
Critical Issues for Society's Health

Although it is not possible to address all of the ethical and healthcare issues that might affect American society in the twenty-first century, this last section of the text presents a sampling of those issues. Chapter 20 presents a discussion of the equality and inequality of the healthcare system. It explains how these concepts are defined and measured. It also establishes the ethical positions on which Americans base their assessment of health inequalities and inequities. Finally, the author poses some ideas about dealing with inequalities and inequities when they occur.

In Chapter 21, Hackler presents information about rationing health care and discusses its ethical ramifications. After defining *healthcare rationing*, he gives arguments for situations where this action is ethically defensible. He also presents a mechanism for making morally sound healthcare rationing decisions. This chapter certainly has ramifications for health care for the rest of the twenty-first century.

The remaining chapters present issues that affect individuals and the society in general. In Chapter 22, Warshaw writes about the how clinical practitioners address the issue of domestic violence and the limitations in their ability to do so effectively. She also presents some of the ethical dilemmas faced by these clinicians and the need for society to make greater efforts to address this social problem. Chapter 23 is especially germane in light of recent events. It provides an overview of the government, healthcare system, and individual's response to both human-caused and natural disasters. Problems that arise in the planning and response for these efforts are discussed in relationship to ethics theory and principles.

The final chapter (Chapter 24) provides a summary of all four sections. It also presents what the author refers to as "emergent ethical issues." These issues include the continuing effects of technology on society and individuals and the the myriad of potential ethical issues posed by technology diffusion. Another second issue presented in this chapter is that of disease experience, specifically childhood obesity. This condition presents major concerns for the future of both health care and the ethics of treatment for society.

Chapter 24 also discusses patient-focused care with emphasis on the influx of baby boomers and their desires for quality health care. It includes information about the ethics of providing care that emphasizes the patients, their needs, and the maintenance of fiscal responsibility. Finally, the author presents a brief discussion of the environment as an emerging issue for health care and relates this issue to ethical theories and principles.

Health Inequalities and Health Inequities

Nicholas King

OVERVIEW

In this important chapter, King addresses one of the most difficult ethical issues for U.S. society—the nature and extent of health of inequalities or disparities in America. He also discusses health inequities with respect to the population in general and specific groups. King then explains the ethical issues associated with health inequalities and inequities from a theoretical and practical view. Using tables as illustration, he presents some ideas about how to reduce healthcare inequities. This chapter increases understanding about this complex ethical and logistical issue.

INTRODUCTION

People have long recognized that some individuals are healthier than others and that some live longer than others do, and that often these differences are closely associated with social characteristics such as race, ethnicity, gender, location, and socioeconomic status. The introduction of the regular collection of vital statistics by European states in the nineteenth century enabled Edwin Chadwick and other social reformers to quantify and compare the health and living conditions of different social classes. More recently, epidemiologists, sociologists, geographers, and other researchers have used advanced qualitative and quantitative methods not only to identify and track a wide variety of health inequalities, but also to produce increasingly sophisticated models to explain their causes and consequences.

As knowledge and understanding of health inequalities has increased, so too, has the political will to reduce or eliminate them. One of the two goals of the United States' Healthy People 2010 initiative is “to eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.”¹ In the United Kingdom, the release of successive government reports on socioeconomic inequalities in health in 1980 (the “Black Report”) and 1987 (the “Health Divide” report) stimulated increased scrutiny of the National Health Service. Other countries and nongovernmental organizations have undertaken major initiatives to address health inequalities both within and between nations.

This chapter reviews the central ethical issues raised by the existence of health inequalities, their study, and attempts to reduce or eliminate them. These issues can be summarized in a series of basic questions: What are health inequalities? Why are some health inequalities also health inequities? How are they measured? What is the best way to reduce or eliminate health inequities?

WHAT ARE HEALTH INEQUALITIES?

To understand the issues associated with health inequities, it is important to first define how a society defines and assesses health. It is also important to have a concept of what constitutes an inequality as it applies to health care. Finally, since all inequalities are not inequities, one must also take the normative view of ethics to determine what are true health inequities for a society.

