ARE ALL HEALTH INEQUALITIES REALLY UNJUST?

SAĞLİK SİSTEMİNDE GÖRÜLEN TÜM EŞİTSİZLİKLER GERÇEKTEN ADALETSİZ MİDİR?

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Abstract

It is well known that health outcomes are not allotted evenly among countries, between regions in a country, and even among people living in the same neighborhood. For example, while a Japanese person enjoys living 83.1 years in 2009 on average, life expectancy at birth for a Zambian person is only 47.9 years, pointing out that there are notable disparities in the health of differing groups. Lifestyle factors, biological factors, and social gradients lead to most health inequalities. Health inequalities are unjust and avoidable when they arise due to the unfair distribution of the social gradients such as education, income, and social status. However, some are not unjust and hence acceptable if they are derived completely from free choices fully informed adults make such as smoking, alcohol, risky hobbies. Therefore**,** governments should provide equal and fair opportunity for health and improve health status of the worst off, but they have to keep in mind that even with the best policies, unequal but just health outcomes may still persist as a residual.

Keywords: Health inequality, justice in health, social gradients, unfairness.

Özet

Sağlık çıktılarının ülkeler arasında, aynı ülkedeki bölgeler arasında, hatta ve hatta aynı komşuluk alanı içinde yaşayan insanlar arasında eşit paylaştırılmalığı çok iyi bilinmektedir. Örnek vermek gerekirse, 2009 yılında Japon bir kişi ortalama 83,1 yıl yaşarken, Zambiyalı birisinin doğuşta hayatta kalma beklentisi 47,9 yıldır. Bu da farklı gruplar için sağlık çıktılarındaki dikkat çeken farklılığa işaret etmektedir. Yaşam tarzına ilişkin faktörler, biyolojik etkenler, sosyal belirleyiciler sağlıktaki eşitsizliğin önemli bir kısmına sebep olmaktadır. Sağlıkta görülen eşitsizlikler; eğitim, gelir ve sosyal statü gibi sosyal belirleyicilerin adaletsiz dağılımından kaynaklanır ise, hem adaletsiz hem de önlenebilirdir. Fakat, bazı eşitliksizler, bilinçli kişilerin alkol tüketimi, sigara kullanımı, tehlikeli hobileri gibi özgür seçimleri sonucu ortaya çıkıyorsa, adaletsiz olmasına ragmen kabul edilebilirdir. Bu yüzden, hükümetler en kötü durumda olan kişilerin sağlık statülerini iyileştirmek ve bu gruba eşit fırsatlar sunmak zorundadır, ama en iyi politikalar da uygulansa eşit olmayan ama adil sağlık çıktılarının yine de var olabileceğini göz önünde bulundurmalıdırlar.

Anahtar Kelimeler: Sağlıkta eşitsizlik, sağlıkta adalet, sosyal belirleyiciler, adaletsizlik.

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Introduction

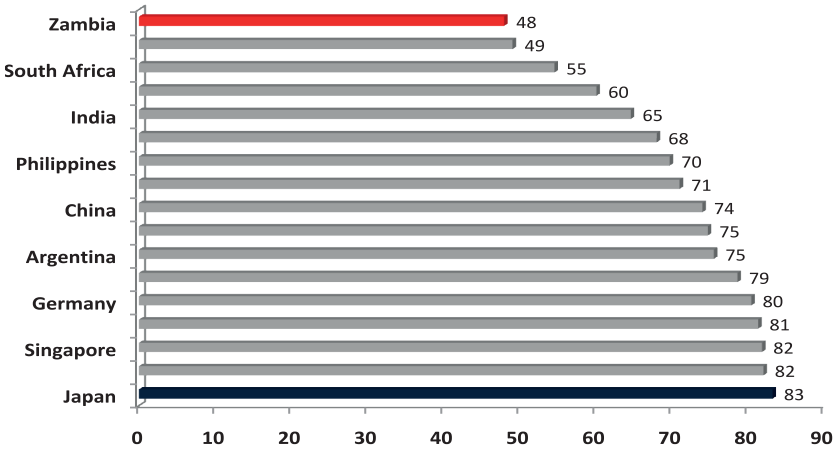
It is well documented that good health is not evenly distributed among countries, between regions within the country, and even among people living in the same region. For example, while a Japanese person enjoys living 83.1 years in 2009 on average, life expectancy at birth for a Zambian person is only 47.9 years (Figure 1) (WHO, 2011). In the Unites States (U.S), life expectancy at birth ranges from 74.8 years (Mississippi) and 81.5 (Hawaii)[2]. Moreover, in 2008, American women lives 5 years longer compared to American men on average.[3] All these examples clearly address that there are marked disparities in the health of different groups. Yet, are all inequalities in health unfair? and can we eliminate all health inequalities? In order to answer these questions, I will firstly describe what the health inequality is and outline the major determinants of health inequalities. Then I will debate whether all health inequalities are unfair by pointing out the main characteristics of the health inequalities. My view is that health inequalities are unfair when they arise from external environment and conditions mainly outside the control of the individuals. However, I also argue that some are not unfair since they are attributable to biological variations or free choice. Finally, I will list the policy recommendations to reduce health inequalities. I believe that we can only mitigate, but not eliminate the effects of the social contingencies related with unequal health outcomes through government interventions. Consequently, whatever is done, some inequalities will still persist as a residual.

