



## CHAPTER ONE



# The Politics of Health Inequities

## *Contested Terrain*

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Even though mortality rates overall declined dramatically in the twentieth century and life expectancy increased, the United States nevertheless faces an increasing level of inequity in the health status and mortality of those with less material resources in relation to their social class, particularly in communities of color (Kawachi, Kennedy, and Wilkinson, 1999; Arno and Figueroa, 2000; LaVeist, 2002). For example, African Americans experience excess mortality and morbidity rates substantially higher than those for whites (National Center for Health Statistics, 2000; Williams, 1999). Differences in aggregate health status become inequitable when they are systemic and unjust, a result related to a lack of political power (Whitehead, 1987; Dahlgren and Whitehead, 1991; Evans and others, 2001; see also Chapter Twelve). That is, these patterned, persistent inequities (Beaglehole and Bonita, 1997; Bartley, Blane, and Davey Smith, 1998; Drever and Whitehead, 1977; Institute of Medicine, 2002) are due primarily to failed political struggles and power imbalances, not ad hoc events, individual failure, or the inevitable consequences of modern society. Material conditions such as poverty, inadequate housing, and excessive air pollution, generated by law, public policy, corporate decision making, and sometimes violence, produce and perpetuate health inequities. These conditions often derive from the institutional political and social power conferred by great inequalities of wealth (Callinicos, 2000; Halfon and Hochstein, 2002). Yet most discussions of health, whether in scholarship or the mass media, rarely touch on political

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conflict. Health is usually about health of the individual, health care, behavior and lifestyles, or developments in medical research. Although equitable access to health care is necessary, it represents only a small part of the requirements necessary for eliminating health inequities (Beaglehole and Bonita, 1997). The United States, for example, is not investing to create the social and economic conditions for health (Arno and Figueroa, 2000). Yet historically, major advances in health status resulted from broad social reforms. These include actions such as the abolition of child labor, shortening of the working day, introduction of social security, reductions in the scale of poverty, improvements in the standard of living, and guaranteeing employment or at least a minimum wage, as well as efforts to improve sanitation, ensure safe food, and provide adequate housing. Improvements in living and working conditions led to reductions in deaths from major infectious diseases. Public health as a discipline arose as an organized response to the negative consequences of industrialization. Later, legislative developments such as the Social Security Act, the Clean Air Act, the Mine Safety Act, and the establishment of the Occupational Safety and Health Administration and Medicare were major steps that improved health for millions of people (Rose, 1992; Porter, 1999).

Although macro-level forces explain only part of a complex story of social structures, conditions, and events that influence health, they have generally been neglected until recently. Even less well examined is the part that power, politics, ideology, and conflict play in how those forces come to influence health and create inequities. Social conflicts involving inequalities continue to be displaced into the market or specializations within science, evading politics.

This chapter presents a framework for understanding and acting on health inequities. I begin by outlining major social, economic, and political forces that contribute to health inequities, explaining their connection through the concepts of class, race, gender, and social justice. I then consider the way in which contemporary ideologies that organize the social order limit critical thinking, thereby constraining effective action. The last part of the chapter offers suggestions for communicating and organizing more effectively to eliminate health inequities both within and outside of the health professions.

This is an opportune historical moment to examine inequities in health and well-being and to question the definition of health. As social and economic inequality widens dramatically and becomes impossible to ignore, the connection between the vulnerability of people who live on the margins and the importance of working together collectively as a community for the public good has become more salient, if unarticulated. A clearer picture is emerging of the relationship between community-level well-being, resources for basic infrastructure, economic equality, and good health (Institute of Medicine, 2002). Yet in the United States, the federal government continues to target diseases rather than health and redirects resources toward bioterrorism and military preparedness instead of the public health infrastructure (Altman, 2003).

Worldwide, growing social and economic inequality, a basic cause of inequalities in health status, is equally stark (Kim and others, 2000; United Nations Development Program, 1999; Beaglehole and Bonita, 1997; Wilkinson and Marmot, 1998). The richest two hundred people in the world have wealth equivalent to 41 percent of the world's population. About 20 percent of the world's population receives over 80 percent of domestic investment and global trade and income (United Nations Development Program, 1999). According to the World Health Organization, the gap between rich and poor within the industrialized countries, including the United States, is widening (Beaglehole and Bonita, 1997; Labonte, 1998; Wilkinson and Marmot, 1998; Arno and Figueroa, 2000; Callinicos, 2000).

Strikingly, in the United States, income and wealth inequality is greater than in any other industrialized country in the world (Ackerman, 2000; Kawachi, Kennedy, and Wilkinson, 1999; Wolff, 2002), wider than it has been for fifty years and continuing to deteriorate (Wolff, 2002; National Center for Health Statistics, 1998; Reich, 1997; Pappas and others, 1993; Madrick, 2002; Phillips, 2002; Pear, 2002; Krugman, 2002; Miringoff and Miringoff, 1999; Congressional Budget Office, 2001). A survey by the Federal Reserve Board in 2003 indicates a sharp rise in inequality, countering conventional notions about the boom years of the 1990s (Andrews, 2003). The share of wealth received by the wealthiest fifth of the population is greater than at any time since World War II (Wolff, 2002). Almost one-quarter of all children in the United States live in officially defined poverty (Danziger, Danziger, and Stern, 2000). In 2000, nearly one-fourth of the U.S. population earned poverty-level wages (Mishel, Bernstein, and Schmitt, 2001). Household net worth has declined dramatically since 1983 (Wolff, 2000). Tax rates for the wealthiest Americans also continue to decline as their wealth increases (Congressional Budget Office, 2001).

Great social costs arise from these inequities, including threats to economic development, democracy, quality of life, the exclusion of people from full participation in society, and the social well-being of the nation (Kawachi and Kennedy, 2002). Inequality limits people's freedom to develop their capacities and capabilities to the fullest (Sen, 1992). Countries with the most inequality often show signs of social disintegration, violence, and greater poverty (Wilkinson, 1996). Investments in infrastructure such as schools, transportation, and the environment tend to be lower in such societies. Economic growth and productivity gains have not led to better wages or more leisure time.

Serious health consequences result from these inequities, accumulating over the course of a lifetime (Davey Smith and others, 1997). They range from increased and unnecessary excess rates of mortality, morbidity, and psychological stress to reductions in economic productivity (Kuh and others, 2002). Even if people have access to the necessities of life, research shows that that may not be enough to participate fully in society, particularly in relation to things like access to adequate employment, adequate nutrition, modern communications

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technology, specialized training and skills, or health services (Kawachi and Kennedy, 2002). The most egalitarian countries in the world, not the richest, have the best health status (Wilkinson, 1996; Daniels, Kennedy, and Kawachi, 2000). In the United States, data show that states with greater inequality, such as Texas, Louisiana, Mississippi, New York, and West Virginia, have poorer health status than states with greater equality, such as Wisconsin, Utah, Minnesota, and Iowa (Miringoff, Miringoff, and Opdyke, 2001; see also Kaplan and others, 1996, and Kawachi and Kennedy, 2002).

Since the time of Rudolf Virchow, a public health pathologist, and sanitary reformer Edwin Chadwick in the nineteenth century, Western researchers and health professionals have understood the importance of the relationship between social class and mortality and morbidity (Hamlin, 1998; Sram and Ashton, 1998; Rosen, 1993; Porter, 1999; Antonovsky, 1967). A growing and significant body of research accumulated since the 1980s documents unequivocally that poverty, poor quality of life, and income inequality are principal causes of morbidity and mortality (Black and others, 1988; Acheson, 1998; Kawachi, Kennedy, and Wilkinson, 1999; Lynch and Kaplan, 1997; Kawachi, 2000; Kaplan and others, 1996; Wilkinson, 1996; Shaw, Dorling, and Davey Smith, 1999).<sup>1</sup> A wealth of data specifically demonstrate the relationship of racism to inequality in health status and the continuing high mortality rates of African Americans and other people of color, including Latinos and Native Americans, compared with other groups (Williams, 2000; Williams and Collins, 2002; Krieger and others, 1993; Waitzman and Smith, 1998; Northridge and Shepard, 1997). Moreover, health effects of socioeconomic status may be related not only to absolute levels of poverty or severe deprivation *but also to inequality itself* (Marmot and others, 1991). Individuals with relatively high socioeconomic status are less healthy than those with even higher status.

The particular macro-level pathways by which health inequities link to specific exposures are intricate. Establishing how given social contexts interact with multidimensional biological and psychological pathways to cause disease with any quantifiable certainty remains a challenge. These pathways are often tied to the way production and investment decisions, labor market policies, neighborhood and workplace conditions, and racism and sexism connect with individual histories. Essentially, social injustices become embodied in the individual as disease.

The relationships between class and racial inequality and the distribution of disease are gaining increasing attention. Beginning in the early 1990s, many organizations and government agencies initiated intensive action and dedicated resources toward the elimination of health inequities in Canada, Britain, Australia, Sweden, the Netherlands, and, to a lesser extent, the United States. In Britain, the health secretary called for a debate about the National Health

Service to “move away from a preoccupation with health service structures towards a concentration on improved health outcomes across the nation” and argued for “the biggest assault our country has ever seen on health disadvantage [to] start to break the link between poverty and ill health” (Department of Health, 2001). The Department of Health established national targets to reduce health inequalities within a larger policy agenda (Bull and Hamer, 2001). In Australia, the Health Inequalities Research Collaborative works with the federal government to enhance the evidence base across many disciplines and link it to the promotion of public policy, programs, and practice development. In Sweden, the National Public Health Committee proposed goals linked to social determinants of health, particularly full employment and reducing poverty (Östlin and Diderichsen, 2000; Diderichsen and others, 2001). In the Netherlands, the Dutch Ministry of Health conducts research designed to reduce socioeconomic inequities in health through comprehensive strategies with long-term goals (Mackenback and Stronks, 2002). Moreover, the World Health Organization (WHO; 2000) lent its support to minimizing health disparities.

In the United States, advances have been limited. In 2000, the U.S. Department of Health and Human Services established national health goals for 2010, including the elimination of health disparities and ways to assess them, although these goals remain largely symbolic and unprioritized. President Clinton signed into law the Minority Health and Health Disparities Research and Education Act of 2000, which established the National Center on Minority Health and Health Disparities at the National Institutes of Health. Although the Office of Minority Health in the Department of Health and Human Services hosted the National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health in 2002 attended by more than two thousand people, little has come of it. It is conceivable that the attention by the federal government to health disparities reflects a desire to reduce expenditures for state-funded health care and not to transform society to eliminate the root causes of health inequities. The influential report *The Future of the Public's Health*, produced in 2002 by the Institute of Medicine, repeatedly stresses the importance of health inequities as leading to deterioration in population health. What may be done as a result remains to be seen, given the political climate and the reluctance to confront the political and economic interests that cause inequity. In Minnesota, one of the few states to initiate serious action to eliminate health inequities, the Department of Health in the late 1990s established the Minnesota Health Improvement Partnership Action Team on Social Conditions and Health (2001; see also Chapter Twenty-Six). This ongoing initiative seeks to identify action steps to address health disparities and increase analysis of the social conditions that affect health. Nonprofit public-interest organizations, academics in social epidemiology, and grassroots community groups represent some of the main

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sources that have been articulating bold visions, innovative theoretical perspectives, and strategies for action (see Chapter Nineteen and <http://www.thep-raxisproject.org>). Some organizations may be counted as acting on health inequities even if they do not specifically identify their primary work as health-related.<sup>2</sup> As Nancy Krieger (2001b, p. 421) notes, “Novel investigations informed by the Civil Rights, women’s, and other social movements have begun to analyze the health impact of non-economic as well as economic forms of racial discrimination and the ways in which these insults can be buffered or amplified by community characteristics.”