Health

In order to define the term *health inequalities*, one must first answer the question of what is *health*? The answers vary considerably, from narrow definitions focusing on the absence of disease to broader ones encompassing a wide range of measures of subjective and objective characteristics. At one end of the spectrum, Norman Daniels advocates the use of a relatively narrow definition of health as “normal functioning, that is, the absence of pathology, mental or physical.”² By contrast, the World Health Organization Constitution defines it as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”³ More expansive definitions of health might include happiness, freedom from disability, quality of life, and the capacity to lead a socially meaningful and economically productive life. Narrow definitions have the benefit of being objectively measurable by biological and physiological characteristics, but fail to capture aspects of human experience that might be more relevant to assuring social justice, such as happiness and capabilities. Broader definitions rectify this limitation, but often involve highly subjective judgments by researchers or patients, and thus are more difficult to adequately measure and compare.

Researchers assess health status in many ways. Under a narrow definition of health, the most common health indicators are mortality, survival, life expectancy, disease incidence, and disease prevalence. Definitions that are more expansive might also include physiological indicators of overall health (e.g., height, weight, body mass index, and blood pressure), symptoms, self-rated health status, sense of well-being, social connectedness, and productivity. Different kinds of health problems have different classification schemes. The *International Classification of Diseases (ICD) Manual* provides standard definitions of physical illness based around etiopathies that alter organ function and produce symptoms. ICD classifications are widely accepted and are used in clinical diagnosis and health research. By contrast, the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* defines mental health problems in terms of symptoms rather than etiology, which has been subject to considerable criticism.⁴

Because different populations can have radically different health belief systems, definitions of health, or subjective experience of symptoms, comparing populations to determine the levels of inequality between them can be difficult. This is particularly true when trying to compare rates of mental illness, symptoms, or self-reported health status between nations with widely disparate cultures. For this reason, international health inequalities often are expressed in terms of mortality or infant mortality rates, which—although

collected haphazardly in some locations—are thought to be the most objective indicators of health status available.

Discussions of health inequalities might also utilize measures of health care, including rates of diagnosis, treatment, cost, insurance coverage, quality, survival, symptom reduction, or some other health outcome measure. Strictly speaking, *health inequalities* should be distinguished from *inequalities in health care*. Although the two are often linked, this is not always the case. Some inequalities in health care do not necessarily lead to health inequalities, whereas many health inequalities occur in the context of healthcare equality.

Inequality

A *health inequality* is a descriptive term that can refer either to the total variation in health status across individuals within a population or to a difference in average or total health between two or more populations. In Table 20–1, the average body mass index (BMI) of populations A and B are identical, but the variation within population A is clearly larger than that *within* population B. Thus, we may say that there is greater total inequality within population A than population B, but that there is relative equality *between* the two populations. Although there is some debate over which is a more scientifically rigorous measurement,⁵ most scholarly work on the topic defines health inequalities as differences in health between populations.

Because health inequalities generally involve the comparison of *population averages* (although other measures can be used), great care must be taken in making inferences regarding individuals. In Table 20–2, the average BMI of population A is lower than that of population B. However, the two individuals with the highest BMI are in population A, and the individual with the lowest BMI is in population B. Thus, benefiting (or suffering) from an inequality is a property of the respective populations, A and B, but *not* a property of individuals selected from those populations.⁶

Why Are Some Health Inequalities also Health Inequities?

In contrast to the descriptive term *health inequality*, *health inequity* is a normative term that refers to a difference that is judged to be morally unacceptable.⁷ Although all health inequities are, by definition, health inequalities, not all health inequalities are health inequities. For example, because

Table 20–1 Average BMI—Example 1

	Population A	Population B
	40	30
	38	29
	18	27
	16	26
<i>Average</i>	28	28

Table 20–2 Average BMI—Example 2

	<i>Population A</i>	<i>Population B</i>
	35	33
	34	32
	22	31
	21	20
<i>Average</i>	28	29

elective cosmetic surgery is generally not considered a necessity for good health and functioning, unequal access to it might not be considered an inequity. Similarly, because skydiving is generally considered to be a freely chosen behavior, the fact that the mortality rate for falls from great heights is much higher among skydivers is generally not considered a health inequity.

