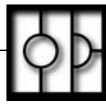

Freedom to Make Choices for Health: Plus 40 Years

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In the 1969 inaugural issue of the *School Health Review*, Douglass[1] examined four major issues he felt were central to the question of choices one has about health: (1) problems with health care delivery methods; (2) persistent poverty in our population and its impact on health; (3) systemic problems inherent in social and institutional arrangements, what he referred to as the "network of health and health related pathologies;" and (4) difficulty communicating or clarifying values in society, as evidenced by our failure to reconcile the values we preach with the health care that we practice. To begin his thesis, he argued that a person must be understood as a totality rather than as a sum of component parts. To address this perspective, he believed that health professionals must embrace a multidisciplinary approach to health care. W.E.B. Dubois had expressed the same opinion in a study 70 years earlier, addressing a health system which compared the health statistics of blacks with those of whites. Even then, he challenged us to focus on "the absolute condition rather than their relative status."[2(p. 148)]

To provide some historical context for the time in which Douglass' paper was written, we gathered statistics on key health indicators such as poverty rate, life expectancy and infant mortality. Poverty rate is a key indicator that defines the very notion of choice and freedom. In 1966, whereas the poverty rate for blacks was 41.8% compared to just 11.3% for whites, in 2008, the poverty rate for blacks was 24.7% and 8.6% for whites.[3] As one could assume, the gaps remain for the other health indicators. In 1960, life expectancy was 70.6 years for whites and just 63.6 years for blacks.[4] Nearly 40 years later, there was still inequity between the two groups. In 2007, life expectancy was 78.3 years for whites and 73.7 years for blacks.[5] Infant mortality rate (IMR) followed a similar pattern. In 1960, IMR was 22.9 for whites and 44.3 for blacks;[6] the IMR in 2005 was 5.76 for whites and 13.63 for blacks.[7]

Although many of these overall statistics have improved remarkably over the last few decades, persistent gaps remain between whites and blacks. With all of the progress in the field of health care over the last three decades, why do these staggering statistical differences still exist? These gaps reveal inter-group differences as well as intra-group differences that are not commonly examined. Intra-group differences, as will be seen later, often correspond to systemic problems that remained unaddressed.

Are we free to make choices for health? When Douglass asked this question in 1969, he proposed that the inherent structure of the system makes it impossible for individuals to select health. Therefore, understanding the meaning of *choice* (i.e., right, power, or ability to decide among selections or alternatives) provides a potentially useful perspective in studying the persistent gaps in health inequity from the late 1960s, to today. Furthermore, the question of having choices in health care evokes memories of the 2009 town hall debates (or shouting matches, as it were), in which the question of health care reform became a polarizing discourse. This national debate is at the core of the question regarding choices for health care in the context of the four issues raised by Douglass: a broken down and unsustainable health care system, persistent poverty and the plight of the uninsured, health-related pathologies exemplified in the roles of the tobacco and food industries in today's health problems, and conflicts between American values (e.g., out of many, one; versus looking out for number one).

When these four basic factors are combined, the issues of choice and freedom to choose boil down to a question of available options and the comparative benefits that may arise from each. Secondly, there is also the notion that *health choices* refer specifically to *health care*. Yet when we explore the context of health conditions, it is clear that health choices made long before clinical encounters create varying levels of vulnerability to ill health. Furthermore, the ability to make choices is dependent upon the social and institutional conditions which may or

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may not make options readily available. Indeed, what can be concluded is that the whole concept of *choice* becomes quite problematic given the complex layers of factors that limit both freedom to choose and the number of options. The concept becomes even more complex when located within the broader sense of belonging represented in identities that are institutionally, socially and culturally anchored.

The groups with which we are identified (e.g., gender, race, ethnicity, sexual orientation) are not matters of choice, but matters of chance which influence how one seeks affirmation and belonging. Although housing and living conditions can be matters of choice for some, for many they become another form of identity. Taking identity into consideration, a reference to freedom of choice renders a limited view of how one makes health decisions. Thus, the notion of choice has often ignored some of the most critical factors influencing our health.

Concern over the conflation of choice in health has led to the examination of root causes of illness, health disparity and inequity, and most recently, social determinants of health. In the World Health Organization report on Closing the Gap in a Generation, commissioners on the social determinants of health identified three recommendations that are keys to unlocking inequity in health, echoing the notion that limitation of choice is sufficient to explain health decisions.[8] These recommendations are: (1) to improve daily living conditions by focusing more resources and education on early childhood development, working conditions, social protection and positive aging; (2) to tackle the inequitable distribution of power, money and resources to eliminate gender and other inequities, improve governance and support civil society; and (3) to measure and understand the problem and assess the impact of action by monitoring and reporting on inequity, training policy makers and strengthening public health research.[8] All of these recommendations serve as reminders that improving health conditions must begin with transforming our social and institutional arrangements to level the playing field for all. Indeed, one of the findings in the report stressed the importance of recognizing intra-group differences, thus focusing on the totality of their conditions, not just on how a group compares to another group. For example, an almost 20-year difference in life expectancy existed between groups living within 20 miles of each other in both Scotland and Washington. In both cases, the difference stemmed from conditions that determined the options available for health rather than the freedom to choose.

