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Epidemiology and Ideology: Why health equity is problematic in the United States

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ABSTRACT

Health and healthcare are central elements to the achievement of social justice. Braveman and Gruskin are proponents of health equity as a means to realize social justice. They define health equity as the “absence of systemic barriers to health” that are derived from the unequal power, influence, and capital of marginalized groups within societies (2003, p. 254). John Rawls and Norman Daniels have theorized that social justice requires a fair distribution of goods in a society and that good health is of moral importance to this effort, respectively. Thus, having fair access to a healthy life is a crucial element in the attainment of a just society. However, social justice, achieved through fair access to good health, is made problematic in the United States. Specifically, in the United States, epidemiology is guided by traditional standards of scientific methodology requiring proof to a high degree of certainty. This standard often neglects social factors that may be as relative to causation as readily discernable factors. Social factors that affect health may be invisible or hidden within structural elements of society. In the United States, these structural components are often influenced by America’s historic imperialistic ideology that serves to preference the dominant culture over “others.” Given traditional scientific notions of causality and predominant American ideology, structural issues relative to health inequity are often discounted or demoted as causal elements, making the realization of social justice elusive.

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INTRODUCTION

Health and healthcare are vital to the achievement of social justice. John Rawls has theorized that social justice requires a fair distribution of goods in a society. Extending this theory, Daniels (2001) postulates that good health and a just society are interdependent, noting that “[h]ealthcare is of special moral importance because it helps to preserve our status as fully functioning citizens” (p. 4). The idea that health is essential to a citizen’s realization of their full potential for taking advantage of what society has to offer is implicit in Daniels’s argument that health preservation protects our “opportunities and capabilities” (Daniels, 2001, p. 6). Thus, having fair access to a healthy life is important in the realization of a just society. However, fair access to good health is made problematic by both its definition and its moral priority in the United States. Specifically, the United States proffers a politically libertarian and individualistic ideology that promotes self-reliance and detests governmental involvement. Thus, fairness is determined by what one can achieve by one’s own merits and actions. The acceptance of help is viewed as a character flaw. This ideology could be considered fair if everyone were on a level playing field. But such is not the case, and indeed, social inequalities are expressed in the extreme differences in various social

determinants of health in the United States. As an example, Patel and Rushefsky (2014) note that minority groups tend to have “lower educational achievement and higher unemployment rates, higher crime rates, lower incomes, and therefore higher poverty rates” than whites (p. 214). They further note that minorities have higher age-adjusted death rates than whites due to “diabetes, cardiovascular disease, cancer, infant mortality, and substance abuse” (Patel & Rushefsky, 2014, pp. 214-215). In light of these glaring inequalities and society’s historic ideology, common sense and some studies have implicated structural processes and policies as contributory causes to poor health outcomes in some marginalized groups in America. For social justice to be achieved in the United States, a moral challenge to the present dominant ideology must be made. One such ideological notion that should be challenged is the U.S.’s traditional scientific epidemiological standard that discounts social causation as valid and/or important. This standard neglects the necessary ethical analysis required for the realization of health equity. In sum, it is the traditional American ideology, expressed in traditional epidemiological methodology and in societal structural processes and policies, that makes health equity problematic in the United States.

The Relationship between Health Equity, Social Justice, and Social Structures

Braveman and Gruskin (2003) are proponents of health equity as a means to realize social justice. They define health equity as “the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage” (p. 254). It is this inequality in social standing that is investigated as a potential cause for poor health often realized by some groups in American society. Specifically, these groups have been identified as those typically oppressed by the dominant group in the United States, white privileged heterosexual males. These oppressed groups, defined as the “Other,” include “women, Blacks, Chicanos, Puerto Ricans and other Spanish-speaking Americans, American Indians, Jews, lesbians, gay men, Arabs, Asians, old people, working-class people, and the physically and mentally disabled” (Young, 1990, p. 40). This list is not exhaustive, but it is instructive to reveal that the “Other” is the majority of citizens residing in the U.S. Therefore, a practical and moral argument can be made that the protection of the opportunities of “Others” is important for society, overall. Specifically, if the health of these groups is adversely affected and if the groups’ members cannot realize their full potential, society suffers both productively and morally. While productive loss is obvious, moral suffering also occurs when unfair and discriminatory societal structures cause such deficiencies in health.