Determining whether a particular inequality (or class of inequalities) constitutes an inequity requires a moral judgment based on *a priori* beliefs about justice, fairness, and the distribution of social resources, and thus it is one of the primary areas in which ethical analysis plays a role. Commentators generally define *health inequities* by referring to either the populations affected by inequalities or the causes and consequences of inequalities.

One way of determining whether a health inequality qualifies as an inequity is through reference to the relative social position of different populations. If a health inequality benefits a population that is in some way already socially or economically advantaged, then we may deem that inequality unjust through its association with a prior distributive injustice. This “egalitarian liberal” perspective⁸ judges health inequalities to be morally wrong primarily because they suggest that some individual’s or groups’ rights are being violated, thus negatively impacting their health. Paul Farmer argues that ill health, and health inequalities in particular, are evidence of injustice or structural inequity in the world “even though it may be manifest in the patient.”⁹ More specifically, Paula Braveman contends that

[a] health disparity between more and less advantaged population groups constitutes an inequity *not* because we know the proximate causes of that disparity and judge them to be unjust, but rather because the disparity is strongly associated with unjust social structures; those structures systematically put disadvantaged groups at generally increased risk of ill health and also generally compound the social and economic consequences of ill health.¹⁰

The existence of health inequalities might indicate that a given population has disproportionately suffered international military and economic exploitation,¹¹ inequitable distribution of economic resources,¹² or historical patterns of race-based economic and social injustice.¹³

This definition of health inequity accords with John Rawls’ “difference principle” of distributive justice: that social inequalities should be of benefit to the least-advantaged members of a society.¹⁴ It also has the benefit of using a *pri-*

ori judgments about social or economic inequity as the foundation for adjudicating claims of health inequity. Thus, for example, an economically disadvantaged population does not need to repeatedly prove that every health inequality adversely affecting them constitutes an inequity.

However, this definition also suffers from significant drawbacks. First, the *a priori* identification of disadvantaged populations can be contentious or arbitrary in some situations. Would a health inequality favoring those with annual incomes of \$5 million over those with annual incomes of \$2 million constitute an inequity? In most countries, despite their lesser social status, women enjoy a longer lifespan than men do. This is possibly because of genetic factors, but also possibly because of lower rates of risk behaviors, such as smoking and alcohol use. Few observers identify this as a health inequity.

At the same time, many observers argue that the dramatically higher rates of morbidity and mortality from HIV/AIDS among women in a number of countries¹⁵ are evidence of serious health and social inequities.¹⁶ By contrast, higher rates of HIV/AIDS among men in richer nations, such as the United States, have seldom been identified as a gendered health inequity (though the delay in devoting health resources to the disease during the 1980s was frequently cited as evidence of a sexual-orientation health inequity). In addition, how might this definition account for novel forms of sociological categorization that may be accurate but do not lend themselves easily to judgments of relative disadvantage? For example, if one makes judgments about race-county combinations that indicate that low-income rural blacks who live in the South have a lower life expectancy than low-income whites in Appalachia and the Mississippi Valley.¹⁷

This definition also neglects situations in which a genuinely unjust distribution of health might happen to benefit those in socially superior positions—as, for example, when a major pollutant happens to affect disproportionately a nearby wealthy community. Finally, if other social inequities exist and have (rightly or wrongly) been deemed socially acceptable, does this mean that the resultant health inequalities cannot qualify as unjust? Many American cities tolerate a certain level of homelessness as socially acceptable. Are higher rates of tuberculosis and mental illness among the homeless therefore socially acceptable as well?

