pressure to test and retest results, raising the bar for scientific validity even higher (Michaels *2008*). The solution is not to litigate, as it were, the science, but to recognize that communicating risk is a social process that goes beyond science messaging and must take cultural attitudes, perceptions, and symbolic meanings into account (Krimsky and Plough *1988*). Where profound value disagreements prevail, public health legitimately prioritizes its core values but cannot speak for everyone. Stakeholder views require a fair hearing, whether through media research, stakeholder analysis, or direct solicitation of input from individuals, focus groups, or public meetings. By design, a fair, transparent ethical decision-making procedure can help determine what value tradeoffs are feasible and what values may be nonnegotiable. Such a deliberative procedure can help to gain public acceptance and become part of the justification for a course of action.

To those accustomed to rigorous research methods and evidence-based standards of practice, navigating the world of ethical values and rules can be perplexing. Values, as the term itself implies, manifest valences, that is, variable degrees of commitment or estimations of importance along a continuum. Individuals rank values differently, change their rankings, and alter their relative ranking of values in different contexts. The range of options for ethical rules is far more limited, namely, to obey or not obey. Nevertheless, the ethical rules governing particular situations also vary from country to country or even from jurisdiction to jurisdiction within a country. Despite this variability in values and ethical rules, reducing ethical judgment to mere opinion or to a consensus of opinion relative only to personal or cultural preferences would be a mistake. Ethical values and rules enjoy the approval of history, custom, law, and religious tradition, but they also find anchor biologically, psychologically, and socially in human life. Value judgments and ethical determinations, then, are not relative as much as correlative; that is, they correlate and resonate with these deeper roots of human life that we share. If humans indeed share a set of fundamental values, then ethical conflicts primarily reflect differences in prioritizing values in a particular context, rather than a fundamental disagreement about values. This point of view provides grounds for optimism about the possibility of finding a deeper basis for understanding and mutual respect, if not agreement when ethical tensions surface.

Ethics and Morality

Although many use the terms ethics and morality interchangeably, we will distinguish the formal discipline of ethics from the common morality that guides everyday actions and behavior. Morality refers to a society's shared, stable beliefs about what is good and bad, right and wrong. Through upbringing and socialization, each generation passes this common morality to the next. Common morality envelopes the individual like an ecosphere of shared customs, rules, and values. For most circumstances, people habitually rely on this common morality to guide their conduct, and it serves them well, just as standard practice generally serves professional practitioners well. Still, common morality can fall short were rules conflict, where it inadequately illuminates novel moral problems, or where intense disagreement prevails among rival stakeholders. In such instances, the formal discipline of ethics offers a deliberate, systematic way of addressing troubling moral issues, conflicts, and dilemmas.

Ethical Principles

Principles are general categories, rules, or guidelines that form the basis of a discipline. In ethics, there are various kinds of principles and many examples of each kind. The kinds include basic ethical categories (e.g., virtues, values, or rights), ethical commands or rules of conduct (e.g., not stealing, not harming, or treating others with respect), and guidelines for weighing outcomes (e.g., achieving the greatest good for the greatest number, distributing burdens and benefits fairly, or properly proportioning benefit to harm). Ethical principles like justice or respect for autonomy are simultaneously values, ideals, and the basis for deriving rules of conduct. Such rules serve as ethical standards to evaluate past and pending actions, programs, and policy recommendations. When addressing complex or controversial issues or issues involving numerous stakeholders, many different principles can come into play. However because ethical decision-making depends on context (e.g., on local circumstances, community stakeholders, and decision-makers), no formula can determine the most relevant ethical principles.

Nevertheless, most ethicists and practitioners working in a field would agree that certain principles, theories, or frameworks provide more helpful guidance for that field. Given the need for flexibility, some prefer to speak not of ethical principles but of "general moral considerations" that can guide public health practice (Childress et al. *2002*). At any rate, a complex ethical challenge involving stakeholders with competing moral claims frequently demands consideration of a variety of ethical principles and theories to address the situation and justify a proposed intervention. For these reasons, it will be useful both to examine several ethical theories used in public health ethics and to provide at the end of the chapter a framework that is generally applicable to ethical issues that arise in public health.

Ethical Theories

As used here, an ethical framework refers to a tool or approach for practically addressing ethical challenges that often includes a stepwise procedure. An ethical framework may rely heavily on just one ethical theory, but frameworks generally take a pragmatic approach that procedurally allows for using a variety of theories or principles as the issue or context demands. Whereas an ethical framework has a practical orientation, an ethical theory also addresses more fundamental questions, so-called "metaethical" questions. Does morality originate in divine command, human nature, or human convention? Is it essentially a habit, intuition, form of reasoning, or a quality or purpose of an action? An ethical theory will offer a distinct, coherent understanding of the source and nature of morality that will shape how one reasons about moral issues and determine which principles are most important. Two persons employing the same theory, however, will not necessarily reach the same conclusion about an ethical issue; much will depend on which aspects of the issue they deem most important and on how they weigh different factors. Nevertheless, because a particular ethical theory tends to favor certain principles or types of principles, using the same theoretical approach will lead to similar lines of reasoning and selection of principles.

The diversity of ethical theories does not imply their mutual opposition so much as points to the extensive range of the moral landscape and the need to illuminate its various contours. A helpful way of illuminating this landscape is to distinguish theories depending on whether they focus on the actor, the action, or the results of the action.

Aristotle's virtue ethics is an ethical theory that focuses on the moral character of the actor or agent (Bartlett and Collins *2011*). Classic virtues are dispositions or stable patterns of behavior that lie between extremes of vice; courage, for example, lies between the extremes of cowardice and foolhardiness in taking risks. Habit and practice are necessary to develop virtues whose possession we equate with good character and that equip a person to be effective in society or an organization. Because good character translates into virtuous action that others aspire to emulate, we tacitly invoke virtue ethics whenever we ask how an outstanding public figure or health leader would handle a situation. In a modern professional context, virtues also include the skills the profession has identified that lead to success in that profession and which professional education and training instill in practitioners. Once established, virtues readily become the standards of obligation and accountability to evaluate professional performance and function similarly to the rules and principles of duty discussed below.

Holding public health institutions accountable for the professional competence of their employees illustrates virtue ethics (Public Health Leadership Society *2002*). More recently, the capabilities approach has exploited the potential of virtue ethics to guide decisions about policy or interventions in a way that goes beyond matters of professional training and responsibilities. This approach takes a broader developmental view of human agency and capacity building. It conceives health as a fundamental capability necessary for individuals to succeed in society, one on which many further capabilities depend (Sen *2009*; Ruger *2010*).

An ethical theory that focuses on action or, more properly, the rules governing action, is deontology. The word deontology comes from the ancient Greek word, deontos, which means duty. Because duties oblige us to obey rules that govern actions or conduct, they bind or constrain the will ahead of action. In judging whether an action is right or wrong, deontology ignores consideration of harmful or beneficial consequences and relies on these rules of duty to serve as the standard of judgment. People usually have rules of duty or obligation in mind when they speak of ethical standards or worry that standards are breaking down. Examples of these rules include religious commandments to honor parents, not lie, or not steal, and rules of social interaction such as treating people fairly, doing them no harm, or respecting their rights. Rights often are said to stand in reciprocal relation to duties. Thus, the right to free speech presupposes a duty to respect the right of others to speak, or the public health obligation to ensure conditions for maintaining health presupposes a right to health.

Deontology as a theory owes most to Immanuel Kant’s view of “goodwill” and his closely linked account of autonomy. A person of morally good will does the right thing for their own sake, which means acting purely for the sake of duty. Duties are moral rules or laws that bind the will and limit the scope of action. For Kant, basing a decision for one’s action solely on duty without regard to the potential good or bad consequences of the action is the only legitimate basis for moral action. Kant even goes so far as to say that “free will and a will under moral laws are the same” (Gregor et al. *2012*).

Kant conceives duty as the quintessential expression of autonomy, which may come as a surprise to those who equate autonomy with rational free choice or even just following one’s preferences without interference. However, the meaning of autonomy for Kant derives from its literal meaning in Greek, autos (self) and nomos (law); namely, self-legislating. Autonomy enacts from within the moral rules and principles that bind the will and guide action. However, not every self-originating impulse should be obeyed; only actions conceivable as universal laws morally bind the will. Morally laying down the law for oneself entails legislating for everyone, but universally legislating does not mean asserting one’s will over others. Nor does it mean that the ethical content of a moral law or duty is valid eternally and everywhere. Rather, it refers to the “categorical imperative” an unconditional requirement for an action to be moral. To qualify as a duty, a rule that commands action must apply to every rational person. Stealing, for example, could never qualify as a duty, because a situation where everyone steals from everyone else would undercut the one-sided advantage of stealing that the thief hopes to exploit. Although self-directed, autonomous action is necessarily other regarding.

Kant maintains that the categorical imperative can be expressed in two other ways equivalent to universality, namely, “respect for humanity” and a “kingdom of ends” (Gregor et al. *2012*). In each, this other-regarding dimension of autonomy is evident. Respecting humanity means never treating persons as mere means or objects but always treating them as ends, that is, regarding them as fellow autonomous agents. Autonomously agreeing on actions, interventions, or policies requires that decision-makers mutually consider and understand their reasons for action and be willing to abide by the rules derived from these reasons as laws they collectively impose upon themselves (O'Neill *2002*).

The idea of a fellowship of mutual consideration comes out most clearly in Kant's concept of a kingdom of ends. This concept is the ideal of a systematic union or commonwealth of autonomous individuals making laws that apply to everyone. This ideal presupposes that ethical deliberation places respect for others as ends, as autonomous agents, above self-interest. The core idea is that we only consider actions that could gain acceptance by a community in which all see themselves as sovereigns who lay down universal laws binding on themselves and others. The hope is that the body of law governing society progressively embodies this ideal. Such mutual regard in laying down the moral laws that will bind one's actions differs significantly from insistence on noninterference with individual free choice, let alone with personal preferences. Conversely, the aspiration behind Kant's view of autonomy harmonizes well with the public health obligation to address collective problems through collective action.

For utilitarianism, judging the rightness of an action depends on an estimation of its subsequent practical outcome or result rather than on its conformity to principles of duty. Utilitarianism considers ethically best that course of action that will result in the greatest net benefits over harms. A utilitarian approach underlies cost-benefit analyses that weigh an intervention's costs (risks, harms, burdens, or disadvantages) against its benefits (advantages, utility, improvements, cost savings). In addition to its focus on consequences, utilitarianism is egalitarian, communitarian, and scientific in outlook. It is egalitarian in considering everyone's benefit and equally weighting each person's good, as opposed to privileging certain people. It is communitarian in attempting to increase benefits to society rather than individuals, seeking the "greatest good for the greatest number." It endeavors to be scientific by quantifying harms and benefits, accounting for probability, and calculating net benefit. Calculating net benefits over harms is less problematic when relevant factors employ a common scale of measurement, for example, weighing the financial costs of treating a disease with the cost savings from preventing that disease. Comparing different outcomes (e.g., financial costs versus quality-adjusted life years) sometimes involves difficult judgments about the relative value of each outcome. Because the utilitarian approach seeks to determine and promote the collective good based on aggregate measures, it readily lends itself to justifying public health interventions.

Law Versus Ethics

Laws share certain deontological features with ethical principles of action (and with religious commandments). They all define one's obligations or duties and typically take the form of rules or commands regarding what one should or should not do. They can lay down positive requirements to fulfill but more commonly establish parameters that prohibit certain actions or constrain liberty in some way. Laws do not differ from ethical rules primarily based on content, because an ethical rule can become a law without changing the rule's content. For Kant, at least, the crucial difference between ethics and law concerns one's reason for obeying; namely, whether one acts purely voluntarily out of a sense of duty or merely in external conformity with duty, either to appear to be moral or out of fear of penalty or punishment. Laws are rules enforced by penalty or punishment, which many people might otherwise break. Society can tolerate the flouting of some rules, but disobedience of more important rules can disrupt society or create danger. For these reasons, society establishes and enforces laws regarding socially important matters, not leaving their compliance up to individual prerogative. An ethical rule's enactment as law, therefore, implies agreement by society or the law's enactors on the importance of strictly regulating the behavior the law governs. The law can be a blunt instrument that effectively compels compliance, which suffices to satisfy the reasons for its enactment, even if it cannot coax voluntary obedience from an inward sense of duty.

In theory, deontologically evaluating a past or proposed action is a straightforward binary determination of compliance or noncompliance with a legal or ethical rule. In practice, however, defining a rule's scope or determining exactly which actions fall under it can prove difficult. Moreover, when different rules apply, determining which should take precedence often becomes problematic, especially when they conflict. Lying to protect a relative, for example, can put the duty to speak truthfully into conflict with familial obligations. Determining which rule takes precedence can involve reasoning clearly from ethical principles, weighing the underlying values embodied in the law, or considering the practical impact of the intervention in context. Because laws demand compliance, they are more rigid. Additional legal stipulations can prioritize or specify how to apply laws in certain situations, but doing so increases their complexity. Ethical guidelines operate more flexibly than rigid, compulsory laws and more readily accommodate compromise. With ethical guidelines, decision-makers can consider and rank the underlying values the ethical rules serve to promote. Doing so allows for trade-offs between competing ethical considerations and for deciding which values it makes sense to prioritize in the given context. Conversely, the law's comparative rigidity can be a virtue where only stricter oversight and enforcement will ensure compliance and establish order.

Across cultures, legal, ethical, and religious rules prohibiting basic offenses such as lying, theft, and murder show considerable overlap. However, cultures vary in exactly which rules are matters of individual choice and which are matters of legal enforcement and punishment. This variability also applies to the status of rules and standards governing research on human subjects. Even within a country, significant variability can prevail in whether human subjects' research rules and standards are legal regulations or ethical guidelines (U.S. Department of Health and Human Services *2015*). Some see the lack of legal regulation as a breach of protections, but others prefer guidelines, arguing that regulations tie reviewer hands, making it more difficult to make trade-offs or nuanced judgments based on moral discernment of the particulars of each case (Verweij and Dawson *2009*). Because each approach offers advantages and disadvantages, political culture and local context must ultimately decide whether human subjects' research rules exist as enforceable regulations or ethical guidelines.

Regardless of whether it takes the form of guidelines or law, research ethics will govern only a fraction of the ethical issues that the field of public health must address. In many areas of public health practice, there are no specific ethical guidelines or regulations. To address ethical challenges in these areas or to address emergent challenges, the ethical practice of public health therefore requires the ability to use general ethical frameworks. Such frameworks can employ checklists of questions and stepwise procedures. However, because novel challenges continually emerge and changing contexts introduce nuances no set of rules can anticipate, public health professionals ultimately need to practice ethical decision-making over time to cultivate moral judgment and discernment.

By laying down and enforcing what may, must, or cannot be done, legal rules function as boundaries of acceptable behavior. Ethics, science, budgets, or politics, each in its way, also can restrict the scope of action. Public health practitioners and officials therefore first need to conduct a feasibility analysis to determine the relevant limits on possible interventions or policies. Determining these limits seldom will restrict the scope of action to a single possible course. Given multiple possibilities, most people will aspire to the best course of action beyond the legal floor of minimally acceptable behavior yet within the other relevant limits. As a result, the ethical challenges public health practitioners face seldom involve stark choices between right or wrong, good or evil. A good feasibility analysis will have ruled out any unethical or illegal options or alternative courses of action in advance. Rather, the tough choices more frequently involve selecting the best alternative from among competing goods, each of which to a greater or lesser degree realizes the public health goal and embodies relevant stakeholder values.

Whereas determining and complying with the various limits on action is largely an analytic process, designing alternatives is a synthetic, creative process. Alternatives should all realize the public health goal and incorporate the perspectives and values of subject matter experts and relevant stakeholders. Deciding upon the best alternative must take into account how it will realize the public health goal in a particular context and concerning the stakeholders. For example, advocating contraceptives to reduce unwanted teen pregnancy might seem to promise success based on efficacy studies, but ethical controversy could render such a program less than optimal in some contexts. Political culture or social norms can confer partisan advantage or disadvantage to some alternatives, while other alternatives may enjoy an advantage because of the experience and expertise of a health department. Whatever alternative practitioners finally choose, their choice will presuppose a prioritizing of values. The foregoing account highlights because public health practitioners need to see ethics as something more than a compliance matter. It transcends compliance because public health ethics also involves practical decision-making, which should include stakeholder analysis, the incorporation of stakeholder values in the design of alternatives, and a fair, transparent deliberative process to evaluate alternatives.

Public Health Ethics

Compared with more established fields of practical ethics such as clinical ethics, research ethics, and bioethics, the field of public health ethics is relatively new. Consequently, many public health practitioners may be better acquainted with these more established fields than with public health ethics. In particular, practitioners may already be acquainted with the four principles these fields rely on for ethical evaluation: beneficence, nonmaleficence, respect for persons (autonomy), and justice (U.S. Department of Health, Education, and Welfare *1979*; Beauchamp and Childress *2012*). Applying to health and research, these four principles also are relevant to public health, but having arisen to address issues in other fields, they need to be adapted to a public health context. Even then, they still fall short of addressing the ethical challenges that arise in public health. Examining these related ethics fields and showing how the four principles fit into a public health context can serve by way of contrast to indicate what is distinctive about public health ethics.