This new attention offers possibilities for challenging the way in which many nations now address health inequities and rethinking the definition of a healthy society. It presents opportunities to investigate the role of social class, economic conditions, gender discrimination, and racism in perpetuating health inequality. Yet in the United States, the challenge is not being met. Policymakers often do not act, even with the knowledge that social and physical environments in which people live and work will significantly affect their health and well-being. I will examine why this issue is challenging for policymakers later in this chapter. But first I consider the social and political forces that cause health and health inequities. What makes one society healthier than another? Why do some groups of people historically have better health than other groups?

### SOURCES OF THE INEQUITABLE DISTRIBUTION OF DISEASE

Robert Beaglehole and Ruth Bonita (1997, p. 4) note that “the foundations of health are common to all and include basic requirements such as adequate food, safe water, shelter, safety and hope. . . . These foundations have a more profound long-term effect on health status than the activities of the health system.” Creating healthy populations depends on the organization of material conditions in everyday life. These conditions, often referred to as the social determinants of health, are deeply connected to the foundations of existence, to the entirety of economic and social life (Link and Phelan, 1995). They include such things as the quality and affordability of housing, level of employment and job insecurity, standard of living, income level, availability and quality of mass transportation, education, social services, crime rates, air and water quality, forms of economic development, racism, poverty, workplace conditions, and political equality. For example, without access to quality housing, education, a living wage, and mass transportation, many people not only become more vulnerable to stress and disease but are also more likely to lack access to resources that enable them to fulfill their capacities and experience well-being. These

determinants influence health through biological and psychological pathways that affect individuals and may weaken community supports, thereby causing greater susceptibility to disease.

Social networks, educational systems, and family structure may affect the health of populations, although it remains difficult to quantify and segregate precisely the role of specific determinants. A strong organic link exists between the physical environment and ecosystem and the economic and social health of a community. As Robert Chernomas (1999, p. 17) comments, “the environment in which germs and genes travel is more important in determining disease than germs and genes themselves.” Social environments, governed by particular structures of power and privilege, act to create differentials in health status. These disadvantages—interconnected, cumulative, and intergenerational—reduce the capacity for full participation in society.

Independent of individual behavior, the character of the political and economic system and of the ecosystem structure the possibilities for health and illness (McMichael, 2001; see also Chapter Sixteen). For example, a segregated community with high crime rates, low-paying jobs, high levels of pollution, deteriorating schools, one-party political dominance, and limited social supports is more likely than other communities to have many residents with poor health. Many diseases that contribute to inequalities have long histories. Contemporary research suggests that “differences in levels of health and well-being are affected by a dynamic interaction among biology, behavior, and the environment, an interaction that unfolds over the life course of individuals, families, and communities” (Smedley and Syme, 2000, p. 2).

No linear progression of causes can explain patterns of health inequities. The relationships are synergistic, and their sources remain embedded in major economic and social institutions, public policies, and infrastructural arrangements in given circumstances. In part they derive from historical relationships of power and property, racism, and gender discrimination. Income inequality by itself, for example, will not explain a great deal without an examination of relevant linkages with factors like racial segregation, educational opportunities, and the tax structure. This makes demonstrating causality difficult, although the general failure to invest in human development contributes to inequities in health outcomes.

Before highlighting the characteristics of specific determinants and policies that promote health inequalities, I present an overview of the links between major social determinants and the larger social order as a way to explain why social and economic inequality exists in the first place. Without such a context, it is difficult to identify effective strategies that do not rely on single-issue politics or an approach directed toward isolated phenomena instead of organized injustice.

## CLASS, RACE, GENDER, AND HEALTH INEQUITY

The following framework, though brief and preliminary, suggests a way to explore core characteristics and dynamics of the social structure that link most determinants of health. Hierarchies of power considered through the lens of deeply embedded class, race, and gender relations provide the connections between these social and economic determinants, their distribution, and the basis of inequality more adequately than a determinant-by-determinant analysis. Such a theory seeks to explain the specific macro-level characteristics defining the organization of interests and privilege that lead to inequity.

Class relations, always affected by gender and race, contain an independent dynamic within each of the power structures that underlie them. However, for the purpose of linking social determinants of health within the dominant institutions of market relations that govern society on an unequal basis, we can say that racism and sexism are rooted in various forms of material exploitation. The social determinants of health must not be isolated as a list of subjects for “interventions.” As Nancy Krieger (1993, p. 166) explains:

What is not seen is the way in which the underlying structure of racial oppression and class exploitation—which are relationships among people, not between people and things—shape the “environments” of the groups created by these relations. [We must] see the causes of disease and the environment in which they exist as a historical product . . . constructed by society. . . . The same virus may cause pneumonia in blacks and whites alike, just as lead may cause the same physiologic damage—but why the death rate for flu and pneumonia and why blood lead levels are consistently higher in black as compared to white communities is not addressed. [We need a view that can] comprehend the all-important assemblage of features in black life.

### Class

The concept of class—which here refers to social groups and their relationship to capital, labor, the labor process, property, and economic ownership—opens the possibilities for exploring the causes of social and economic inequality itself (see Scambler, 2002). Class analysis can show why inequality is not the impersonal, chance, or inevitable result of industrialization, modernization, technology, or the business cycle. It provides an explanation of social development. In class-based societies, people are systematically compelled to cede the surplus they produce to those who control the productive resources and private property. Class thereby reflects the content and processes that define the relations of a capitalist social order. How societies organize production and allocate resources and investments within a particular class formation will affect population health and the distribution of disease.

Carles Muntaner (2002) notes certain misunderstandings with respect to the relationship between class and health inequities and imbalances in political power:

The recent growth of health disparities scholarship has not been accompanied by a parallel development in its key construct: social class. Rather, new research has kept the “social” in social inequalities to a minimum. . . . The typical pattern of relying on a single ordering of income does not tap into the social mechanisms that explain how individuals arrive at different levels of material resources. . . . By focusing on the properties of social positions rather than persons, power relations clash with the lay assumption that a person’s social class reflects some intrinsic attribute. [p. 562]

Class analysis also provides an approach for exploring the continuing reproduction of health inequities, the relationship of health to major economic and political processes, and methods for evaluating strategies to eliminate health inequities, with an emphasis on progressive social change. Given that inequities in political power strongly affect social and economic inequity, what specific features of class power lead to social injustice?

Political power in capitalist societies is the result of antagonistic class interests between capital and labor, not general divisions among people. The outcome of the struggle between these class interests determines the production of society and the specific direction of social change. History is the process through which social change occurs. Class inequity derives not mainly from consumption or distribution but from production and property relations. It concerns the original appropriation of the surplus value created by labor, not advantages that arise from income or occupational status as a location in a generalized hierarchy (see, for example, Wood, 1995a). The concept of class, and its connection to a specific form of domination produced through historically structured social relations, helps explain why health inequities exist. It also suggests the need for structural changes to eliminate health inequities, rather than interventions or services to ameliorate the effects.

What are class antagonisms about? Erik Olin Wright (1994) relies on concepts of oppression and exploitation that are neither pejorative nor general. That is, exploitation has a precise and specific definition in a given social order such as capitalism. Thus he explains the connection to class: “Economic oppression can be defined as a situation in which three conditions are satisfied: (a) the material welfare of one group of people is causally related to the material deprivations of another, (b) the causal relation in (a) involves coercively enforced exclusion from access to productive resources, [and] (c) this exclusion in (b) is morally indictable” (p. 39). He further explains the particular nature of exploitation within capitalism by noting that “the material well-being of exploiters

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causally depends upon their ability to appropriate the fruits of labor of the exploited . . . [whereby] inequalities . . . are rooted in ownership of and control over productive resources. . . . The exploiter needs the [efforts of the] exploited” (pp. 39–40). The incessant drive to increase the rate of capital accumulation (that is, the unending quest for economic growth because of competition) by reducing labor costs and social investments creates inequities and uneven development, in part because of requirements associated with the need for flexible labor markets, secure infrastructural environments (the conditions and materials necessary for capital accumulation to occur), and increased levels of productivity. Accumulation depends on subjecting people to market imperatives and making them dependent on the market. Establishing these conditions, which are endlessly changing, requires constant negotiation. The class perspective demonstrates why reform and managerial approaches cannot resolve deep antagonisms that concern the conditions of existence. Increasing corporate globalization, however, may result in the expulsion of those already on the margins of society as more people become excluded from production and consumption.

### Race

Racial and gendered structures of power and inequality profoundly influence health status because hierarchies of all kinds determine life chances and opportunities. As with class, various forms of racial and gender discrimination and oppression become embedded in social institutions, policies and cultural practices, rules, symbolic codes, and conditions in everyday life. The codings that occur in association with these identities often obscure their connection to class interests. Equally important, racial and gender relations influence class relations dialectically. This sometimes hinders identifying the primacy of one over the other.

Race is a constantly shifting category that is relatively new in human history. Like class, race involves historically constructed social relations that are constantly in flux (see, for example, Omi and Winant, 1993; Cooper and David, 1986). That is to say that although race has been viewed as both an ideology and a real condition based on experience, it is not fixed. The concept has been used as an ideology to justify political domination, exploitation, and exclusion, as well as a means to liberation by those seeking to forge collective identities that could motivate activism for change. Institutional racism, discussed in the next section, concerns practices that reinforce domination.

U.S. government policy demonstrates the many uses of race and ethnicity for political purposes, both in seeking to define or categorize people, as in the census, and in the distribution of resources. Equally important, government policy uses race in profiling individuals as suspects in crimes, determining who gets housing and educational subsidies, and setting other requirements for resource distribution that determine class position. A problem of race for epidemiology and addressing health inequities is not the confusion of racial differences in

health outcomes with biological and genetic differences but rather the failure to recognize the effects of racism on health (LaVeist, 2002; Krieger, 1993; Williams and Collins, 2002).

### Gender

Gender is also an ideological social construct related to traditions, behaviors, and relations between the sexes that establish a basis for moral and social life. As such, it often functions as a vehicle for the systemic appropriation of reproduction, labor, and sexuality from women. Gender relations, which influence the economy, vary historically and geographically, with no clear connection to real sexual differences. Gender discrimination or sexism derives from relations of domination and subordination connected to power imbalances (Barrett, 1980). Differentials in health outcomes between the sexes are more often attributable to sexism than to biological differences. Gender discrimination also results from inequities in political representation, the division of labor, gender segregation in labor markets, social stratification, and privatization within the family, which limit women's access to resources available to men and within different groups of women (Kawachi and others, 1999). Many government policies (welfare) and definitions (the family, mental health), implemented through gendered rules and practices within predefined property relations and class positions, determine the nature of exploitation. But the power associated with patriarchy transcends the question of roles and must be explored within a broader "structural context of men's and women's lives" through the lens of the social relations of gender (Annandale and Hunt, 2000, p. 22).

The division of labor along sexual lines, patterns of employment according to gender, and changing household structures have often led women, particularly of low socioeconomic status, to be denied access to resources and advantages available to men, thereby creating systemic disadvantages that may limit life chances and negatively influence health. Economic insecurity can lead to psychosocial stress. Early parenthood creates special stresses for young and poor women. Occupational segregation and limits on advancement help sustain economic inequities. At the same time, age and education differences play a role in determining health outcomes that hinder the evaluation of their implications.

Transforming the debate about social and economic inequality and health inequities suggests the usefulness of a framework to counter that of the market, discussed later. Such a perspective, offering a basis for major social change, would help clarify goals and objectives in determining what it means to achieve health equity. It would also provide a basis for organizational and public policy alternatives and identify methods to increase public awareness about the need for new ways of thinking about realizing a healthy society and involving the public as full participants in the process. I believe that a perspective grounded in the values of social justice, at the root of public health, provides an adequate basis for exploring the causes of health inequities and what to do about them.

## OUTLINING A SOCIAL JUSTICE PERSPECTIVE

Disparities in health status among different population groups are unjust and inequitable because, as noted, they result from preventable, avoidable, systemic conditions and policies based on imbalances in political power. Without a perspective grounded in values of social justice, approaches to inequities in health will likely aim at symptoms, continuing to rely on cures, treatments, or individual interventions rather than transforming institutions that cause health inequities. While behavior clearly influences premature mortality and health, more basic ongoing socioeconomic conditions affect and condition behavior (Smedley and Syme, 2000). The process by which decisions about investment, labor market policies, taxation, and neighborhood development become linked with individual life histories strongly influences the pathways through which inequality develops.

