Social Justice, Health Inequalities and Methodological Individualism in US Health Promotion

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This article asserts that traditionally dominant models of health promotion in the US are fairly characterized by methodological individualism. This schema produces a focus on the individual as the node of intervention. Such emphasis results in a number of scientific and ethical problems. I identify three principal ethical deficiencies: first, the health promotions used are generally ineffective, which violates canons of distributive justice because scarce health resources are expended on interventions that are unlikely to produce health benefits. Second, the health promotions used tend to expand health inequalities between the affluent and the least well-off. Third, the health promotions used are likely to intensify stigma against the least well-off, a deficiency that itself may exacerbate the ‘densely-woven patterns of disadvantage’ that characterize life on the tail of the social gradient. Because Powers and Faden’s health sufficiency model of social justice argues that the amelioration of such clusters of disadvantage should be the primary ethical goal of public health policy, methodologically individualist models of health promotion are ethically deficient and should not stand as primary approaches for health promotion in a just social order.

Introduction

This article argues that the methodological individualism that characterizes traditionally dominant models of health promotion in the US is ethically deficient. Tracking Elster’s conception, I define methodological individualism as ‘the doctrine that all social phenomena (their structure and their change) are in principle explicable only in terms of individuals – their properties, goals, and beliefs’ (Elster, 1982: 453). As I use it, the key feature of methodological individualism is the extent of the explanandum of social phenomena that is intended to be captured by the explanans of individual properties, goals and beliefs. Hodgson (2007) points out that few truly deny that individual behavior and action is mediated by and through social interactions; the point, for my purposes, is the emphasis on individual agency as a central explanatory framework for social phenomena of health.

Although there is increasing recognition that approaches to health promotion which treat the individual as the node for health intervention are suboptimal, there has been little work expressly exploring the implications of such approaches from a public health ethics perspective. This article offers a contribution to filling this gap and identifies three central ethical deficiencies in these traditionally dominant models: First, they expend scarce health resources on interventions that produce little measurable health benefits. Second, they increase health inequalities between the affluent and the disadvantaged. Third, they facilitate the intensification of stigma against the most disadvantaged members of American society.

I begin by shoring up the empirical claim that historically dominant trends in US health promotion favor methodological individualism. I explore some of the epidemiologic difficulties with such a preference and then move on to detail the three ethical deficiencies articulated earlier.

Methodological Individualism in US Health Promotion

In this necessarily brief assessment of dominant trends in US health promotion, the intention is not to suggest that it is a monolithic entity nor to deny the very real local differences that necessarily attend any complex social endeavor. Rather, the aim is simply to articulate...
high-level perspectives, attitudes and approaches that exert significant influence in shaping downstream policies and practices. Canadian health policy scholar Dennis Raphael has very recently published an extensive survey of national health promotion policies and priorities among different classes of modern welfare states in the West (Raphael, 2011a, b). The thoroughness of this survey enables reliable and valid conclusions to be drawn regarding the state of comparative health promotion among the welfare states considered, conclusions whose reliability is further confirmed from other sources in the literature regarding US health promotion.

The weight of the evidence strongly suggests that the US is an outlier among modern welfare states in its attitudes, practices and beliefs regarding health promotion. Although there is no US professional association exclusively devoted to health promotion professionals, the flagship journal, the American Journal of Health Promotion, embraces a definition of health promotion as ‘the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health’ (O’Donnell, 2009: iv).

This emphasis on lifestyle change is a key feature of US health promotion. While the definition of health promotion from even the flagship US journal does not by itself establish practices, there is little disagreement in the literature that US incarnations of the emphasis on lifestyle change overwhelmingly center the individual. As Woolf et al. point out, ‘[f]or many years, the prevailing model motivating US clinical and public health strategies to foster healthy behaviors has been that of a rational agent freely choosing a particular action or object of consumption’ (Woolf et al., 2011: S39). The fact that the individual actor is designated the locus for the change desired shows an immediate link between methodological individualism and the emphasis on lifestyle and behavioral change in mainline US health promotion.