Research Ethics, Clinical Ethics, and Bioethics: Principles and the Four Principles

Research ethics entails the wider notion of scientific integrity but is best known and most developed in medical research involving human subjects. The development of human subjects' research ethics guidelines can neither be divorced from breaches of ethical conduct in human subject's research nor wholly reduced to a reaction to these events. But beginning with the Nuremberg Code (*1947*), balancing risks and benefits to research subjects and getting their informed consent have been cornerstones of international research ethics guidelines. Far more influential than the Nuremberg Code, the Declaration of Helsinki from the World Medical Association (WMA) is a fundamental document in international human subjects' research ethics guidelines. Its initial 1964 version included provisions for proxy consent for those with diminished autonomy. Its 1975 revision called for a review of research by an independent committee, now known as an ethics review committee (WMA *1964*, 1975, 2013). The use of such committees began spreading under the aegis of WHO and then in response to the HIV/AIDS pandemic, as the number of large-scale vaccine and drug trials grew in developing countries. In the United States, research regulations outlined in the Common Rule govern ethics review committees as well as all human subjects' research that receives U.S. government funding (U.S. Department of Health and Human Services *2009*). In the United States, a standing ethics review committee generally functions within a specific governmental or university institution and therefore is referred to as an institutional review board (IRB). Beginning in 1982, the Council for International Organizations of Medical Sciences (CIOMS), in collaboration with WHO, proposed international ethical guidelines for biomedical research involving human subjects (CIOMS *2002*).

Our discussion of these documents has only highlighted key provisions of what is required to ensure the safety of human subjects. CIOMS's most recent research guidelines (*2002*), for example, contain more than 60 pages of text, explanation, and commentary. However, ensuring ethical conduct and scientific integrity in research requires more than the oversight function of ethical review committees. It also requires extensive training not only in research ethics but also in several related areas. Training and guidelines should cover, among other things, mentoring of junior researchers, authorship and publications policy, conflicts of interest that arise in partnerships and collaborative science, and data acquisition, management, sharing, and ownership. Ethics training can help develop moral judgment. The hope is that training and application will enable practitioners to reason about new, difficult, or ambiguous cases in morally discerning ways.

Clinical ethics addresses the ethical issues that arise in clinical practice. Until the advent of bioethics, medical professionalism emphasized the healthcare provider's obligation to prioritize the patient's welfare, the healthcare provider's professional judgment about what would most benefit the patient, and the importance of establishing patient trust. The traditional model of clinical ethics was frankly paternalistic. Under the influence of bioethics, many healthcare providers began embracing a more patient-centered model of care that emphasized patient autonomy and informed consent. This patient-centered model conceives care as a contract between patient and provider. The emphasis on contracts strikes some as an inappropriate consumerist model that undervalues professional judgment and undermines patient trust in the medical profession. Tensions between these two models have led to a compromise that reasserts the importance of medical professionalism and clinical judgment, while acknowledging the importance of respecting patient autonomy (ABIM Foundation et al. *2002*).

Bioethics has a range of meanings, the first of which applies to ethical issues brought about by advances in biomedicine and biotechnology. Ethical issues that arise from using life-sustaining technologies in end-of-life and beginning-of-life care epitomize this sense of bioethics. But bioethics also arose in response to medical paternalism and to the abuse of human subjects in medical research. Bioethics has championed informed consent, patient autonomy in doctor-patient relationships, and the safety of human subjects in research. However, many bioethicists think the focus on clinical ethics and personal autonomy unduly restricts bioethics' purview. They advocate a more holistic, social justice approach in bioethics, which has been referred to as "population-based bioethics" or "integrative bioethics" (Sodeke *2012*). It can be argued that this expansion of bioethics beyond clinical ethics into population issues moves bioethics into the arena of public health ethics (Callahan and Jennings *2002*).

Principlism came into being in a 1979 document called the Belmont Report (U.S. Department of Health, Education, and Welfare *1979*). The report was the work of the U.S. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, which convened in 1974 partly in response to the exposé of the U.S. Public Health Service Tuskegee Syphilis Study. The Belmont Report became the basis for revising 45 CFR 46, the so-called Common Rule, part of the legally binding U.S. Code of Federal Regulations, governing the protection of human subjects (U.S. Department of Health and Human Services *2009*). The Belmont Report clearly explained the underlying ethical principles that informed existing regulations and provided an ethical framework for thinking about subsequent regulations. Principlism has remained the predominant ethical framework in biomedical ethics (Beauchamp and Childress *2012*). Its explanatory groundwork accounts for much of its success, but its relevance to medicine and research, the prestige that attaches to these fields, and its compatibility with liberal individualism also have played a role.

Beneficence (doing good) and non-maleficence (not harm) date back to the Hippocratic Oath as medical principles. Collapsing them both into beneficence, as the Belmont Report does, underscores the practical consideration that biomedical decisions generally aim to optimize net benefit over harm, rather than to maximize only benefits or minimize only harms or risks. However, these principles are distinct, not mere opposites. Not harming has a certain priority (first, not harm), because not benefitting someone seems a less serious offense than doing that person harm. That priority partly reflects the human tendency more readily to forgive overlooked benefits (errors of omission) than deliberate actions resulting in harm (errors of commission).

Justice has several meanings that include due process and fair deliberative procedure, properly assessing what people are owed or due, and equitable distribution of burdens and benefits. According to philosophic tradition, justice has always functioned dually, applying to individuals but more importantly, serving as an overarching principle for adjudicating competing claims in relation to the group or to other members of society. The phrase, “social justice,” then is redundant but in political contexts marked by individualism serves as a reminder of justice’s social dimension. This phrase came into vogue in public health circles to counter the ideology of “market justice,” which views the equal access of individuals to the free market as a valid, reliable, and preferred means for sorting out issues of economic and social justice (Beauchamp *1976*). The notion of health equity, which compares different groups, primarily refers to this social dimension of justice, although the denial of access to health care, a contributing factor to health inequity, violates what the individual is owed.

Respect for persons emphasizes that individuals, as agents in charge of their own lives and bodies, have the right to make decisions and choices free from undue interference. Respect for persons forms the basis of informed consent, namely, the right of patients and human research subjects to be informed of, and to assent to, medical or research procedures they might undergo, especially procedures that pose potential harm or risk. Conducting research on human subjects or performing medical procedures on patients without their prior knowledge or consent in most cases violates their autonomy. However, health professionals have a special (i.e., paternal) obligation to look out for the welfare of people with diminished decisional capacity such as those in a coma or the very young, and to protect them from harm.

These four principles were originally conceived as prima facie principles, that is, each expressed a self-evident though not binding obligation, and none had an inherent priority over another. However, in many Western countries and the United States in particular, respect for persons has dominated discussion in bioethics, clinical ethics, and research ethics where it often takes precedence as a moral consideration over the other principles. This ascendancy most likely reflects the high value that these countries place on liberty and freedom. At any rate, in public discourse generally and in public debate about public health interventions, respect for persons often amounts to an insistence on noninterference with individual free choice or with personal preferences. Although Kant's other-regarding idea of moral autonomy, harmonizes well with collective decision-making, the insistence on noninterference with personal choice often creates impediments to the implementation of public health interventions. In part for this reason, the social justice movement has had to challenge the emphasis on respect for persons to promote the public good and health equity.

Contrast Between Clinical Ethics and Public Health Ethics

Because public health and clinical practice can overlap, the items in the respective columns represent tendencies along a continuum rather than stark opposites. Where separate agencies carry out public health services and medical care, these contrasts may be more pronounced. The overlap between public health and clinical practice makes it even more important to highlight their differences to bring out distinctive features of public health ethics.

The Belmont principles of beneficence (seeking benefits), non-maleficence (avoiding harm), respect for persons, and justice remain important in public health, but must be extended to accommodate the broader scope of public health interventions. This broader scope entails many types of professionals, interventions, and policies that display a political and social dimension, and a wider range of activities such as community engagement, intersectoral collaboration, collective decision-making, and governmental administration. As a result, prevailing political philosophies and culture will necessarily shape the way public health functions. The crucial point is that differences of scale that produce a higher order of complexity also produce qualitative differences that introduce different patterns of causation. Among other things, this means that social factors do not merely represent aggregated individual factors and so cannot always be addressed in the same way as individual factors.

Individual Versus Relational Autonomy

For understanding what is qualitatively distinct about public health, the contrast between respect for individual persons and the relational autonomy of community members is key. Respect for persons upholds an individual's right to make independent decisions free from undue pressure, but relational autonomy emphasizes that individual actions occur in the context of other people whom these actions will affect. The potentially harmful impact of individual action on the welfare of others sets a limit to individual action. Relational autonomy draws attention, then, to the interdependence of people living in communities and to the solidarity that arises from the emotional bonds that shared lives create. Anthropology teaches that people always find themselves in a network of social relations, while evolutionary biology has shown how profoundly people are built from the physiological ground up as sociopolitical beings. Because it presupposes the social context of language and reasoning ability, individual autonomy also depends developmentally on relational autonomy. That is, people only become autonomous through relations and interactions with others. As African humanism (ubuntu philosophy) epitomizes it, umuntu ngumuntu ngabantu, “a person is a person through other persons” (Louw *2008*).

Familial and communal deliberate processes are foundational for the development of individual autonomy and provide an even deeper basis for collective decisions than the type of solidarity that comes to the fore in crises or the face of common predicaments. Kant would reject any suggestion that developmental context, emotional bonds, or feelings of solidarity underpin moral autonomy. Nevertheless, moral autonomy and relational autonomy both display an inner-directed, but other-oriented feature that readily aligns with collective decision-making.

These points about the foundational character of social relatedness, solidarity, interdependence, and communal decision-making do not readily align with certain features of social contract theory, on whose principles liberal democracy is based. Whereas virtually every other political tradition conceives the sociopolitical realm as a natural feature of human life, social contract theory posits humankind’s original state, the state of nature, as one of solitary individualism. In this view, society or at least civil society comes into existence voluntarily through a contract that creates government through the consent of the governed (Riley *1982*). Although never seriously advanced as a scientific account of society’s origins, social contract theory nevertheless has exerted a powerful influence as a political founding myth. As such, it has made personal liberty, free choice, and consent of the governed presumptive values of societies whose governing political philosophy rests on social contract theory. By “presumptive,” we mean that the value, norm, or claim is assumed to be valid or have priority so that the onus is on the person who objects to the presumption to justify a different value, norm, or claim.

Personal Autonomy as a Presumptive Value of Liberal Democracy

Personal autonomy in a clinical and research context generally means respect for the patient’s right to receive an explanation of a medical procedure or research intervention, to be informed of any potential benefits or harms, and to freely choose whether to accept the procedure or participate in the research. More generally and in other contexts, personal autonomy has come to mean an insistence on liberty, free choice, and noninterference with personal preferences. Personal autonomy in this more general sense owes more to John Stuart Mill’s nineteenth-century views on liberty than to Kant’s eighteenth-century idea of autonomy (O’Neil *2002*; Dawson *2011*). An important aspect of Mill’s view of liberty is the “harm principle,” which holds that “the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others” (Mill *1989*). What people choose to do regarding themselves is no business of government. Interfering with this private sphere of self-determination constitutes governmental paternalism. This interference diminishes the sphere of liberty that affords individuals the chance to direct their own lives and develop their talents and character to the highest degree. A chief advantage of a democratic society, one that benefits the entire society, is the creative social dynamism that emerges from the synergism between individuals who are developing their talents and abilities.

Arguably, the primary aim of the harm principle is to promote the kind of individual self-development that benefits society rather than to champion every exercise of free choice. At any rate, some have sought to distinguish this edifying version of personal autonomy from an all-encompassing version that demands undue deference to any personal choices and preferences merely because they are personal (O'Neill *2002*; Dawson *2011*; Powers et al. *2012*). Presuming, or insisting on, the validity of personal autonomy makes more sense in the delimited context of medicine and biomedical research on human subjects where an individual's body is the focus of activity. It makes less sense in the far wider sphere of public health activity where social interactions and the interdependence of people come into play. Absolutizing personal autonomy in the sphere of public health would give effective veto power over every collective decision aimed at the public good to any individual who felt constrained by that decision. A more moderate version might distinguish levels of importance of personal choices and exercises of liberty. A collective decision concerning the public good could override some personal choices and limit liberty, even when they did not involve direct harm to others. Such decisions, when made in the context of a fair, transparent process of ethical deliberation involving stakeholders, are more likely to get buy-in from a community and less likely to be labeled paternalistic.

Because public health considers the relationship between individuals and the collective good, it necessarily has a political dimension. How a country's political culture balances this relationship will drive and constrain public health practice and so shape the nature of the ethical frameworks that are appropriate to a country's politics (Hyder et al. *2008*). In the brief history of public health ethics, the most important ethical frameworks have emerged in the political context of liberal democracy. Many of these frameworks reflect the tensions between public health's obligation to act collectively for the common good and the presumptive value of personal autonomy. The principle of least infringement and Kass's code of restraint illustrate the effort to mediate such tensions (Kass *2001*). The code of restraint strives to balance autonomy claims against the obligation to safeguard community health by determining what intervention most effectively protects health while minimally infringing on liberty. In a liberal political context that recognizes Mill's harm principle, this strategy justifies the trumping of personal autonomy as long as imminent harm threatens the populace, for example, in a deadly outbreak of contagious disease. But where the threat of harm to others is indirect or not immediate, as with the obesity epidemic, the harm principle less readily justifies a liberty-limiting intervention such as banning or taxing certain foods. Utilitarian approaches that weigh the health advantages of intervention and the disadvantages of obesity support obesity intervention but limiting interventions to those that do not restrict personal choices also has limited effectiveness. Jennings considers the relative merits of these approaches in his overview of the ethical issues in environmental and occupational public health. His discussion raises the question of the extent to which an ethical framework should adapt itself to the presumptive values of the political context or should reflect the nature of the practical field under investigation. To some extent, it must do both.

The three-step framework offered in the next section is designed to guide decision-makers, through questions, to assess the ethical dimensions of a case, including which moral considerations (e.g., population utility or liberty) may have more weight than others, given the issue or context. This contextual approach provides the flexibility and starting point for deliberation to accommodate the issues globally and to uncover the varying perspectives of stakeholders with potentially different presumptive moral norms (e.g., solidarity versus individual rights).

Ethical Frameworks

What at first glance demarcates public health ethics from related fields of health ethics are the ethical problems that public health professionals typically encounter in their practice and the ethical frameworks used in practice to address these problems. Regarding these ethical problems, this casebook offers a representative, but not exhaustive, sample. Regarding ethical frameworks, this chapter has suggested two competing criteria for choosing. On the one hand, ethical frameworks should be grounded in their topics. Dawson (*2011*) expresses the point succinctly by arguing that public health should be the foundation of public health ethics. Accordingly, we have presented a view of public health ethics that builds on the definitions of public, health, and public health, and the goals of public health practice. But we have also defined ethics and indicated how public health ethics draws on numerous ethical theories and can provide a moral guide grounded in the norms of benefiting others, preventing harm, and providing utility. We have pointed out its distinguishing principles based on the facts of community and interdependence. Lastly, we have situated public health ethics within the process of ethical decision-making about which options are the most justifiable means to achieve public health goals in a particular context. In the end, grounding public health ethics in public health may require public health leaders to have the courage to advocate public health values and goals, even when that position is unpopular. Such a stance may be justified, for example, where the feasibility of a much-needed public health intervention requires a long-range strategy to change social norms or build social consensus.

On the other hand, precisely because public health itself is practical, pragmatic, and community-oriented, an ethical framework designed for it must accommodate itself to a country's presumptive values and political culture. This consideration illustrates that the feasibility of public health interventions usually depends on their alignment with the political culture, while their success usually implies public acceptance. Many established frameworks, like that of Kass, seem designed with a liberal political context in mind that gives presumptive weight to individual liberty, which may limit the range of interventions that can be justified. Newer approaches to ethical analysis in public health place more emphasis on social values like equity and solidarity, although these newer approaches often are difficult to put into practice (Lee *2012*). In addition, while newer approaches may offer clear reasons to justify a broader range of interventions, the reasons may be less persuasive if they do not consider the presumptive values in context. Daniels discusses the ethical conflicts that arise during pandemics between the standard goal of improving population health and emergency contexts that demand allocating scarce resources in a way that treats people fairly. He asks, if in the pandemic context, we believe that saving the most lives trumps giving priority to those who are sickest, can we justify revising the usual priority given to the sickest in health care?

Arguably, what would be most useful is not a set of frameworks designed for specific presumptive values, but, rather, a framework that can accommodate any presumptive values and consider them values rooted in public health or context. The three-step framework that follows is a straightforward tool to help practitioners analyze the ethical tensions in a particular context. It addresses Daniels' tough question directly by considering health care's presumptive prioritization of the sickest about the public health value of saving the most lives in a pandemic.