Health inequality and its main determinants

Although the health of people have improved remarkably during the last 150 years, health inequalities are still common throughout the world and are seen even in the most developed countries. For instance, in the U.S, Asian Americans enjoy a life expectancy of 87.3 years, and African Americans, 74.3 years, a gap of 13 years (Figure 2). Asian American life expectancy ranges from 92.4 in Connecticut to 81.7 in Hawaii.

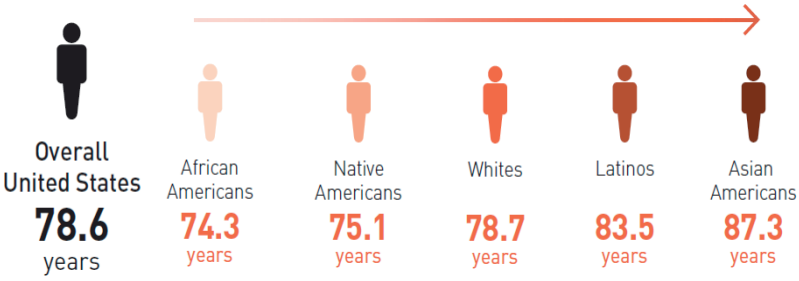
2 American Human Development Project. Measure of America 2010-2011
3 U.S. National Center for Health Statistics. National Vital Statistics Reports (NVSR)

Figure 1: Life Expectancy at Birth, 2009



Source: WHO. World Health Statistics 2011

Figure 2: Life Expectancy at Birth in U.S for different Ethnic Groups



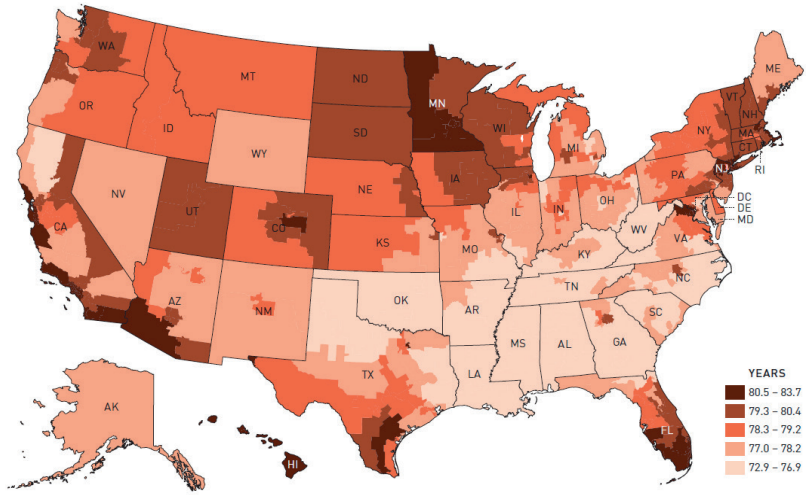
Source: American Human Development Project. Measure of America 2010-2011 www.mesureofamerica.org

Dahlgren and Whitehead (2007) define health inequalities as *the systematic differences in health status or in the distribution of health determinants between different population groups.* In addition, health inequality is the generic term used to define differences, variations, and disparities in the health achievements of individuals and groups (Kawachi et al, 2002). A straightforward example of health inequality is higher incidence of a disease in group A as compared with group B of population P. If the disease is randomly or equally distributed among all groups of population P, then there is no presence of health inequality in that population. In other words, health inequality is a descriptive term that needs not to imply moral judgment. To further exemplify this point, imagine

individual X who dies at age 40 during a sky diving accident. His identical twin, Y, who does not enjoy this hobby, lives at an age of 80. In this case, the unequal life spans of A and B reflects a personal choice that would not necessarily be attributed to moral concern. Besides such voluntarily assumed risks, other examples of health inequality that we would not normally consider unjust include pure chance such as a random genetic mutation or life stage differences. Hence many forms of health inequalities are also undoubtedly inequitable (Kawachi et al, 2002).