Theories of disease causation and powerful ideologies such as individualism and the market limit critical thinking about the desirable means for confronting health inequities. A discourse based on social justice supports collective responsibility for achieving healthy communities; it also addresses the social and economic conditions at the core of health inequities.

The commitment to social justice is as old as Western political thought. Social justice has been an animating ideal of all modern democratic governments. Yet its meaning remains obscure, and theories put forward by political philosophers to explain it have often failed to capture the way many people think about it. Social justice is not a thing but rather an ongoing series of relationships that permeate everyday life. Social justice concerns the systematic treatment of people as members of a definable group, such as women or African Americans.

Historically, at least two features define the application of social justice: an opposition to inequality, based on recognition of common human interests, and support for democracy. First, social justice demands an equitable distribution of collective goods, institutional resources (such as social wealth), and life opportunities. Beyond distributional questions, Amartya Sen (1992) defines a just society as one that ensures the development and the capacities of all of its members. Second, social justice calls for democracy—the empowerment of all social members, along with democratic and transparent structures to promote social goals. This is another way of describing political equality.

Inequality in goods production and distribution, resources, and capacities is a negative consequence of unequal privilege, power, and exploitation. Race, class, and gender (along with a more recent addition, sexual identity) have historically been cited as the primary cleavage lines of social injustice. Equality, a goal of social justice, is more than a formal category such as equality before the

law or equal opportunity. It is also more than an association with sectarian parties. According to Philip Green (1998), equality concerns “the systematic treatment of representative persons, viewed in the abstract as members and subjects of some organized social whole, rather than with the treatment of particular individuals with unique needs and interests” (p. 4). Achieving equality requires not merely redressing or ameliorating inequitable outcomes but creating a society that does not produce material inequality. Thus, beyond redistribution, it includes rethinking production and the conditions of production within a politics through which it becomes possible to articulate demands for social needs. Equality also means equalizing the circumstances over which people have no control and access to conditions that enable people to realize themselves however they wish. As Amartya Sen (1992) notes, the freedom to achieve through equal access to well-being with freely chosen goals is vastly different from equality of opportunity.

It is also useful to distinguish the concept of equality from equity. Equality refers to sameness, whereas equity refers to fairness. Our concern, as previously stated, is with differences in health status that are unjust. Phrased another way, the goal is to eliminate inequitable differences that systematically favor advantaged social groups. This might mean, for example, valuing communities, families, and the ecosystem over transnational corporations and their interests. Inequality tends to undermine democracy, the second feature of social justice.

Democracy has always depended on the willingness of ordinary people to participate, with or without the support of legal authorities, in social movements aimed at the collective empowerment of *whole classes of people*—women, minorities, workers, youth, the aged. It also depends on support for the social relations and political arrangements necessary to sustain and expand that power. Involving more than formal processes such as voting, it is defined through cooperation, not in the sense of acquiescence, but in relation to participation in all institutions that direct society and shape people’s lives. These institutions include the family, schools, and businesses, as well as greater popular control over basic social decisions that determine what gets produced and distributed and for whom. Conventional uses of the term typically weaken the connection of democracy to class as well as the idea of popular power.

Democracy’s roots in this regard derive from principles of inclusion rather than exclusion. In addition, democracy requires access to productive resources and the removal of barriers to economic well-being. Greater democracy means subjecting more issues and investment decisions to public decision making, expanding the political agenda. Democracy, a goal of social justice and not merely a means, is achievable only if equality, participation, and mutual respect are part of our institutions. In recent times, U.S. policy has denied social values

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in favor of market values, making it increasingly difficult to identify public forums and media willing to examine the importance of social justice to the development of a democratic society. Achieving social justice is about changing society so that claims for freedom, equality, and democracy receive adequate expression and so that the politics by which people pursue these goals gain acceptance as normal rather than exceptional and suspect. This sort of change depends on social solidarity, community, mutual reliance, and cooperation.

What has social justice to do with health? Nancy Krieger (1998) notes, “Social justice is the foundation of public health. . . . It is an assertion that reminds us that public health is indeed a public matter, that societal patterns of disease and death, of health and well-being, of bodily integrity and disintegration, intimately reflect the workings of the body politic for good or ill” (p. 1603; see also Sretzer, 1988). Ann Robertson (1998) reminds us that “attempts throughout the twentieth century to align public health with a social justice agenda reveal the persistence of the moral thrust of public health” (p. 1419). The International Society for Equity in Health’s definition of health is “the absence of systematic and potentially remediable differences in one or more aspect of health across populations or population subgroups defined socially, economically, demographically or geographically” (Macinko and Starfield, 2002).

Broadly speaking, what principles might define the practice of social justice in the context of the public’s health? According to Dan Beauchamp (1988), beyond the “abstract psychology of justice as fairness,” we need to develop “shared loyalties to common institutions [that would] create popular solidarity based on political and communal loyalties stemming from the experience of common possession of shared institutions” (p. 24). In Beauchamp’s view, “Public health stands for collective control over conditions affecting the common health” (p. 17). Acting on principles of social justice to assure health equity at the level of practice might begin with a commitment to social welfare, the well-being of all—or stated another way, a commitment to meet human need to eliminate health inequities as a priority and to equalize life chances. It would further involve an effort to expose and dramatize health inequities in a way that presents them not as individual and isolated problems but as *public* or *collective* issues.

Unfortunately, capitalist societies remain structured for inequality, through the division of labor, political and legal inequality, vast discrepancies in wealth, and hierarchical relations within the family. Beyond seeking to create more equitable government, communities must be able to choose actions that will enhance their capacities within institutions, as they exist. This means that the culture must become more supportive of equality. More important than redistributive justice is creating a society that is just in all of its basic structures, from production to the family.

## SPECIFIC SOCIAL DETERMINANTS OR PROXIMATE SOURCES OF HEALTH INEQUITIES

Having concluded my brief consideration of class, race, and gender and the outlines of a perspective grounded in social justice, I now return to the description and implications of several major social determinants of health, recognizing the importance of their interconnectedness and their synergistic, dynamic character within particular social structural relations. They are proximate causes of health inequities within the larger social order of capitalism. Thus the intersection of decisions in land use planning, corporate development, hiring practices, and loan policies of banks, for example, can be connected to class interests, racism, gender discrimination, and health outcomes in a meaningful way. At the same time, compared with even thirty years ago, the determinants I shall discuss function in the context of a more insecure world with greater risks at every turn, less protections from the market, less social stability, and fewer institutions willing to address the disruptions to ordinary social life.

### Inequality of Income and Wealth

Although income does not measure social welfare per se, less egalitarian societies with income inequalities have poorer overall health (Wilkinson, 1996). Research consistently demonstrates that inequality of income and wealth has a major impact on health outcomes, in connection with material deprivation, although it is not by itself a causal factor (Lynch and others, 1998). This is because lack of income limits access to resources related to the capacity to experience good health. Because lower-income people lack the ability to take advantage of the amenities, technologies, and conditions available to higher earners, social exclusion tends not only to marginalize the less well off but also to make them less healthy; they are in effect shut off from the prerequisites for good health. Political and cultural conditions and changing interpretations of what constitutes life's necessities thus play an important role in successful participation in society. Absence of control over social resources leads to changes in the built environment, such as suburban sprawl, which segregates people by income, thereby increasing social exclusion and limiting access to resources. High homicide rates, low birth weight, low high school graduation rates, and high unemployment rates are all linked to low income (Kaplan and others, 1996). As Kawachi and colleagues (1999) note, "The evidence shows . . . that the distribution of income among members of society matters as much for their health and well-being as does their absolute standard of living" (p. xi).

Inequality of wealth, or accumulated assets, is even more striking than the income gap (Wolff, 2002). People who are worse off, in terms of class, income, housing, education, and so on, have worse health. People who live in

communities with extensive deprivation and deterioration can experience poor health, even when we control for individual disadvantage (Davey Smith and others, 1998). As Lynch and colleagues contend in Chapter Seven of this volume, “the effect of income inequality on health reflects a combination of negative exposures and lack of resources held by individuals, along with systematic underinvestment across a wide range of human, physical, health, and social infrastructure.” Income inequality must be understood in relation to the multiple pathways or social contexts that affect individual outcomes. According to Wilkinson (1996), social disintegration is also directly related to high levels of economic inequality. As economic inequality increases, health declines (Raphael, 2000). Thus inequality itself is an issue, not just deprivation. The effects of social class on health and living in a stratified society suggest the need to eliminate inequalities, not merely increase income. This will become more apparent as wages continue to fall and the gap in wealth between rich and poor continues to increase.

### Poverty and Deprivation

Perhaps the single most important determinant of ill health, long known, is absolute poverty, particularly as it relates to life expectancy, high infant mortality, and a wide range of diseases (Black and others, 1988). A significant body of research since the early 1980s documents clearly that poverty, poor quality of life, and low socioeconomic status are principal causes of morbidity and mortality, predisposing people to chronic disease in both the short and long term (U.S. Department of Health and Human Services, 1999; Kuh and Ben-Shlomo, 1997; Townsend, 2000). Poverty, a broad and multidimensional concept, is often a by-product of income and wealth inequality. The U.S. Census Bureau reported that the proportion of Americans living in poverty in 2001 had risen substantially since the previous census a decade earlier (Pear, 2002). Most live in families. In the United States, the data show a steady and substantial increase in the proportion of children in poverty since 1973. The poor have become a permanent class of people, even though the United States is one of the richest countries in the world with a rising life expectancy (but one that is still lower than that of Japan and all the nations of Western Europe; see Bagdikian, 2003).

Individuals at a socioeconomic disadvantage are more susceptible to death and disease, regardless of specific diseases, due to their greater exposure to the conditions that produce disease. A strong relationship exists between degree of economic inequality and child poverty (Kuh and Ben-Shlomo, 1997). These cumulative disadvantages occur within a historical legacy of socioeconomic and racial inequality. Poverty and correlated living conditions impose constraints on many aspects of everyday life that affect access to requisites for good health such as good nutrition, adequate housing, education, transportation, recreational facilities, and environmental conditions (Shaw, Dorling, and Davey

Smith, 1999; see also Pantazis and Gordon, 2000). Social and psychological effects of absolute poverty are also harmful. Uncertainty, lack of control over one's life, helplessness, chronic stress, anxiety, and depression all contribute to ill health and even death (Brunner and Marmot, 1999). Poor health can be a cause of poverty, and poverty can occur as a consequence of ill health. Given the economic chaos of recent years, as evidenced by increasing consumer debt, more people forced into relying on defined contribution benefit plans for their retirement, and the potential reorganization of Social Security as a social insurance system, we may expect increased stress and greater numbers of people slipping into poverty, thereby negatively affecting health outcomes and well-being.

### Institutional Racism

Reliable data collected over the past two centuries consistently demonstrate that African Americans and many other people of color, including Native American and Latino populations, experience more illness and mortality than whites (Byrd and Clayton, 2002; Cooper and David, 1986; Krieger and others, 1993; National Center for Health Statistics, 2001; Vega and Amaro, 2002). Black Americans have a mortality rate 33 percent higher than whites; infant mortality is 2.4 times higher (see Chapter Three). These inequities are institutional to the extent that they arise from laws, policies, and restrictions on participation in decision making. They also result from efforts by the state to incorporate people of color into the dominant culture and stabilize the social order in ways that deny people's culture and history and otherwise constrain their lives. Institutions that reinforce these outcomes connect to a long history of social relations concerning racial policies, practices, and the analytical paradigms that seek to explain race and racism. Beyond economic circumstances, racism is a powerful force leading to persistent disadvantages in health outcomes (Krieger and others, 1993; Polednak, 1993). Thus even when we control for socioeconomic status, racial disparities in health remain, due to highly correlated factors such as segregation, economic disadvantage, and discrimination that affect life chances. David Williams (1998, p. 29) argues that "black-white differences in SES . . . are a direct result of the systemic implementation of institutional policies based on the premise of the inferiority of blacks and the need to avoid a social contract with them." The most basic type of group oppression, racism takes many forms, all of them restricting opportunities.