Public Health Decision Making

Public health is a social and political undertaking. Thus, making difficult choices in public health implicates important social, cultural, and political norms embedded in a particular context and community of stakeholders (Childress and Bernheim *2008*). Regardless of whether decision-makers work in a government public health agency, community nonprofit, nongovernmental organization (NGO) from another country, or a global organization, decision-makers must rigorously assess the public health issue in context, to minimally be able to act "in ways that preserve the moral foundations of social collaboration" at the core of collective health activity (Calabresi and Bobbitt *1978*). The context specifically includes attention to stakeholders and relationships among public health stakeholders and community members, including the common understanding of their roles, obligations, and collaborations. Especially in global public health, it is important to note that even the decision makers are stakeholders, in some sense, and often, when they are health professionals, they have their own social-cultural norms and their own professional codes that can provide guidance. Appeals to the codes of professions, however, do not provide a sufficient justification for a public health decision, since justifications should be grounded in a society's widely shared ethical values and norms.

Engaging stakeholders and addressing claims, especially those of the people most affected by a public health issue, in ethical analysis, is especially important and can sometimes support and strengthen the collaboration and cohesion needed for public acceptance of a decision.

The ways to engage and reason with stakeholders in an ethical analysis will vary in different settings and communities, depending on community values, cohesion, and expectations, and can range from establishing an ethics board for deliberation to gathering information from focus groups or social media, to including stakeholder representatives on the decision-making team. Stakeholder norms and claims are a critical feature for an ethical analysis to achieve a primary goal in public health—the development and maintenance of relationships of trust, defined in a report from IOM as "the belief that those with whom one interacts will take one's interests into account, even in situations in which one is not in a position to recognize, evaluate, or thwart a potentially negative course of action by those trusted" (IOM *1996*).

Ethical analysis is a dynamic process and, particularly for the practice of public health, is best accomplished through group deliberations that involve understanding others' perspectives and thinking independently and imaginatively. Public health professionals often must decide how best to realize numerous important societal norms and values when pursuing public health goals. Ethical tensions do occur in public health and at times require overriding an important principle, value, or moral consideration to undertake a justifiable public health action. However, a structured ethical analysis can often lead to imaginative alternatives that transcend or minimize ethical tensions and to decisions that most or many stakeholders find acceptable.

6.

TOPIC: THE SOCIAL CONSTRUCTION OF HEALTH

On March 19, 2014, a “mystery” hemorrhagic fever outbreak occurred in Liberia and Sierra Leone. This outbreak was later confirmed to be Ebola, a disease first discovered in what is now the Democratic Republic of Congo. The 2014-2016 outbreak sickened more than 28,000 people and left more than 11,000 dead (CDC 2020). For the people in West Africa, the outbreak was personally tragic and terrifying. In much of the rest of the world, the outbreak increased tensions but did not change anyone’s behavior. Infection of U.S. medical staff (both in West Africa and at home) led to fear and distrust, and restrictions on flights from West Africa was one proposed way to stop the spread of the disease. Ebola first entered the United States via U.S. missionary medical staff who were infected in West Africa and then transported home for treatment. Several other Ebola outbreaks occurred in West Africa in subsequent years, killing thousands of people.

Six years after the massive 2014 epidemic, the people of West Africa faced another disease, but this time they were not alone. The Coronavirus pandemic swept across the globe in a matter of months. While some countries managed the disease far better than others, it affected everyone. Highly industrialized countries, such as China, Italy, and the United States, were early centers of the outbreak. Brazil and India had later increased, as did the U.K. and Russia. Most countries took measures that were considered extreme closing their borders, forcing schools and businesses to close, transforming their people’s lives. Other nations went further, completely shutting down at the discovery of just a few cases. And some countries had mixed responses, typically resulting in high rates of infection and overwhelming losses of life. In Brazil and the United States, for example, political leaders and large swaths of the population rejected measures to contain the virus. By the time vaccines became widely available, those two countries had the highest numbers of coronavirus deaths worldwide.

Did the world learn from the Ebola virus epidemic? Or did only parts of it learn? Before the United States faced the worst COVID-19 outbreak in the world, the government shut down travel, as did many countries in Europe. This was certainly an important step, but other measures fell short; conflicting messages about mask-wearing and social distancing became political weapons amid the country’s Presidential election, and localized outbreaks and spikes of deaths were continually traced to gatherings that occurred against scientific guidance. Brazil’s president actively disputed medical opinions rejected any travel or business restrictions and conflicted with many people in his government (even his political allies); Brazil’s slower pace of vaccination compared to the U.S., saw a steep increase in cases and deaths just as the United States’ numbers started to decline.

Both those opposed to heavy restrictions and those who used them to fight the disease acknowledge that the impacts went far beyond physical health. Families shattered by the loss of a loved one had to go through the pain without relatives to support them at funerals or other gatherings. Many who recovered from the virus had serious health issues to contend with, while other people who delayed important treatments had larger problems than they normally would have. Fear, isolation, and strained familial relationships led to emotional problems. Many families lost income. Learning was certainly impacted as education practices went through sudden shifts. The true outcomes will likely not be fully understood for years after the pandemic is under control.

So now, after the height of the coronavirus pandemic, what does “health” mean to you? Does your opinion of it differ from your pre-COVID attitudes? Many people who became severely ill or died from COVID-19 had other health issues (known as comorbidities) such as hypertension and obesity. Do you know people whose attitudes about their general health changed? Do you know people who are suspicious of the government, and more or less likely to listen to doctors or scientists? What do you think will be the best way to prevent illness and death should another pandemic strike?

Medical sociology is the systematic study of how humans manage issues of health and illness, disease and disorders, and healthcare for both the sick and the healthy. Medical sociologists study the physical, mental, and social components of health and illness. Major topics for medical sociologists include the doctor/patient relationship, the structure and socioeconomics of healthcare, and how culture impacts attitudes toward disease and wellness.

The Social Construction of Health

The social construction of health is a major research topic within medical sociology. At first glance, the concept of a social construction of health does not seem to make sense. After all, if disease is a measurable, physiological problem, then there can be no question of socially constructing disease, right? Well, it’s not that simple. The idea of the social construction of health emphasizes the socio-cultural aspects of the discipline’s approach to physical, objectively definable phenomena.

Sociologists Conrad and Barker (2010) offer a comprehensive framework for understanding the major findings of the last fifty years of development in this concept. Their summary categorizes the findings in the field under three subheadings: the cultural meaning of illness, the social construction of the illness experience, and the social construction of medical knowledge.

The Cultural Meaning of Illness

Many medical sociologists contend that illnesses have both a biological and an experiential component and that these components exist independently of each other. Our culture, not our biology, dictates which illnesses are stigmatized and which are not, which are considered disabilities, and which are not, and which are deemed contestable (meaning some medical professionals may find the existence of this ailment questionable) as opposed to definitive (illnesses that are unquestionably recognized in the medical profession) (Conrad and Barker 2010).

For instance, sociologist Erving Goffman (1963) described how social stigmas hinder individuals from fully integrating into society. In essence, Goffman (1963) suggests we might view illness as a stigma that can push others to view the ill in an undesirable manner. The stigmatization of illness often has the greatest effect on the patient and the kind of care they receive. Many contend that our society and even our healthcare institutions discriminate against certain diseases like mental disorders, AIDS, sexually transmitted diseases, and skin disorders (Sartorius 2007). Facilities for these diseases may be sub-par; they may be segregated from other healthcare areas or relegated to a poorer environment. The stigma may keep people from seeking help for their illness, making it worse than it needs to be.

Contested illnesses are those that are questioned or questionable by some medical professionals. Disorders like fibromyalgia or chronic fatigue syndrome may be either true illnesses or only in the patients' heads, depending on the opinion of the medical professional. This dynamic can affect how a patient seeks treatment and what kind of treatment they receive.

The Social Construction of the Illness Experience

The idea of the social construction of the illness experience is based on the concept of reality as a social construction. In other words, there is no objective reality; there are only our own perceptions of it. The social construction of the illness experience deals with such issues as the way some patients control the manner in which they reveal their diseases, and the lifestyle adaptations patients develop to cope with their illnesses.

In terms of constructing the illness experience, culture, and individual personality both play a significant role. For some people, a long-term illness can have the effect of making their world smaller, more defined by the illness than anything else. For others, illness can be a chance for discovery, for re-imaging a new self (Conrad and Barker 2007). Culture plays a huge role in how an individual experiences illness. Widespread diseases like AIDS or breast cancer have specific cultural markers that have changed over the years and that govern how individuals and society view them.

Today, many institutions of wellness acknowledge the degree to which individual perceptions shape the nature of health and illness. Regarding physical activity, for instance, the Centers for Disease Control (CDC) recommends that individuals use a standard level of exertion to assess their physical activity. This Rating of Perceived Exertion (RPE) gives a more complete view of an individual's actual exertion level, since heart rate or pulse measurements may be affected by medication or other issues (Centers for Disease Control 2011a). Similarly, many medical professionals use a comparable scale for perceived pain to help determine pain management strategies.

The Social Construction of Medical Knowledge

Conrad and Barker show how medical knowledge is socially constructed; that is, it can both reflect and reproduce inequalities in gender, class, race, and ethnicity. Conrad and Barker (2011) use the example of the social construction of women's health and how medical knowledge has changed significantly in the course of a few generations. For instance, in the early nineteenth century, pregnant women were discouraged from driving or dancing for fear of harming the unborn child, much as they are discouraged, with more valid reason, from smoking or drinking alcohol today.

Global Health

Social epidemiology is the study of the causes and distribution of diseases. Social epidemiology can reveal how social problems are connected to the health of different populations. These epidemiological studies show that the health problems of high-income nations differ from those of low-income nations, but also that diseases and their diagnosis are changing. Cardiovascular disease, for example, is now the both most prevalent disease and the disease most likely to be fatal in lower-income countries. Globally, 70 percent of cardiovascular disease cases and deaths are due to modifiable risks (Dagenais 2019).

Some theorists differentiate among three types of countries: core nations, semi-peripheral nations, and peripheral nations. Core nations are those that we think of as highly developed or industrialized, semi-peripheral nations are those that are often called developing or newly industrialized, and peripheral nations are those that are relatively undeveloped. While the most pervasive issue in the U.S. healthcare system is affordable access to healthcare, other core countries have different issues, and semi-peripheral and peripheral nations are faced with a host of additional concerns. Reviewing the status of global health offers insight into the various ways that politics and wealth shape access to healthcare, and it shows which populations are most affected by health disparities.

Health in High-Income Nations

Obesity, which is on the rise in high-income nations, has been linked to many diseases, including cardiovascular problems, musculoskeletal problems, diabetes, and respiratory issues. According to the Organization for Economic Cooperation and Development (2011), obesity rates are rising in all countries, with the greatest gains being made in the highest-income countries. The United States has the highest obesity rate at 42 percent; some of these people are considered severely obese, which occurs in 9 percent of U.S. adults (Hales 2020).

Wallace Huffman and his fellow researchers (2006) contend that several factors are contributing to the rise in obesity in developed countries:

- Improvements in technology and reduced family size have led to a reduction of work to be done in household production.
- Unhealthy market goods, including processed foods, sweetened drinks, and sweet and salty snacks are replacing home-produced goods.
- Leisure activities are growing more sedentary, for example, computer games, web surfing, and television viewing.
- More workers are shifting from active work (agriculture and manufacturing) to service industries.
- Increased access to passive transportation has led to more driving and less walking.

Obesity and weight issues have significant societal costs, including lower life expectancies and higher shared healthcare costs.

While ischemic heart disease is the single most prevalent cause of death in higher-income countries, cancers of all types combine to be a higher overall cause of death. Cancer accounts for twice as many deaths as cardiovascular disease in higher-income countries (Mahase 2019).

Health in Low-Income Nations

In peripheral nations with low per capita income, it is not the cost of healthcare that is the most pressing concern. Rather, low-income countries must manage such problems as infectious diseases, high infant mortality rates, scarce medical personnel, and inadequate water and sewer systems. Due to such health concerns, low-income nations have higher rates of infant mortality and lower average life spans.

One of the biggest contributors to medical issues in low-income countries is the lack of access to clean water and basic sanitation resources. According to a 2014 UNICEF report, almost half of the developing world’s population lacks improved sanitation facilities. The World Health Organization (WHO) tracks health-related data for 193 countries and organizes them by region. In their 2011 World Health Statistics report, they document the following statistics:

- Globally in 2019, the rate of mortality for children under five was 38 per 1,000 live births, which is a dramatic change from previous decades. (In 1990, the rate was 93 deaths per 1,000 births (World Health Organization 2020.) In low-income countries, however, that rate is much higher. The child mortality rate in low-income nations was 11 times higher than that of high-income countries 76 deaths per 1,000 births compared to 7 deaths per 1,000 births (Keck 2020). To consider it regionally, the highest under-five mortality rate remains in the WHO African Region (74 per 1000 live births), around 9 times higher than that in the WHO

European Region (8 per 1000 live births) (World Health Organization 2021).
- The most frequent causes of death in children under five years old are pneumonia, diarrhea, congenital anomalies, preterm birth complications, birth asphyxia/trauma, and malaria, all of which can be prevented or treated with affordable interventions including immunization, adequate nutrition, safe water and food and quality care by a trained health provider when needed.

The availability of doctors and nurses in low-income countries is one-tenth that of nations with a high income. Challenges in access to medical education and access to patients exacerbate this issue for would-be medical professionals in low-income countries (World Health Organization 2011).

Health in the United States

Health in the United States is a complex and often contradictory issue. On the one hand, as one of the wealthiest nations, the United States fares well in health comparisons with the rest of the world. However, the United States also lags behind almost every industrialized country in terms of providing care to *all* its citizens. The following sections look at different aspects of health in the United States.

Health by Race and Ethnicity

When looking at the social epidemiology of the United States, it is hard to miss the disparities among races. The discrepancy between Black and White Americans shows the gap clearly; in 2018, the average life expectancy for White males was approximately five years longer than for Black males: 78.8 compared to 74.7 (Wamsley 2021). (Note that in 2020 life expectancies of all races declined further, though the unprecedented COVID-19 pandemic was a significant cause.) Other indications show a similar disparity. The 2018 infant mortality rates for different races and ethnicities are as follows:

- Non-Hispanic Black people: 10.8
- Native Hawaiian people or other Pacific Islanders: 9.4
- Native American/Alaska Native people: 8.2
- Hispanic people: 4.9
- Non-Hispanic White people: 4.6
- Asian and Asian American people: 3.6 (Centers for Disease Control 2021)

According to a report from the Henry J. Kaiser Foundation (2007), African Americans also have a higher incidence of several diseases and causes of mortality, from cancer to heart disease to diabetes. In a similar vein, it is important to note that ethnic minorities, including Mexican

Americans and Native Americans, also have higher rates of these diseases and causes of mortality than White people.

Lisa Berkman (2009) notes that this gap started to narrow during the Civil Rights movement in the 1960s, but it began widening again in the early 1980s. What accounts for these perpetual disparities in health among different ethnic groups? Much of the answer lies in the level of healthcare that these groups receive. The National Healthcare Disparities Report shows that even after adjusting for insurance differences, racial and ethnic minority groups receive poorer quality of care and less access to care than dominant groups. The Report identified these racial inequalities in care:

- Black people, Native Americans, and Alaska Native people received worse care than Whites for about 40 percent of quality measures.
- Hispanic people, Native Hawaiian people, and Pacific Islanders received worse care than White people for more than 30 percent of quality measures.
- Asian people received worse care than White people for nearly 30 percent of quality measures but better care for nearly 30 percent of quality measures (Agency for Healthcare Research and Quality 2020).

Health by Socioeconomic Status

Discussions of health by race and ethnicity often overlap with discussions of health by socioeconomic status, since the two concepts are intertwined in the United States. As the Agency for Health Research and Quality (2010) notes, “racial and ethnic minorities are more likely than non-Hispanic whites to be poor or near poor,” so much of the data about subordinate groups is also likely to be pertinent to low socioeconomic groups. Marilyn Winkleby and her research associates (1992) state that “one of the strongest and most consistent predictors of a person’s morbidity and mortality experience is that person’s socioeconomic status (SES). This finding persists across all diseases with few exceptions, continues throughout the entire lifespan, and extends across numerous risk factors for disease.” Morbidity is the incidence of disease.

It is important to remember that economics are only part of the SES picture; research suggests that education also plays an important role. Phelan and Link (2003) note that many behavior-influenced diseases like lung cancer (from smoking), coronary artery disease (from poor eating and exercise habits), and AIDS initially were widespread across SES groups. However, once information linking habits to disease was disseminated, these diseases decreased in high SES groups and increased in low SES groups. This illustrates the important role of education initiatives regarding a given disease, as well as possible inequalities in how those initiatives effectively reach different SES groups.

Health by Gender

Women are affected adversely both by unequal access to and institutionalized sexism in the healthcare industry. According to a recent report from the Kaiser Family Foundation, women experienced a decline in their ability to see needed specialists between 2001 and 2008. In 2008, one-quarter of women questioned the quality of their healthcare (Ranji and Salganico 2011). Quality is partially indicated by access and cost. In 2018, roughly one in four (26%) women—compared to one in five (19%) men reported delaying healthcare or letting conditions go untreated due to cost. Because of costs, approximately one in five women postponed preventive care, skipped a recommended test or treatment, or reduced their use of medication due to cost (Kaiser Family Foundation 2018).