The societal structures, or social determinants, that affect health include a person’s living conditions (safety, proximity to healthy food sources, etc.), quality of education, existence of social support, availability of transportation, and other areas that may affect a person’s “power, money, and resources” in society (Popay, 2012, p. 59). The United States, with its well-established history of cultural imperialism, has forwarded an ideology of marginalization and oppression of “Others,” even today. Many times, such pervasive ideology is represented in societal policies and processes that shape the conditions of one’s life, thus affecting health. Braveman (2014) states:

[A]t a population level, greater harm to health may be done as a result of unintentional discriminatory processes and structures... Examples of such processes and structures—which persists as a legacy of slavery and “Jim Crow,”... include racial segregation, criminal justice codes and patterns of enforcing them, and tax policies that make schools dependent on local funding. These examples no longer reflect conscious intent to discriminate, but nevertheless persist and transmit economic and social disadvantage—with health consequences—across generations.” (p. 7)

It is this invisible perpetuation of discrimination that often produces adverse health outcomes within marginalized groups. While there is an inherent moral argument against discrimination, the United States has also enacted laws against such and has made international gestures indicating its disdain for discrimination. Braveman et al. (2011) point to human rights agreements, which the U.S. has signed (although not ratified), that call for citizens to have a “right to a system of health protection which provides equality of opportunity to enjoy the highest attainable level of health” (p. S150). These agreements prohibit unintentional, as well as, intentional discrimination. Braveman (2014) convincingly argues that the word “unintentional” connotes causes that may not be readily discernable when she states that “[b]ecause human rights agreements and principles prohibit de facto (unintentional or structural) as well as intentional discrimination, we do not have to know the causes of a health difference to call it a health disparity” (p. 7). It is this lack of necessity for the existence of a direct causal link between societal structures and unequal group health that causes the concept of health equity to be problematic in the United States.

The Methodological Problem with Health Equity

Braveman and Gruskin (2003) note that health inequity involves health disparities that are “systematically associated with social disadvantage” and that such disadvantage is “reasonably based on current scientific knowledge to believe that social determinants could play an important part in the disparity at one or more points along the causal pathways leading to it.” (p. 256) In essence, social disadvantages may be linked to poor health. The authors note that causes for health disparities may be numerous and complex. It is within this complexity that all issues of the importance and valid use of health equity as a measure of social justice reside. In the traditional scientific paradigm of epidemiology as well as the traditional ideology of the United States, a valid causal pathway mandates scientific standard of statistical significance; not moral justification for problem and solution determination. Preda and Voigt (2015) argue that “addressing social determinants of health...presents a number of methodological problems. The standards of evidence that have become prominent in medical contexts cannot be straightforwardly applied to population-level interventions, and because of differences in contextual factors, an intervention that works well in one place can fail in another.” (p. 33) The authors seem to argue against the conclusion that health inequities involve a set of “normative assumptions” that social health inequalities are unfair and socially unjust, and they seem to argue that “societal changes” are not the most appropriate means to redress health inequalities (p.

28). As an answer to these assertions, Schrecker (2013) makes a strong point when he suggests that scientific rigor in social epidemiology should be contingent on the element of value. He noted the acceptable difference in evidentiary rigor in the field of law when comparing substantiality of evidence regarding criminal cases versus civil cases, which is instructive here. Criminal cases require more proof than civil cases. Society has determined that such difference is fair. Like the legal system, it could be argued that such difference in required proof of causation, with social epidemiology research on health inequities requiring less, is morally justifiable as it is ethically more important to set policies that may end up not being effective than not to try to affect health positively by investigating “probable” causes.

The Ideological Problem with Health Equity

Preda and Voigt (2015) state that “[e]mpirically, the correlation of particular behaviors with social factors is not sufficient to establish causation. Neither does the fact that that behavior is patterned establish the normative conclusion that particular individuals are not responsible for their choices.” (p. 32) The authors are forwarding the traditional ideology that proximal causes related to the individual, such as biology and behavior, are more “valid,” and inherently more important, than more distant social structures, such as racism and sexism. The authors point to individual causal factors that may prevent health equality by noting a study by Hilary Graham that showed that although cigarette smoking is more likely among lower income groups, “an improvement in socio-economic circumstances is unlikely to result in either an immediate reduction in smoking or an immediate improvement in health.” (2015, p. 33) The authors believe that population-based increase in wealth did not affect this group’s health-defeating behavior, and therefore, they find it problematic to link health equity to social justice. However, this view takes the moral element out of the equation. Venkatapuram and Marmot (2009) state that “[t]hose who assert that epidemiology is a purely descriptive, natural science governed only by the logic of the scientific method and motivated primarily by scientific curiosity deny the link between epidemiology and the background moral concern for human health and its constitutive role in social justice.” (p. 81) Preda and Voigt discount this moral point of health equity, which recognizes that some elements in health inequality are invisible and steeped in historical, discriminatory, and oppressive structures. These structures continue to be present in societal policies and processes. Given the difficulty of discerning the intent behind such structures, a moral and common-sense process for causation

determination may allow for a more nuanced approach to health-related population health research.