One example is evidence of the location of polluting industries in communities of color (Bullard, 1994; United Church of Christ, 1987; Center for Policy Alternatives, 1995). Another example concerns the discriminatory employment practices that have kept African American, Native American, Hispanic Americans, and other populations disproportionately at lower socioeconomic levels. Everything from segregated housing to discriminatory banking practices and

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poor-quality schools has cumulatively contributed to severe stress and unhealthy environments. In addition, people of color are more likely to experience police harassment and receive longer prison sentences than whites. In addition, racial prejudice itself is a force, collectively, for poorer health outcomes in many communities of color (Kennedy and others, 1999). Worse health outcomes occur at every level of income. Political power plays a crucial role in these results. The health status and living conditions of African Americans improved significantly in the 1960s and 1970s during the height of the civil rights movement, demonstrating the inverse relationship between advances in political power and a decline in mortality rates.

### Gender Discrimination

Female poverty continues to rise in the United States, and the gender gap in after-tax median income is still relatively wide (Christopher and others, 2000). Extensive health inequities with respect to life expectancy, morbidity and mortality rates, maternal mortality rates, depression, and chronic conditions such as hypertension and diabetes exist among women, particularly African American women, regardless of socioeconomic status and race (Krieger and others, 1993). This suggests that interrelated conditions and experiences, including social status, working conditions, segregation, limited employment opportunities, and neighborhood safety, are important determinants of health inequities. Limited resources and multiple stressors in poor neighborhoods provide multiple pathways for ill health. As Arline Geronimus (2001, p. 133) notes, “American women in ethnically marginalized or economically disadvantaged populations have not enjoyed improved health or prolonged life in equal measure to those in more advantaged groups.” She notes that this is especially true among African American women. Divorced and widowed women and those with child care responsibilities experience additional burdens, including gender discrimination in getting credit and gaining support from social service bureaucracies (Schulz, 2001). Violence against women has been associated with malnutrition (United Nations Children’s Fund, 1998). Sexual harassment on the job, especially for low-income workers, generates further stresses related to health outcomes (Kawachi and others, 1999).

### Corporate Globalization and Internationalization of Capital

Globalization is a “new logic and structure of rule,” a form of sovereignty without boundaries, according to Michael Hardt and Antonio Negri in *Empire*. It places increasing control of speculative finance capital and the flow of the world’s resources in the hands of large, unaccountable transnational corporations, thereby reducing the ability of national governments to influence economic practices (Hardt and Negri, 2000; see also Sassen, 1998; Amin, 1997; Petras and Veltmeyer, 2001). Subjecting people more forcefully to market

imperatives for the purpose of expanding capital, globalization generates tremendous instability and inequality in communities all over the world (Kim and others, 2000). Markets governed by supranational institutions with their own rules, such as the World Trade Organization (WTO), come to dominate almost all aspects of social life, accentuating inequalities. Constant and rapid shifting of capital, resources, and jobs to locations of lowest production costs and cheap labor anywhere in the world, as well as the acceleration of global production, has led to the disintegration of communities, weakening of social institutions, higher unemployment, dislocation, insecurity, uneven development, and other stressors related to illness (Weisbrot and others, 2001).

Increasing social and economic inequalities through so-called free (not fair) trade policies and structural adjustment policies undermine the public's health in many ways, from the increased exportation of harmful products such as tobacco and toxic waste to the forced exportation of needed natural resources in developing countries (International Forum on Globalization, 2002; see Chapter Five). An endless and rapid investment-disinvestment cycle and the quest for economic growth and expanded markets with new forms of finance capital lead to the depletion of natural resources. The unlimited drive for growth also results in exploitative labor practices and destabilizes communities by reducing governments' ability to maintain a secure resource base to provide essential services that protect and improve health. Graham Scambler (2002) argues that growing inequities in health worldwide cannot be explained without reference to "the interlinked capital flows and fortunes of peoples from 'peripheral' nation-states in the Third World. . . . Greater transnational corporate penetration into nation-states in the Third World is associated with increased rates of infant mortality in those countries over time" (p. 155).

The vast resources and power of global corporations also enable them to limit governments' authority to enact protective labor, health, safety, and environmental laws by making countries compete with each other, and they shape national and international relations in many other ways without democratic accountability. Increases in international competition, and hence attempts to increase economic growth, reduce the bargaining power of labor and people with limited education. The benefits produced by corporate globalization tend to be unevenly distributed (see Chapter Five).

### **Degradation of the Environment and the Ecosystem: Disproportionate Burdens**

While the ecosystem and nature have always been utilitarian objects for exploitation under capitalism, the current search for new markets and cost-cutting measures, along with the drive for endless economic growth, degrades the environment to a point that dangerously accelerates the destruction and depletion of ecosystems (Kovel, 2002). These changes in turn provide new opportunities for

the development of infectious diseases and the return of old ones like tuberculosis and malaria. As Joel Kovel explains, “Malnutrition, unemployment, social alienation, systemic poisoning by chemical discharges, and the subtle effects of radioactive fallout and, indeed, of climatic change itself—all increase the likelihood that infections will take hold and become both lethal and pandemic” (p. 16). According to Tony McMichael (2001, p. xii), “Human economic activity on Earth’s atmosphere, oceans, topsoil and biodiversity is weakening the planet’s life-support systems,” thereby increasing “risks for future populations.” The limits of the planet’s carrying capacity, coupled with more intensive extraction of material resources such as oil, gas, and coal and with the use of chemicals and toxic production processes, give rise to new health concerns that disproportionately affect poorer communities. The number of floods, droughts, and natural disasters appears to be increasing, with indications that human activities are a main cause, affecting the poor most severely (Kim and others, 2000).

As life’s necessities, such as water and seeds, become privatized in an aggressively deregulated world economy, the result is severe environmental degradation, denoted by outcomes like unchecked global climate change, habitat destruction, deforestation, the loss of biodiversity, ozone depletion, and increased carbon dioxide emissions. Consequently, we can expect a disproportionate rise in cardiovascular disease, asthma, and premature death among people living under conditions where these effects are cumulative. Assaults on the ecosystem also destroy people’s livelihoods, traditional cultural practices, and identities as their communities become subsumed into global modes of production (Tarbell and Arquette, 2000).

In the United States, the poor and communities of color are likely to experience a greater decline in their health and well-being than others, as they are exposed to a disproportionate share of environmental hazards such as lead and toxic waste and the associated risks (Bullard, 1994; Northridge and others, 2003). A study by James Boyce and colleagues (1999) suggests that power inequality is directly related to environmental degradation and therefore to the public’s health.

### **Destruction of the Public Sector: Privatization, Deregulation, and the Elimination of Social Supports**

In the twentieth century, the greatest reductions in inequality in health status occurred as a result of the introduction of major policy initiatives and legislation whereby the government accepted responsibility for the collective health of the nation (Rosen, 1993; Porter, 1999). Social supports and the productive use of resources matter much more than economic growth (Sen, 2001).

Typically, societies with weak social supports have higher rates of economic inequality (Wilkinson, 1996). We can expect that the reduction of the social wage will have negative effects on health status. Increases in inequality in

health status have occurred when such initiatives and social reforms began to decline. Beginning with the Reagan administration, major reductions in expenditures on social programs and preventive services, along with a general attack on living standards, resulted in sharp increases in income inequality. These cut-backs also disrupted the organizational infrastructure that sustains political activism. As support for and investment in necessary infrastructure declines in the public sector—schools, mass transit, low-income housing—health risks increase (see Keating and Hertzman, 1999; Townson, 1999). Contemporary movements to privatize public health itself into separate parts opposes the demonstrated need for more unified systems approaches that are necessary to eliminate inequities (see Rhein and others, 2001). Reduced expenditures for public health programs and the misdirection of resources toward diseases rather than the conditions that produce disease will likely increase inequities further.

Reductions in social supports are not really about shrinking government in the name of efficiency but rather are a means to make people vulnerable and available for labor markets as cheap labor. The political goal in reducing the role of the public sector is to eliminate policies that protect people from the vagaries of the global market (Teepie, 2000). Coinciding with the elimination of social supports are attempts to apply market imperatives to an increasing proportion of the public sector and to end protective regulation (Beauchamp, 1988; Teepie, 2000). Examples include the campaign to privatize Social Security and Medicare, the press to convert health care more completely into a commodity, and industry efforts to control the earth's water supply. These actions are likely to increase health inequities.

### Workplace Conditions and Employment

A strong connection exists between work and health, particularly given the relationship of work to family life and the well-being of communities, and the documented relationship between socioeconomic status and health (Amick and Lavis, 2000; see also Chapter Nine). In the United States, recent years have witnessed a decline in health and safety regulations for workers and a speedup in the pace of work, especially in the more dangerous industries and among the less skilled. But employment affects health apart from the specific character of the work process. Insecurity plays an important role in healthy outcomes, especially for groups without political power in the globalized, restructured economy. With rapidly changing patterns of employment and declining social supports that would guarantee income in new welfare provisions, increasing levels of stress exacerbate inequities among the most vulnerable in the population, increasing the potential for illness (Wilkinson and Marmot, 1998). Many employers reduce their full-time workforce, relying on temporary workers or contractors, often as a means to avoid paying benefits. Unemployment and chronic underemployment have a long association with serious health risks,

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including suicide, depression, violence, and alcohol abuse, particularly with continuing reductions in unemployment benefits (Dooley and others, 1996). Equally important for health is the level of control employees have over their work conditions. Those with less control, who tend to be in the lower social classes, have worse health outcomes—particularly with respect to cardiovascular and chronic diseases—as well as psychological problems and a greater opportunity in general for injuries and illness. And workers are losing more control in globalized labor markets, particularly where wages are lowest and unions are scarce. All of these features of work connect to the changing nature of global economic forces in a deregulated environment, including the division of labor, challenges to collective bargaining, increased exploitation, and the weakening of the labor movement in the United States.

### Housing, Neighborhoods, and Land Use

Individual health risks are related to community health, residential location and density, characteristics and design of the built environment, and the uses of space (see Fullilove and Fullilove, 2000; Harvey, 1996; Fitzpatrick and La Gory, 2000). Yen and Syme (1999, p. 293) note that “areas have characteristics that are more than the sum of the individuals living in them. . . . [They] exhibit a patterned regularity of disease rates over time even though individuals come and go.” Poor neighborhoods have multiple disadvantages affecting health (Northridge and others, 2003). Segregation (which influences access to employment and educational opportunities through isolation), substandard housing (a source of asthma and lead poisoning), overcrowding, failure to enforce housing regulations, lack of social services, deteriorating neighborhood conditions (crime, poor sanitation services, heavy traffic), discrimination in lending practices by banks reducing accessibility to affordable housing, and places where significant economic disinvestment occurs have been shown to contribute to inequities in health (Fitzpatrick and La Gory, 2000; Bashir, 2002). These forces and conditions parallel many health problems, from asthma, injury, and accidents to lead poisoning, heart disease, and psychosocial stress (Bashir, 2002). Infants, the poor, and the elderly are most at risk. Women living in low-income, minority communities are at greater risk for heart disease (Le Clere, Rodgers, and Peters, 1998). According to James Krieger and Donna Higgins (2002, p. 760), “Exposure to substandard housing is not evenly distributed across populations. People of color and people with low income are disproportionately affected.” Spatial relations thus increase health risks, and the uses of space depend on highly politicized decisions.

