

# Ethical Choices in Public Health Policy and Practice<sup>1</sup>

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## Abstract

*Public health policy and practice priorities involve ethical choices across "spheres of justice" (Walzer 1983) that are related to potential benefits and risks for communities. This paper addresses an important issue about how public health funds are allocated in response to local, regional, and national priorities and interests in light of ethical consequences of those priorities and decisions. Current federal policy emphasis on bioterrorism preparedness has the potential to divert public health resources with negative impacts on community health and group disparities in healthcare. This paper compares ethical decisions for local programs made by public-health professionals in the southwestern United States, in response to policy changes, using ethnographic evaluation and participant observation of a statewide peer-review process. Ethical choices and local health priorities vary among rural and urban communities in relation to diverse social, economic, political, and inter-organizational environments.*

## Introduction

Public health policy and practice involve ethical choices that are framed by the coexistence of "spheres of justice" that are socially constructed (Walzer 1983). Since these choices have significant implications for health benefits and risks for local communities, what constitutes social justice in a given case/situation must be analyzed from an ecological, relational, and contextual perspective. Within this context, distributive justice involves decisions for health and social resources that are not made in isolation, but in interaction and relation to coexisting issues. They are framed within a matrix of complementary and competing social and ethical spheres (Lurie and Lurie 2001) that affect relationships among health and social policies.

Walzer's model offers a valuable perspective on distributive justice and the prevention of domination within each sphere, such as health and social welfare, the economy, or national security. However, when the model is interpreted as representing mutually exclusive spheres, it can be criticized as divorcing health from the social and economic causes of health disparities. Yet rather than limiting application of this model to the micro-allocation of medical resources as bioethicists have proposed, those concerned with health and social policy need to ensure that "... the totality of social institutions, practices and policies is designed toward ... preventing systematic inequalities affecting multiple dimensions of well-being" (Powers 2005:10). This is the goal of international health planning based on

social epidemiology, for community health (Pan American Health Organization 1996).

This paper addresses the ethical issue of deciding which public health goods and services should be allocated. The concept of "local justice" connotes ethical issues in the allocation of goods in separate institutional arenas, for example, problems such as allocating a given amount of goods among a selected number of recipients, by different mechanisms in various locations (Elster 1990, 1992, 1995). This paper compares ethical choices related to local justice in public health policy and practice in the United States, based on a case study that compares local public health programs and planning.

## Ethical Perspectives in Public Health

Contemporary public health research and practice in the United States tend to identify social justice with resolving inequalities that affect low-income and medically underserved populations, issues of fairness in access to health care, and eliminating or reducing health disparities across diverse socioeconomic and ethnic groups (Krieger et al. 2005; Kass 2001; U.S. Department of Health and Human Services, 2000). Public health also applies communitarian ethical approaches (Emanuel 1991) that are implicit in participatory- and community-based research and interventions.

From a broad social policy perspective, current federal policy emphasizes on domestic security and bioterrorism preparedness for public health and health care (Moreno, 2004), and on volun-

tary and faith-based responsibility for health and social programs, have the potential for diverting public resources from programs to maintain and improve community health. This may result in negative impacts on the potential to attain "health for all" in local communities (Whiteford and Manderson 2000; Labonte and Schreker 2004), with implications for social justice.

The current use of national security as a dominant political issue in the United States tends to cross-cut social "spheres" and to have a comprehensive or far-reaching impact on ethical choices and decision-making to distribute economic resources for health and social welfare programs, and to enhance national security. This has stimulated controversy in medicine and public health. Bioterrorism prevention and response requires collaboration among public health, medical and community institutions, professionals, and community members. Medical ethicists have sought to place the threat of bioterrorism in historical perspective, and to respond to ethical dilemmas it poses for health care and protection of individual liberties (Moreno 2004).

Public health is now developing academic ethics education that acknowledges the context of bioterrorism. In general, public health ethics applies contrasting but not mutually exclusive ethical perspectives—from primary concern with protecting individual rights, to utilitarianism—in epidemiological, environmental, and community health policy, practice, and research. Professional ethics for research and intervention in public health are guided by bioethical principles of autonomy, beneficence, non-maleficence and justice (Brannigan and Boss 2001; Coughlin and Beauchamp 1996; Jennings 2003). In health protection, risk assessment, health planning, education and research, confidentiality, individual and community informed consent are ethical standards (Marshall and Rotomi 2001).

