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Health Inequalities

by Lawrence O. Gostin and Eric A. Friedman

The perceived injustice of the hoarding of global wealth (50 percent of it in 2017)¹ by the top 1 percent of individuals has driven both left- and right-wing political populism that is deeply suspicious of globalism, trade liberalization, and corporate wealth and influence. Wealth, though, is hardly the only area where vast inequalities are manifest. Socioeconomic position is also a core determinant of whether a person will be able to live a long and healthy life.

Health inequalities are embedded in a complex array of social, political, and economic inequalities—as the Covid-19 pandemic is making glaringly evident. Responding to health inequalities will require systematic action targeting all the underlying (“upstream”) social determinants that powerfully affect health and well-being. Systemic inequalities are a major reason for the rise of modern populism that has deeply divided politics and infected politics, perhaps nowhere more so than in the United States. Concerted action to mitigate shocking levels of inequality could be a powerful antidote to nationalist populism.

A basic yet critical start to addressing health inequalities is to recognize them, which demands improving data collection and analysis so that overall improvements in health do not disguise the dark reality of health inequalities. Certainly, global indicators show vast progress in reducing poverty and ex-

tending life. (The United States is an outlier, as average life expectancy ticked down three years running, mostly due to “diseases of despair,” such as opioid overdoses and suicides, until edging upward in 2018.²) Globally, deaths of children under five, maternal deaths, and deaths from infectious diseases (like HIV/AIDS, tuberculosis, and malaria) have all been trending down for years.

Yet aggregate health data mask a deeper reality: health gains have disproportionately benefited the well-off, leaving the poor and middle-class behind. A baby born in a largely white, wealthy suburb of St. Louis can expect to live thirty-five years longer than one born in a mostly black, lower-income suburb a few miles away.³ Average life expectancy among black South Africans is sixteen years lower than for whites.⁴ While people in Japan and Switzerland live an average of eighty-four years⁵ (Monaco’s life expectancy is eighty-six⁶), those in the Central African Republic and Lesotho average fifty-two and fifty-three years, respectively, and those in Chad, Sierra Leone, and Nigeria, fifty-four.⁷ (The United States ranks twenty-sixth among Organisation for Economic Co-operation and Development countries, near the bottom, with an average of seventy-nine years.⁸) The circumstances of your life—where you are born, your identity, your socioeconomic position—are the greatest predictors of your future.

Most health gains align with the United Nations Millennium Development Goals (MDGs), which used aggregate measures of progress, thereby concealing grossly inequitable distribution. Within countries, the wealthier 60 percent of populations saw rapid reductions in HIV, for example, while the poorer 40 percent made few gains.⁹ In Paraguay, the indigenous Aché people have a tuberculosis incidence seventy-five times that of the country’s population overall,¹⁰ while TB incidence among Canada’s indigenous Inuit people is over three hundred times that of nonnative Canadians.¹¹

In low- and middle-income countries, 99 percent of communities have seen lower child mortality,¹² but one study found that in one-quarter of sixty-four countries surveyed, the poorer 40 percent of the population were experiencing worse MDG health outcomes as the MDG period progressed.¹³ Persistent opportunity gaps mean that more than half the world’s population lacks access to essential health services.¹⁴ In New York City, maternal deaths of black women are twelve times higher than those of white women.¹⁵ And even early Covid-19 data has made clear that black Americans are becoming infected and dying at considerably higher rates than white Americans are.¹⁶ At the current rate, many countries will not close core health equity gaps this century, much less achieve the U.N.’s Sustainable Development Agenda’s pledge that “no one will be left behind” by 2030.¹⁷

Public discontent with these alarming health disparities is palpable. Much of the anger is directed toward the very rich—the top 1 percent—and at “greedy” corporations, especially those selling health products and services, like pharmaceutical companies and health insurers. As the costs of essential medicines and health insurance inextricably

rise, the public perceives that profit trumps health. There can be little doubt that the richest 1 percent and mega corporations leverage their influence to gain advantage, such as lower taxes and lax regulation. We're seeing a race to the bottom, with corporations of all sorts seeking the lowest tax and weakest regulation destinations. Transnational corporations are not paying their fair share for the social safety net (including health costs), and they evade more rigorous health, safety, and environmental regulations—all of which threatens people's health.

In essence, this is the populist claim: advantages are going to the wealthy and bypassing middle- and lower-income people. Undoubtedly, this narrative rings true, but there are other deeply consequential reasons for health inequalities.