Similarly, Brownell et al. note that ‘American approaches to diet, physical activity, and obesity have largely focused on the individual. Predominant approaches have been to educate individuals and implore them to alter their behavior. This view . . . is consistent with the American focus on individualism in culture and politics’ (Brownell et al., 2010: 382). Scholars such as June Lowenberg (2007) have warned that the dominance of the discourse of individualism and individual agency in US health promotion practice threatens to undermine the traditional holism in public health nursing, an argument obviously predicated on the fact that US health promotion practice is highly and unusually individualistic. Finally, Howard Leichter’s historical survey demonstrates the enduring nature of such individualism [itself unsurprising given the highly individualist US political culture (Kingdon, 2002)]: ‘The timelessness and persistence of holding the individual person responsible for his or her own health status has its genesis in one of the most distinguishing historical features of American culture and politics, namely the extraordinary emphasis on individual rights and responsibilities’ (Leichter, 2003: 604).

This assignation of responsibility is important inasmuch as it facilitates stigma, which will be addressed in detail later. For now, the key is to understand that the emphasis on individual agency in US health promotion as the central explanatory framework for health grounds the view that methodological individualism fairly accounts for core features of US health promotion.

The dominance of methodological individualism in US health promotion differs in many ways from the World Health Organization’s (WHO) conception of health promotion, which, as memorialized in the 2005 Bangkok Charter, defines it as ‘the process of enabling people to increase control over their health and its determinants, and thereby improve their health’. Absent from this latter conception is (i) the idea of a linkage between ‘core passions and health’ and (ii) any reference to the significance of lifestyle change. Instead, the emphasis is on increasing people’s agency.

These differences are significant. In much of the global South, for example, centering health promotion on the need to link ‘core passions’ to health seems almost perversive, as the widespread material deprivation and exposures to deleterious conditions are obviously key obstacles to health. On Maslow’s hierarchy of needs, many millions of these people focus all of their efforts on fulfilling physiological and safety-based needs (i.e. subsistence) rather than the kinds of creative pursuits that facilitate self-actualization. As such, the pursuit of core passions and their impact on health seem a distinctly First World problem. Moreover, the fact that the US definition urges health promotion professionals to support individuals’ efforts to change their lifestyles presupposes that individuals enjoy the agency to do so. The undeniable fact that most people on the planet lack agency over their social and economic lives sufficient to make such choices significantly undermines the scope of the provision and again buttresses the suspicion that the US definition is a distinctly First World approach.
Of course, the fact that the US approach may be inappropriate for the global South does not establish that it is inappropriate for the US. However, increasing evidence suggests that individuals and groups in the global North may also lack significant agency and control that results in adverse health outcomes (Commission on Social Determinants of Health, 2008). In other words, part of the explanatory power of a focus on socioeconomic conditions is the likelihood that such factors are prime determinants of health outcomes in both the global South and the global North. As Venkatapuram, Bell and Marmot note,

the W.H.O.’s Commission on Social Determinants of Health demonstrated that the health of individuals in both rich and poor countries could be evaluated within one framework of analysis, that the preventable deaths and suffering of the disadvantaged and the social gradient as it affects health in both rich and poor countries are the result of the way in which we organize our societies through economic, social, and political policies and practices (Venkatapuram et al., 2010: 8).

Thus, whether in the global South or the global North, a lack of agency and control is problematic both because it interferes with individual and community capacity to harness material and non-material resources and because significant research suggests that such agency and control is powerfully correlated with health (Martikainen et al., 2002; Muntaner and Chung, 2005).

Moreover, it seems difficult to imagine how agency and control can be substantially improved across and within populations without altering the structural conditions that have such enormous effect in expanding or contracting such agency. As Raphael puts it, ‘health promotion as outlined by the WHO represents a commitment to improve health and wellbeing through societal change. This concept of health promotion—not to be confused with its narrow incarnation focused on behavioural change—has its origins in structural analyses of health issues . . . ‘ (Raphael, 2011a: 3). However, there is no question that the US conception of health promotion is out-of-step with the WHO definition. Raphael concurs, noting that the US model of health promotion is so far removed from the variations used in other modern welfare states as to justify its exclusion from his analysis: ‘[T]he USA is not examined since it is such a negative outlier in its health promotion and public policy approaches to the provision of the prerequisites of health . . . ‘ (Raphael, 2011a: 6). The very fact that Raphael excludes the US demonstrates the point, since one reason for such exclusion is the fact that the extent of the methodological individualism apparent in US health promotion and its emphasis on individual agency and responsibility for health is unique among Organization for Economic Co-operation and Development (OECD) countries (Raphael, 2012).