Yet practitioners and researchers have responded in divergent ways to the recent enactment of emergency response legislation, under the Model State Emergency Health Powers Act (MSEHPA) that gives public health authorities broad powers to abate serious threats, albeit to be exercised in the least restrictive manner (Hodge and Gostin 2004). A major trend in public health has been to interpret this mandate

as an opportunity to expand local resources, to support a range of public health programs, and to develop research and training in this area. While many public health professionals and organizations have embraced bioterrorism preparedness as a resource for a broad range of community health programs, others express concern over disproportionate emphasis on bioterrorism. Some seek to expand direct support for basic public health services (Bayer and Cosgrove 2004), increasingly threatened by federal funding reductions (Krisberg 2005). As their concern has been posed by public health researchers and policy analysts:

Should we be guided by a perspective that focuses on a hypothetical bioterrorism as a main concern while relegating to the background the monumental issues of infectious disease, food borne illness and chemical accidents, not to mention the daily problems that are inadequately attended?" (Sidel et al. 2001:717).

This question emerged as a key issue from the case study, and raised ethical issues that must be addressed by local public health practitioners and researchers.

## **CASE STUDY: PUBLIC HEALTH PEER REVIEW PROCESS**

### **Background and Methodology**

This case study is an analysis of a public health program evaluation process in a populous, ethnically diverse southwestern state. It applies ethnographic research methods of participant observation and key informant interviewing to evaluate the peer review process of a statewide association of local public health professionals. The case study is based on a program evaluation by the applied anthropologist that was not subject to review under institutional guidelines for human subjects research. The evaluation and case study applied ethical guidelines of confidentiality and consent for observations, interviews, recording and reporting findings. The evaluation report was reviewed by the project coordinator and association director, and the director reviewed the case study.

In the comparative process evaluation of local programs, ethical choices made by public

health directors in response to policy changes related to current and potential programs were found to vary across urban, suburban, and rural communities. Since the state of Texas does not mandate public health departments in each of the 254 counties, which range from a few thousand to two million inhabitants, only a minority of cities or counties have organized public health departments, but each has a local health officer (Lurie 2003). Those without a local health department rely on the Health Service Region in which they are located; the state is divided into 11 regions that were initially designated for tuberculosis control. One local health officer encapsulated this diversity of public health program organization in a comment: "If you've seen one health department, you've seen one health department."

The statewide Texas Association of Local Health Officials (TALHO) Peer Review Project was developed with support from the state health department, to meet the basic goals of improving public health and health care. It was implemented in 2001 and evaluated by the University of North Texas Health Science Center from October, 2002 through August, 2003. TALHO became a nonprofit organization in 1998 with a grant from the Texas Telecommunications Infrastructure Board for the state Health Alert Network (HAN), an electronic information system to warn practitioners about major public health threats from specific disease outbreaks, and received Bioterrorism-Public Health Preparedness funding from the federal Centers for Disease Control through the state health department.

TALHO also expanded memberships to promote liaisons with local health officers. The mission of the association is:

To promote health, prevent disease, and protect the environment in order to ensure the public's health in Texas through leadership, vision, advocacy and commitment to the principles of public health practice in local communities and throughout the state (Texas Association of Local Health Officials, 2004).

The peer-review project was designed to foster interaction among local health departments, around program evaluation and innovation, and as a voluntary professional alternative to state

accreditation. The project was implemented through association meetings that included focus groups, and coordinated with the school of public health. A key component was redesign of the association's website as a centralized, interactive, and accessible forum for public health peer review across agencies and regions. The website was to be a resource for local program development through access to information that was posted for the peer-review project, for the seventy-five local health officers who are members. The peer-review process applied a participatory approach using six focus groups that were conducted by local health officers with peers from 20 locations, in the state capitol and a north-central city. They applied results to develop categories for local program review, conducted a pilot session and implemented the project.

Based on results of the Texas focus groups and a similar project in Washington State, forms were developed for local health officers to compare organizational structures and "best practices" and conduct self-assessments of their programs. Relevant forms were disseminated to local health departments through the pilot peer-review meeting and on the website. The first step in implementing reviews was to align peer-review teams with local health units that were similar in structure, function, and size. This step was completed by over thirty local health officers; they selected peer-review self-assessment modules on: "Public Health Assessment," "Helping People Get Services," "Protecting People From Disease and Other Health Threats," "Environmental Health," and "Promoting Healthy Living." The pilot peer-review session, meetings and conference calls with project staff and association members, and training sessions for local health officers provided preparation for peer-review site visits. These were coordinated with volunteer participants for eight urban, suburban and rural communities in the central, northwestern, southeastern, southwestern, and far-western regions of the state.