We can see an example of institutionalized sexism in the way that women are more likely than men to be diagnosed with certain kinds of mental disorders. Psychologist Dana Becker notes that 75 percent of all diagnoses of Borderline Personality Disorder (BPD) are for women according to the *Diagnostic Statistical Manual of Mental Disorders*. This diagnosis is characterized by instability of identity, mood, and behavior, and Becker argues that it has been used as a catch-all diagnosis for too many women. She further decries the pejorative connotation of the diagnosis, saying that it predisposes many people, both within and outside of the profession of psychotherapy, against women who have been so diagnosed (Becker).

Many critics also point to the medicalization of women's issues as an example of institutionalized sexism. Medicalization refers to the process by which previously normal aspects of life are redefined as deviant and needing medical attention to remedy. Historically and contemporaneously, many aspects of women's lives have been medicalized, including menstruation, premenstrual syndrome, pregnancy, childbirth, and menopause. The medicalization of pregnancy and childbirth has been particularly contentious in recent decades, with many women opting against the medical process and choosing a more natural childbirth. Fox and Worts (1999) find that all women experience pain and anxiety during the birth process, but that social support relieves both as effectively as medical support. In other words, medical interventions are no more effective than social ones at helping with the difficulties of pain and childbirth. Fox and Worts further found that women with supportive partners ended up with less medical intervention and fewer cases of postpartum depression. Of course, access to quality birth care outside the standard medical models may not be readily available to women of all social classes.

Mental Health and Disability

The treatment received by those defined as mentally ill or disabled varies greatly from country to country. In the post-millennial United States, those of us who have never experienced such a disadvantage take for granted the rights our society guarantees for each citizen. We do not think about the relatively recent nature of the protections, unless, of course, we know someone constantly inconvenienced by the lack of accommodations or the misfortune of suddenly experiencing a temporary disability.

Mental Health

People with mental disorders (a condition that makes it more difficult to cope with everyday life) and people with mental illness (a severe, lasting mental disorder that requires long-term treatment) experience a wide range of effects. According to the National Institute of Mental Health (NIMH), the United States has over 50 million adults with mental illness or mental disorder, or 20 percent of the total adult population. Of these, 13 million have what is considered serious mental illness or mental disorder (5 percent of the adult population); serious mental illness is that which causes impairment or disability (National Institute of Mental Health 2021). Finally, 16.5 percent of children aged 6-17 experienced mental illness or disorder (National Alliance on Mental Illness 2021).

The most common mental disorders in the United States are anxiety disorders. Almost 18 percent of U.S. adults are likely to be affected in a single year, and 28 percent are likely to be affected over the course of a lifetime (Anxiety and Depression Institute of America 2021). It is important to distinguish between occasional feelings of anxiety and a true anxiety disorder. Anxiety is a normal reaction to stress that we all feel at some point, but anxiety disorders are feelings of worry and fearfulness that last for months at a time. Anxiety disorders include obsessive-compulsive disorder (OCD), panic disorders, posttraumatic stress disorder (PTSD), and both social and specific phobias.

The second most common mental disorders in the United States are mood disorders; roughly 10 percent of U.S. adults are likely to be affected yearly, while 21 percent are likely to be affected throughout a lifetime (National Institute of Mental Health 2005). Mood disorders are the most common cause of illness-related hospitalization in the U.S. (Agency for Healthcare Research and Quality 2021). Major mood disorders are depression and dysthymic disorder. Like anxiety, depression might seem like something that everyone experiences at some point, and it is true that most people feel sad or “blue” at times in their lives. A true depressive episode, however, is more than just feeling sad for a short period. It is a long-term, debilitating illness that usually needs treatment to cure. Bipolar disorder is characterized by dramatic shifts in energy and mood, often affecting the individual’s ability to carry out day-to-day tasks. Bipolar disorder used to be called manic depression because of the way people would swing between manic and depressive episodes.

Depending on what definition is used, there is some overlap between mood disorders and personality disorders, which affect 9 percent of people in the United States yearly. A personality disorder is an enduring and inflexible pattern of long duration leading to significant distress or impairment, that is not due to the use of substances or another medical condition. In other words, personality disorders cause people to behave in ways that are seen as abnormal to society but seem normal to them.

Disability

Disability refers to a reduction in one's ability to perform everyday tasks. The World Health Organization makes a distinction between the various terms used to describe disabilities. They use the term impairment to describe the physical limitations while reserving the term disability to refer to the social limitation.

Before the passage of the Americans with Disabilities Act (ADA) in 1990, people in the United States with disabilities were often excluded from opportunities and social institutions many of us take for granted. This occurred not only through employment and other kinds of discrimination but also through casual acceptance by most people in the United States of a world designed for the convenience of the able-bodied. Imagine being in a wheelchair and trying to use a sidewalk without the benefit of wheelchair-accessible curbs. Imagine a blind person trying to access information without the widespread availability of Braille. Imagine having limited motor control and being faced with a difficult-to-grasp round door handle. Issues like these are what the ADA tries to address. Ramps on sidewalks, Braille instructions, and more accessible door levers are all accommodations to help people with disabilities.

People with disabilities can be stigmatized by their illnesses. Stigmatization means their identity is spoiled; they are labeled as different, discriminated against, and sometimes even shunned. They are labeled (as an interactionist might point out) and ascribed a master status (as a functionalist might note), becoming "the blind girl" or "the boy in the wheelchair" instead of someone afforded a full identity by society. This can be especially true for people who are disabled due to mental illness or disorders.

Many mental health disorders can be debilitating and can affect a person's ability to cope with everyday life. This can affect social status, housing, and especially employment. According to the Bureau of Labor Statistics (2011), people with a disability had a higher rate of unemployment than people without a disability in 2010: 14.8 percent to 9.4 percent. This unemployment rate refers only to people actively looking for a job. Eight out of ten people with a disability are considered "out of the labor force;" that is, they do not have jobs and are not looking for them. The combination of this population and the high unemployment rate leads to an employment-population ratio of 18.6 percent among those with disabilities. The employment-population ratio for people without disabilities was much higher, at 63.5 percent (U.S. Bureau of Labor Statistics 2011).

Comparative Health and Medicine

There are broad, structural differences among the healthcare systems of different countries. In core nations, those differences might arise in the administration of healthcare, while the care itself is similar. In peripheral and semi-peripheral countries, a lack of basic healthcare administration can be the defining feature of the system. Most countries rely on some combination of modern and traditional medicine. In core countries with large investments in technology, research, and equipment, the focus is usually on modern medicine, with traditional (also called alternative or complementary) medicine playing a secondary role. In the United States, for instance, the American Medical Association (AMA) resolved to support the incorporation of complementary and alternative medicine in medical education. In developing countries, even quickly modernizing ones like China, traditional medicine (often understood as "complementary" by the Western world) may still play a larger role.

U.S. Healthcare

U.S. healthcare coverage can broadly be divided into two main categories: public healthcare (government-funded) and private healthcare (privately funded). The two main publicly funded healthcare programs are Medicare, which provides health services to people over sixty-five years old as well as people who meet other standards for disability, and Medicaid, which provides services to people with very low incomes who meet other eligibility requirements. Other government-funded programs include service agencies focused on Native Americans (the Indian Health Service), Veterans (the Veterans Health Administration), and children (the Children's Health Insurance Program).

Private insurance is typically categorized as either employment-based insurance or direct-purchase insurance. Employment-based insurance is health plan coverage that is provided in whole or in part by an employer or union; it can cover just the employee, or the employee and their family. Direct purchase insurance is coverage that an individual buys directly from a private company.

Even with all these options, a sizable portion of the U.S. population remains uninsured. In 2019, about 26 million people, or 8 percent of U.S. residents, had no health insurance. 2020 saw that number go up to 31 million (Keith 2020). Several more million had health insurance for part of the year (Keisler-Starkey 2020). Uninsured people are at risk of both severe illness and also chronic illnesses that develop over time. Fewer uninsured people engage in regular check-ups or preventative medicine and rely on urgent care for a range of acute health issues.

The number of uninsured people is far lower than in previous decades. In 2013 and in many of the years preceding it, the number of uninsured people was in the 40 million range, or roughly 18 percent of the population. The Affordable Care Act, which came into full force in 2014, allowed more people to get affordable insurance. The uninsured number reached its lowest point in 2016, before beginning to climb again (Garfield 2019).

People having some insurance may mask the fact that they could be underinsured; that is, people who pay at least 10 percent of their income on healthcare costs not covered by insurance or, for low-income adults, those whose medical expenses or deductibles are at least 5 percent of their income (Schoen, Doty, Robertson, and Collins 2011).

Why are so many people uninsured or underinsured? Skyrocketing healthcare costs are part of the issue. While most people get their insurance through their employer, not all employers offer it, especially retail companies or small businesses in which many of the workers may be part-time. Finally, for many years insurers could deny coverage to people with pre-existing conditions previous illnesses or chronic diseases.

The Patient Protection and Affordable Care Act (often abbreviated ACA or nicknamed Obamacare) was a landmark change in U.S. healthcare. Passed in 2010 and fully implemented in 2014, it increased eligibility for programs like Medicaid, helped guarantee insurance coverage for people with pre-existing conditions, and established regulations to make sure that the premium funds collected by insurers and care providers go directly to medical care. It also included an individual mandate, which requires everyone to have insurance coverage by 2014 or pay a penalty. A series of provisions, including significant subsidies, are intended to address the discrepancies in income that are currently contributing to high rates of uninsurance and underinsurance. In 2012 the U.S. Supreme Court upheld the constitutionality of the ACA’s mandate. 29 million people in the United States have gained health insurance under ACA (Economic Policy Institute 2021).

The ACA remains contentious. The Supreme Court ruled in the case of *National Federation of Independent Businesses v. Sebelius* in 2012, that states cannot be forced to participate in the PPACA’s Medicaid expansion. This ruling opened the door to further challenges to the ACA in Congress and the Federal courts, some state governments, conservative groups, and independent businesses. The ACA has been a driving factor in elections and public opinion. In 2010 and 2014, many Republican gains in Congressional seats were related to fierce concern about Obamacare. However, once millions of people were covered by the law and the economy continued to improve, public sentiment and elections swung the other way. Healthcare was the top issue for voters, and the desire to preserve the law was credited for many of the Democratic gains in the election, which carried over to 2020.

Healthcare Elsewhere

Healthcare in the United States has some areas for improvement. But how does it compare to healthcare in other countries? Many people in the United States are fond of saying that this country has the best healthcare in the world, and while it is true that the United States has a higher quality of care available than many peripheral or semi-peripheral nations, it is not necessarily the "best in the world." In a report on how U.S. healthcare compares to that of other countries, researchers found that the United States does "relatively well in some areas such as cancer care and less well in others such as mortality from conditions amenable to prevention and treatment" (Docteur and Berenson 2009).

One critique of the Patient Protection and Affordable Care Act is that it will create a system of socialized medicine, a term that for many people in the United States has negative connotations lingering from the Cold War era and earlier. Under a socialized medicine system, the government owns and runs the system. It employs doctors, nurses, and other staff, and it owns and runs the hospitals (Klein 2009). The best example of socialized medicine is in Great Britain, where the National Health System (NHS) gives free healthcare to all its residents. And despite some U.S. citizens' knee-jerk reaction to any healthcare changes that hint at socialism, the United States has one socialized system with the Veterans Health Administration.

It is important to distinguish between socialized medicine, in which the government owns the healthcare system, and universal healthcare, which is simply a system that guarantees healthcare coverage for everyone. Germany, Singapore, and Canada all have universal healthcare. People often look to Canada's universal healthcare system, Medicare, as a model for the system. In Canada, healthcare is publicly funded and administered by separate provincial and territorial governments. However, the care itself comes from private providers. This is the main difference between universal healthcare and socialized medicine. The Canada Health Act of 1970 required that all health insurance plans must be "available to all eligible Canadian residents, comprehensive in coverage, accessible, portable among provinces, and publicly administered" (International Health Systems Canada 2010).

Heated discussions about the socialization of medicine and managed-care options seem frivolous when compared with the issues of healthcare systems in developing or underdeveloped countries. In many countries, per capita income is so low, and governments are so fractured, that healthcare as we know it is virtually non-existent. Care that people in developed countries take for granted like hospitals, healthcare workers, immunizations, antibiotics and other medications, and even sanitary water for drinking and washing is unavailable to much of the population. Organizations like Doctors Without Borders, UNICEF, and the World Health Organization have played an important role in helping these countries get their most basic health needs met.

Theoretical Perspectives on Health and Medicine

Functionalism

According to the functionalist perspective, health is vital to the stability of society, and therefore sickness is a sanctioned form of deviance. Talcott Parsons (1951) was the first to discuss this in terms of the sick role: patterns of expectations that define appropriate behavior for the sick and for those who take care of them.

According to Parsons, the sick person has a specific role with both rights and responsibilities. To start with, the sick person has not chosen to be sick and should not be treated as responsible for her condition. The sick person also has the right to be exempt from normal social roles; they are not required to fulfill the obligation of a good person and can avoid her normal responsibilities without censure. However, this exemption is temporary and relative to the severity of the illness. The exemption also requires legitimation by a physician; that is, a physician must certify that the illness is genuine. The responsibility of the sick person is twofold: to try to get well and to seek technically competent help from a physician. If the sick person stays ill longer than is appropriate (malingers), they may be stigmatized.

Parsons argues that since the sick are unable to fulfill their normal societal roles, their sickness weakens society. Therefore, it is sometimes necessary for various forms of social control to bring the behavior of a sick person back in line with normal expectations. In this model of health, doctors serve as gatekeepers, deciding who is healthy and who is sick—a relationship in which the doctor has all the power. But is it appropriate to allow doctors so much power over deciding who is sick? And what about people who are sick, but are unwilling to leave their positions for any number of reasons (personal/social obligations, financial need, or lack of insurance, for instance).

Conflict Perspective

Theorists using the conflict perspective suggest that issues with the healthcare system, as with most other social problems, are rooted in capitalist society. According to conflict theorists, capitalism and the pursuit of profit lead to the commodification of health: the changing of something not generally thought of as a commodity into something that can be bought and sold in a marketplace. In this view, people with money and power—the dominant group—are the ones who make decisions about how the healthcare system will be run. They therefore ensure that they will have healthcare coverage, while simultaneously ensuring that subordinate groups stay subordinate through lack of access. This creates significant healthcare—and health—disparities between the dominant and subordinate groups.

Alongside the health disparities created by class inequalities, there are several health disparities created by racism, sexism, ageism, and heterosexism. When health is a commodity, the poor are more likely to experience illness caused by poor diet, to live and work in unhealthy environments, and are less likely to challenge the system. In the United States, a disproportionate number of racial minorities also have less economic power, so they bear a great deal of the burden of poor health. It is not only the poor who suffer from the conflict between dominant and subordinate groups. For many years now, same-sex couples have been denied spousal benefits, either in the form of health insurance or in terms of medical responsibility. Further adding to the issue, doctors hold a disproportionate amount of power in the doctor/patient relationship, which provides them with extensive social and economic benefits.

While conflict theorists are accurate in pointing out certain inequalities in the healthcare system, they do not give enough credit to medical advances that would not have been made without an economic structure to support and reward researchers: a structure dependent on profitability. Additionally, in their criticism of the power differential between doctor and patient, they are perhaps dismissive of the hard-won medical expertise possessed by doctors and not patients, which renders a truly egalitarian relationship more elusive.

Symbolic Interactionism

According to theorists working in this perspective, health and illness are both socially constructed. As we discussed at the beginning of the chapter, interactionists focus on the specific meanings and causes people attribute to illness. The term medicalization of deviance refers to the process that changes "bad" behavior into "sick" behavior. A related process is demedicalization, in which "sick" behavior is normalized again. Medicalization and demedicalization affect who responds to the patient, how people respond to the patient, and how people view the personal responsibility of the patient (Conrad and Schneider 1992).

An example of medicalization is illustrated by the history of how our society views alcohol and alcoholism. During the nineteenth century, people who drank too much were considered bad, lazy people. They were called drunks, and it was not uncommon for them to be arrested or run out of town. Drunks were not treated sympathetically because, at that time, it was thought that it was their fault that they could not stop drinking. During the latter half of the twentieth century, however, people who drank too much were increasingly defined as alcoholics: people with a disease or a genetic predisposition to addiction who were not responsible for their drinking. With alcoholism defined as a disease and not a personal choice, alcoholics came to be viewed with more compassion and understanding. Thus, "badness" was transformed into "sickness."

There are numerous examples of demedicalization in history as well. During the Civil War era, enslaved people who escaped from their enslavers were diagnosed with a mental disorder called drapetomania. This has since been reinterpreted as a completely appropriate response to being enslaved. A more recent example is homosexuality, which was labeled a mental disorder or a sexual orientation disturbance by the American Psychological Association until 1973.

While interactionism does acknowledge the subjective nature of the diagnosis, it is important to remember who most benefits when behavior becomes defined as an illness. Pharmaceutical companies make billions treating illnesses such as fatigue, insomnia, and hyperactivity that may not actually be illnesses in need of treatment, but opportunities for companies to make more money.

7.