The overall urban environment, and the process of urbanization itself, plays an important role in creating health disadvantages and a specific ecology of health or illness, particularly in conjunction with increasing levels of environmental pollution and toxic waste in locations with poor-quality housing (Northridge and

Shepard, 1997; see also Harvey, 1996). Thus land use and zoning decisions can determine who has access to necessities like clean air and mass transit, as well as education and support networks (Bullard, Johnson, and Torres, 2000; Mollenkopf, 1983). In New York City, for example, the location of most of the city's bus depots has been linked to increases in asthma rates for children in Harlem (Sclar and Northridge, 2001). Many of these conditions result from the outcomes of political battles over property rights and profit versus the public interest (Sclar and Northridge, 2001). Cities are particularly vulnerable to shifts of capital to more lucrative locations, as well as budget deficits resulting in uneven development, leading to stress and disorganization (see Harvey, 2001; Davis, 1990; Smith, 1984).

### **Weakening of Working-Class Power, Strengthening Power of Capital**

An international study examining relationships between political variables and health indicators found a high correlation between working-class power and population health (Muntaner and others, 2002). Additional studies have found that more conservative governments worsen the health status of disadvantaged populations (Davey Smith and Dorling, 1996; Hicks and Swank, 1992). Political outcomes influence the distribution of investments in infrastructure and services that affect health. Levels of political participation can also affect morbidity and mortality rates (Kawachi and others, 1999).

Since 1973, the power of the working class and labor has been weakening in the United States. The deterritorialization of production, the decline of labor unions, and reduced voter turnout have contributed to this weakening, as well as the absence of any truly oppositional political party. In the United States, the federal government has increasingly come under greater control of well-financed corporations and wealthy individuals that make enormous monetary contributions to political campaigns (Phillips, 2002). These changes have given capitalist forces, investors, and owners of significant property an almost overwhelming edge in political power to act against the social well-being of the population. International treaties and new global institutions further enhance their power, as well as limits on the capacities of citizens to take protective legal action (see Chapter Five). Corporate policies and practices embodying capitalist power, apart from the specific effects of globalization, have negative consequences that generate health inequities for populations and individuals. These include, among many possibilities, economic disinvestment in poor communities, extensive layoffs, mass firings and restructuring, gentrification, targeting of industrial and toxic waste facilities in communities of color, elimination of protective regulatory structures, profiteering by drug companies seeking to maintain control of patents, financial speculation, use of dangerous technologies, restricting competition, shifting the tax burden to the less fortunate, tax subsidies to wealthy corporations, and failure to improve living conditions for farmworkers. Specific

policies supported by capital to strengthen their position in relation to the workforce include failure to increase the minimum wage, reductions in unemployment compensation, elimination of health and safety regulations, weakening rights of labor to organize, and opposition to full employment and long-term job opportunities. All of these forces result in potential stresses and exposures leading to poorer health and well-being.

Both the unwillingness to invest in urban infrastructures and support for unproductive investments yielding short-term gain destabilize many economies. Concentration of wealth among fewer transnational corporations, driven by short-term financial gain, has led to a crisis of governance, limiting democracy. Economic concentration in the mass media reduces viewpoints critical of corporation actions. Corporate strategies, often intentionally designed to make populations vulnerable to labor markets, serve to reduce costs. Wage cuts, outsourcing, benefit reductions, and layoffs are some examples. They contrast with policies to invest in workers to increase productivity or to support community infrastructures.

### Further Assaults on Democracy

Equity depends on democracy and accountability. Without political equality, economic equality becomes less realizable, further weakening the political power of ordinary citizens. Dan Beauchamp (1988, p. 135) remarks that “democratic discussion, with its creation of conflict and mass publics around health and safety issues, often . . . plays a key role in improving the public’s health, setting the stage for . . . planned health education campaigns, changes in mass behaviors, and policy development, encouraging differing conceptions of problems.” The history of public health in the United States is littered with battles between health authorities and business (Porter, 1999).

The United States, of course, was not founded as a democracy, since only white propertied men originally had political power. But today most elected officials, unduly swayed by corporations through huge contributions, take no action to reduce the extraordinary influence of wealth in the political system by those able to control resources and the mass media.

Antidemocratic trends, closely related to corporate globalization of finance capital, further diminish equal access to decision making over the basic forces that affect people’s lives. In addition, many corporations narrowly define concepts of health and safety and the legitimate role of government in protecting the public. Moreover, the integration of news, public relations, and entertainment all constrict a true democratic process. Increased secrecy in government and rule through the WTO and other international institutions circumscribe public arenas for organized civic action. Accountability barely exists. Decisions about the development of technologies and products, the use of resources, and conditions in the workplace have profound implications for human development and health. The

more they become private and beyond the reach of political and public authority, the weaker democracy becomes. Private interests then override public well-being. Addressing health inequities requires collective decision making and debate about fundamental features of society as a whole. The assaults on democratic institutions thus limit the kind of debate that would support necessary action to tackle health inequities.

## IDEOLOGICAL OBSTACLES TO ELIMINATING HEALTH INEQUITIES: PARADIGMS AND POLITICS

In the mass media, very little public discussion occurs about root causes of health inequities and their consequences (Wallack and others, 1993, 1999; see also Chapter Twenty-Seven). With exceptions, few decision makers examine the relationship of inequalities in health status to racism or social, political, and economic inequality. None suggest the need for major political and economic transformations to eliminate health inequities. Many analysts and policymakers instead focus on symptoms and treatments, microanalysis of individual risk factors, and changing people's behavior and lifestyles, not conditions or places. They present options primarily through a biomedical model and remedial solutions, mostly associated with health care, rarely stressing social transformation.

What accounts for the lack of public attention to the processes that maintain and perpetuate social inequality that influence health inequities? Why is there no national debate? Why does government consider only ameliorative responses or limited regulation, rather than institutional transformations that would eliminate the causes of health inequities? At the simplest level, addressing the social determinants of health is made difficult because the phenomena are not especially observable. Achieving healthy communities is a process, not a measurable status. Measuring improvements in service delivery is certainly easier than achieving well-being in specific population groups. Many analysts still refuse to consider how people function as social beings in an ecological context (see Chapter Nineteen). In addition, governments mostly attend to single issues or "problems" through categorical programs for each that preclude a more integrated and comprehensive focus. They direct strategies to act on individuals, not communities, regions, or classes.

But perhaps most crucial in limiting the capacity to contest the root causes of inequality and expand public debate are various ideologies reflected in everyday life, based on hierarchies of power. Ideologies are systems of meaning and practice within a culture that guide the interpretation of everyday life. Embodied in social and political structures, they play an important role in legitimating and obscuring structures of political power associated with class, race, and gender (Metzaros, 1989; Deetz, 1992). They represent forms of social

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consciousness. Always in flux, contradictory, uncontrollable, and contested because of changing historical circumstances, they emerge from social relations and the conflicts within them. Capitalist ideologies exist mainly to contain conflict, neutralize or dissolve it, silence opposition, circumscribe alternative conceptions of society, mobilize consent, and otherwise legitimate inequality. Corporate public relations machinery and the mass media present the application of market relations to all aspects of social life as permanent and inevitable (Thompson, 1990). Counterideologies often develop from social movements and organizations resisting oppression. They may expose ideologies as arbitrary social constructions. But people concerned with security, family, and well-being constitute their own worldview. Dominant ideological discourses can become irrelevant to people's culture or lives. Ideologies are not necessarily the product of political strategy or direct class interests. Their character and content derive from the nature of the social relations that constitute a society. Thus free markets, contractual agreements, and individualism are capitalist ideologies, as are identities such as "consumers" (a label that ignores the role people play as producers of value and as citizens in a democracy). Why are ideologies important in discussions of health inequities? As Sylvia Tesh (1988, p. 154) observes:

The politics of prevention is the struggle over the assignment of meaning to suspected causes of disease, for the political meaning that a causal statement acquires largely determines what kinds of prevention policies a society develops. Will "environmental hazards" bring to mind microparticles much like viruses and bacteria or uncontrollable industrial production? Will "occupational stress" come to mean terrible job conditions or tense workers? . . . Will the popular literature about unhealthy diets mainly discuss unscrupulous advertisers, or will it concentrate on inadequate health education? In short, will disease prevention policies place responsibility on individuals or on institutions and structures in the wider society?

Historical experience conditions consciousness that shapes the categories, concepts, and contexts for understanding health. Oppositional discourse always exists, produced by the particular oppressions of a given social order. But the ideas of certain interests tend to dominate in any particular moment; they condition the interpretations of the real and the possible. Thus the power of ideology lies in what is taken for granted.

Inequality often seems to occur as the result of natural economic forces. The separation of the political from the economic in liberal democracies conceals class interests and distorts the capacity to act and to articulate a plan of action outside of well-defined boundaries. A major feature of contemporary ideology with respect to health inequity is a refusal to recognize its systemic origins, roots, or logic, and therefore attempts to explore the relationship of

political power to health inequities appear fruitless. In U.S. culture, a *political unconscious*—to misappropriate a term from Frederic Jameson (1981)—represses knowledge of our active participation in the production of inequality—an unwillingness to face the historical legacy, hidden realities, and political struggles that gave rise to and perpetuate inequity. Ideologies that limit the boundary of acceptable action and domesticate the struggles to address health inequities—in part by defining the nature of legitimate discourse and knowledge—have their roots, as noted, in class, race, and gender relations.

Many people are searching for better ways to present their vision of a more just and sustainable society and to stimulate robust public dialogues about central concerns in their lives. However, the space for and quality of public discourse is diminishing (McChesney, 1999; see also Deetz, 1992; Fraser, 1990; Ryan, 1989). The distribution of political power within the class structure creates systems of meaning, limiting critical inquiry by influencing the definition of issues, identities, what things mean, categories of analysis, what is desirable and possible, and common sense. Corporate public relations experts, economists, and pundits, mostly from conservative think tanks, dominate the mass media. The atrophy of imagination and the appropriation of culture often results in a further loss of meaning, the debasement of language, and the trivialization of public debate. Equally important, many voices have been effectively silenced or excluded from mainstream systems of representation. The struggles and suffering of those who experience inequities remain unarticulated. In addition, the discourse and practices of the health professions circumscribe national dialogue about confronting the social determinants of health, if inadvertently. Solutions to inequity, presented generally in medical or managerial terms, conceal injustices. Worse, new attacks are mounting against researchers engaged in the study and analysis of health inequities (see Muntaner and Gomez, 2002).

Given the urgency of investigating the elements of power beneath the surface of what otherwise appear to be inevitable and natural arrangements of human affairs in capitalist societies, several ideologies stand out that hinder full-scale debate on health inequities.

### **Interventions and Reform Versus Structural Systems Change**

Interventions and reform refer to piecemeal, short-term actions, primarily through government policy, that respond only to the consequences or effects of inequality rather than to inequality itself while perpetuating the institutions that support it. Structural systems change requires deliberate long-term actions that lead, even if gradually, toward a transitional stage of development that addresses conditions to support health equity. That is, reforms may be effective if they are part of a comprehensive plan of action leading to broad change that eliminates

the basic exploitations of the social order. As long as disadvantaged populations seek concessions while remaining in a subordinate position, reforms will fail and only perpetuate inequity.

Yet much of the debate and discourse on decreasing inequality remains focused not on causes but on access to health care and modification of individual behavior (see U.S. Department of Health and Human Services, 2000). Moreover, the reformist paradigm, by defining injustices as social problems in need of solutions, draws attention to features of the social environment that are least likely to effect permanent change. Supporters of remedial approaches tend to accept prevailing social conditions without exploring how they got that way. In traditional epidemiology, this is a result of certain features of clinical training and a professional perspective that takes the individual as the unit of analysis (Krieger, 1994; McMichael, 2001). It is also due to a discomfort with integrating political and social analysis. If we were back in the 1850s, the discussion to eliminate slavery would not emphasize best practices, model programs, or improvements in service delivery. Abolitionists identified slavery as a major institution of social injustice in American society and called for radical change.