We Can't Fix What We Don't Measure

The U.S. gross domestic product was up for ten straight years before Covid-19,¹⁸ but economists were seeing a disconnect between rosy economic indicators and deep social discontent. The public is not wrong in feeling despair; the fault is with the data. The GDP is a measure of aggregate national economic growth, but wealth growth most benefits the top 10 percent. At least before the economic ramifications of Covid-19, upper-income families had more wealth than they did before the Great Recession, while middle- and lower-income families remained well below prerecession (2007) levels,¹⁹ and the wealth of middle- and lower-income families is sure to fall further due to the pandemic. A new indicator, *distributional accounts*, would show how much of the economy's bounty is flowing to various income groups.²⁰

The failure to gather, analyze, and disseminate the most pertinent data also hampers understanding of health disparities. With limited exceptions, statisticians measure overall health outcomes, so we have too little understanding of who is left behind, where they live, and why they suffer disproportionate health burdens. Most importantly,

if policy-makers are blithely unaware of health inequities, they are unlikely to do anything about them. Thus, the first step in addressing health inequities is to measure them. By all means, continue aggregate assessments of the health of the nation, but also rigorously examine granulated data to understand better the stark variances in health outcomes.

It's about Public Health and Social Determinants

When discussing solutions to problems of health and equity, the political class almost invariably talks about health care and, specifically, about how to achieve universal health coverage. The Democratic primaries feature outsized debates on "Medicare for All," while Tedros Ghebreyesus, director-general of the World Health Organization, says, "All paths lead to universal health coverage."²¹ Yet, as important as medical services are, they are not particularly strong drivers of population health. The more consequential health services by far are population-based public health interventions like sanitation, potable water, safe nutritious food, vector abatement, and alcohol and tobacco control. And public health measurements do not track visits to doctors or hospitals but, rather, the incidence and prevalence of injuries and diseases in the population. Less than 5 percent of all health dollars in the United States flow to public health, with the rest invested in medical and hospital services.²²

If you ask any epidemiologist what the single biggest predictor of health outcomes is, she would point to social determinants outside the health sector, including employment, education, housing, and transportation. Yet while a physician can, for example, counsel an asthmatic patient to avoid environmental triggers, if the patient lives in a neighborhood replete with indoor and outdoor pollution, or if she is homeless, no amount of medical care will prevent wheezing and breathing difficulties.

Deeply rooted structural factors, such as low social status or racism, are causally related to poor health. Scholars observe that a history of racial segregation adversely affects health outcomes

for African Americans across generations.²³ The remedies for health inequities are therefore complex, requiring action across sectors, including access to justice. Intersectoral collaboration and action require new mindsets across government agencies. Yet the data we collect do not account for systemic structural factors. Without explicit attention to them, little progress will be made.

And It Calls for Respecting Others

As important as health and economic equity are, they offer only a partial explanation for populism's rise. The United States appears separated by social class, education, and geography. Working-class rural inhabitants feel that the wealthy, professional classes in the city look down at them. And many of these well-off city dwellers may, in fact, not understand concerns from the heartland; some might not even genuinely listen to them. In short, the polity feels that it is told that it must trust people they see as "the other," those who seem very different culturally and politically. Voting for a plain-speaking, even vulgar and dishonest populist leader is, in part, a rebellion against a feeling of being neglected, even disrespected. And, as many rural Americans see their communities becoming more diverse and see cultural norms shifting, some respond by turning to politicians who exploit their fears, and even their prejudices.

There are also tangible realities undermining health and well-being in rural America. Rural Americans struggle to find well-paying jobs, quality education, and health services. Small towns suffer the loss of the many educated young people who migrate to cities. In many communities, affordable health insurance is scarce, qualified health workers either leave or never come, and hospitals are closing. And many rural populations live in states that haven't expanded Medicaid under the Affordable Care Act, thus blocking health care access for the working poor.

A combination of low socioeconomic status and a diminishing social safety

net is driving deep systemic inequalities in health. The sense among less-educated, rural voters of being disrespected contributed to President Trump's election in 2016. However, he has cut Supplemental Nutrition Assistance Program benefits, undermined the Affordable Care Act, and allowed work requirements for Medicaid coverage—actions that contribute to health inequalities and harm many of the very people who voted for him. Just recently, the Supreme Court allowed the Trump administration's "public charge" rule to take effect even as challenges to the rule continue to work their way through the courts. The rule is a major obstacle for legal immigrants who require public assistance, including Medicaid, housing vouchers, and food stamps, and will cause many of these people to go without vital support.²⁴

What Can We Do Now?

If we want to fix health inequalities, we must focus on them. Equity solutions require dedicated, sustained, prioritized, and well-resourced plans, which we call "health equity programs of action."²⁵ Programs of action would be systematic and systemic and would include explicit targets, costed actions, rigorous measurement, and accountability through a comprehensive national effort. Every country could benefit. The United States could choose to lead, which would be a powerful political commitment to health equity and justice.

The Sustainable Development Agenda's pledge to leave no one behind will surely go unfulfilled unless we act decisively. With inequities causing millions of preventable deaths globally every year, offending the deepest values of fairness, there is no time to lose. It would be a grave injustice to see 2030 approaching and, yet again, find the world has failed to dramatically reduce

health inequalities. And if we succeed, an intangible yet powerful benefit will be to restore a sense of dignity for all of society and, in turn, act collectively to elect truthful, compassionate leaders who bring us together as a nation.

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