TOPIC: THE ECONOMICS OF HEALTH DISPARITIES

Health is influenced by a myriad of factors, many of them beyond genes or biology. Factors such as income and wealth, housing quality, access to greenspace, access to healthcare, education, stressful environments, and more – are often lumped into a category we call the Social Determinants of Health (SDOH). The U.S Department of Health and Human Services provides a broad definition as:

> Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Variance in these environments and conditions that people are born into and live in cause stark differences in health outcomes. Life expectancy overall is influenced by zip code. Life expectancy at birth can vary by 10 years or more between different census tracts within the same county (NCHS, 2022). Indeed, as the Vice President of the California Endowment (a non-profit health equity advocacy group) Dr. Tony Iton states: “When it comes to health, your zip code matters more than your genetic code.” (Iton, 2021).

Health Disparities

Health disparities refer to differences in health outcomes (morbidity and mortality) between populations that are not based in genetics or individual biology. Health inequities are defined as an increased risk of poorer health correlated with race/ethnicity, gender, sexual orientation, socioeconomic status, health insurance status, rural/urban residence or (geographical location), and housing status (U.S. DHHS, HRSA, Office of Health Equity., 2020). Although the terms “disparities” and “inequities” are often used interchangeably (even in this text), it is the inequities in health opportunities that often lead to the disparities we see in health outcomes of different groups. In other words, we are recognizing that there are differences in how long we live and what diseases affect us (and how seriously sick we become) that have more to do with social, economic, political, and environmental factors than any genetic or biological influence. Why do people in one zip code live longer than those in another? Why is income or education level such a strong predictor of health? These social determinants of health are perhaps the strongest predictors of overall population health. “Health inequities refer to inequalities that are unfair, unjust, avoidable or unnecessary, and that can be reduced or remedied through policy action”(U.S. DHHS, HRSA, Office of Health Equity., 2020). Pursuing health equity – providing opportunities for all to attain their highest level of health – is a paramount role for public health (Healthy People 2030, n.d.).

Race and Ethnicity

The concept of different races within the species *homo sapiens* is a social construct; it has no basis in genetics or biology (Yudell et al., 2016). Races are categorized as characteristics of an external phenotype (such as skin color, eye color, hair type), and/or as a cultural identity or inheritance. A person's race may be a part of their own social identity, or could be applied to them by society, based on their appearance.

Ethnicity is different from race in that it is more associated with a cultural heritage, language, religion, customs, shared history, or attachments to ancestral land (Seabert et al., 2021). Ethnicity is also socially constructed, and an ethnic identity may change over time with different generations. For example, a person with dark skin may be treated by other members of society as Black (racially). Assumptions and stereotypes may be made about them, microaggressions aimed at them and they may experience discrimination for being Black. The same person may also identify as ethnically Nigerian-American. Their parents or grandparents may have immigrated from Nigeria, they may adopt and express various customs and cultural expressions of both Nigerian and American culture – and perhaps a Nigerian-American subculture. Another individual with light skin may check the box for "White" or "Caucasian" on government documents, and may be ethnically Armenian. Each person's lived experience within society is influenced by all of their identities, whether the identity is ascribed to them by U.S. society, or owned and expressed by themselves.

How both race and ethnicity influence health outcomes via the social determinants of health has much more to do with racism, xenophobia, and ethnocentrism in American social, economic, and political structures than any influence from genetics, or cultural behaviors. (Genetic predispositions to specific health conditions that can be passed to offspring are covered briefly in chapter 9). Racial health disparities are not genetic predispositions to poor health. Ethnicities are poorly defined, complex, and fluid. Ethnicity in public health research often depends on self-identification with arbitrary classifications (such as "Hispanic" or "Asian"). Yet race and ethnicity are still used by the U.S. government in collecting census data, and still used in epidemiology – particularly to help identify health inequities that may be caused by systemic and structural racism, and Anglo/European-ethnocentrism (Bhopal, 1997).

Race and Ethnic Health Inequities

A recent report from the Office of Minority Health, an agency of the U.S. Department of Health and Human Services (DHHS), outlines how federal policies have caused and maintained structural disadvantages to obtaining long, healthy lives in minoritized communities. This report also uses the term *minoritized groups* rather than *minority or minorities* to further describe how structures and policies have affected populations, rather than these disparities being a result of numbers of a specific demographic in a population. (These terms will also be adopted in this text). The assertion is that racial and ethnic disparities in health and health outcomes are significantly caused or made worse by historical or existing governmental policies, and therefore a path toward health equity involves new federal policies and accountability (National Academies of Sciences, Engineering, and Medicine, 2023).

The United States' early history of Native American extermination, land seizure, kidnapping of native children and required assimilation has caused, and continues to perpetuate significant health repercussions for American Indians and Alaskan Natives (AIAN). Concurrently, the forced immigration and enslavement of Africans, subsequent Jim Crow laws, and even purposeful public health abuses (such as the Tuskegee Syphilis Study), have negatively affected the health of Black Americans for centuries. Additionally, federal policies relating to immigration and social services also play a role in health disparities, particularly those experienced by immigrants and asylum seekers, and their children. Although health disparities are also correlated with poverty and lack of education, those racial and ethnic inequities exist at all socioeconomic strata – indicating that the explanation lies beyond income or education alone. A section in the report summarizes just some of the health inequities in America:

> There are higher rates of childhood asthma among low-income households, higher morbidity and mortality from chronic diseases among individuals with lower educational attainment, and higher exposure to air pollution among residents of disinvested communities—disproportionately individuals who are racially and ethnically minoritized. Moreover, the effects of the structural determinants of health on many health outcomes persist when accounting for income and education (National Academies of Sciences, Engineering, and Medicine., 2023).

According to an earlier DHHS Health Equity Report in 2019-2020, significant racial disparities in health and social determinants of health have persisted across the decades. Although measures like life expectancy and educational status have improved for all Americans, there are still differences in these and other measures between racial groups. Racially minoritized groups have twice or higher the poverty rates as non-Hispanic Whites do (U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Health Equity., 2020). According to the most recent report from the U.S. Census Bureau tracking poverty rates for the year 2022, the poverty rate for those identifying as non-Hispanic White or Asian was 8.6%, whereas it was 17.1% and 16.9% for those identifying as Black and Hispanic respectively, and 25% for American Indian and Alaskan Natives (Shrider & Creamer, 2023).

This disparity in poverty rates is also reflected in the increased likelihood of minoritized populations living in impoverished zip codes. Southeastern and Southwestern states tend to have the highest poverty rates, a trend which has remained consistent over time, and is consistent with higher unemployment rates in these areas. Neighborhoods that have been historically racially segregated as “non-White” have associations with lower life expectancy and higher rates of homicide, infant mortality, and all-cause mortality, as well as higher rates of mental distress, community violence, excessive drinking and smoking, and HIV prevalence (U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Health Equity., 2020). These neighborhoods often also have higher exposures to environmental toxins like air pollution and lead (Doctrow, 2022).

According to the KFF (formerly known as the Kaiser Family Foundation) health tracking polling, many disparities exist with how safe minoritized groups feel in their homes and neighborhoods, and how discrimination impacts everything from housing to healthcare. This foundation conducted a survey on racism, discrimination, and health in a representative sample of 6,000 Americans in 2023. Hispanic, Black, Asian and AIAN individuals are less likely to report feeling safe in their neighborhoods. About twice as many racially minoritized respondents reported a family member being victimized by violence as did White respondents. Also consistent with earlier surveys, minoritized groups are significantly more likely to have a family member who has experienced mistreatment from law enforcement (Artiga, 2023). “Nearly half of Black Americans say they have been afraid their life was in danger due to their racial background,” (Reich, 2022). All of these disparities impact health on multiple levels across the lifespan; not the least of which is the heightened chronic stress due to discrimination, racism, and poverty.

Systemic Racism

Systemic and structural racism cause disparities in access to goods, services, and opportunities using laws, policies, practices, or attitudes. Systemic racism is often hidden, and practices or social values are accepted as the norm without questioning whether racism had any influence on their creation. Below are two examples of how systemic and structural racism continue to impact racially minoritized communities and cause health inequities.

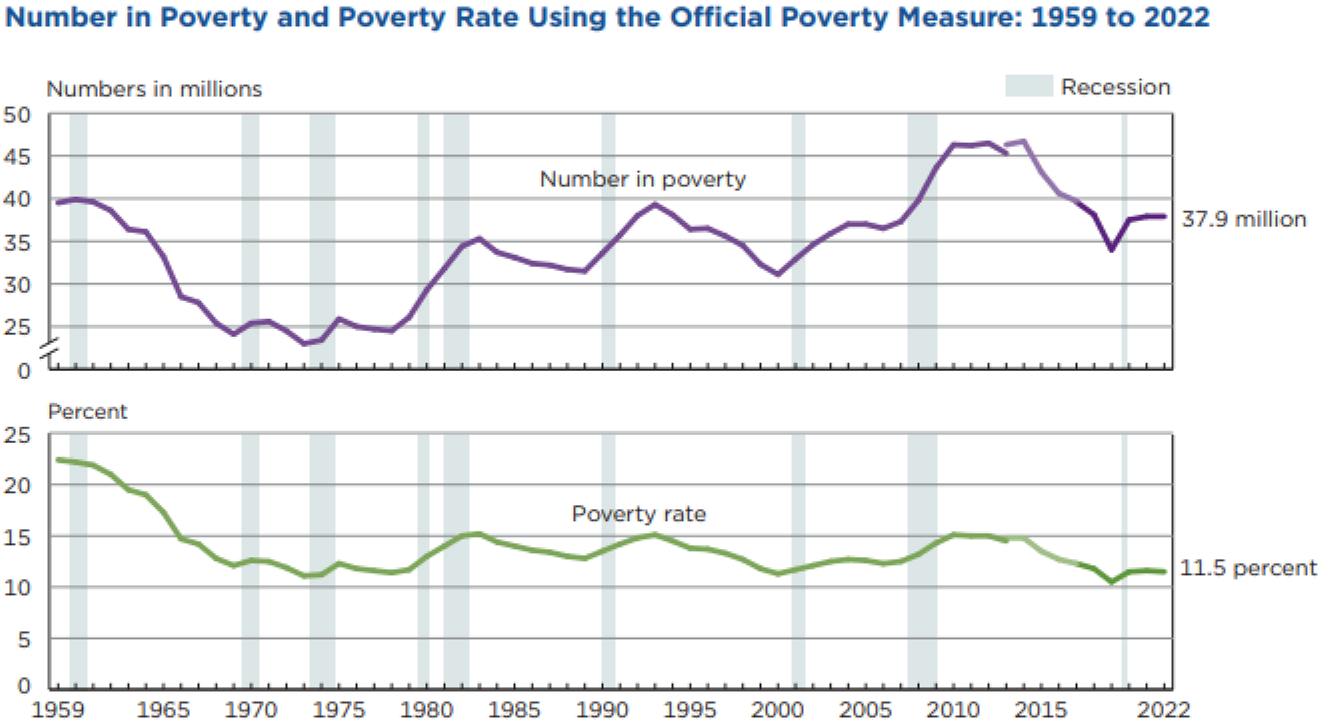
Systemic racism has influenced neighborhoods through redlining: a practice of segregating Black Americans into urban neighborhoods and denying them residential loans. Black neighborhoods were considered financial “risks” by banks and lenders. Newly-built housing tracts often came with contracts requiring that anyone who purchased one of the new houses could not sell it later on to folks from other races or ethnicities – thus keeping suburban communities segregated. Even when the Fair Housing Act of 1968 opened up FHA loans for Black Americans legally, the practice of discrimination continued on within financial institutions. At the same time, home prices continued to increase in the suburbs, which continued to keep loans out of reach for many (Rose, 2023). A majority of those communities that were redlined almost a century ago are still low income, minoritized neighborhoods. Since home ownership is one of the primary mechanisms of building wealth for the middle class, this had a generational effect on racial wealth disparities (Reich, 2019).

Structural racism also influences access to education and economic advancement via funding for public schools. Public schools are funded primarily by state taxes and local property taxes, with much smaller portions from federal funds or community fundraising. This means that if home values are lower in a particular neighborhood, their school district gets less money compared to a school district with higher home values. In those states that have approved them, voucher programs also redirect tax dollars from public schools into private, charter schools – cutting into public school budgets even further. Schools in lower income neighborhoods tend to have more trouble attracting and maintaining teachers, and they may spend more of their limited resources on safety measures and behavioral interventions rather than enhancing learning programs (Reich, 2023). In school, young Black men are more likely to receive harsher punishments, and schools are more likely to call the police when disciplining them – thus increasing the risk of incarceration and eroding trust (P. A. Braveman et al., 2022). In these ways and many others, both current and historic policies continue to create structures and systems that provide fewer opportunities for wealth and impact long-term health outcomes in racially minoritized neighborhoods.

Economic Stability

Economic stability refers to the ability to afford things like housing, food, and health insurance, and the social structures and built environments that come along with wealth. Economic stability can certainly be assessed with income levels, but income alone may not provide a complete picture. Other metrics like home ownership (which can be a surrogate for wealth), or self-reported stress about food or housing are also important ways to measure the effects of money on health. Population economic stability is certainly affected by macroeconomic and political factors such as inflation, unemployment rates, and the minimum wage. Individual changes in socioeconomic status such as job gain or loss, property ownership or loss, and even marriage or divorce can also be factors that impact health outcomes.

Poverty is a significant factor in many different health outcomes. Poverty in America is defined as an income at or below a certain standard set by the U.S. federal government, which changes over time due to inflation. In 2022, the poverty level for an individual annual income was set at $14,880, or $29,950 for a family of 4. This is up from $12,880 and $26,500 respectively just a year prior in 2021 (U. S. C. Bureau, 2023b). Over 37 million Americans currently live at or below the poverty rate by this official poverty measure, which in 2022 was 11.5% (as seen in Figure 22 below). Notably, these income limits do not change in different areas to reflect the geographic variance in the cost of living. So it may require an income significantly higher than the poverty rate to be able to afford housing and food in a larger metropolitan area where these things can be more expensive. Additionally, some folks who receive government assistance may not be factored into the official poverty measure, so a supplemental poverty measure (SPM) is also used as a metric to account for these factors. The SPM for 2022 was 12.4%, and although the official poverty measure did not change between 2021-2022, the SPM increased by 4.6% over that year (Shrider & Creamer, 2023).



Number in Poverty and Poverty Rate Using the Official Poverty Measure: 1959 to 2022

Note: Population as of March of the following year. The data for 2017 and beyond reflect the implementation of an updated processing system. The data for 2013 and beyond reflect the implementation of the redesigned income questions. Refer to Table A-3 for historical footnotes. The data points are placed at the midpoints of the respective years. Information on recessions is available in Appendix C. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar23.pdf>.
Source: U.S. Census Bureau, Current Population Survey, 1960 to 2023 Annual Social and Economic Supplements (CPS ASEC).

Figure 22: Emily A. Shrider and John Creamer, U.S. Census Bureau, Current Population Reports, P60-280, Poverty in the United States: 2022. (CC0; U.S. Government Publishing Office, Washington, DC, September 2023)

Many of those living in poverty are children. Childhood poverty is calculated using the SPM which takes into account people receiving social assistance like the Supplemental Nutrition Assistance Program (SNAP). There are also racial differences with poverty for children, with the highest poverty rates in Hispanic and Black children, and the lowest poverty rates in non-Hispanic White children. In 2020 and 2021, social assistance programs were expanded in response to the pandemic, which included SNAP and the Child Tax Credit (CTC). The latter specifically reduced childhood poverty significantly (in all groups) – lifting 5.3 million people out of poverty, including 2.9 million children (U. S. C. Bureau, 2022). In 2021 childhood poverty hit a historic low at 5.4%, but then climbed back up to 12.8% in 2022. The expiration of the expanded CTC benefits is at least partially to blame for this relapse in poverty (Parrott, 2023). Food and housing insecurity negatively impact childhood health in several ways; including poor nutrition, a lack of physical activity, behavioral and academic problems in school, and higher risk of health problems like obesity and type II diabetes (U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Health Equity., 2020).

Whether you have a lived experience of poverty or can imagine it, wondering if you'll be able to pay rent, utilities, buy food, and medicine can be mentally and emotionally debilitating. Worrying about housing costs can cause severe psychological distress, and is associated with poorer self-reported health. Even risks of chronic diseases like heart disease, high blood pressure, and diabetes are associated with higher stress around housing affordability. Additionally, home ownership is often a proxy for wealth, so renters are more likely to experience this kind of stress than homeowners. The majority of renters who live in government-subsidized housing are women (⅔), and often these renters are single or divorced, and experience much higher distress levels than those who own a home. (U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Health Equity, 2020).

Obesity rates, diabetes rates, and sedentary rates increase inversely with wealth (American Diabetes Association). Wealthy people are more likely to engage in healthy behaviors like exercise and less likely to engage in unhealthy behaviors like smoking. Wealth in terms of home ownership also increases the social cohesion of a neighborhood, with those who own homes reporting more trust in their neighborhood. This social cohesion also results in more engagement in voluntary organizations and local activities (religious centers, sports, community activities, etc.). In fact, parents living in wealthier neighborhoods are far more likely to report social support of their community in watching out for each other's children and helping each other out. People who own their home are also likely to live there for longer than if they were renting (U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Health Equity., 2020). Wealth and home ownership are thus strong factors in health and well-being outcomes for individuals and communities.