The reformist perspective, seeking to absorb demands, leads only to limited policy choices and narrowly defined interventions unrelated to the scale and scope of the sources of inequity. It does little to prevent future inequities, as acting on their origins would. Options for change, in this view, rarely stress institutional failure. The potential for transforming community organizing, popular struggle, and the demonstration of responsibility for health inequities thereby becomes limited to programmatic and organizational issues about better service delivery or ways to educate the poor.

### Individualism

Individualism, a powerful philosophy and practice in U.S. culture, limits the public space for social movement activism (Buechler, 2000). By transforming public issues into private matters of lifestyle, self-empowerment, and assertiveness, individualism precludes organized efforts to spur social change. It fits perfectly with a declining welfare state and also influences responses to health inequities (see Chapter Twenty). From this perspective, each person is self-interested and possessed of a fixed, competitive human nature. Everyone has choice and the potential for upward mobility through hard work—ignoring how we develop through the process of living in society (Tesh, 1988). Individualism presumes that individuals exist in parallel with society instead of being formed by society.

Individualism also supports a view that distrusts cooperative collective activity, situates people as isolated citizens, inhibits understanding the patterned nature of inequality, and looks to change individual behavior, not the conditions

that give rise to inequalities. It represents, as Lawrence Wallack notes in Chapter Twenty-Seven, “one of the major barriers to collective action and a cornerstone of a market system that generates excess public health casualties.” Individualism supports the belief that, as Ellen Wood (1995b, p. 6) notes, “there are no structured processes accessible to human knowledge.” Individualism often leads to essentially blaming the victims of oppression for their own condition because of personal dysfunction. Moreover, individualism limits the ability to evaluate the social and historical dynamics of health and illness and leads to a greater emphasis on increasing social capital, social cohesion, and other psychosocial approaches, distorting connections to politics and power (Muntaner, Lynch, and Davey Smith, 2001).

The mass media almost always cover health as a personal issue, with emphasis on individual behavior, choice, and habits. Risks become personal risks, and health issues become medical issues. News coverage rarely presents stories about community health. Options, mainly posed in relation to fragmented policy, shun institutional critique (Lindbladh and others, 1998). Stories on health, as Lawrence Wallack suggests in Chapter Twenty-Seven, “communicate personal responsibility rather than social accountability.” In his view, public health campaigns “are governed by the idea that people need more and better personal information to navigate a hazardous health environment rather than that people need skills to better participate in the public policy process to make the environment less hazardous.” Journalists typically fail to *link* historical patterns associated with social conditions or the great shifts in wealth favoring the affluent and corporations to health outcomes. The crimes of the Enron Corporation represent an example of framing a problem to appear as the result of individual misconduct rather than institutional failure, ineffective laws and policies, or the pressures of short-term financial gain in a capitalist social order.

The individualist focus distracts critical thinking and eschews long-term approaches. For example, the stress on individual choice ignores the influences of the social environment that impose choices by offering only a limited set of alternatives. Thus the media typically encourage people to drink bottled water or place a filter on their sink in reaction to potential contamination in the water supply instead of participating in a planning process that would evaluate the health implications of economic activity that might cause illness. An example of the latter would include the development of health impact assessments prior to initiating a redevelopment project or redesign of a community.

The clinical tradition in medicine and medical research further conditions the individualist response. It promotes behavioral change and health education through personal responsibility rather than institutional change. As Lawrence Wallack indicates in Chapter Twenty-Seven, “Traditional behavioral-oriented media campaigns . . . have been limited . . . in part due to the failure of these campaigns to adequately integrate fundamental public health values related to

social justice, participation, and social change.” According to Dennis Raphael (2000, p. 194), “Most public health discourse and professional activity remains focused, with some notable exceptions, upon program delivery to low-income individuals identified as being at high risk for poor health outcomes.” And as Graham Scambler (2002, p. 121) argues, “Medical discourse contributes to social control by reinforcing accommodation to a generally unchanged context.” Competing concepts of health and health determinants regarding socioenvironmental versus lifestyle and medical explanations exacerbate conflicts among competing approaches to eliminating health inequities (McKinley and Marceau, 2000). Interestingly, a belief in the biological determinants of social reality is well suited to a politics seeking to avoid institutional change.

### **The Discourse of Markets and Economic Growth: Neoliberalism**

The application of market-oriented discourse, with its emphasis on rational choices, prices, and risks, to health and the ecological system dominates contemporary analysis. Market discourse, guided by profitability, stresses the accumulation of capital and values such as efficiency over human need. Health inequities are interpreted as inevitable “externalities.” The concept of the market, presented as the solution to almost all problems, excludes the possibility of an alternative social order. In this view, nothing exists outside the boundaries of markets, where all matter constitutes capital. Market perspectives assume that competition is more important than cooperation for achieving innovation. Although health, the ecosystem, and energy are not commodities like any others, thinking of health and well-being as commodities shapes ideas about the possibilities for ensuring healthy populations. For example, some people argue for a balance of interests in deciding whether millions of workers should experience pain and suffering because it might cost industry some profits to put ergonomic standards in place or that clean air should be a marketable good, traded with credits. Some economists seek to place a value on human life. Equally important is the way the language of economic growth and technological progress serves as a means to exclude politics by translating injustices, such as poverty, into social problems or private matters to be resolved by the natural result of impersonal market forces.

Market ideology not only separates the economic from the political—creating the impression that the market works outside of politics—but also portrays markets and the economy as disembodied, devoid of content, thereby obscuring exploitation within the class system. Externalizing markets as stable abstractions that work on their own through isolated individual decisions legitimates the failure to intervene in the economy on behalf of marginalized populations. It also leads to the depoliticization of basic issues about community health. Applying market criteria so broadly further supports the idea that capitalism is inevitable and permanent. Moreover, consumption replaces politics or at least

serves as a distraction from politics. Shareholders become more important than ordinary citizens. Evidence suggests that policies directed primarily toward the creation of wealth and economic growth cannot reduce poverty (see Chapter Five). In the United States, economic growth often parallels inequality and deteriorating quality of life for many. Current indicators of social well-being—such as the gross domestic product, the Conference Board’s consumer confidence reports, and the Dow Jones Industrial Average remain dominant measures in the media every day, often accepted uncritically. Regular presentation of indicators that would reflect public health concerns and social well-being—unemployment rates, air pollution levels, infant mortality rate—are absent (Miringoff and Miringoff, 1999).

### Science and Epidemiology

Solutions to major chronic diseases are sometimes sought through new technologies, victory in the laboratory, or new medications. This belief in scientific progress and rationality often goes unchallenged. Scientific research, by itself, cannot address health inequities without political action, for many reasons. For one, the calculation of risk is difficult and essentially unmeasurable, indirect, and indeterminate for a whole range of conditions that are global in scope—chemical, nuclear, environmental, and rooted in historical injustices. Second, outcomes are not always quantifiable, particularly when developing long-term solutions focused on communities rather than individuals. Third, the phenomena are not directly observable. For example, the poor do worse on measures of health status, but why? What data are necessary to help rectify inequality, target policy, and redistribute resources? Health and wealth are closely associated, and measuring differences between social groups can help determine progress in reducing the gaps. Beyond the very basic descriptive data on health outcomes, better analytical techniques can explain more about the causal pathways that influence inequities. This includes identifying characteristics of communities, devising more accurate measures of racial and ethnic identity, and generating knowledge about the condition of the community infrastructure.

But there is a broader political issue: Whose questions define research agendas, particularly as they relate to population health? Within what theoretical and methodological frame? (See Chapter Twelve.) Many people view science as a value-free discourse, uninfluenced by the culture in which it resides or the uses to which it is put. But science and policy remain inseparable; they are culturally based and related to social projects (Kuhn, 1962; Aronowitz, 1988; Harding, 1986). As Nancy Krieger (1993) argues, in the so-called environmental model, “individuals are harmed by inanimate objects, physical forces, or unfortunate social conditions (like poverty)—by things rather than people. That these objects or social circumstances are the creations of society is hidden by the veil of ‘natural science’” (p. 165). The reliance on experts and technical expertise

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tends to obscure policy debates on broader questions about what constitutes legitimate knowledge, the relationship of knowledge to policy, and the objectives of so-called experts. Community-based researchers often rely on different methodologies that are more concerned with health effects and the impact of social conditions on culture than traditional scientists. In addition, the demand for proof of risk places on the defensive those seeking to challenge decisions, including decisions related to economic development, that may negatively influence the health status of given population groups.

The health professions, and the discipline of epidemiology in particular, often have a tendency to avoid both the study of structural social factors and involvement in social policy decisions (Wing, 2000). Of course, this is true of the social sciences more generally. Epidemiology is singled out only because of its deeper implication with health issues. As in most professions, critical influences on its own historical and political development, presuppositions, and epistemological traditions are often lacking (Shy, 1997; Wing, 2000; Yen and Syme, 1999; see also Chapter Nineteen). Until very recently, epidemiology as a discipline primarily emphasized risk factors, observed phenomena, and the agents of disease in methodological approaches focused on the body, not structured social relations (Berkman and Kawachi, 2000). Its theoretical paradigms, driven by the biomedical sciences, downplay the historical conditions and social context that make populations vulnerable, including class and racism (Wing, 2000). Many analysts still consider ill health mainly in relation to altered biochemical processes, lifestyles, or random events in the environment, devoid of social, economic, and cultural context.

Within the health community, debate continues on interpretation of the findings on health inequities and how to address the social determinants of health. Epidemiology has been generally ineffective in developing useful explanations to deal with social forces. Nancy Krieger (2001a, p. 44) comments, "Ignoring social determinants of social disparities in health precludes adequate explanations for actual changing population burdens of disease and death, thereby hampering efforts for prevention." And as Steve Wing (2000, p. 30) reminds us, "Populations . . . are not inherently defined as organized groups with unique histories involving economic, social, and ecological relationships. . . . Epidemiological studies [treat these factors] as individual attributes or exposure markers rather than as aspects of social and economic organization that provide the context for biopsychosocial development." Ideology plays an important role in epidemiology because data are a social product requiring interpretation, within a specific frame of values and theory of disease causation (Krieger, 1992). Powerful institutions often determine what concepts are appropriate for empirical research (Harding, 1986). For example, the United States does not publish health differentials by class or in ways that would draw attention to systemic outcomes necessary to protect the health of vulnerable populations (Krieger, 1992). The

categories and variables addressed always express competing interpretations about the causes of disease.

How are scientific ideologies to be countered? It is not that science cannot tell us useful things. Questions, theories, and methods guide research, determined by institutions with agendas. As Stanley Aronowitz (1988, p. 341) indicates, "Truth is the critical exposition of the relations of humans to nature within a developing, historically mediated, context. . . . We can discover the external world as a product of the collective labor of centuries, not by observation, but by construction of . . . concepts that are contradictory to the certainty of the senses that only report the surfaces." Thus clearer articulation of the values guiding science is necessary to evaluate research goals and findings. As health inequities result from a clash of interests, the scientific world of prediction and control cannot resolve what is ultimately a political crisis.

Given the breadth and scope of the phenomena of health inequities and the political and ideological obstacles to generate support for social justice, I offer an outline for directing progressive energies.

## **SOCIAL CHANGE AND HEALTH INEQUITIES IN CAPITALIST SOCIETY: FUTURE DIRECTIONS**

Health is a product of many social, political, and economic forces and institutions outside of health that produce risks for health and illness. The achievement of equity in health status is not about improving the management of disease or simply increasing resources. Realizing health requires cooperation and coalitions among disparate organizations and communities in a coordinated campaign against social and economic inequality, including the institutions that sustain it. Health inequities are not primarily the result of accidents of nature or individual pathology but result from long-standing conditions and injustice, often attributed to a particular regime of capital accumulation, racism, and sexism. Changing disease patterns are still primarily a function of changes in political power and processes of production, consumption, and distribution in a historically specific context.

The achievement of health equity cannot, in my view, be realized fully within the present capitalist market economy. A major objective must be to democratize rather than privatize more dimensions of production and social life. This does not mean relying on centralized government controls. Instead, it refers to greater public control over life's necessities. For example, with respect to economic redevelopment, communities ought to decide on the type and location of investment, based on needs and health considerations, rather than allowing developers to make these decisions.