Comprehensive evaluation of the peer-review process and outcome was conducted by way of forms for local health programs, training sessions, peer-review site visits, and professional interaction. This evaluation was based on participant observation and open-ended interviews

with project staff, site visit teams, local health officers and staff. Participants' responses in peer review training and site visit interactions throughout the project were analyzed. A small sample of local health department directors who declined to participate in the peer review were also interviewed; of those, some were unable to participate. The director of the county health department of the central metropolitan area where the state capitol is located also declined. Another director changed an initial positive response on receiving information about the project, on the grounds that the peer-review process would not help with "the struggles we currently face."

The pilot peer-review session was held in a north central city that has a combined city and county health department, regional psychiatric hospital, and military base. In this county, a department of bioterrorism links hospitals, law enforcement, and morgue services, and health-care providers have access to the electronic Health Alert Network. The pilot peer-review session was perceived as a positive experience by the reviewers from two centrally located counties and by local participants. This session served as a model of the process and was refined for site visits across the state.

Two training sessions for potential peer reviewers were held in February of 2003. The first, at a new public health school, drew 17 local public health administrators and staffers from across the state. In the second session, held in the capitol, the 14 participants were directors and staffers of health departments from various regions, state health department staffers, and the TALHO executive director. The training sessions focused on communication, interviewing skills, and team-building, rather than on public health issues, and served as interactive forums to motivate volunteers for peer-review visits in urban, suburban, and rural counties. Participants' comparisons of local programs were reviewed by association officers and posted on the website.

Most participants selected priorities and exchanged local "best practices." Printed modules were used as a framework for the review of disease surveillance, preventive and primary care, health education, and crisis response. As a whole, the peer-review process was effective in eliciting

and comparing public health practices and challenges in dealing with local issues, and reinforcing relationships among local and state public health professionals. It served as a basis for comparison with other state and national models, such as accreditation. Several local health officers expressed concern about standardizing performance measures and professional training, due to regional differences in public health priorities, organization of agencies and available resources. State support for peer review was eventually terminated as a consequence of wide-scale reorganization and merging of state agencies, but the state health department recommended that it be integrated into regional meetings and informal networking among local health officers.

The value of the peer-review process, as perceived by participants, lay in opportunities for interaction, mutual assessment of programs, and exchange of solutions to such problems as those in environmental health, West Nile Virus control, immunizations, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and tuberculosis (TB) control, and food-borne illness prevention. The project fostered information-sharing among a proportion of local health officers across the state, enhancing their ability to evaluate programs and develop innovations, through "networking" on specific issues. This was a forum for sharing common responsibilities and challenges, and comparing variations in public health practice. The extent of participation in peer review on the website varied with local priorities, resources, emerging public health policies, and changes in state social and political environments. Ethical issues were found to be embedded in the process of decision-making on local programs and resources.

### **Findings on Ethical Choices in Public Health**

National and local debate over the role of public health in the so-called healthcare safety net has escalated since the proposal by a National Institute of Medicine report for "reinventing public health" (Lee 1993; Aday 2005). This idea shifts healthcare for medically underserved areas toward population-based health education, administration, information management,

training and health policy (Baker et al. 1994; Aday 2005). Redirection of practice and research away from indigent health care has ethical implications for community health research and intervention, especially as related to health disparities. This national and local transformation of public health has been further compounded by federal and state mandates for bioterrorism preparedness, given the need to prevent and control infectious and chronic diseases, and environmental risks.

In the case study, ethical issues for local justice emerged throughout the peer-review process. During the second training session, a proposal to include bioterrorism preparedness in peer-review elicited debate over the diversion of resources from basic public health needs. The need to conserve resources is also implied in the website program description:

In these troubling times where resources are stretched to the limit and Public Health infrastructure is tested on all sides, Peer Review offers an opportunity to expand and enhance the way we, as Health Care Professionals, do business (Texas Association of Local Health Officers 2003).

Ethical choices in public health by local officers, staff and community leaders, in seven rural and urban areas, focused on decisions in allocating resources for bioterrorism preparedness, as compared with prevention and primary care. Their priorities were influenced by regional social, political, economic and inter-organizational environments for obtaining and sharing resources and services.