A more common definition of health inequity focuses on the *causes and consequences* of a given health inequality, rather than the specific populations that it affects.¹⁸ Under this viewpoint, a health inequality qualifies as an inequity if it is *systematic*, *avoidable*, and *unjust*. The most widely-cited example of this point of view is Margaret Whitehead's definition of health inequities as "differences [in health] which are unnecessary and avoidable but, in addition, are considered unfair and unjust."¹⁹

A *systematic* health inequality is one that consistently affects two or more populations and is not the result of random variation. For example, some so-called "cancer clusters" (elevated incidence of cancer in a community) are in fact the transient result of random variation. This has led to conflicts between community members who feel victimized by an apparent health inequity and health officials who argue that no such inequity exists.²⁰

The criterion of *avoidability* has several components.²¹ Health inequities must be *technically avoidable*—that is, a successful means of reducing the

inequality must exist. They must be *financially avoidable*—that is, sufficient resources exist to rectify the inequality. Finally, they must be *morally avoidable*—that is, rectifying the inequality must not violate some other social value, such as liberty or distributive justice.

The third criterion is an *unjust cause*. Whitehead²² lists the following determinants of inequality:

1. Natural, biological variation
2. Freely chosen health-damaging behavior, such as participation in certain sports and pastimes
3. The transient health advantage of one group over another when that group is first to adopt a health-promoting behavior (as long as other groups have the means to catch up fairly soon)
4. Health-damaging behavior where the degree of choice of lifestyles is severely restricted
5. Exposure to unhealthy, stressful living and working conditions
6. Inadequate access to essential health and other public services
7. Natural selection or health-related social mobility involving the tendency for sick people to move down the social scale

Whitehead argues that health inequalities resulting from the first three determinants are neither unjust nor unfair, and thus should not be considered health inequities. By contrast, health inequalities arising from the latter four are unjust and unfair, and thus qualify as health inequities. Examples of inequalities that would not qualify as inequitable under this definition would include: Ashkenazi Jews' elevated risk of developing breast cancer, because of their slightly higher rates of carrying the BRCA1 and BRCA2 mutations;²³ the previously mentioned example of skydivers, whose freely chosen behavior elevates their risk of death; the higher rates of some communicable diseases among people living in temperate climates, because the insect vectors for those diseases are more prevalent than in colder climates; and early recipients of a vaccination campaign.

This definition of health inequity avoids the criticisms leveled at the first definition, and it accords with Iris Young's observation that, in general, it is not patterns of inequality *per se* that are morally wrong, but rather those whose causes and consequences we deem to be unjust.²⁴ However, like the previous definition, it suffers from some significant drawbacks. First, the degree to which many high-risk health behaviors are "freely chosen" is a topic of considerable debate. Three of the top nine "actual causes of death" in the United States—consumption of tobacco, alcohol, and illegal drugs—involve the use of substances that are highly addictive,²⁵ which might significantly diminish the element of free choice. Both lung cancer rates and cigarette consumption (a primary risk factor for lung cancer) increase as socioeconomic status diminishes.²⁶ Are the resultant socioeconomic inequalities also inequitable?

A second problem with this definition is that, by favoring cause over population as the deciding factor, health inequalities that benefit otherwise socially-advantaged populations would be deemed inequitable and thus ostensibly in

need of social remedy. This result contradicts most peoples' intuition that social justice by definition involves redistributing social resources to the disadvantaged, rather than the other way around.

Perhaps the most significant problem with this definition is that many health problems have multicausal etiologies, and it is difficult or impossible to isolate a single, overriding causal factor. Diseases of the heart and cardiovascular system result from a complex combination of "just" causes, such as genetic predisposition and health behaviors (diet, exercise, smoking, etc.), as well as "unjust" causes, such as stressful living and working conditions and inadequate access to preventive health care. In some cases, it might be possible to quantify the relative contribution of each determinant to a population's health through sophisticated regression analyses. Yet this leaves open the question of whether moral judgments of inequity should be entirely dependent upon the outcome of statistical analyses.

Finally, a health inequality might be judged to be morally wrong not because there is something inherently bad about health inequality, but rather because it is evidence of, or a contributing factor to, some other morally unacceptable situation. A health inequality thus "acts as a signpost—indicating that something is wrong."²⁷ For example, from an "objective utilitarian" perspective,²⁸ a health inequality between two subpopulations might be judged bad because it indicates that the sum total of health in the entire population is not being maximized. In this case, inequality *per se* is not seen as morally wrong, and the rectification of the health inequality would simply be a means toward the end of maximizing overall population health.