Admittedly, leading health promotion figures and organizations in the US are increasingly aware of the pronounced limitations in an approach that focuses so heavily on individual decisions and individual health behaviors. Thus, for example Healthy People 2020, the cabinet-level road map that governs national health objectives in the US, for the first time expressly adopts an ecological model of health that addresses attention to both ‘individual-level and population-level determinants of health and interventions’ (2011). This shows a marked difference from Healthy People 2010, which emphasized the ‘four health pillars’ of physical activity, nutrition, screening and lifestyle choices, with relatively little attention to the ways in which macrosocial variables profoundly determine the agency to harness these resources.

However, it is important to distinguish between traditionally dominant models and practices of US health promotion and future trends. Nowhere is the weight of this history more significant than as to social welfare policy, as Swank notes: ‘Generally, welfare states are path dependent in that the cognitive and political consequences of past policy choices constrain and otherwise shape efforts . . . ‘ (Swank, 2005: 187). Accordingly, the heavy and decades-long focus within US models of health promotion on individual choices and lifestyle can hardly be swept aside by the relatively recent cognizance regarding the infirmity of methodological individualism in health promotion. Indeed, despite the signs of changing perspectives among high-level policymakers, there is very little evidence that daily practices of US health promotion have shifted away from a focus on individual lifestyle and behavioral change. Whether they will do so in the future is of course an open question. What this article attempts to supply is an ethical analysis justifying the view that such a shift is morally justified if not mandated. I turn now to this ethical analysis.

**Ethics, Social Epidemiology and Disadvantage**

This article continues my emphasis on practical ethics in conceptualizing inequalities and population health, of a Goldilocks course between too little theory and too much (Goldberg, in press). On the one hand, ethical theory is critical because ‘the notion that epidemiologic
evidence ‘speaks for itself’ in generating policy implications is dubious. Moving directly from the descriptive to the normative perpetrates the naturalistic fallacy; the mere fact that the world is a certain way does not as such demonstrate the way the world ought to be (Goldberg, in press). On the other hand, ‘intricate philosophical debates on whether modified versions of prioritarianism are preferable to strict egalitarianism are not and should not be a prerequisite to collective action’ (Goldberg, in press).

Tracking this course, it is first necessary to address some practical ethical implications of findings drawn largely from social epidemiology. Doing so lays the groundwork for the ethical critique that follows. First is the clustering of disadvantage, a natural fact that public health ethicists are increasingly emphasizing (Wolff and de-Shalit, 2007; Wolff, 2009). The idea is that across a population, the prevalence of one social disadvantage makes it significantly more likely that members of that population will experience other social disadvantages. Thus, a group whose members generally experience low socioeconomic status is more likely to have members achieving low educational attainment, living in inadequate housing, facing significant risks of violence, stigmatization, discrimination, etc. Of course, clustering is a group phenomenon; it is entirely possible that any individual within the disadvantaged group may escape the slings and arrows of compound disadvantage. However, in the aggregate, the clustering effects are real, and groups which experience some disadvantages are likely to experience many others. In explaining their health sufficiency model of social justice, Powers and Faden put it this way: ‘Inequalities of one kind beget inequalities of another, and over the course of a lifetime . . . the compounding of disadvantages makes avoidance or escape difficult without heroic effort or unexpected good luck’ (Powers and Faden, 2006: 193).

These facts are not incompatible with a belief that autonomy matters and that even in cases of severe deprivation, individuals retain some capacity to make better and worse health decisions. The argument is simply that considered across a disadvantaged population, there is little justification for expecting large numbers of people to somehow overcome the enormous power deleterious socioeconomic conditions possess in determining risky health behaviors. As Voigt puts it: ‘We can describe this situation as a problem of social justice without saying that the choices involved are not voluntary or autonomous. The unequal background conditions in which these choices are made are enough to raise concerns about the health inequalities to which they may lead’ (Voigt, 2010: 94). This point also suggests that the role of individual agency in health promotion can be preserved. It does not follow from the claim that methodological individualism is problematic that individuals lack ability to influence their health. Rather, the problem is the paramount importance of such individual agency in dominant practices of US health promotion, when there exists compelling evidence suggesting that macrosocial variables exert enormous power in shaping the range of choices available to individuals. Individual agency is relevant to health promotion, just as it is relevant to conceptualizing social justice in health (Voigt, 2010). The argument here is simply that the dominance of a model of health promotion in which such agency is regarded as the primary node of intervention is suboptimal. Those who wish to preserve some role for individual agency in US health promotion (as opposed to affording it dominance) need not be dissuaded by the arguments herein.