### **ETHICAL ISSUES IN DECISION- MAKING FOR RURAL AND URBAN PUBLIC HEALTH PROGRAMS**

#### **Geographic Area One**

In one rural area, the health officer raised the ethical dilemma in carrying out the mandate to persuade public health nurses to take smallpox vaccinations; many resisted vaccination because they were reluctant to expose patients to the disease. Other ethical concerns included the lack of resources for expanding laboratories and electronic communication systems, such as the Health Alert Network, contrasted with needs for allocating

resources to provide basic public health services such as immunizations, health education, food service inspections, environmental testing and West Nile virus control.

#### **Geographic Area Two**

In comparison, the impact of the terrorist attack on the United States on September 11, 2001, and federally mandated preparedness was considered by a second rural southwestern county to take precedence over routine public health duties because no additional funds were available from the state or federal government. Health education and other programs were delayed. Another nearby county health department considered putting bioterrorism on the organizational chart since it is taking an inordinate amount of time and resources, and staffers must be integrated with those in other programs.

#### **Geographic Area Three**

A county health administrator in a central suburban town supported both extensive preventive health and primary care services, and a new bioterrorism unit under the direction of an epidemiologist, the Health Emergency Alert Response Team (HEART), to disseminate electronic and printed information from the CDC on infectious diseases such as severe acute respiratory syndrome (SARS), smallpox, and West Nile virus, for local healthcare providers. This is complemented by clinical services and sudden infant death syndrome (SIDS) health education, based on research on African-American infant mortality on this important local problem. The director responded to a challenge by the peer reviewer from a nearby county that bioterrorism preparedness should take priority by affirming an ethical decision that clinical services are fundamental to the public health department's mission and cannot be provided solely by community groups; they are to be retained based on community needs assessments. Primary and prenatal care are important services for over 1200 Medicaid recipients; clinical care by nurses, funded by grants, is perceived as ethically essential in the absence of a public hospital. The clinic implemented HIPAA guidelines for patient care by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that took effect on

April 14, 2003, to be followed by health plans, doctors, hospitals and other healthcare providers. In addition, the Women's, Infants and Children's program (WIC) is the largest public health program in the county, serving 7,800 clients. Immunizations increased with the population, and the Children's Health Insurance (CHIP) outreach program receives strong community response.

### **Geographic Area Four**

Ethical choices in programs for the above department contrast with those in the reviewer's urban county health department, which transferred Medicaid health services to the public hospital when it separated from the city health department, although a community coalition of racial and ethnic minority leaders advocated greater access to health care and public hospital services. The county health department provides immunizations, clinical referrals, epidemiological information, TB control with directly observed therapy for a diverse patient population, including Mexican, African, and Vietnamese immigrants, and homeless persons. It coordinates health information assessments, preventive clinics, community health education, mobile immunizations at WIC clinics with nurses, child health and family planning with a contract physician and six centers, but has no prenatal or primary care. In contrast, it emphasizes its bioterrorism preparedness program, directed by an epidemiologist and surveillance response manager, with four community response teams and a "defense council" of local hospitals. An Epidemiological Health Intelligence Center and electronic information system complement health education programs on heart health, diabetes, obesity, infant mortality, sexually transmitted diseases (STDs), AIDS, and suicide prevention. The political context of public health is indicated by the county's relationship with a congresswoman who formerly supported programs for youth substance abuse treatment and diabetes research on the national Health and Human Services committee, before moving to the Defense Committee.

### **Geographic Area Five**

In a third county with a large metropolitan area in this region, ethical choices have been

made to coordinate bioterrorism preparedness and emergency response by both the city and county health departments and hospitals, while supporting federally qualified community clinics and public hospital Community-Oriented Primary Care clinics. This hospital conducts health information assessments, treats undocumented patients, and has succeeded in reducing infant mortality. The county health department focuses on both preventive health and epidemiological programs, while the city department maintains environmental health.

### **Geographic Area Six**

In comparison with this region, in a remote northwestern city with a large state university, the health department reorganized programs to meet state policy priorities, including bioterrorism. Public health planning ranges from health improvement to weapons-of-mass-destruction responses. The department responded to the anthrax scare with Federal Bureau of Investigation (FBI), police, and hazardous-materials (HAZMAT) units, and it is a test site for the Syndromic Surveillance System (SSS) and the Rapid Syndromic Validation Project (RSVP) developed at Sandia National Laboratories, Albuquerque, New Mexico. Physicians and primary care providers report warning signals of an emerging public health threat or disease; the system is to be linked to hospitals, minor emergency clinics, health science center, school district, and medical examiner's office. A new laboratory is to be built for bioterrorism testing, storage of the Metropolitan Medical Response System stockpile, and a portion of the National or State Pharmaceutical Stockpile.