Similarly, some researchers argue that pervasive health inequalities across the entire socioeconomic spectrum are indications not of injustices directed at particular subpopulations, but fundamental social problems that adversely affect the health of all but those at the absolute top of the social hierarchy. Michael Marmot argues that socioeconomic gradients in chronic disease and life expectancy result from comparatively low levels of autonomy, social engagement, and social gradient.²⁹ Similarly, Richard Wilkinson argues that low social cohesion and pervasive psychosocial stress in societies with greater income inequality leads to shorter life expectancy.³⁰ If these authors are correct that almost every member of a society is in some way subject to health inequality, then attempts to encourage health equity could appeal to self-interest rather than social injustice.

HOW ARE HEALTH INEQUALITIES MEASURED?

Regardless of which definition of health inequity one uses, determining whether a specific situation is inequitable requires that the health status of at least two populations be measured and compared. In order to do this, one must determine which *populations* it is most appropriate to compare and the most appropriate *measures* that should be used in comparing these populations. Although these determinations are based primarily on technical judgments to ensure the most statistically valid measurement and data analysis, they also require ethical judgment regarding the appropriate focus of description and intervention.³¹

Populations

By definition, inequalities are differences between groups of people. Specifying the composition of these groups is vital and involves important ethical decisions.

First, the populations chosen should differ from one another in some way that is socially or morally important. We would thus expect that health inequalities among socially important groups. Race/ethnicity, gender, education level, or socioeconomic status (SES) would deserve scrutiny, whereas health inequalities among groups with different hair or eye color—distinctions that carry little social or moral weight—would be of less interest. In general, there is significant overlap between commonly-accepted social and political distinctions and populations of interest to health inequalities researchers. However, the moral relevance of some distinctions—geographic differences between U.S. states, political differences between conservative or liberal governments—are more ambiguous.

Second, health inequalities generally involve establishing a *comparison group* that serves explicitly as a reference against which one or more populations are compared, and implicitly as an ideal target to be achieved by all groups. A number of choices of comparison groups exist, any one of which is technically sound, but each of which carries different ethical implications. Consider the hypothetical example shown in Table 20–3. Clearly, significant health inequalities exist among the different racial/ethnic groups. However, the *amount* of inequality depends on the choice of comparison group. Which is the most appropriate in this case? Several answers are possible:

- We might choose the *total population average* as the reference group. Intuitively, it seems most just to consider the average of the general population as the standard of fairness against which to judge any particular subpopulation, much as we might consider a fair distribution of income to be one in which everyone clustered closely around the average.³² In this example, the relative risk of the worst-off group (Hispanics) when compared to the total average is 1.75.
- We might choose the *best-off population* as the reference group. Although it is unfeasible to expect that every group in a society might earn as much as the best-off group, often it is possible to expect all groups to enjoy the

Table 20–3 Disease Prevalence, per 100,000

<i>Subgroup</i>	<i>Disease Prevalence</i>
Non-Hispanic White	7.6
Black	12.4
Hispanic	16.8
American Indian/Alaskan Native	6.9
Asian/Pacific Islander	10.2
<i>Total</i>	<i>9.6</i>

best possible level of health. Indeed, in some cases—for example, life expectancy, immunization coverage, or access to life-saving HIV medications—it is difficult to justify expecting anything less than the best possible health status as a fair and just outcome. In this example, the relative risk of the worst-off group (Hispanics) when compared to the best-off group (American Indians/Alaskan Natives) is 2.44.

- We might choose the *most socially advantaged population* as the reference group. Under the first criterion, a health inequity is *by definition* a difference that favors a more (or most) socially advantaged population over a less socially disadvantaged one, and we would be less concerned with comparisons between relatively disadvantaged populations. In this example, the relative risk of the worst-off group (Hispanics) when compared to the most socially advantaged group (Non-Hispanic whites, the majority population) is 2.21.
- Finally, we might choose some *independently defined target rate* as a reference category. Many common health indicators, including blood pressure, body mass index, and total cholesterol level, have widely-accepted thresholds separating high and low risk. It might be most just to expect all groups to pass that threshold, regardless of the relative rates of other groups. (The above example is not pertinent to this choice.) Moreover, using this reference category would ensure that all groups use a medically justifiable amount of some healthcare resource, which is useful in cases where some subpopulations “overutilize” that resource.