In any event, Powers and Faden argue that these clusters form ‘densely-woven patterns of disadvantage’. They further argue that the existence of these clusters suggests a plausible answer to the pressing question of ‘which inequalities matter most? The answer we propose is that inequalities that contribute to systematic patterns of disadvantage are the ones that matter most’ (Powers and Faden, 2006: 193). Under this reading, then, insofar as there is an ethical mandate to redress health inequalities, those inequalities that deserve the most attention and resources are those that have the potential to shape ‘densely-woven patterns of disadvantage’.

Second, the sufficentarian idea at the core of Powers and Faden’s model exists in tension with the ethical necessity to remedy differences within and between identifiable groups that have been adjudged unfair. That is, it remains unclear whether it is ethically sufficient to ensure the most disadvantaged reach an agreed-upon level of health if that kind of leveling up does not diminish health inequalities. Indeed, it is perfectly consistent with a generic sufficiency model of health to level up the least well-off to the threshold at the same time inequalities between the affluent and the least well-off increase. There seems something intuitively problematic about this, and the problem may be apprehended through a typology of public health policy based on the work of epidemiologist Geoffrey Rose (Benach et al., 2011).

In conceptualizing public health priorities, Rose articulated a quandary known as the prevention paradox (Rose, 1985, 1992; Allebeck, 2008). He documented that greater improvements in overall population health can be obtained by implementing low-intensity
interventions applied to a whole population when compared with applying high-intensity interventions to a select group at high-risk for developing disease. However, most modern egalitarian theories emphasize the ethical primacy of attending to the least well-off, who in many cases are identical to the most epidemiologically high-risk groups. Thus, the dilemma exists in the apparent fact that the most promising means of improving overall population health is to direct the lion’s share of resources away from the groups that most ethical theories mandate deserve the most attention.

Benach et al. conceptualize this tension in terms of the two primary goals of public health policy: to improve overall population health and to compress health inequalities. Maximization of overall population health can in some cases expand health inequalities. The ethically optimal public health policy, of course, is one which both improves overall population health and narrows health inequalities. An example of a classic public health intervention that accomplishes these goals is sanitation. Presuming sanitation is equally distributed, it stands to improve overall population health. In addition, because the least well-off bear disproportionate burdens of waterborne disease, sanitation improves their health more so than the health of the affluent, thereby compressing health inequalities. Sanitation is therefore properly regarded as an ethically optimal public health intervention.

Before turning to assess the ethical implications of this evidence for dominant practices in US health promotion, it is critical to note one final complicating factor regarding the prevention paradox. Namely, even while an ethical quandary exists in favoring a whole population approach, there is increasing evidence that interventions targeted at high-risk groups have a tendency to increase health inequalities. This is because it is typically the most affluent who possess the resources needed to capture the health benefits of the intervention—hence Capewell and Graham refer to this class of interventions as ‘agentic’ (Capewell and Graham, 2010). Moreover, they note that this expansion of inequalities occurs even when the intervention in question is specifically applied to the high-risk group. An example of this phenomenon is smoking cessation programs, which have in the US been intensively marketed at high-risk groups (Bell et al., 2010). Because people who have access to more and better resources generally find it much easier to quit smoking, smoking cessation programs have increased health inequalities in smoking-related diseases even while they have contributed to improved population health (Jarvis and Wardle, 2006; Bell et al., 2010). It certainly does not follow that such programs are ethically deficient, although one might justifiably infer that adopting such programs targeted at high-risk groups as a primary public health intervention is ethically suboptimal.

Three Ethical Deficiencies in Traditionally Dominant Approaches to US Health Promotion

In this section, I develop the claim that traditionally dominant approaches to health promotion in the US that are fairly characterized by strong reliance on methodological individualism suffer from three ethical deficiencies.

First, a methodologically individualist approach to health promotion makes it highly likely that the specific practices and interventions used will be ineffective. This becomes an ethical issue insofar as expending scarce health resources on interventions that the best evidence suggests will produce few measurable health benefits raises distributive concerns. The evidence supporting the empirical premise in this argument—that the interventions in question are likely to be ineffective—rests at least in part on the considerable data suggesting that one of the primary contributors to social gradients of health is social gradients of risky health behaviors. For example Stringhini et al. recently reanalyzed the data from Whitehall II, one of the most important epidemiologic studies of the last half century and concluded that contra to the research group’s original conclusions, more than two thirds of the mortality gradient was explained by a gradient in health behaviors (Stringhini et al., 2010).