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What can be done to realize a more equitable society? Making major improvements in the health of vulnerable populations and anticipating future increases in health inequities depend on a clearly articulated agenda that directly addresses social and political inequality and the systems of power that sustain it. This agenda might include measures aimed at institutional change connected to conditions that give rise to disease patterns over time. For example, making strategic investments in the infrastructural conditions linked with population health throughout the life span and the social roots of suffering, premature death, and disability might be a good start. This would include ensuring resources for childhood development and education, affordable housing, clean air and water, and adequate income. Though it is necessary to engage in multiple struggles within the state, focusing on state power alone, without considering the forces arrayed by transnational capital, will limit transformation of social arrangements necessary to avoid endless remediation.

A preliminary challenge is to identify the requirements for confronting political interests and systems of rules that maintain those interests and to reclaim the political power that would make change possible. This is not an unrealistic or impossible objective if the direction of change is given priority over the speed of change. Effective reforms must lead to social transformation if they are not to perpetuate the cycle of inequity. That is, transformational reforms would address the social relations that generate inequity and the colonizing ideologies that make invisible the structures of exploitation that support those relations (see Gorz, 1973).

The remainder of this chapter explores, in a preliminary way, two things: public policy objectives that may support the elimination of health inequities and political strategies to achieve the objectives, with attention to reframing the debate by defining an appropriate narrative and organizing for change, including reclaiming the mission of public health within a social justice framework and aligning with and learning from the practice of social movements.

## POLICY OBJECTIVES: OPPORTUNITIES AND LIMITATIONS

According to the Acheson Report, “All policies likely to have an impact on health should be evaluated in terms of the impact on health inequalities” (Acheson, 1998, p. xi). But policy effects are difficult to measure over time, particularly when seeking to change institutions and structures or improve the quality of life. Success is even more difficult to evaluate when seeking to narrow the gap between socioeconomic groups rather than making general improvements in health status. However, egalitarian policies are important, even if measurement is impossible. Investments and resources shift about the planet every day without justifying evidence on the effects or social consequences for health. Thus those seeking to protect and promote the health of particular groups should

demand some leeway in making choices without perfect knowledge. In doing so, attention to the values that underlie policy and policy menus are critical, because the type and level of social change necessary are more comprehensive than policy list making would allow. Public policy affects the potential for health and illness in a variety of ways, positively and negatively. According to the Canadian Public Health Association (1996), "Policies shape how money, power and material resources flow through society and therefore affect the determinants of health. Advocating healthy public policies is the most important strategy we can use to act on the determinants of health. . . . Deficit reduction and private sector economic growth can be unhealthy for people. These policies may increase economic inequalities, environmental degradation, social intolerance, and violence."

Policy agendas, however, are part of a political strategy of different interests; for example, large landlords try to influence housing codes, automobile manufacturers try to limit safety features, polluting industries seek to limit regulations, and child advocacy groups lobby for public funding that invests in children. Who are the beneficiaries of public policy? A core theme of the policies categorized and listed here is to strengthen communities and, as Paula Braveman argues in Chapter Twelve, "to remove obstacles to achieving optimal health, giving the highest priority and devoting additional resources to removing obstacles for those with more barriers to health to begin with, because of underlying social disadvantage." The suggested sample of policy menus, mostly related to increased social investments, aims to generate security based on social citizenship. This includes, among other things, controlling the flow of capital and meeting basic social needs.

Recognizing the limits to what public policy can accomplish, the following suggested policy menus attempt to provide both social activists and policy-makers with one element of a strategic approach to achieving health equity. Taken together, their purpose is to shift resources and power toward disadvantaged social populations.

#### *Labor and Employment*

It is important to ensure that labor is less subject to labor markets as a commodity and to the whim of employers seeking cheap labor. At the same time, the workplace must be made safer, healthier, and more democratic.

- Support labor market and workplace policies that consciously increase employment at a living wage.
- Increase the minimum wage and unemployment compensation.
- Support living-wage ordinances and campaigns to elevate the standard of living.
- Support pay equity.

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- Create healthy working conditions.
- Support full-employment policies and the rights of workers.
- Support strong health and safety regulations, and expand long-term employment opportunities and training.

*Public Investment in Children and Neighborhoods: Strengthening Communities*

- Invest in children in order to eliminate childhood poverty and provide support throughout the course of life.
- Promote optimal childhood development in ways that can have lifelong consequences and reduce long-term risk, such as ensuring a proper diet and nutrition, providing early interventions, supporting high-quality public education, and abolishing child poverty to reduce infant mortality.
- Invest in public education, particularly teachers and school structures, as well as training.
- Invest in neighborhoods, public goods, and social infrastructure by revitalizing communities and offering increased access to social services.
- Create healthy and safe living conditions.
- Ensure adequate nutrition.
- Strengthen communities by developing employment policies that increase employment opportunities and training, facilitate networking and social interaction, and open new sources of access to investment capital.

*Institutional Racism and Discrimination*

- Enforce antidiscrimination laws.
- Support diversity in communities through zoning and land use laws that promote integration and low-income housing.
- Support an end to segregated housing and equitable distribution of social services.

*Taxation*

- Develop a more progressive tax system than the present one, which favors the well-off.
- Increase the amount and coverage of the earned-income credit.
- Tax capital gains at the same rate as wages.
- Eliminate subsidies for wealthy corporations, such as those in energy, agriculture, timber, and mining.
- Stop cutting taxes on the rich, and rescind recent tax cuts.

*Income Supports*

- Raise standards of living through cash or in-kind transfers and income supports.
- Provide adequate income maintenance and distribution policies and other social insurance systems.

*Environmental Regulation*

- Support full enforcement of laws, such as the Clean Air Act amendments, that seek to reduce pollution levels.
- Eliminate, not just regulate, certain forms of production and products that damage the ecosystem or cause global warming.

*Social Services and Community Infrastructure*

- Ensure equity in service delivery and access to services such as schools, transportation, libraries, and recreational facilities.
- Increase social spending on the social or public infrastructure and public goods to improve neighborhoods.

*Housing and Land Use*

- Eliminate land use and zoning regulations that have permitted the creation of sprawl.
- Ensure affordable, safe housing, and oppose the concentration of poor people in federal housing projects that segregate them.
- Create healthy living conditions, including safe and well-designed communities and homes.
- Support sustainable economic development.
- Oppose the locating of toxic waste facilities in communities of color.

*Health Care*

- Establish a system of health and health care institutions that is available to all.
- Integrate public health criteria into economic redevelopment and community development.

*Trade*

- Support fair and equitable global trade policies.
- Support a moratorium on the negotiation of new trade agreements.

*Research, Data Collection, and Surveillance and Monitoring*

- Support the appointment of a Council of Social Advisers to match the Council of Economic Advisers. (See Miringoff and Miringoff, 1999.)
- Support and develop health impact assessments for social and economic initiatives to evaluate the impact of programs, policies, and projects on the health of the population and to reveal possible inequalities.
- Support the collection of government data by class, investigate racism as a fundamental cause of ethnic inequities in health and its effects on health, and support the development and implementation of a health equity index to provide a core measure to focus public attention on health inequities.
- Develop effective ways of measuring and monitoring the impact on health inequities of policies and practices in housing, taxation, education, the health care system, and other aspects of society.

*Democracy*

- Support democratic control over major investment decisions
- Strengthen public participation in health decision making.
- Locally, create a systemic health planning process to form an integrated public health infrastructure with collaborative partnerships among the many agencies whose decisions affect the public's health.
- Support the chartering of corporations, and provide localities with more control over corporations.

Realizing these policies will not occur without long political struggles that involve both resistance to ongoing oppressions and strategies for shifting consciousness and building coalitions for social change. What are some possible avenues for transforming the dialogue and narratives used to debate the issue of health inequality? Let's look at a few.

## **REVITALIZING IMAGINATION AND REFRAMING THE DEBATE: IDEOLOGY AND CONSCIOUSNESS**

A major obstacle to achieving equality in health status is a belief in its impossibility, based on a deeper belief that progressive social change is impossible. It is not. The contemporary system of political power is the result of struggle, not a natural order. Given the confusion and despair sometimes expressed about improving the quality of life for everyone, it is important to demonstrate the many ways in which people participate in struggles for social justice in everyday

life. In order to transcend accommodation, it is necessary to overcome assumptions and the symbolic universe of the current order. Contingencies, resistance, and dreams for an expanded view of life, beyond the value of the market, are always present because ideologies are unstable, especially when they become detached from meaning in people's everyday lives. How can activists politicize health and health inequities within the realm of public debate, removed from the experts?

One approach is to envision a politics of emancipation, a positive view that seeks not only to overcome constraints to achieving a healthy society for everyone but also to imagine what life and work might look like without exploitation and with forms of democratic governance in support. Without a vision of a transformed reality and examples, historical or contemporary, achieving real social change becomes extremely limited. Transforming public consciousness about health inequities—why they matter and what to do about them—involves the ability to imagine and present a vision of a world without inequities, in part by making explicit the contradiction between the values expressed in the culture and the realities of how people live. Such a vision of a social economy of well-being would emphasize reciprocity and the old idea of the common good in place of market values. Dan Beauchamp (1988, p. 21) contends, "Alleviation of modern public health problems requires the reduction of risks that are faced by the community considered as a whole. . . . Preventive measures taken to reduce risks provide benefits that seem marginal when viewed from the standpoint of individuals considered privately." Eliminating health inequities will require reimagining the social order to expose and reject the myths, discourses, and practices that define social health (and wealth) and thereby expand the realm of legitimate debate. A critical discourse of resistance and possibility, linking many progressive interests, would support debate grounded in material realities. That is, the debate would shift away from treating the consequences of inequity and toward the fundamental injustices, institutions, practices, and conditions that cause and perpetuate health inequities. Such a discourse could invigorate action toward systemic change that would lead to a more equitable and more democratic social order.

The contesting and disruption of unquestioned concepts about health and well-being are important, particularly the idea that not everyone deserves to be healthy and that no collective action is necessary to establish the prerequisites for health equity and well-being. Bounded by a reformist paradigm, the contemporary dominant view of health refuses to recognize either real social divisions or the role of property and the conditions of production and its consequences. Opposing this view depends on embedding a discourse and practice about the collective, social, common dimensions of human existence in order to legitimate the idea of public control over a wider realm of social life associated with population health and reducing the unfettered role of capital.

One step in contesting current ideologies is to reconfigure the representation of health equity in order to highlight other systems of meaning that organize the world and raise questions now absent from current debates. Those systems of meaning would clarify common interests that unite people and ultimately create an agenda and a political project by showing the possibility of another kind of social reality. Making the case for social justice and equality as a value requires telling stories that highlight the features of a more equitable society. Such stories would include exposing the link between politics, science, and values. As Sylvia Tesh (1988, p. 3) comments, "I argue not that values be excised from science and from policy but that their inevitable presence be revealed and their worth be publicly discussed." An important objective, then, is to translate public health knowledge and outrage about inequities into issues of public concern.

Earlier I indicated some of the key ideological frames that limit critical thinking. Market ideology and the so-called invisible hand of the market provide some extraordinary excuses for decisions that harm human health. The mantra to reduce government in favor of the market does not suggest what form or principle of governance it opposes, nor does it allow for the interrogation of what true governance by the market means. It is important to explode the myth that there exists a private realm that is autonomous from public consequences and unaffected by corporate decisions. Invoking the precautionary principle is one method of taking the offensive. For example, the struggle to protect the public's health is often stymied by the request to prove with scientific evidence that harm will result from a given decision. Questioning the economic and political interests of the authorities who make decisions that affect the public's health can help reverse this way of thinking. Community residents might insist, for example, that developers provide proof demonstrating that no harm will result to the public's health from decisions regarding economic development, social programs, tax reductions, and capital investment.