Measurement

A wide variety of statistical measures of inequality are available, from simple averages to sophisticated measures of total inequality. A comprehensive review of these measures is beyond the scope of this chapter. Instead, it will use the example of absolute and relative measures to illustrate the ethical issues often involved in choosing between different measurement strategies.

Two of the simplest measures of health inequality are the absolute and relative difference between populations. The *absolute difference* (AD) is a *number* resulting from *subtraction* of the numerical measure of one group’s health status from another. The *relative difference* (RD) is a *ratio* resulting from *division* of the numerical measure of one group’s health status from another. Consider the example shown in Table 20–4.

Clearly, inequalities exist and favor population B for both conditions. Suppose one could fund efforts to reduce only one of these inequalities. Absent

Table 20–4 Mortality rate, per 100,000

	<i>Population A</i>	<i>Population B</i>	<i>AD</i>	<i>RD</i>
Heart disease	80	60	20	1.333333
Cancer	270	230	40	1.173913

Table 20–5 U.S. Infant Mortality Rate, per 100,000 live births

	<i>Black</i>	<i>White</i>	<i>AD</i>	<i>RD</i>
1950	43.9	26.8	17.1	1.6
1998	13.8	6	7.8	2.3
<i>Change</i>	<i>30.1</i>	<i>20.8</i>	<i>–9.3</i>	<i>1.5</i>

Source: Data from D. Mechanic, “Disadvantage, Inequality, and Social Policy,” *Health Affairs* 21, no. 2 (2002): 48–59.

other considerations, one might reasonably decide to fund the larger inequality, but which one is larger? In absolute terms, the inequality in cancer rates is twice as large (40 vs. 20) as that in heart disease; but in relative terms, the inequality in heart disease rates is almost twice as large (33% vs. 17% higher for population A). There is no consistent standard for judging which measure is more appropriate in this case. A reasonable case could be made that the AD is more important, because eliminating it would save more lives in absolute terms, and thus cancer should receive funding. Conversely, one might reasonably argue that the RD better represents the “true” inequity, because it is not affected by the number of cases involved, and thus heart disease should be funded.

The choice of the appropriate measure is particularly important when assessing health inequalities over time, as well as the relationship between *distributive* considerations (in this case, health inequalities) and *aggregative* ones (in this case, overall health). In some cases, measures that improve aggregate health in an entire population and all of its subpopulations might simultaneously increase inequalities between the more and less advantaged members of the population. Consider Table 20–5.³³

Between 1950 and 1998, overall infant mortality in the United States declined precipitously for all racial groups. The absolute reduction in infant deaths during this period was almost 50 percent higher among blacks than whites (30.1 vs. 20.8), and the absolute difference in rates decreased (from 17.1 to 7.8), which indicates that blacks benefited *more* than whites did from reductions in infant mortality during this time period. However, during the same period the relative difference between the two groups increased (from 1.6 to 2.3), indicating that blacks benefited *less*. So, were racial inequalities in infant mortality better or worse in 1998 than in 1950? Did improvements in infant mortality disproportionately benefit whites or not? Was there a trade-off between overall population health and health inequalities or not?

WHAT IS THE BEST WAY TO REDUCE OR ELIMINATE HEALTH INEQUALITIES?

Even if we can reach agreement that a measurable health inequality exists, that it constitutes an inequity, and that it deserves to be addressed, there is no single rationale for determining the most ethically-sound way to reduce or eliminate that inequity. Several ethical considerations play a role in deciding between possible interventions.

The first consideration concerns the relationship between equality of *treatment* and equality of *outcomes*, embodied in the principles of horizontal and vertical equity. *Horizontal equity* refers to the equal allocation of resources (in this case, health care) across a population. Universal healthcare accords with this principle on the grounds that everyone needs health care, and no individual or group should receive disproportionately better or worse care than another.