However, there remains vigorous debate over the extent to which health behaviors are important determinants of health. The resolution of this debate does not materially affect my argument. This is because either health behaviors play a significant role in health inequalities (Stringhini et al., 2010) or they do not (Dinca-Panaitescu et al., 2011). If they do, there is no doubt that larger social and economic conditions play an enormous role in structuring a gradient in those behaviors (Dunn, 2010; Stringhini et al., 2010). If they do not, there is no doubt that larger social and economic conditions play an enormous role in structuring a gradient in health (Commission on Social Determinants of Health, 2008). In either case, the root distal causes are the upstream macrosocial factors and the levels of
deprivation people experience. To put it in counterfactual terms, in a world where risky behaviors are important determinants of health, these upstream factors affect health and exacerbate inequalities in part through the mediation of health behaviors. In a world where risky behaviors exert only negligible effects on health, these upstream factors affect health and exacerbate inequalities through myriad pathways and factors other than health behaviors.

Although these arguments suggest the primacy of the same kinds of public health policy priorities regardless of the extent to which risky behaviors mediate health—action on the macrosocial determinants of health—the upshot for the ethics of health promotion is identical in either case: emphasis on the role of the individual in altering risky behaviors is suboptimal. If health behaviors turn out to have relatively little effect in mediating health, there is self-evidently little reason to direct resources to changing such behaviors. If health behaviors do mediate health to a significant extent, the significant socialization of such behaviors suggests that methodological individualism will be relatively ineffective. In either case, the conclusion is the same: methodological individualism in health promotion is not likely to be effective. I will continue my discussion by assuming that risky behaviors do in fact mediate health to a significant extent, as this makes the argument against methodological individualism more complicated and more interesting. Where health behaviors turn out to be irrelevant to health, there is obviously little justification for focusing on changing such behaviors.

Even presuming that behaviors do mediate health, there is robust evidence that many risky health behaviors such as smoking (Jarvis and Wardle, 2006; Woolf et al., 2011), promiscuity (Akers et al., 2010) and obesity (Ogden, 2009; Woolf et al., 2011) are disproportionately concentrated among the least well-off in the US. It is possible to infer individual culpability from this fact, i.e. that members of the most disadvantaged groups in American society are by virtue of some defect in either knowledge or volition more likely to engage in behaviors that result in their getting sicker and dying quicker (Leichter, 2003). Alternatively, one could conclude that there is something about the socioeconomic conditions in which the most disadvantaged live that renders risky health behaviors more likely. And in fact there is an abundance of evidence supporting the latter point (Factor et al., 2011), from targeted advertising of cigarettes to the poor (Voigt, 2010) to the importance of relieving ennui engendered by the lack of opportunities in disadvantaged neighborhoods (Akers et al., 2010; Voigt, 2010) to the significance of obesogenic environments in shaping patterns of obesity-related diseases (Woolf and Braveman, 2011; Woolf et al., 2011).

From this evidence, it follows that a model of health promotion that focuses on educating individuals to discourage the pursuit of risky health behaviors is very likely to be ineffective because such a model diminishes the role that macrosocial variables play in determining health behavior. If it is structural conditions that profoundly shape the distribution of health behaviors, it follows that targeting health promotion activities at individuals is likely to be ineffective in improving population health. The empirical evidence confirms this supposition, showing by a number of measures that individualized health promotion activities often seem to have little appreciable effect on health outcomes (Ebrahim and Davey Smith, 2001; Raphael, 2003; Jarvis and Wardle, 2006). The American Journal of Health Promotion concurs, noting prominently in the description of its theme for its 2012 conference that

three decades ago, we thought that education was enough. We thought all we had to do was help people understand the health risks of tobacco, junk food, alcohol and drugs, and the health benefits of exercise, nutritious foods, stress management, and proactive medical self-care. We thought people would use this knowledge to transform their lives. Three decades of research and practical experience have shown us that education is not enough, in fact, it may not be very important at all (O’Donnell, 2011).

The principal reason this kind of health education is generally ineffectual is because of the power socioeconomic conditions possess to determine the choices and behaviors people possess and pursue. The ethical implications of this natural fact are self-evident given the widely accepted conclusion drawn from virtually any model of distributive justice that expending scarce resources on health interventions justifiably believed to be of little benefit to the population for whom they are intended is ethically inappropriate.