Employment

It is important to note that employment status has a significant effect on economic stability. Both unemployment and under-employment impact a person's ability to pay their bills and their sense of security in meeting their basic needs. Underemployment includes intermittent unemployment, poverty wages, or being unable to find a job that matches or appropriately compensates the person's education level and skill set. Part-time employment can also fall into this category, as many workers who would like to work full-time must take several part-time jobs instead. And, do these jobs pay a "living" wage – that is, can someone work the equivalent of full-time, or 40 hours per week, and afford rent and food based on their area's typical prices? If not, a person may have to work overtime, juggle multiple jobs, live with several family members or roommates, and/or accept substandard living conditions (see Housing Instability and Quality below). Many low-wage jobs are also high-stress, which has an impact on mental health and a correlation with substance abuse (*Employment – Healthy People 2030*, n.d.).

Housing Instability

A lack of sufficient and quality housing affects health in both large cities and rural areas. Perhaps the first problem we think about with a lack of housing is homelessness, or a state of being unhoused. Although images of tent encampments on sidewalks are often what is portrayed on the news media to describe the “homelessness crisis”, the unhoused population includes more people than those visibly living on the street. Folks who have no permanent residence may be living out of their car, in hotel rooms, or “couch surfing” and staying with friends or family temporarily. They may also be living in temporary subsidized housing or staying in shelters overnight. Housing status can be dynamic and change rapidly over time, so it can be difficult for public health officials to get a true count of housing needs in a particular area. For example, the Los Angeles Homeless Services Authority (LAHSA) conducts a point-in-time count of unhoused individuals over 3 days, twice per year, which includes those in shelters, transitional housing, and hospitals, as well as a visual count conducted by volunteers across the city (Greater Los Angeles Homeless Count, 2024). This may still undercount some individuals who lack permanent housing, or are housing insecure – which can also mean being at risk for losing housing within the next couple of weeks. Housing instability is obviously a complicated problem.

Both a lack of permanent housing and housing insecurity can cause significant physical and mental stress. Those without housing are at higher risk of being assaulted, are likely to go hungry and have food insecurity, and lack access to basic hygiene facilities – which increases risks of infectious disease and malnutrition. The psychological stress of housing insecurity can be debilitating; anxiety, depression, and substance abuse are common. Yet American society adds to these hardships by stigmatizing and dismissing those who are unhoused as “lazy” or “drug addicts” (Bhattar, 2021). Local governments often take steps to remove homelessness from the sight of other residents, many times without actually providing sufficient housing for those affected. Some attempts to convert or build temporary housing facilities are met with strong opposition from local residents due to this stigma (Canadian Observatory on Homelessness, 2021). Hostile architecture like bars in public benches, or pylons under bridges are built to make it impossible for people to find shelter in those locations. Some local governments make camping on the street illegal, increasing the likelihood of hostile police interactions and incarceration for the unhoused. Assaults by private individuals and police officers on the homeless have been documented (Bhattar, 2021).

Individuals experiencing a lack of housing are not a monolith, yet homelessness does tend to affect marginalized groups at higher rates. Some are suffering from mental illness and addiction. Veterans suffering with post-traumatic stress disorder (PTSD) often lack housing and may have other disabilities as well. There are also those who have one or more jobs and their wages are insufficient to support them. Other individuals have been kicked out of a family home, or left abusive relationships. LGBTQ+ youth can be at a high risk of homelessness, and victims of domestic abuse often face homelessness while leaving an unsafe relationship. A lack of affordable housing in many areas of the U.S. exacerbates these problems (Bhattar, 2021). College students are also often among those lacking housing. For example, a CA State Assembly report found that 5% of UC students, 10% of CSU students, and 20% of community college students in CA reported experiencing some form of housing insecurity – often from a lack of affordable housing close to the campus they are attending (Burke, 2022). Lacking those basic necessities can have a significant impact on the academic performance of those students.

Housing Quality

Substandard housing is also a public health issue. The U.S. Department of Housing and Urban Development (HUD) considers substandard housing to be any permanent residence lacking hot and cold water, sink, toilet, or shower, and kitchen facilities like a stove, refrigerator, and sink with running water. Living in a place without any of these utilities can affect personal hygiene, the ability to cook fresh and healthy meals, and ultimately increases the risk of both infectious and chronic diseases. A recent report estimates that substandard housing affects over 1.5 million people living in cities and over 368,000 people living in rural areas. American Indian and Alaskan Natives have the highest rates of lacking appropriate plumbing and kitchen utilities, followed closely by rural communities and people with disabilities (Swendener et al., 2023).

Even if housing has adequate plumbing and kitchen facilities, there may be other issues that impact health such as rodent or insect infestation, mold, lack of heating or cooling, or exposure to household toxins like lead or formaldehyde. Even low levels of lead exposure can have significant effects on neurodevelopment in children. Dilapidated structures pose higher risks for injuries for children, older adults, and people with disabilities (*Quality of Housing – Healthy People 2030*, n.d.).

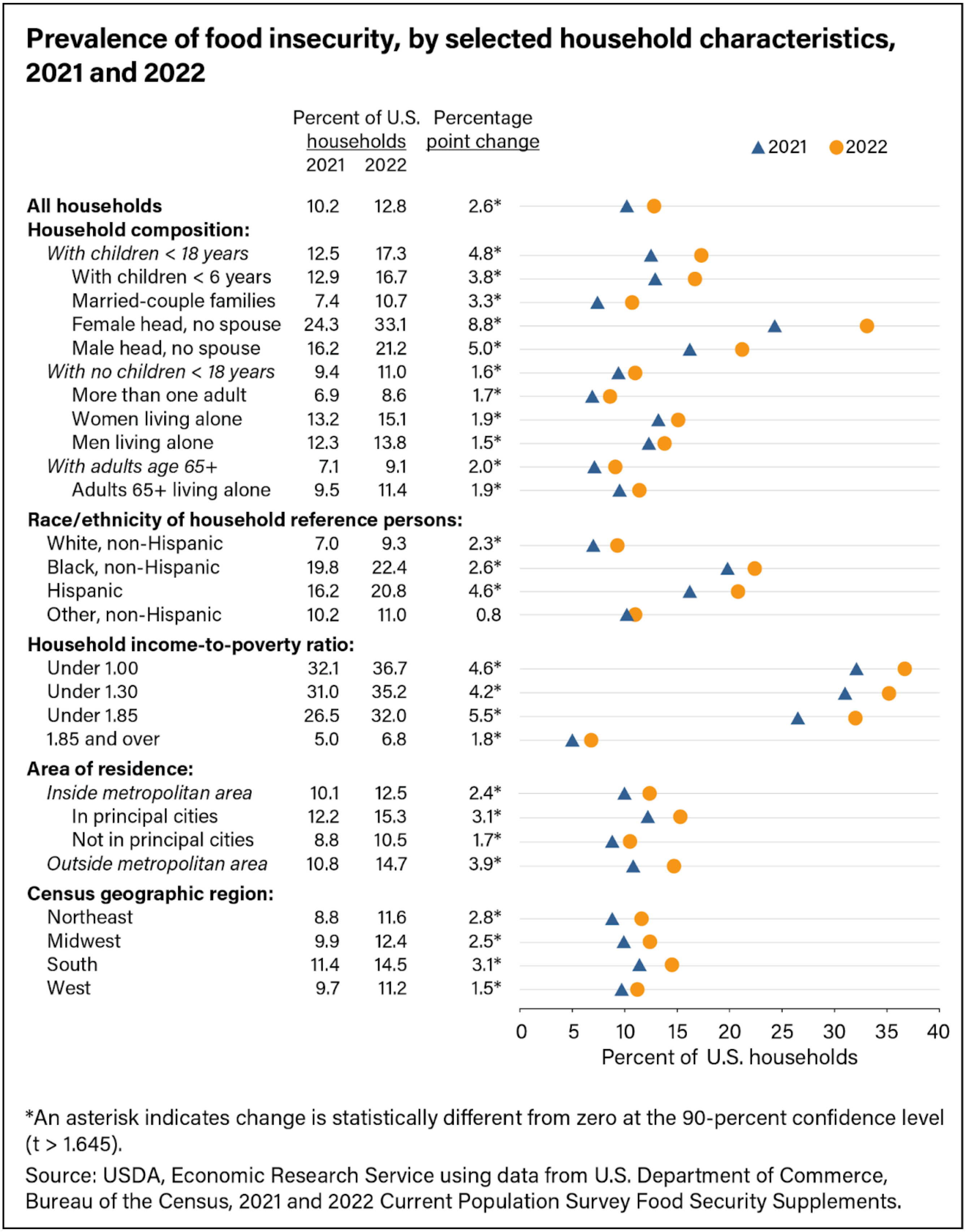
A lack of disposable income can make it difficult to pay for home repairs, and landlords can sometimes shift responsibilities to tenants – particularly in competitive rent markets. One report found that even prior to the COVID-19 pandemic, nearly 15% of rental homes either needed substantial repairs, had rodent infestations, or lacked some resource (like heating or water), and these homes were more likely to be rented to the poorest – and most rent-burdened families (U.S. Government Accountability Office, 2020).

Other issues around housing include struggling to pay rent or a mortgage, spending more than 30-50% of income on housing, overcrowding, and having to move frequently (*Housing Instability – Healthy People 2030*, n.d.). Housing is considered “affordable” when it costs 30% or less of the household income (Braveman et al., 2011). Children who have to move more than 3 times in one year have much poorer health and are also less likely to have health insurance. Overcrowding increases the risks of infectious disease transmission and can also impact mental health. The COVID-19 pandemic only highlighted the impact of overcrowding and poor ventilation in living spaces. All of these factors can impact both physical and psychological health of individuals and the social cohesion of a community. Over their lifespans, people living in areas of poverty or experiencing homelessness have significantly worse health outcomes (*Housing Instability – Healthy People 2030*, n.d.).

Food Insecurity

Food insecurity describes not only experiencing the physical pain of hunger, but also not knowing when or where the next meal will be, and/or a reduction in the quality and desirability of food. In fact, the USDA describes two levels of food insecurity as being low food security and very low food security depending on whether or not a person has limited access to only quality or both quality and *amount* of food (*Food Insecurity – Healthy People 2030*, n.d.). Food insecurity is also associated with obesity, diabetes, and other chronic diseases that are often caused by overconsumption of calories. This is sometimes referred to as the food insecurity paradox. Although to date research has not identified a clear reason for this, one of the proposed mechanisms focuses on food cost vs. quality. For example, a person may have adequate access to total calories (or too many calories), yet those calories may be provided by highly processed foods with very little nutritional value. They may not be able to purchase fresh fruits and vegetables, meat, fish, eggs and dairy products, and/or their meals might mostly consist mostly of canned, frozen or prepackaged foods, or meals from vending machines, fast-food restaurants, and convenience stores. These cheaper, more convenient food products also tend to be higher in fat, sugar, salt, and calories. Thus, although in developing countries food insecurity is associated with dangerously low body weight, in wealthier countries like the U.S. food insecurity is associated with obesity – particularly in women (Carvajal-Aldaz et al., 2022). In terms of other health effects, certainly worrying about the next meal or being able to afford food impacts a person's stress level and their mental health as well (*Food Insecurity – Healthy People 2030*, n.d.).

In 2022, food insecurity affected 12.8% of households, which is a significant increase since 2021, when food insecurity was at 10.2%. Rates of food insecurity were the highest – and increased the most between 2021 and 2022 – for single mothers with children under 18 (*USDA ERS*, 2023). See Figure 23 below.



Prevalence of food insecurity, by selected household characteristics, 2021 and 2022

	Percent of U.S. households		Percentage point change
	2021	2022	
All households	10.2	12.8	2.6*
Household composition:			
With children < 18 years	12.5	17.3	4.8*
With children < 6 years	12.9	16.7	3.8*
Married-couple families	7.4	10.7	3.3*
Female head, no spouse	24.3	33.1	8.8*
Male head, no spouse	16.2	21.2	5.0*
With no children < 18 years	9.4	11.0	1.6*
More than one adult	6.9	8.6	1.7*
Women living alone	13.2	15.1	1.9*
Men living alone	12.3	13.8	1.5*
With adults age 65+	7.1	9.1	2.0*
Adults 65+ living alone	9.5	11.4	1.9*
Race/ethnicity of household reference persons:			
White, non-Hispanic	7.0	9.3	2.3*
Black, non-Hispanic	19.8	22.4	2.6*
Hispanic	16.2	20.8	4.6*
Other, non-Hispanic	10.2	11.0	0.8
Household income-to-poverty ratio:			
Under 1.00	32.1	36.7	4.6*
Under 1.30	31.0	35.2	4.2*
Under 1.85	26.5	32.0	5.5*
1.85 and over	5.0	6.8	1.8*
Area of residence:			
Inside metropolitan area	10.1	12.5	2.4*
In principal cities	12.2	15.3	3.1*
Not in principal cities	8.8	10.5	1.7*
Outside metropolitan area	10.8	14.7	3.9*
Census geographic region:			
Northeast	8.8	11.6	2.8*
Midwest	9.9	12.4	2.5*
South	11.4	14.5	3.1*
West	9.7	11.2	1.5*

*An asterisk indicates change is statistically different from zero at the 90-percent confidence level (t > 1.645).

Source: USDA, Economic Research Service using data from U.S. Department of Commerce, Bureau of the Census, 2021 and 2022 Current Population Survey Food Security Supplements.

Figure 23: Prevalence of Food Insecurity by Selected Household Characteristics, 2021 and 2022. Source: USDA, Economic Research Service using data from U.S. Department of Commerce, Bureau of the Census, 2021 and 2022

Education Access

On the whole, higher levels of education are linked with better paying jobs *and* better health over the lifespan. Graduating from college decreases the risk of future unemployment (and thus many of the health factors that come with economic instability), and college graduates report better health than those who only complete high school. College education is more often required for white-collar jobs, which tend to pay better wages and are more likely to provide health insurance benefits. This also means college graduates may be able to afford better quality housing, and have more access to healthy dietary patterns and leisure-time physical activity. Unhealthy behaviors like smoking and drinking excessively are lower in more educated populations (*Enrollment in Higher Education – Healthy People 2030*, n.d.).

Education levels of parents are also correlated with the health of the rest of the family. Childhood obesity is negatively correlated with the education level of the head of the household (HHS reports). If parents have higher education, children are less likely to experience adverse childhood experiences (ACEs). These types of experiences can include trauma from physical or sexual abuse, neglect, witnessing a family member use drugs or have mental health problems – including attempting or committing suicide – or having a family member become incarcerated. They can also include witnessing violence in the home or community, becoming homeless, or experiencing stress from housing and food insecurity (U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Health Equity., 2020).

As mentioned earlier, racial disparities in health and life expectancy persist across educational strata. However, one increasingly common cause of death primarily affects white, non-college educated, middle-aged men, who live in mostly rural areas and small towns. Correlated with the decline in blue-collar job opportunities in middle America, so-called “deaths of despair” have increased over the last decade. These include deaths from suicide, drug (mostly opioid) overdoses, and liver disease, all associated with physical and psychological pain (Scutchfield & Keck, 2017). This is a tragic example of a combination of social determinants of health converging: unemployment, poverty, and a lack of access to healthcare (mental health care in particular), all contributing to higher rates of depression and substance abuse.

High School Graduation and Enrollment

Graduating high school is often used as a key metric since it is associated with better economic opportunities. Most jobs – even entry level, minimum wage jobs – require at least a high school diploma or equivalent. Dropping out of high school is associated with other social determinants of health such as poverty and unemployment, but also health outcomes such as higher risk for chronic disease. Teens who have gotten pregnant during high school are more likely to drop out, as are students who have less support for their education from parents. A perception of safety and caring in the classroom is also important. Students are more likely to complete high school when they feel like their teachers are invested, and don't apply unfair punishment or discipline within the classroom (*High School Graduation – Healthy People 2030*, n.d.).

In recent years, high school completion rates have improved, however disparities still exist. For example, in the 2019-2020 academic year, the graduation rate was 87%, which is the highest it was in 8 years. Asian/Pacific Islander and White student graduation rates (93% and 90%) were still the highest compared to Hispanic (83%) Black (81%) and American Indian/Alaska Native (75%) (*COE*, 2023). And these racial disparities continue into college enrollment. According to the Bureau of Labor Statistics (BLS) in October of 2022, 62% of 16-24 year olds who had graduated high school the year prior were enrolled in college. This percentage was not a significant change from the 2 years prior, but prior to the pandemic in 2019 the college enrollment percentage was just above 66%. Women are also significantly more likely to go to college, with 66% of young women and only 57% of young men enrolling. Enrollment rates in 2022 were highest for Asians (72%), slightly lower for Blacks (64%) and Whites (62%) and lowest for Hispanics (58%) (*College Enrollment and Work Activity of Recent High School and College Graduates Summary*, 2023).