Vertical equity refers to the allocation of different resources for different levels of need. Health care or public health programs that target a disadvantaged social group accord with this principle, on the grounds that unequal allocation of resources might be necessary in order to achieve equal health outcomes. An extreme emphasis on vertical equity is liberation theology's injunction that the poorest members of a society should always be accorded preferential treatment, because they bear the greatest burden of social inequality.³⁴ In choosing between these two principles, it is worth asking: If everyone receives the same treatment, are unequal outcomes ethically problematic? If everyone has the same outcome, are unequal treatments ethically problematic?

A second issue is the aforementioned relationship between distributive and aggregative considerations, and the cases of "leveling up" or "leveling down" to achieve the goal of equity. Consider the following four situations shown in Figures 20–1 through 20–4.

Assume that the rate being measured in these charts is something beneficial, such as access to life-saving medications. Figure 20–1 represents the current situation, in which the total population rate is 27.5, and a simple index of total inequality³⁵ is 5. Suppose that we wish to *both* improve overall access to life-saving medication *and* reduce the total inequality of access in this population. In Figure 20–2, the total population rate is better (higher), and each sub-population has benefited, but the total inequality is worse (also higher).

In Figure 20–3, the total inequality has been greatly reduced, but overall access has been slightly reduced; the access rate of the two best-off popula-

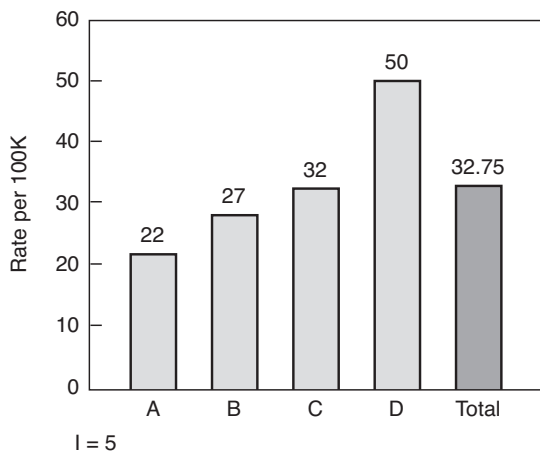
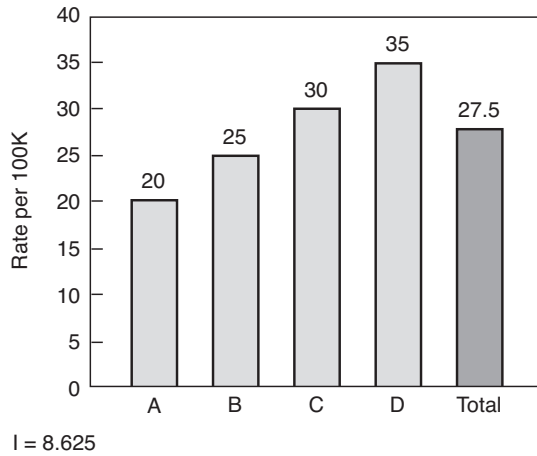
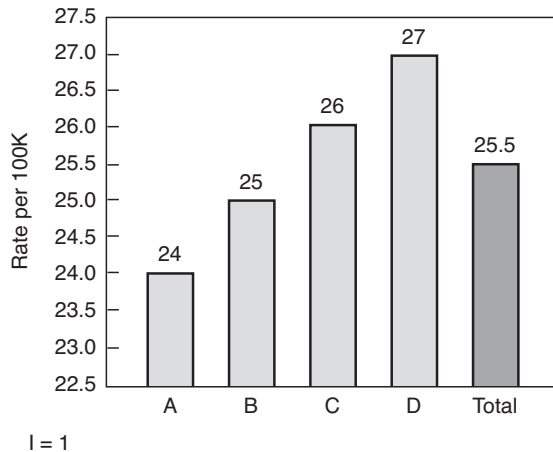


Figure 20–1

**Figure 20–2**

tions has decreased, but that of the worst-off has increased. Finally, in Figure 20–4, total inequality has been reduced to zero, and overall access has dropped slightly. The access of the top two populations has decreased, while that of the bottom two has increased. Which of the other three situations represents the best trade-off between the reducing inequity and improving overall health?