However, the ethical problems with methodologically individualist models of health promotion go beyond simple distributive problems related to ineffectiveness. The second ethical deficiency in such models is that their focus on individual agency has a tendency to increase health inequalities. While leading authorities on health promotion in the US have generally apprehended the problems apparent in the general ineffectiveness of individualized approaches, their focus on effectiveness elides the critical distinction between the two goals of optimal public health policy: to maximize overall health and to
compress health inequalities (Benach et al., 2011). Even where health promotion activities have proven effective in improving overall health, their emphasis on individual agency runs a substantial risk of exacerbating health inequalities, as the earlier example of smoking cessation programs demonstrates.

Moreover, note that the expansion of inequalities characteristic of many agentic health promotion interventions is consistent with substantial improvements in population health among both the affluent and the disadvantaged. It is because the improvements among the affluent are greater than those among the disadvantaged that absolute inequalities increase. However, recall that leading US health promotion authorities and institutions have admitted that agentic interventions targeted at changing individuals’ risky behaviors have generally proven to be ineffective. So there exists two layers of ethical deficiency in the individualized approach that has traditionally dominated US health promotion: these practices are generally ineffective in improving the health of the most disadvantaged and they simultaneously increase inequalities between the affluent and the disadvantaged. This double deficiency is arguably a fatal flaw in the use of a methodologically individualist approach to health promotion, as it fails both prongs of Benach et al.’s criteria for optimal public health policy. Such approaches must therefore not be utilized as central frameworks for health promotion.

An interlocutor might well respond to this argument by noting that many modern theories of justice deny that an increase in inequalities between the affluent and the least well-off is categorically unjust. Even if such an increase is independently morally bad, it does not follow that the increase renders the most disadvantaged worse-off than they would have been absent the health promotion intervention. Indeed, under a contractualist account of justice, it is conceivable that moral agents might deem it fair for health inequalities to increase if the trade-off is a significant absolute gain in the health of the least well-off.

Although there is merit to this response in the abstract, at most it shows that a particular intervention considered in isolation could conceivably satisfy a suffici- centarian model of social justice even where it leads to an expansion in health inequalities. It certainly does not follow that a public health approach—consisting of a bundle of interventions, policies and practices—that is likely to expand health inequalities is to be preferred over a public health approach that contracts health inequalities (assuming they each improve overall population health). Rose’s whole-population approach is in fact intended to do precisely this, and the example of sanitation earlier demonstrates that specific interventions exist, which maximize both of these goals. Thus, even where a specific intervention that increases health inequalities between the affluent and the least well-off is judged morally permissible, that permissibility does not translate into a justification for preferring an approach consisting of such interventions over competing approaches that are more likely to contract health inequalities while improving health. And in any event, defenders of methodologically individualist approaches to health promotion cannot avail themselves of this claim to moral permissibility given the evidence that such approaches are ineffective in leveling up the least well-off.

The third ethical deficiency that attends methodologically individualist models of health promotion is the likelihood that such models will intensify stigmatiza- tion of the most marginalized groups in American society. In its emphasis on individual choices that people make and the extent to which those choices reflect behaviors that are generally associated with positive or negative health states, US health promotion has enabled, if not directly caused, a similar focus on the moral responsibility of the individual. As Leichter points out: ‘At the center of all the health promotion admonition, advice, and advocacy [over the last half-century] was this question: To what extent were morbidity and premature mortality self-inflicted, the result of uninform- ed, careless, and avoidable personal behavior?’ (Leichter, 2003: 603). Leichter further notes that while US health promoters have traditionally been aware of the impact of macrosocial determinants on health, experts nevertheless ‘placed much of the blame for seemingly avoidable morbidity and premature mortality on Americans’ alleged personal careless and imprudent lifestyle choices’ (Leichter, 2003: 604).8 The result, Leichter explains, was an ‘outpouring of state and federal legislation to educate citizens about the dangers of their daily habits . . .’ (Leichter, 2003: 608).

This focus on ‘evil’ personal habits acts as a catalyst for stigma, which, in context of disease and health, has historically needed very little assistance to flourish (Goldberg, 2010). Tracking the classic Goffmanian (1963) approach in which stigma results in a ‘spoiled identity’, Link and Phelan (2006) posit that stigma has two essential components: first, an in-group must mark an out-group as different in some identifiable respect and second, the in-group must assign a normative judgment, a notion of deviance to the out-group on the basis of that difference. Although in theory it is possible to define an out-group as different without a subsequent assignation of deviance, the history of disease stigma
shows that the marking of a social group as different due to disease or poor health frequently leads to assignations of deviance.