Health inequalities show themselves in many ways. For instance, the prevalence of cancer varies between different age groups, with older people tending to be sicker than younger people due to natural ageing process. Life expectancy also differs among countries and even regions within the country. In addition, mortality and morbidity increase with declining social position: the poorer, the higher mortality and morbidity; the richer, the lower mortality and morbidity. Consequently; just to present some statistics, life expectancy at birth for men in one of the district of Glasgow, Calton, is 54 years (28 years less than that of men in Lenzie, a few kilometers away from Calton) and the prevalence of long-term disabilities among European men aged 80+ years is 58.8% among the lower educated versus 40.2% among the higher educated.[4]

Figure 3: Life Expectancy at Birth in U.S States



Source: American Human Development Project. Measure of America 2010-2011 www.mesureofamerica.org

4 WHO. Key concepts on social determinants of health. http://www.who.int/social_determinants/final_report/key_concepts_en.pdf

The causes of health inequalities are complex, and involve lifestyle factors such as smoking, nutrition, and exercise; social gradients[5]- income, poverty, housing, and education; and biological factors. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where individuals live, environment, genetics, people's income and education level, and their relationships with friends and family all have considerable impacts on health. Individuals are unlikely to be able to directly control many of the determinants of health. These determinants include the above factors[6]:

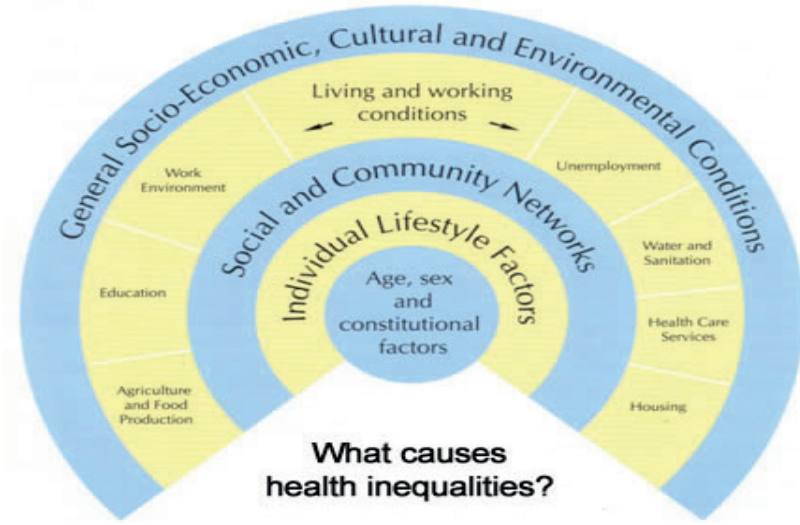
- *Income and social status* - higher income and social status are closely linked to better health. The greater the gap between the richest and poorest, the greater the differences in health.
- *Education* – low education levels are tied to poor health, more stress and lower self-confidence.
- *Physical environment* – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. People in employment are healthier, particularly those who have more control over their working conditions
- *Social support networks* – greater support from families, friends and communities is associated with better health. Culture - customs and traditions, and the beliefs of the family and community all affect health.
- *Genetics* - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses. Personal behavior and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health.
- *Health services* - access and use of services that prevent and treat disease influences health
- *Gender* - Men and women suffer from different types of diseases at different ages.

I believe that we can only eliminate the social gradients and change some part of the lifestyle factors, but could not alter biological factors to remedy health inequalities. Classifying the causes of health inequality will make us life easier when arguing whether all health inequalities are unfair or not.

5 Marmot M. 2004. The status syndrome: How social standing affects our health and longevity. London. Bloomsbury Publishing Plc.