Many other considerations regarding the appropriate distribution of social resources play a role in determining the best approach to reducing health inequities. Given a number of different subpopulations (e.g., multiple racial or ethnic groups or education levels), are some subpopulations more or less “deserving” of direct intervention to reduce health inequities? Consider another example. Epidemiological evidence indicates that

**Figure 20–3**

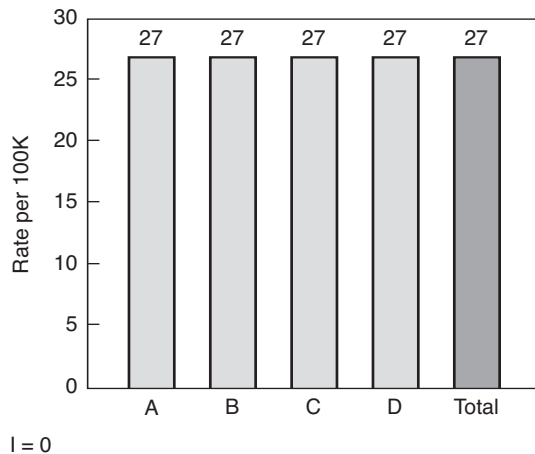


Figure 20–4

differences in socioeconomic status, nutrition, exposure to pathogens and toxic substances, and health care very early in life can have profound impact on health status and inequalities later in life.³⁶ This raises the possibility that the best way to reduce health inequalities in the long term might be to invest as heavily as possible in pre- and postnatal health care, perhaps at the expense of health care much later in life, when reducing inequalities might be prohibitively expensive. Is this an acceptable triaging of social resources?

CONCLUSION

Despite repeated calls for and considerable resources devoted to their elimination, dramatic health inequities persist and in some cases are increasing. This review might make the task of addressing health inequities seem unnecessarily daunting, or even insurmountable. In some cases, the task is indeed complex. However, the existence and persistence of significant gaps in the health and longevity between the most- and least-advantaged populations worldwide compels us to take action, no matter how challenging the task.

SUMMARY

The author begins by defining the essential concepts for understanding the ethical problem posed in the chapter. He then explores the ethical difference between an inequality and an inequity. King goes further and explains how inequalities are measured and the issues associated with defining populations and measurement standards. Finally, he presents areas to consider in reducing or eliminating health inequalities.

QUESTIONS FOR DISCUSSION

1. What is the difference between health inequalities and inequities in health care?
 2. What ethical theories help to define if a health inequality is truly an inequity?
 3. How can health inequalities be used as indicators of larger social problems for socioeconomic groups?
 4. How do researchers use ethics to specify populations when studying health inequalities?
 5. In the author's view, what is the best way to decrease health inequality?
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NOTES

1. U.S. Department of Health and Human Services, *Healthy People 2010: Understanding and Improving Health*, 2nd ed. (Washington, D.C.: U.S. Government Printing Office, 2000).
2. N. Daniels, "Equity and Population Health: Toward a Broader Bioethics Agenda," *Hastings Center Report* 36, no. 4 (2006): 22–35.
3. World Health Organization, "Preamble to the Constitution of the World Health Organization," *Official Records of the World Health Organization* 2 (1946).
4. P. R. McHugh, "Striving for Coherence," *Journal of the American Medical Association* 293, no. 20 (2005): 2526–2528.
5. See C. J. L. Murray, E. E. Gakidou, and J. Frenk, "Health Inequalities and Social Group Differences: What Should We Measure?" *Bulletin of the World Health Organization* 77, no. 7 (1999): 537–543; and P. Braveman and S. Gruskin, "Defining Equity in Health," *Journal of Epidemiology and Community Health* 57 (2003): 254–258.
6. Making inferences about properties of individuals from aggregate group statistics is commonly referred to as the *ecological fallacy*.
7. The term *health disparity* often is used interchangeably with *health inequities*, particularly in the United States, but it also is used interchangeably with *health inequality* in other countries. For this reason, I will use the terms *health inequality* and *health inequity* throughout this chapter.
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32. A related problem concerns whether to include the subpopulation of interest in the total population average.
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