The notion of a universal solution that focuses on the tree as though it is more important than the forest is not a new concept.[9] For example: "…it is the understanding of the forest that allows us to appreciate the ways in which the individual trees are shaped by the meanings constituted in the forest – the context."[9] Thus, although trees may appear as the countable and comparable units in the forest, not understanding the totality of the forest means ignoring the context that shapes the trees.

It has been documented that the extent to which children and youth are free to make choices for health is influenced by factors that either promote or hinder their ability to respond effectively to the challenges of health care. Choices in health care for youth may be promoted by the recognition that governments have an obligation to ensure that everyone is entitled to the highest attainable standard of health. Contrarily, factors that undermine freedom to make choices for health include poverty, deprivation, unemployment, hunger, poor housing conditions, and limited infrastructure, including limited supply of adequate health care systems. Since the enactment of the Universal Declaration of Human Rights in 1948, it is well understood that everyone is entitled to the highest attainable standard of physical and mental health despite the reality that some governments may not have the ability to fully ensure that people realize these rights. The question posed by Joseph Douglass becomes pertinent, because if governments cannot set up conditions to ensure that people realize their rights, how then can we expect people to make even simple choices for their health? In conditions whereby even the highest attainable standard of health is restricted or simply not available, it is almost impossible for people to make choices relative to their health care needs, not to mention choices surrounding education, housing, employment and nourishment needs, which are all necessary to "provide not only an absence of illness but a feeling of well-being, self-worth, or completeness."[1]

A comparison of health indicators in developed countries and developing countries often does not offer an understanding of choices available to youth in these settings about health care. Indeed, over the years studies on health care choices in both developed and developing countries have contributed limited knowledge to the predominant factors that influence youth choices in health care. To achieve high quality health care at a lower cost, closer attention should be paid to the hierarchy governing choices as well as the trade-offs youths encounter when making them. For example, options about health choices for youth in these countries are subject to differences in national priorities. What is deemed a high priority in one nation can be a low priority for another nation. Indeed, what the world economic meltdown revealed was the fallacy evident in some public health recommendations that advocate for youth education about health choices. It is wrongly assumed that negative health outcomes in poorly resourced countries are the result of uniform individual decisions. The combination of the global economic reality and the evident pandemic of obesity, especially in rich nations, has renewed the realization that negative health cannot be changed to positive health by focusing only on individual choices without a resolute focus on the roles of institutions and government in creating the context within which positive health decisions can be made. Some of these decisions are evident in policy priorities about school curricula, including what is taught in school, the infrastructure of the school environment and non-content related services, like health services and provision of food.

Many of the factors governing options and choices in schools and health care are often beyond individual control and this is particularly relevant for youths in developing countries. Whereas youth in developed countries may have some standard of health care, many in developing countries are often denied these rights, or in some cases the rights are subject to the demands of other pressing needs, such as the right to an adequate education, and access to sanitation, safe water and proper nutrition. This is not to say that all youth (both youth in developing countries and developed countries) do not encounter these pressing needs. Indeed we argue that the right to health, as well as the right to fulfill basic fundamental needs, is a persistent problem for all youth, and it contributes to increasing health inequities commonly observed in all societies. When one considers the health care choices of youth in developing countries, however, we argue that the extent to which a youth is free to make choices for health care is governed not only by individual differences, but also by factors related to pressing basic fundamental needs, sociocultural negotiations in health care decision making, access issues, and the failure to recognize or emphasize the right to the highest standard of attainable health for all youth.

The issues raised by Douglass about the limited health care choices available in the U.S. remains today. Addressing the contexts of health by focusing on issues of poverty, housing and education is still the key to improving the health conditions of all Americans. The current system continues to emphasize individual choices even though in reality, the broader institutional contexts like schools and housing significantly impact our vulnerability to health problems. These are conditions that dictate how often we have preventable clinical encounters and how well healthy living is built into our daily environment, such as access to affordable fruits and vegetables. What is also evident is that transforming our environment to offer options that lead to optimum health will not occur without collective efforts to request or even demand it. In an 1857 speech on emancipation by Frederick Douglass, the foremost African American abolitionist in antebellum America, he noted what it takes to achieve the struggle for equity by declaring, "men may not get all they pay for in this world; but they must pay for all they get."[10] Simply stated, any changes to the current system that create an environment where health promotion and disease prevention become central to our political and institutional will requires a resolute and collective effort. This is a renewed call for all in health education and health promotion to work together to achieve the goal of realizing a society where health promotion is a global priority.

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