It should be obvious how a consistent pattern of attributing poor health to the accumulation of risky health decisions and behaviors leads to the stigmatization of those who are identified as making such decisions and demonstrating such behaviors. Through such identification, the out-group is branded, and when the display of such behaviors is regarded as deficient, the out-group is adjudged deviant. Hence, they are stigmatized. Moreover, as Link and Phelan explain, stigma is by definition linked to power gradients (Link and Phelan, 2006). This follows because the capacity to stigmatize rests on in-groups possessing accoutrements of privilege and power sufficient to mark an identifiable group as different and assign deviance. Thus, stigma is linked to larger structural factors relating to social inequalities, which explains why it is that members of groups marginalized on the basis of, e.g. class, race, gender and income have also frequently been stigmatized in context of disease and health.

The argument is not that any individual health promotion professional intentionally stigmatizes members of disadvantaged groups based on the high prevalence of risky health behaviors among the latter. Rather, the argument is that as a dominant approach to conceptualizing health promotion, a model which emphasizes the role of individual agency in changing risky health behaviors greatly facilitates the stigmatization of members of the most marginalized groups who are disproportionately likely to engage in such risky health behaviors. Even if any individual health promotion professional strives to avoid stigmatizing the most disadvantaged, traditionally dominant models and approaches to US health promotion make much more likely the occurrence of such stigmatization. This concern is not mere conjecture; MacLean et al. noted in 2009 that health promotion interventions in North America often act to facilitate stigma against obese persons:

there remains a heavy emphasis on behavioural (lifestyle) approaches to obesity prevention both in health sciences curricula and in health service programs. These approaches focus on the individual as the locus for change, making the client [personally responsible] for all aspects of their situation, as opposed to more environmental or socio-ecological approaches. Health practitioners are exposed to the same stigmatizing beliefs about obesity as the general public and this influences their approach to care (p. 89).

Although there is little controversy regarding the wrongness of such stigma (Goldberg, 2011), Powers and Faden’s model of health sufficiency illuminates some reasons for even greater concern regarding the capacity of dominant models of American health promotion to stigmatize the most disadvantaged.

While a mere increase of inequalities may not necessarily equate to the intensification of what Powers and Faden (2006: 193) term ‘densely-woven patterns of disadvantage’, an increase in stigma does. This follows from the increasing epidemiologic evidence that stigma is independently correlated with adverse health outcomes (Burris, 2002; Link and Phelan, 2006; Puhl and Heuer, 2010). Stigma, in other words, is very likely bad for your health. Second, the corrosive effects of stigma go beyond mere impact on health, which reinforces Powers and Faden’s sufficiency model of social justice in which health is only one of the essential determinants of well-being. As Courtwright puts it, stigma spoils one’s social identity in ways that ‘mark[] a particular trait (like being foreign) across multiple social contexts’ (Courtwright, in press). Stigma thereby can adversely affect a number of these essential determinants, from security to respect to attachment, and obviously erodes trust, which is in turn a key feature of social capital (Woolcock and Szreter, 2005). Accordingly, stigma unquestionably plays a role in the ‘densely-woven patterns of disadvantage’ that characterizes life on the tail of the social gradient. The fact that Powers and Faden’s rubric explains precisely why stigma violates norms of social justice is critical, since, as Courtwright points out, Rawlsian models of distributive justice have generally not addressed the moral significance of stigma (Courtwright, 2009).

Conclusions

This article has evaluated the relationship between traditionally dominant approaches in US health promotion, health inequalities and social justice. Building on research from social epidemiology, I identify three main ethical deficiencies in methodologically individualist models of health promotion. First, because they are generally ineffective, they flout widely accepted baselines among modern theories of distributive justice—the expenditure of scarce resources on health interventions that are justifiably believed to be of minimal health benefit. Second, in their emphasis on individual agency as the key lever of intervention, these traditionally dominant models facilitate an increase in health inequalities between the affluent and the least well-off.
Although this increase might in theory be morally acceptable, the fact that methodologically individualist models of health promotion are generally ineffective in improving population health renders any expansion of inequalities unacceptable. Such models therefore fail both prongs of Benach et al.’s Rosean typology of optimal public health policy: they fail to improve overall population health and they tend to expand health inequalities. Third, even presuming the expansion of inequalities is morally neutral, methodologically individualist approaches are likely to intensify stigma against the least well-off. This intensification itself exacerbates ‘densely-woven patterns of disadvantage’ that characterize life on the tail of the social gradient; any approach to health promotion which exacerbates such webs of disadvantage is therefore to be avoided.