It is probable that many policymakers in the United States hold the same views as Preda and Voigt, due to the country’s libertarian and individualistic ideology that proffers little governmental involvement in personal affairs and a belief that individuals are responsible for solving their problems. This ideology would promote justice in a society where everyone is truly equal, but as previously noted, this is not the case in America, and such inequality is manifested in health disparities. Again, health disparities are “systematic” and are “based on social hierarchy” that “reinforce social disadvantage and vulnerability.” (Braveman et al., 2011, p. S150) “Socially-caused” health disparities link health equity to social justice. It is this social causation that requires health inequity be looked at through a different and more discerning lens than a scientific paradigm based on individualistic ideology.

The Moral Argument for Health Equity

A better lens through which to discern and interpret causation and validity of the relationship between social determinants of health and social justice has been suggested by Ted Schrecker (2013), who argues that research on the social determinants of health may require the application of a separate set of values. He juxtaposes the standards of proof of causation necessary in social determinants of health research with standards of proof utilized in cancer-causing environmental toxicity cases and policies. He noted Paigen’s comments about toxic waste as a cause of cancer. “[T]his is not a scientific issue, nor can it be resolved by scientific methods. This is ethical, for it is a value judgment to decide whether to make errors on the side of protecting human health or on the side of conserving state resources.” (Schrecker, 2013, p. 742) Schrecker further notes that waiting on proof equivalent to a randomized placebo-controlled trial when exploring potential interventions to affect social determinants of health is inappropriate and irresponsible. He notes that social epidemiological validity will be challenged in the field of health equity because of the interests of powerful capitalistic industries that seek to relegate poor health causation to the individual alone. However, these industries’ products, such as tobacco and sugar, have a direct link to poor health, particularly in marginalized groups. Also, such industries may be subject to regulation and a potential decrease in revenues with the advent of adverse policies that affect their bottom line. Thus, they lobby policymakers to protect their interests. This “lobbying” rightfully includes perpetuating individual-based narratives for causes of poor health, because if deeper exploration of causation were to occur, it would implicate their products. This capitalistic, imperialistic ideology, celebrated by the

United States, thwarts the attainment of health equity and is immoral.

While these challenges from “industry” to the investigation of health-related causes outside of the individual are expected in a libertarian capitalistic society such as the U.S., the unexpected challenge to the validity and importance of health equity comes from philosophers such as Preda and Voigt who attempt to dismantle the veracity of the health equity movement by questioning its methodology standards and its lack of consideration of “other” causes for health inequalities who state that “[t]he claim that policies that reduce the unequal distribution of social determinants of health are the most effective way of intervening... is problematic” because it takes individual health behaviors out of the equation. Also, they further stated “standards of evidence that have become prominent in medical contexts cannot be applied to population-level interventions,” which leads to the disbelief that “large-scale social policies will indeed have the desired effects on social inequalities in health.” (p. 33) These statements are short-sighted as they portray an all-or-nothing notion that all interventions must be based on population-level interventions and never individually focused. Health equity advocates do not forward this position (Braveman and Gruskin, 2003; Schrecker, 2013; Braveman et al., 2011; Braveman, 2014).

CONCLUSION

In conclusion, health equity is an essential component of social justice. The moral aspect involved in paying attention to the social determinants of health in research as a means for attaining social justice resolve any problematic methodology concerns. The prevailing ideologies of the United States, libertarianism and individualism, make the acceptance of health equity measures to solve social problems unpalatable. However, the historic marginalization and oppression of groups that have experienced negative health outcomes from societal policies and processes developed by dominant ideal theories and ideologies must be addressed. Braveman et al. (2011) state that “[h]ealth inequity... is a forceful term tending to imply a strong judgment about causality, which may be difficult to support in many

cases that nevertheless deserve attention as health disparities.” (p. S153) It is this moral judgment relative to the causality of health inequities experienced by marginalized groups that infuses justice into research, policies, and interventions necessary for resolution of such inequalities in the social determinants of health, and the realization of social justice in the United States.

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