In this county, open Board of Health meetings prioritize the need to address various health issues and urgent problems, from bioterrorism to sexually transmitted diseases (STD's) and West Nile Virus. Microbiology Laboratory analyses are conducted for food-borne illness outbreaks, HIV/AIDS and syphilis, extensive STD testing and a regional milk and dairy laboratory. This department gives immunizations and has a STD clinic, but it ended direct care in 1995. The large family planning and maternity clinics were turned over to the private sector a year before the state health department cut support, and acute

care clinics, WIC programs and dental care were closed or moved.

However, community health outreach in targeted neighborhoods is supported by grants such as Title V for Maternal and Child Health Education and Head Start coordinated with the local university. The health department collaborates with the local Citizens Advisory Committee and Youth Commission, city and county libraries; the Consortium for Health coordinates school districts, labs, physicians, clinics, day care centers, home health agencies, public and private hospitals.

### **Geographic Area Seven**

In comparison, ethical decisions in public health that have implications for local justice for a county metropolitan area near the Gulf Coast are in transition. This area has an extensive urban medical/public health academic, clinical and research complex, and the city department of health and human services collaborates with the county health department on bioterrorism and smallpox preparedness. In keeping with recent national emphases in public health (Aday 2005), community health planning and education, and risk communication have replaced emphasis on HIV testing by the county. The county relies on local support for services to urban *colonias* of recent Latino immigrants in older residential areas, and its focus is on response to industrial, environmental, and nuclear threats in the port, rather than on infectious disease priorities identified by the state health department. The new director, from an urban health department on the West Coast, held participatory-planning meetings and compared local priorities with those identified by peer reviewers from metropolitan and suburban areas that vary in clinical services.

### **Discussion and Conclusions**

The above comparison of rural, suburban, and urban health programs reveals the complex context of ethical decision-making by public health professionals and communities, related to national and local priorities and competing needs for resource allocation. This context varies geographically, socially, and economically. Rural and suburban areas tend to have greater resource

constraints than urban areas and to rely on urban and regional public health services. This situation affects ethical choices among programs, such as bioterrorism preparedness, local disease prevention and control, and primary clinical care. Urban areas have more economic and human resources, as well as more flexibility to develop new programs. They tend to divide public health responsibilities between city and county health departments, but serve larger, more diverse populations. Urban areas also provide basic public health services, leadership, and training for regions and rural areas in their regions.

During the peer-review process, there were significant changes in health and social policy environments of public health programs across the state. These changes were compounded by inter- and intra-organizational transformation, with comprehensive reorganization of state agencies and consolidation of public health with mental health programs. New national and state public health programs for bioterrorism preparedness and emerging disease responses were developed to be implemented locally, such as disaster response training and vaccinations for public health and medical staff. As a consequence, state funding for peer review was eliminated after one year, and the professional association implemented local training in bioterrorism preparedness that was supported by the school of public health through evaluation research.

In this context, case study findings that local public health practitioners and administrators respond in divergent ways to the mandate for emergency response preparedness for future threats to community health should be considered in health policy and planning. These responses affect local justice through the allocation of resources. While some interpret this as an opportunity to expand public health resources and coordination of services, others are concerned about the impact of disproportionate emphasis on bioterrorism on direct support for public health programs. Local justice and ethical decisions in health and social policy are highly impacted by political emphases on domestic security and the diversion of social welfare and basic health needs to voluntary and private sector responsibility. Ethical decision-making

that attempts to balance individual rights with utilitarian, communitarian (Emanuel 1991), and social justice perspectives is being reframed in a newly dynamic social and political environment.

### Notes

1. Sue Gena Lurie presented a version of this paper under the title "Ethical Choices in Public Health Research and Intervention" in the session organized and chaired by Elisa Gordon on "Making a Difference: Applications of Anthropological Research to Health Policy and Health Practice." She gave the paper on Friday, April 8, 2005, at the 65th Annual Meeting of the Society for Applied Anthropology, Santa Fe, New Mexico, USA.

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