6 WHO. http://www.who.int/hia/evidence/doh/en/

Figure 4: Determinants of Health



Source: Dahlgren and Whitehead, 1991

Characteristics of unfair health inequality

Whitehead (1991) stated that "*Health inequalities that are avoidable, unnecessary and unfair are unjust*." But is it true to say that all avoidable health inequalities arising from small differences in income or educational level are unjust? I believe it is not the case. Just imagine that there are two families, family X and Y, earning nearly the same income. Family X purchases a comprehensive health insurance plan to cover all his/her family's health expenses and minimize the risk of financial bankruptcy. However, Y does not get that insurance and take the risk. Then what if one of the family members of Y develops catastrophic illness and the limited insurance does not cover his expenses. This is a kind of inequality in health and it can be avoidable. However, can we say that it is unjust since it is avoidable? No we cannot, since it is a kind of freedom of choice. It is that person's preference whether to purchase the insurance. If that family had purchased the comprehensive health insurance plan, they would not have faced that problem.

To further refute this argument, now imagine individual A who dies at age 50 due to lung cancer since A has smoked two packs of cigarettes for 30 years. On the other hand, his identical twin, B, who does not smoke anymore, lives to age 85. In this case, the unequal life spans of A and B (the unequal life expectancies of smoker and a non-smoker)

reflects a personal choice that would not necessarily evoke moral concern. Then lifestyle factors such as smoking, obesity, alcohol, sexual behaviors, skydiving, and health insurance depends on the choice of the people, and health inequalities arising from those factors are avoidable yet not unjust. Therefore, my view is that some health inequalities are voluntary and avoidable but not unjust. However, some theorists view the same choices as avoidable since they arise out of constrained and unfair circumstances such as low income, and less education level.

My second argument is that some health inequalities are unavoidable. While there exists avoidable inequalities such as inequalities across countries, sexes or races as a result of social exclusion and other unjust practices aimed at vulnerable groups, namely social gradients; there are also unavoidable inequalities as well. For example, biologically, women in many countries exhibit an advantage in survival over men at every stage of life. This is an inequality between men and women. But can we avoid this inequality? Absolutely we cannot. This health inequality rests upon biological factors.

In addition, some people such as coal miners, radiologists, truck drivers, policemen have more chance to come across with danger since the nature of their job requires more risk. Think about a military man. Since they are assigned to fight during the war, they are more probable to live less compared to other professions. Can we eliminate that health inequality? I propose we cannot. It is possible to mitigate some part of the risk by taking necessary measures. For example, military man can wear bullet proof vest during the war. This can reduce the risk of being killed, but it does not avoid the risk completely.

Therefore, for some health inequalities, it may be impossible or ethically or ideologically unacceptable to alter the health determinants and so the health inequalities are unavoidable due to biological and natural factors. However, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so that the resulting health inequalities also lead to inequality in health because all are the outside the control of the individual and they reflect an unfair distribution of the underlying social determinants of health such as access to educational opportunities, income, safe jobs, and healthcare (Daniels et al, 2000; Woodward and Kawachi, 2000).

Policy recommendations and their goals

When some health inequalities are voluntary and unavoidable, every government intervention to remedy the health inequalities can-

not end up with the desired outcome such as maintaining heath equality among groups. Therefore, policies must target the health inequalities originating from the social gradients. The ultimate goals of the government policy must be to preserve the basic personal liberties, promote the equality of opportunity and improve the health status of the worst off. My recommendations to tackle with the health inequalities is to guarantee universal coverage for all citizens, invest more on equal education, encourage people to start healthy diets, and assure safe and healthy working conditions through setting and enforcing standards.

In order to reduce disparities among individuals, governments should do their best to improve the conditions in which people grow up, work, and grow old holds the greatest promise for longer, healthier lives. The social and economic disparities that breed ill health include low levels of income and education, discrimination and residential segregation, social exclusion, dangerous neighborhoods without places to exercise or buy healthy foods, substandard housing, and the chronic stress that insecurity breeds. Besides, in order to minimize the health risks that people face, especially to the "fatal four" of smoking, poor diet, physical inactivity, and excess drinking -the true leading cause of death in the U.S- governments should launch prevention programs and counter-advertising as well as by creating neighborhood, school, and work environments in which healthy choices are not just possible but probable offers great promise.

Conclusion

Health inequalities are pervasive throughout the world even though there have been substantial improvements in the health status of the people. We all encounter many disparities in health among countries, gender, race and etc. Lifestyle factors, biological factors, and social gradients lead to most health inequalities. Health inequalities are unjust and avoidable when they stem from the unfair distribution of the social gradients such as education, income, and social status. However, some are not unjust and hence acceptable if they are derived completely from free choices fully informed adults make such as smoking, alcohol, risky hobbies. Therefore**,** governments should provide equal opportunity for health and improve health status of the worst off, but we have to keep in mind that even with the best policies, unequal but just health outcomes may still persist as a residual.

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