Higher education can have many benefits for both income and health across the lifespan. Although there are always a small percentage of those with a high school diploma that make more money than bachelor's degree holders, and a small percentage of bachelor's degree holders that make more than graduate degree holders, the general trend for the majority of the population favors college educated individuals getting higher earnings with each level of degree (associates to doctorate/professional degrees) (*The College Payoff: More Education Doesn't Always Mean More Earnings*, 2021). Higher paying jobs are often less dangerous, can lead to growing wealth, better housing, and often come with more reliable access to health insurance and better retirement potential. College graduates are also less likely to engage in harmful health behaviors like excessive drinking, and more likely than their non-college educated peers to adopt positive health behaviors like exercising and getting routine health screenings (*Enrollment in Higher Education – Healthy People 2030*, n.d.)

Nutrition Access

Food insecurity is associated with long term health consequences such as obesity and a higher risk of chronic diseases. This may be because food insecurity does not only include potentially skipping meals or not getting enough to eat, it also includes being forced to opt for cheaper, less-healthy food items. Access to healthy nutrition includes both the availability of healthy foods and their cost.

In order for a person to engage in healthy behaviors, they first must have an environment that allows for those behaviors. Perhaps nowhere is this more obvious than with health-supporting nutrition. According to the USDA, a healthy dietary pattern includes fruits and vegetables, grains (particularly whole grains), low-fat and fat-free dairy products, protein foods (including meat, eggs, and plant-based protein sources), and oils. Eating patterns that include these types of foods are associated with lower rates of chronic diseases including heart disease, diabetes, and some cancers. Epidemiological evidence points to higher rates of obesity and diabetes in neighborhoods with fewer fresh produce sources and more fast-food restaurants. Children who attend schools with a plethora of fast-food chains within ½ a mile tend to eat fewer fruits and vegetables, drink more soda, and are more likely to be obese than those who attended schools without fast-food nearby. Low-income and racially minoritized communities tend to also have fewer grocery stores in their neighborhoods, and have to travel farther to purchase fresh produce (*Access to Foods That Support Healthy Dietary Patterns – Healthy People 2030*, n.d.). This has led to the theory of "food deserts"; geographic locations around the U.S. where healthy food options are scarce, or residents have to travel long distances to reach a grocery store. These are not limited to urban areas either – ironically, people living in rural farmlands may also have to travel long distances to obtain a variety of fresh produce and protein foods. Rural food insecurity rates are similar to the high rates in inner cities (*Rural Hunger and Access to Healthy Food Overview*, 2024). Additionally, "food swamps" refer to areas replete with fast-food restaurants. Some studies indicate that living in a food swamp influences obesity rates even more so than food deserts. A neighborhood can be both a "food desert" and a "food swamp" at the same time (L. D. Burke & Weill, 2023).

Food prices tend to rise with general inflation, but can also outpace inflation particularly for specific food items. According to the USDA, the Consumer Price Index for foods increased dramatically in 2022 at around 10%, above the overall average increase in prices for other goods, and the largest increase in several decades (*Consumer Price Index: 2022 in Review: The Economics Daily: U.S. Bureau of Labor Statistics*, n.d.). This price increase was less during the following year, yet the costs of healthier foods have long been higher than the prices of less healthy, fast-foods or highly processed foods. Furthermore, people who live in low-income communities may pay higher prices for limited fresh produce options at convenience stores than those who live in more affluent communities with more large grocery stores (*Access to Foods That Support Healthy Dietary Patterns – Healthy People 2030*, n.d.). Fast food options and pre-packaged foods are also convenient for people who may not have time to prepare or cook whole foods purchased from a grocery store. The time-cost of healthy food becomes increasingly important to those who work multiple jobs, have long commute times, are caregivers, and/or those who have a disability.

8.

TOPIC: COMMUNITY VIOLENCE

Violence is a critical health problem that has become pervasive throughout the United States. The World Health Organization (WHO) Violence Prevention Alliance has defined violence as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either result in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation” (WHO, 2021).

Violence affects millions of people, and their families, schools, and communities every year. Violence can cause significant physical injuries and mental health conditions such as depression, anxiety, and posttraumatic stress disorder (PTSD). Living in a community experiencing violence is also associated with an increased risk of developing chronic diseases. Concerns about violence may prevent some people from engaging in healthy behaviors, such as walking, bicycling, using parks and recreational spaces, and accessing healthy food outlets (CDC, 2022e).

Violence

Violence is not an individual issue but a societal and global concern. Social justice cannot be ensured as long as the threat of violence exists. According to Healthy People 2030, objectives to address crime and violence include reducing:

- The rates of minors and young adults committing violent crimes
- Nonfatal physical assault injuries
- Firearm-related deaths
- Adolescent sexual violence by anyone
- Sexual or physical teen dating violence
- Bullying of lesbian, gay, or bisexual high school students
- Domestic and Intimate Partner Violence

Domestic and Intimate Partner Violence

The National Coalition Against Domestic Violence (NCADV) defined domestic violence as “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, threats, economic abuse, and emotional/

psychological abuse. The frequency and severity of domestic violence vary dramatically" (WHO, 2021). Furthermore, domestic violence does not discriminate. More than 80 million people in the United States have experienced IPV in their lifetime (California Firearm Violence Research Center, 2022).

Although the terms domestic violence and intimate partner violence are sometimes used interchangeably, the distinction exists in the sense that domestic violence can occur between a parent and child, siblings, or roommates. Intimate partner violence occurs between romantic partners who may or may not be living together in the same household (CDC, 2024e).

Intimate partner violence can exist in all relationships and at every level, including between those who are married or are dating, living together, or encountering each other after the relationship has ended (Kang et al., 2017). Intimate partner violence is a persistent problem. Approximately two in five women and nearly one in four men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and have reported some form of IPV-related impact. Over 61 million women and 53 million men have experienced psychological aggression by an intimate partner in their lifetime (CDC, 2024e). Every year, 3–4 million women in the United States. are abused, and 1,500–1,600 are killed by their abusers.

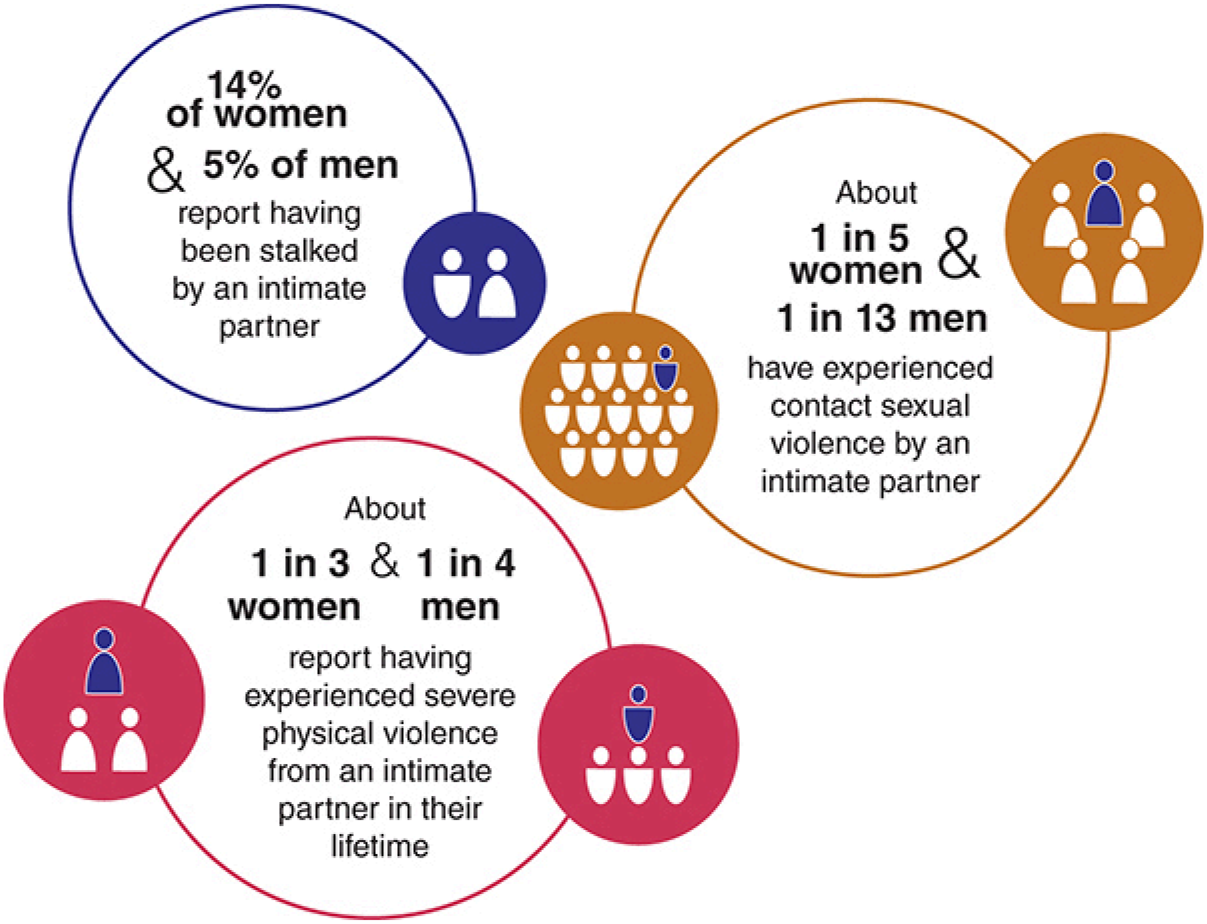


Figure 24: Intimate Partner Violence Statistics (Adapted from CDC, 2022b)

Risk factors for experiencing IPV are considered from the perspective of an individual in the context of relationship, community, and societal factors. Examples of risk factors include low self-esteem, aggressive or delinquent behavior as a youth, witnessing violence between parents as a child, communities with high unemployment rates, and societal income inequality (CDC, 2024). Intimate partner violence often begins early and continues throughout the lifespan. When IPV occurs in adolescence, it is called teen dating violence. Teen dating violence affects millions of U.S. teens each year. Approximately 11 million women and 5 million men who reported experiencing contact sexual violence, physical violence, or stalking by an intimate partner in their lifetime said that they first experienced these forms of violence before age 18 (CDC, 2024e). Data from the CDC's Youth Risk Behavior Survey in 2019 indicated that among U.S. high school students who reported dating during the 12 months before the survey, about one in 12 experienced physical dating violence. About one in 12 of the surveyed high school students experienced sexual dating violence (CDC, 2024e).

Intimate partner violence is preventable. A number of factors may increase or decrease the risk of perpetrating and experiencing IPV. Nurses can play a role in helping to reduce and prevent IPV by doing the following:

- Understanding the risk factors for experiencing violence and identifying protective factors.
- Promoting healthy, respectful, and nonviolent relationships. Nurses can model this through therapeutic communication and through sharing resources that help individuals and couples develop healthy and safe relationships.
- Seeking additional training to understand the shared risk and protective factors. Since addressing and preventing one form of violence may have an impact on preventing other forms of violence, nurses can significantly influence violence reduction and prevention.
- Referring persons experiencing IPV to the domestic violence website and hotline are among other resources that should be offered to persons in this situation. The domestic violence hotline is a shareable resource for people who are affected by IPV (National Domestic Violence Hotline, 2022).

Table 4: Characteristics of Healthy Relationships (Adapted from Virginia Department of Health, 2022)

Healthy Relationships	Unhealthy Relationships
Equality: You make decisions together.	Control: One of you makes all the decisions and is demanding.
Honesty: You can share your feelings and thoughts with each other.	Dishonesty: One of you lies and hides things from the other.
Physical safety: You feel safe with each other. You are not scared of getting hurt.	Physical abuse: One of you hits, slaps, grabs, or shoves the other person.
Respect: You respect each other's opinions, friends, and interests.	Disrespect: One of you makes fun of the other's feelings, thoughts, and opinions.
Comfort: You feel great being yourself, and you are comfortable saying "I am sorry."	Discomfort: One of you might make threats like "I will break up with you if. . . "
Sexual respectfulness: You never force each other to do things you are uncomfortable with.	Sexual abuse: One of you pressures the other or forces sexual activities the other does not want to do.
Independence: You have friends and hobbies outside your relationship.	Dependence: One of you makes threats to do something drastic if the relationship ends.
Humor: You have fun in the relationship.	Hostility: One of you is mean to the other.

An in-depth assessment of the person suffering IPV must be undertaken and a safety plan developed. Establishing a plan does not necessarily mean that the person experiencing the violence is willing and able to leave at that time. The goal is to support the patient's decision, offering support, resources, and contact information if desired.

Protective Factors for Intimate Partner Violence Perpetration

Relationship Factors

The following are relationship factors community and public health nurses need to consider when addressing the needs of individuals at risk for IPV:

- Strong social support networks and stable, positive relationships with others
- Support groups for single, divorced, or separated individuals at risk for IPV
- Screening and referral of individuals acknowledging significant relationship discord
- Screening and referral of individuals expressing impactful relationship satisfaction
- Identification and referral of individuals demonstrating attachment disorders from their adult partners

- Referral of individuals expressing significant emotions of anger and jealousy toward their partner (Capaldi et al., 2012)

Community Factors

Community factors that may help them serve the needs of persons at risk for IVP. Community health nurses should consider these factors:

- Neighborhood collective efficacy (i.e., residents feel connected to each other and are involved in the community)
- Coordination of resources and services among community agencies
- Access to safe, stable housing
- Access to medical care and mental health services
- Access to economic and financial help

LGBTQIA+ Violence

Homophobia, stigma, and discrimination increase the chance for individuals of the lesbian, gay, bisexual, transgender, questioning/queer, intersex, and asexual (LGBTQIA+) community to experience violence. Violence can include behaviors such as bullying, teasing, harassment, physical assault, IPV, and suicide-related behaviors. Several aspects of IPV can be unique to the LGBTQIA+ community (CDC, 2016). "Outing" or threatening to reveal one partner's sexual orientation or gender identity may be used as a tool of abuse in violent relationships and may also be a barrier that reduces the likelihood of help-seeking for the abuse. Prior experiences of physical or psychological trauma, such as bullying and hate crime, may make persons who are LGBTQIA+ less likely to seek help (NCADV, 2018).

Types of Domestic Violence Affecting the LGBTQIA+ Community

Consider the following statistics:

- 20% of victims have experienced some form of physical violence
- 16% have been victims of threats and intimidation
- 15% have been verbally harassed
- 4% of survivors have experienced sexual violence
- 11% of intimate violence cases reported in the 2015 report by the National Coalition Against Domestic Violence Programs (NCADVP) involved a weapon (NCAVP, 2016)

The 2015 U.S. Transgender Survey found that more than half (54%) of transgender and non-binary respondents experienced IPV in their lifetimes. Nurses must understand that the community of

LGBTQIA+ can experience bias from health care and law enforcement (CDC, 2022a). Many times, persons who are not cisgender are discouraged from seeking help for IPV. For many LGBTQIA+ people, IPV often begins in youth or young adulthood. One in five (19%) lesbian, gay, and bisexual high school-aged students have said they have been forced to have sex, compared with 6% of straight students (CDC, 2019). Another study found that nearly one in four (24%) transgender high school–aged students said they have been forced to have sex, as well as 15% of their cisgender peers. In addition, lesbian, gay, and bisexual high school–aged students report elevated rates of physical (13%) and sexual (16%) dating violence, compared with the rates of physical (7%) and sexual (7%) dating violence reported by their straight peers (CDC, 2019; Johns et al., 2019). Transgender students also report high levels of physical (26%) and sexual (23%) dating violence, compared with the rates of physical (15%) and sexual (16%) dating violence reported by their cisgender peers (Human Rights Campaign Foundation, 2022; Johns et al., 2019). Unfortunately, persons who are LGBTQIA+ experience health inequities and discrimination in the healthcare system.

Violence Against Children

Violence is a major public health and human rights concern. An estimated 1 billion children—half of all the children in the world—are victims of violence every year. Children who experience violence have higher risks for health and social problems, such as chronic disease, HIV, mental health issues, substance misuse, and reproductive health problems. Violence also leads to continued cycles of violence, because young people who experience violence are more likely to perpetrate violence against others later in life (CDC, 2024a).

Child abuse and neglect are common. At least one in seven children has experienced child abuse or neglect in the past year in the United States. This is likely an underestimate because many cases are unreported. In 2020 in the United States, 1,750 children died of abuse and neglect.

Children living in poverty experience more abuse and neglect than do those in households that are not impoverished. Experiencing poverty can place a lot of stress on families, which may increase the risk of child abuse and neglect. Rates of child abuse and neglect are five times higher for children in families with low socioeconomic status than for those in higher-status families.

Child maltreatment is costly. In the United States, the total lifetime economic burden associated with child abuse and neglect was about $592 billion in 2018. This economic burden rivals the cost of other high-profile public health problems, such as heart disease and diabetes (CDC, 2024c).

Long-term behavioral impacts of violence on children include aggressive and antisocial behavior, substance abuse, risky sexual behavior, and criminal behavior. Despite these grave physical and mental health consequences, most children who have been victimized by violent acts never seek or receive help to recover. Children who grow up with violence are more likely to reenact it as young adults and caregivers, creating a new generation of persons who have been abused (UNICEF, 2020).