None of the above qualifies as a general argument against health promotion in the US or elsewhere. Rather, the critique is intended to suggest by implication the kinds of approaches and modalities that are more likely to avoid all the problems that attend a methodologically individualist model. Raphael (2011b: 14) observes that ‘health promotion is an explicitly political activity in that it is concerned with the distribution of economic and social resources amongst the population and the political forces that shape this distribution’. Accordingly, health promotion training, education and practices that focus on upstream macrosocial variables, that embody whole population approaches rather than targeting high-risk disadvantaged groups and that treat the objects of their intervention as embodied in social lives and matrices that powerfully structure they and their progeny’s experiences of sickness, injury and death (Krieger and Smith, 2004), are far more likely to be effective, to compress inequalities and to ameliorate stigma.

Conflict of Interest

None declared.

Notes

1. Although Swank is writing in context of welfare states’ efforts to reduce their welfare entitlement expenditures, there is no reason to think that path dependency does not govern a converse scenario in which actors seek a general increase in entitlement expenditures.

2. I offer no opinion here on the complex ethical issue of whether groups can legitimately be regarded as moral agents. See Venkatapuram (2011) for a detailed discussion of the significance of this problem for thinking about health justice.

3. It is possible that those inequalities that shape clusters of disadvantage are distinct from those inequalities whose redress would result in the achievement of sufficiency in the essential dimensions of well-being. Powers and Faden seem to acknowledge the possibility of a distinction when they conclude that ‘[i]t is these inequalities [that contribute to systematic patterns of disadvantage], as well as those that represent a lack of sufficiency in one or more dimension of well-being, that are the primary object for our remedial account of justice’ (Powers and Faden 2006: 193) (emphases added). Teasing out the dynamic between the priorities suggested by a sufficientarian model combined with an emphasis on a certain set of social inequalities is important for the development and extension of Powers and Faden’s approach but is beyond the scope of this article.

4. Kelleher (2011) has suggested that this issue is significant enough to rest at the core of what he terms ‘gradient ethics’, a useful phrase for describing a critical domain of inquiry in public health ethics.

5. This argument is valid in the following way: if it is the case (i) that upstream factors determine the distribution of health behaviors and (ii) that health behaviors determine health and its distribution, then (iii) it follows that upstream factors determine health and its distribution. Admittedly, the validity of this argument is conditional on the robustness of the verb ‘determine’. If the quantum of determination is weak, the conclusion may not follow. For purposes of this article, I assume that the extent to which both upstream factors determine health behaviors and behaviors determine health is robust, a point which the available epidemiologic evidence supports. I appreciate Janet Malek’s assistance in framing these points.

6. I am grateful to Dennis Raphael for discussing these problems with me.

7. It should be noted that O’Donnell’s conclusion is quite different, urging that instead of emphasizing education, health promotion professionals should focus on (i) motivating people to practice healthy lifestyles, (ii) facilitating skill-building and problem-solving capacities and (iii) creating physical and cultural environments that enable healthy choices. While O’Donnell’s awareness of the
insufficiency of education is important, the methodological individualism evident in his prescriptions remains problematic. There is nothing in these recommendations that suggests attention to the macrosocial variables that are prime determinants of both health and of healthy/risky behaviors. Rather, while the emphasis on education has changed, what has not changed in these prescriptions is the emphasis on the individual as the agent of intervention.

8. Leichter lists numerous examples of highly placed health officials and influential policy experts asserting as such in the last few decades, such as John Igleheart, Joseph Califano and Tommy Thompson, the former the longtime director of the influential journal Health Affairs, the latter two former US Secretaries of Department of Health & Human Services (named the Department of Health, Education and Welfare during Califano’s tenure) (Leichter, 2003: 607–608).

9. However, in a recent article, Andrew Courtwright challenges the argument put forth most prominently by Nussbaum (2004) and Burris (2008) that disease stigma is categorically wrong. Although the details of his argument are important, they are beyond the scope of this article. For my purposes, it is sufficient to note that although Courtwright denies that stigma is categorically unethical, he ‘do[es] not want to deny that stigmatization often results in a spoiled identity’ and agrees that ‘[m]ost historical and contemporary examples of stigmatization are morally problematic because of this effect on social identity’ (Courtwright, 2011).

References