School violence can seriously affect children's psychological and physical health. Children who are subjected to violence may experience physical injury, sexually transmitted infections, depression, anxiety, posttraumatic stress disorder (PTSD), and suicidal thoughts. They may also begin to exhibit risky, aggressive, and antisocial behavior. Children who grow up around violence, compared with those who do not, have a greater chance of replicating it for a new generation of persons to be victimized. At its most extreme, violence in and around schools can be deadly. School often becomes the front line for the millions of children and adolescents living in conflict-affected areas. Violence in school can reduce school attendance, lower academic performance, and increase dropout rates. This result of school violence has devastating consequences for the success and prosperity of children, their families, and entire communities (UNICEF, 2021).

Strategies to Combat Childhood Violence

The CDC has recommended Essentials for Childhood to foster the positive development of children and families and, specifically, prevent all forms of child abuse and neglect. While each individual goal is important to community health, the four goals together are more likely to build a comprehensive foundation of safe, stable, nurturing relationships and environments for children. Community health nurse can promote the following strategies:

Goal 1: Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child abuse and neglect

- Adopt the vision of "assuring safe, stable, nurturing relationships and environments to protect children from child abuse and neglect"
- Raise awareness in support of the vision
- Partner with others to unite behind the vision

Goal 2: Use data to inform actions

- Build a partnership to gather and synthesize relevant data
- Take stock of existing data
- Identify and fill critical data gaps
- Use the data to support other action steps

Goal 3: Create the context for healthy children and families through norms change and programs

- Promote the community norm that we all share responsibility for the well-being of

children
- Promote positive community norms about parenting programs and acceptable parenting behaviors
- Implement evidence-based programs for parents and caregivers

Goal 4: Create the context for healthy children and families through policies

- Identify and assess which policies may positively affect the lives of children and families in your community
- Provide decision-makers and community leaders with information on the benefits of evidence-based strategies and rigorous evaluation (CDC, 2021)

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life (Office of Disease Prevention and Health Promotion, 2022). While child abuse and neglect are significant public health problems, they are also preventable (CDC, 2021).

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) include child abuse and neglect but also encompass household events that children may experience as traumatic (Figure 7.3). The CDC–Kaiser Permanente ACE study is one of the largest investigations of childhood abuse, neglect, and household challenges. The study clearly linked ACEs and later-life health and well-being. The greater the culmination of ACEs, the poorer the health outcomes later in life (Felitti et al., 1998).

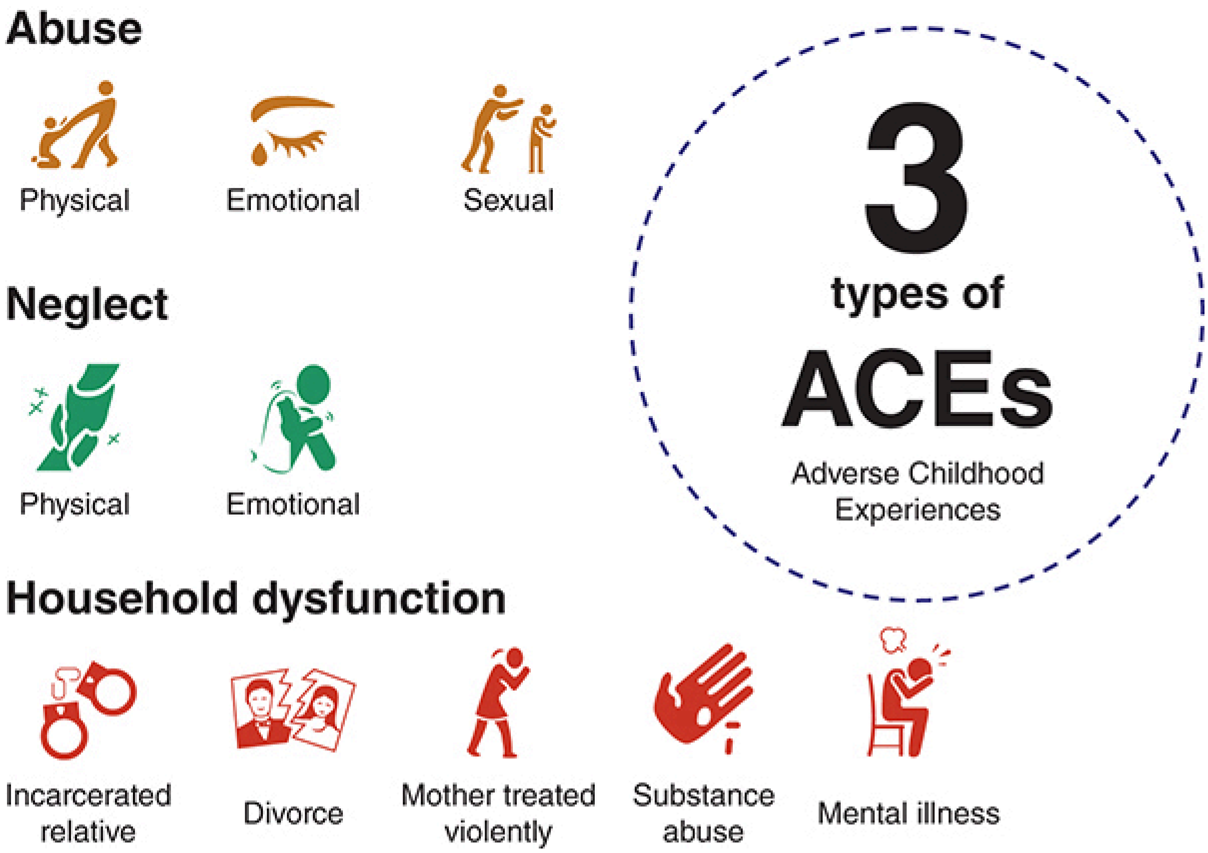


Figure 25: Abuse: physical, emotional, and sexual abuse. Neglect: physical and emotional neglect. Household dysfunction: incarcerated relatives, divorce, mother being treated violently, substance abuse, and mental illness.

Why Are ACEs a Problem?

Adverse childhood experiences are violations of the safety and well-being of children. They also indicate a family structure in which children and adults are suffering. Moreover, the more ACEs a person experiences, the higher their risk for health-related issues such as these:

- Alcoholism
- Unplanned teen pregnancy
- Depression
- Diabetes
- Heart disease
- IPV
- Suicide
- Eating disorders
- Drug abuse
- Sexuality Transmitted Infections

Since the prevention of ACEs is important to the well-being of a vulnerable population (children) and families as well as to public health, the CDC has developed some research-based strategies to prevent ACEs and mitigate their impacts. Table 5 outlines strategies and approaches that public health nurses can facilitate through working with families and communities.

- Social-emotional learning
- Safe dating and healthy relationship skill programs
- Parenting skills and family relationship approaches

Table 5: Preventing ACEs (Adapted from CDC, 2024b)

Preventing Adverse Childhood Experiences	
Strategy	**Approach**
Strengthen economic support to families	• Strengthening of household financial security • Family-friendly work policies
Promote social norms that protect against violence and adversity	• Public education campaigns • Legislative approaches to reduce corporal punishment • Bystander approaches • Men and boys as allies in prevention
Ensure a strong start for children	• Early childhood home visitation • High-quality childcare • Preschool enrichment with family engagement
Teach skills	• Social-emotional learning • Safe dating and healthy relationship skill programs • Parenting skills and family relationship approaches
Intervene to lessen immediate and long-term harms	• Enhanced primary care • Victim-centered services • Treatment to lessen the harms of ACEs • Treatment to prevent problem behavior and future involvement in violence • Family-centered treatment for substance use disorders

Human Trafficking

Human trafficking is also called "modern-day slavery" (U.S. Department of Health and Human Services, 2020). It involves the exploitation of people through force, coercion, threat, and deception and includes human rights abuses. The action means, and purposes model (AMP) describes the definition of human trafficking in the United States, as outlined by the Victims of Trafficking and Violence Protection Act of 2000. For something to be considered human trafficking, at least one item from each circle shown must be present; however, means is not necessary if the person being trafficked is a minor (National Human Trafficking Hotline, 2014). The A M P model of human trafficking describes the actions, means, and purpose.

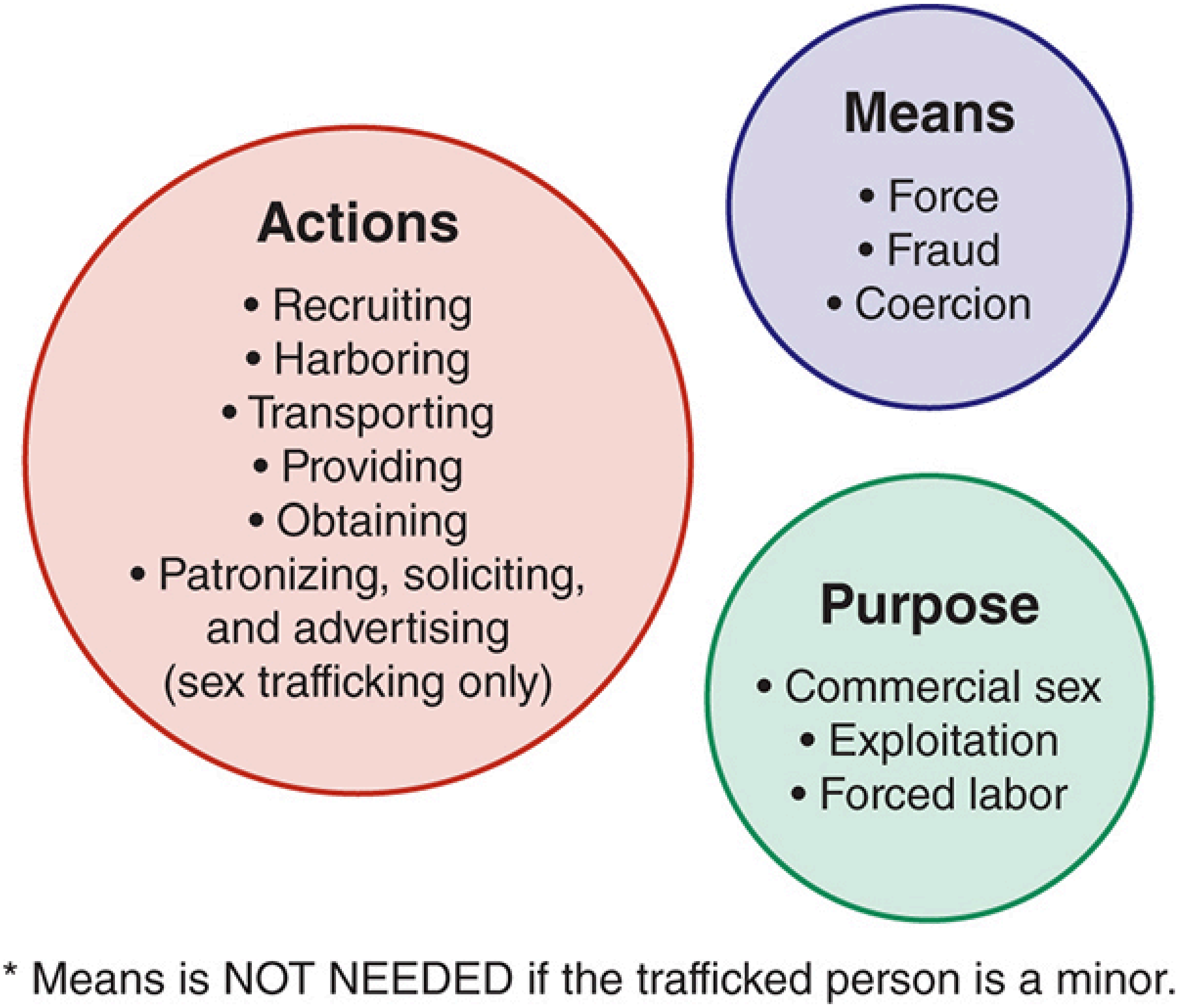


Figure 26: Human Trafficking AMP Model

Human trafficking is a human rights violation that denies individuals their basic freedoms and dignity. Human trafficking is underreported, underrecognized, and under-prosecuted. Currently, there is no national requirement for nurses to engage in annual or continuing education in assessing or reporting human trafficking. This is extremely concerning because 87% of trafficked persons said that while in captivity, they had interactions with a healthcare professional but their captivity went completely undetected (Farella, 2016). House Bill 2282 (February 24, 2017) mandated that the Department of Education develop guidelines for training school personnel. This bill includes the community health role of school nurses.

Understand that many trafficked persons believe that they will be prosecuted. However, U.S. law states that any crimes that occur during captivity are not considered criminal acts by the captive, only by the offender. Communicate early and often with your colleagues and manager to enlist help

Documentation

Document all the following in detail about the person who has been trafficked:

- Signs of physical abuse
- Signs of psychological abuse
- The trafficked person's "story"
- Any laboratory results or assessments that support what your patient is telling you
- Also, document the following behaviors of the offender if they are present
- Not letting the patient speak for themselves
- Holding all currency and important documents
- Not allowing the trafficked person to be alone with the healthcare provider

Protection

Because one in every three trafficked persons is a child, nurses must understand reporting mandates. Nurses are legally mandated to report any suspicion of trafficking cases involving people under 18. However, there is no reporting mandate for adults who are trafficked. Nonetheless, nurses can still protect their patients by doing the following:

- Establishing an anonymous/protected status in clinics, primary care, and acute care settings
- Contacting local police
- Calling the National Trafficking Hotline at 1-888-373-7888
- Involving case management for after-care resources

Gun Violence

Gun violence is a serious public health problem that affects the health and safety of Americans. Important gaps remain in our knowledge about the problem and ways to prevent it. Addressing these gaps is an important step toward keeping individuals, families, schools, and communities safe from firearm violence and its consequences.

A firearm injury is a gunshot wound or penetrating injury from a weapon that uses a powder charge to fire a projectile. Weapons that use a power charge include handguns, rifles, and shotguns. Injuries from air- and gas-powered guns, BB guns, and pellet guns are not considered firearm injuries because these types of guns do not use a powder charge to fire a projectile.

Firearm injuries are a serious public health problem. In 2020, there were 45,222 firearm-related deaths in the United States—that is about 124 people dying from a firearm-related injury each day. More than half of firearm-related deaths were suicides, and more than four out of every 10 were firearm homicides.

More people suffer nonfatal firearm-related injuries than die. More than seven out of every 10 medically treated firearm injuries are from firearm-related assaults. Nearly two out of every 10 are from unintentional firearm injuries. There are few intentionally self-inflicted firearm-related injuries seen in hospital emergency departments. Most people who use a firearm in a suicide attempt die from their injury.

Firearm injuries affect people in all stages of life. In 2020, firearm-related injuries were among the five leading causes of death for people aged 1 to 44 in the United States. Some groups have higher rates of firearm injury than others. Men account for 86% of all victims of firearm death and 87% of nonfatal firearm injuries. Rates of firearm violence also vary by age and race/ethnicity. Firearm homicide rates are highest among teens and young adults 15–34 years of age and among Black or African American, American Indian or Alaska Native, and Hispanic or Latino populations. Firearm suicide rates are highest among adults 75 years of age and older and among American Indian or Alaska Native and non-Hispanic White populations (CDC, 2024d).

The concentration of gun deaths across the U S with places like Los Angeles, Phoenix, New York, Washington, Ottawa, Mexico, and The Bahamas located on the map. The eastern and southeastern parts of the U S experience more gun deaths compared to other regions.

In contrast to the rising levels of gun violence in America, Europe has seen a decline in the homicide rate by 63% since 2002 and by 38% since 1990. The rate in Asia has fallen by 36% since 1990. There are also indications, however, that homicide is underreported in the official statistics in Pacific countries. Firearm suicide rates continued to remain high in the United States (United Nations Office on Drugs and Crime, 2018).

A comprehensive approach is needed to help reduce firearm-related deaths. Strategies that focus on underlying conditions can reduce disparities and the risk for violence while also strengthening protective factors at the individual, family, and community levels. Some actions can have a more immediate impact on preventing violence, and others can be long-term solutions. Prevention is a primary goal. Working with partners, including policymakers; local, state, territorial, and tribal governments; health, education, justice, and social service agencies; businesses; and community organizations can help ensure that local needs are met (CDC, 2022d; WHO, 2014). Gun violence intervention and prevention programs avert interpersonal violence by working with a range of community stakeholders to provide support and intervention to those at the highest risk of being persons who have been victimized and/or perpetrators of violence.

Additional Resources

- CDC – Fast Facts: Preventing Teen Dating Violence
- CDC – Injury and Violence Prevention [Video Playlist]
- CDC – Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices [PDF]
- CDC, VetoViolence (tools and training, prevention information, ACEs resources)
- Disarm Domestic Violence (federal and state legislation and data)
- Gun Violence Archive
- TED Talk – How childhood trauma affects health across a lifetime (Nadine Burke Harris) [Video]
- Vera Institute for Justice – Screening for Human Trafficking: Guidelines for Administering the Trafficking Victim Identification Tool (TVIT) [PDF- Manual]

Resources for Patients/the Community

- 211 (information about local resources and services)
- Commonhelp.org (help with applying for assistance or health care)
- National Domestic Violence Hotline (also available at 1-800-799-SAFE)
- Virginia Department of Housing and Community Development – Housing Assistance

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