Human need is another concept that often becomes absorbed into market ideology. Health is a requirement for active participation in the life of a community, not a marketable good. Thinking of health and well-being as a human need changes the focus away from seeking to measure the immeasurable and toward transformation of institutions (Robertson, 1998).

The individualist perspective, as noted earlier, frames issues as personal and disconnected from larger social factors. Yet the oppressions that afflict people are collective and systematic, based in a large array of institutions. Social change simply does not occur through sequential individual actions. The danger of nuclear waste or farms with contaminated cows transcends the world of individual risk. A necessary step is to reformulate and make salient the conditions for health and politicize its meaning more thoroughly in order to reveal that what appears as objective and neutral is in fact subjective and political. Recognizing health as a social concern and not only a human one is an important objective.

## TAKING ACTION: RECLAIMING PUBLIC'S HEALTH'S MISSION AND PRACTICE—OPPORTUNITIES AND LIMITS

Today a disjunction exists between the ideals and goals of public health and the organization of its institutions. (See Chapter Twenty-Five.) That disjunction partly refers to a narrowing of focus on the technical as opposed to the political and losing the connection to social justice. As Elizabeth Fee notes in her introduction to George Rosen's *A History of Public Health* (1993, p. xxxviii), "When the history of public health is seen as a history of how populations experience health and illness, how social, economic, and political systems structure the possibilities for healthy or unhealthy lives, how societies create the preconditions for the production and transmission of disease, and how people, both as individuals and social groups, attempt to promote their own health or avoid illness, we find that public health history is not limited to the study of bureaucratic structures and institutions but pervades every aspect of social and cultural life."

Returning to the historical roots of public health means pursuing health equity through a social justice lens, beyond programs and interventions. This work entails developing a rights-based approach to public health, but one that sees health as a *social* and not merely an individual right. Proposing equity as a value to pursue supports the necessary redirection of social and political priorities and resources to address health inequities. It would also legitimate transcending remedial action in favor of more fundamental institutional change. The challenge for practitioners is to clarify the values that guide the work of public health within its broadest definition and to make a commitment to a collective idea of prevention. We can explore several areas of activity in public health practice that could influence the social determinants of health, assuming a supportive context in other relevant institutions directed at broad-based social change.

The discipline itself requires reorganization. Public health practice cannot advance without a more coherent philosophy and theory—one that links economics, ecology, geography, space and time, and philosophy of science. The study of health will always be an interdisciplinary undertaking, embedded in social processes and with awareness of a historical timeline that can determine its direction and progress. Given that the source of health depends on so many institutions, public health practice will require more permanent interagency and multidisciplinary coordination, recruiting, and cross-training in many subject areas. Many people perceive the location of public health practice as exclusively within designated health agencies, limited to the health professions. Making common cause with entities outside of the formal public health system means, for example, that health practitioners would work with agencies in economic development, land use, transportation, housing, and education, as well as community organizations. Health cannot be the responsibility of one organization; it must

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be a cooperative effort involving coalitions. A systematic approach to addressing patterns of risk in their social context, at the level of populations, suggests reconstituting the field of public health. That is, beyond forging partnerships and common cause with other public agencies, reorganization would lead to incorporating other disciplines, not merely partnering with them. Schools of public health would cross-train on environmental concerns, for example, to overcome endless specialization.

To improve the public's health and eliminate inequities in health outcomes, the theory, practice, and scope of work in the institution of public health require that attention be given to the broad range of social conditions, institutions, and structures that influence the quality of life. An expanded horizon generates action farther upstream toward addressing the prerequisites for population-based health. Health practitioners' involvement is crucial in activities such as city planning (to design cities to link work and home and reduce urban sprawl), economic redevelopment, and advocacy for public services, global climate change, and international trade.

Often heard in some public health circles is a complaint about the lack of resources or mandates to deal with health inequities, with an implication that social justice concerns are beyond the scope of public health practice. If public health practice is to return to the basic philosophy of social justice that constitutes its roots, then it must attend more forcefully to issues of social and economic inequality, because the conditions and systems of rule under which people live *produce* health. As Bernard Turnock (2001, p. 15) notes, "A critical challenge for public health as a social enterprise lies in overcoming the social and ethical barriers that prevent us from doing more with the tools already available to us. Extending the frontiers of science and knowledge may not be as useful for improving public health as shifting collective values . . . to act on what we already know. [Major public health successes] came through changes in social norms, rather than through bigger and better science." This may mean an explicit identification with goals of social justice and advocating for them, changing roles and expectations. Rethinking the work of public health toward prevention and system building recognizes that, for example, employment status, level of income, and quality of education are essential to the public's health.

Local public health agencies will need to exercise a greater leadership role. This involves seeking more decision-making authority and support for public policy at many levels directed at the elimination of health inequities. Agencies could collaboratively identify methods and incentives to give priority to the health impact of their activities and decisions. Moreover, popular engagement with public health issues facilitates community mobilization. Mobilization can in turn stimulate new demands or changes by addressing unacceptable conditions. Because the determinants of population health result primarily from

conditions in the environment and not the individual, health professionals must support policies such as adequate and affordable housing, public transportation, reduction of sprawl, and a living wage, as well as those opposing discrimination.

A crucial element of leadership is the ability to relinquish control or power to the community by supporting its capacity for making decisions, similar to the way civilians hear evidence as jurors or determine actions based on competing scientific evidence. The field of popular epidemiology emerging in recent years could support grassroots approaches to community health (see Brown, 2000). These approaches consider disproportionate risks in exposure, for example, experienced by communities of color and low-income neighborhoods.

Public health must function as an expression of the community, as its representative seeking to advocate for social change that transforms the conditions that cause ill health. The issue demands political will, speaking out and building partnerships with those in need, and recognizing limited resources within rigid mandates in a conservative climate. Collaboration with and support of the community means an ongoing process of relationship building, dialogue, and cooperative action to address community health needs and issues, based on trust and reciprocity. That process can involve mobilizing resources, gathering information, generating major systems change, or influencing programs and practices associated with health inequities. A key element, however, requires engaging with the public in community decision making and information sharing around social change efforts beyond health protection and disease prevention. Collaboration may include larger community improvement issues or involvement in economic redevelopment policy because they relate to differentials in health status. The health agency and the community work together in planning, designing, implementing, and evaluating all activities. The level of community organization, resources, skills, and training affects collaboration because being heard takes money and resources. Local health authorities must help the community develop its resources and research skills, including obtaining assistance through the local bureaucracies. Investment in capacity building is crucial.

The health professions should work to acknowledge and reinforce the voices of those who experience injustices, emphasizing that they represent the shared experience of all people. Advocating for policies and change that give people more control over life circumstances, productive assets, production processes, and the labor process is essential. Advocates would also support ecologically sustainable development and the evaluation of development projects against criteria based on the protection of human health, ensuring the provision of basic needs such as jobs, good living and working conditions, safe housing, education, and social safety nets.

Communities and health practitioners are developing new decision-making tools for assessing the health impact of social and economic decisions, similar to the environmental impact statement (EIS), that may have a role in addressing health inequities. The health impact assessment (HIA) involves a process and procedures, with an ethical and moral element, for evaluating the effects of policies, programs, and projects on the range of forces that affect health and well-being. A major difference with the EIS is that the HIA is participatory and democratic in its development and implementation and typically incorporates equity in decision making as an objective. It responds to the need for evidence-based policymaking, but within a multidisciplinary model relying on qualitative and quantitative analysis (Scott-Samuel, 1998). Depending on who invokes its use, it has advantages and drawbacks. On the one hand, measures may not exist for structural influences on health. More important, the right to health and a decent standard of living should not have to be proved. On the other hand, the HIA reinforces a broader definition of health, involves the community in a public process, and potentially raises questions about health equity.

Public health practice can also engage in research that emphasizes the cumulative effects of poor social conditions (Davey Smith and others, 1997). Miringoff and Miringoff (1999) rightly argue for the frequent presentation and promotion of indicators that reflect public health concerns—unemployment rates, air pollution levels, infant mortality rate, child abuse, child poverty, homicide rates, access to affordable housing, weekly earnings, and so on, as well the links between social conditions and health. The annually calculated Fordham Index of Social Health (Miringoff, 1995), for example, relies on sixteen measures to provide an overall perspective of human welfare at each life stage. Using such measures or establishing a locally based “wellness” index requires promoting it in the media as a supplement to the endless array of economic indicators.

In addition, the pathogenic effects of social inequalities demand more research (Farmer, 1999). “By what mechanisms, precisely, do such noxious events and processes [racism, gender inequality, growing gap between rich and poor] become embodied as adverse health outcomes? Why are some at risk and others spared?” (p. 1492). The collection of data that focus on systemic outcomes is critical to an enterprise that seeks to eliminate health inequities. As Nancy Krieger (1992, p. 422) notes, “Keeping in mind that the information in U.S. data bases is actively collected, not passively discovered, we must therefore insist that all national vital statistics be reported stratified by gender-appropriate measures of social class, in combination with race/ethnicity and gender.”

Health promotion is another arena for pursuing progressive change. Traditional health promotion emphasizes realizing healthy lives at the level of the individual, without stressing the need to alter economic, social, and ecological environments of populations with respect to the material disadvantages that people face in everyday life. Strategies would aim at removing or lowering risk

for specific populations. For example, more attention would be given to critiquing the fast-food industry and countering its increasing ubiquity, which has extended even in hospitals. But improving health for everyone still leaves a gap. As Sally Macintyre (2000) observes, the rich are more likely to attend to and benefit from health promotion than the poor. “The capacity to benefit from individualized risk management or health education may be least among more disadvantaged people” (p. 1399).

Finally, to advance an agenda to eliminate health inequities, public health practitioners will have to communicate with a broader public more effectively, building a constituency. Lawrence Wallack and his colleagues (1993), in describing effective media advocacy, notes the importance of telling stories from the point of view of public health. These stories, in his view, must illustrate basic principles and values, describe the political context, express the mission of public health, and stress the “importance of community participation and self-determination as a strategy for change” (p. 3). This requires publicizing the relationship between inequities in health status, on the one hand, and social and economic inequality, on the other, translating the research in a way that the media can digest. Health professionals will need to explain why inequality is bad for health and show how everyone benefits from equality, using multiple avenues to articulate their ideas. Examples include developing campaigns, writing newspaper editorials, publishing in popular periodicals, developing seminars and workshops, and initiating speaking engagements. Public health needs to find its moral voice, expressing its values along with the factual information that provides legitimacy to its message. It needs to pressure the media to consider structural causes of health and illness and redirect attention to the social production of health.

Unclear at this moment is whether the contemporary system of public health, with its intellectual and resource constraints, can confront issues of health inequities at the level of populations without restructuring the scope of its work, the training of its workforce, and its analytical underpinnings. These changes will take political will and courage. But public health has allies in many disciplines if it chooses to work with them.

## TAKING ACTION: STRENGTHENING SOCIAL MOVEMENTS

No great social change can occur without persistent pressure and struggle against a class-based society and the economic conditions it produces. Community residents must draft their own social agenda. The achievement of the right to vote, the minimum wage, Medicare, and desegregation of the schools took years of organizing, constituency building, and political will against entrenched institutions and the technologies that sustain them by people in

social movements resisting the consequences of untamed capitalism and racism. In addition, the laws providing corporations with greater sovereignty than individuals, regressive taxation, zoning systems that support segregation, and tax subsidies for wealthy corporations also resulted from great collective organizing among the unions of capital, from chambers of commerce to industry associations and lobbying groups.

To enact and implement healthy public policy, the rarely heard voices will need to hold decision makers accountable for the public's health and the quality of their lives. Most social change addressing health inequalities does not emerge primarily from the professional health community. It derives from the experience of organized groups of people seeking to strengthen social movements to protect and improve their communities. They are challenging the causes of poor health directly through alliances, social mobilization, and coalition-building activities. Since the roots of ill health do not begin solely within their communities but are embedded in national and global policies associated with class, race, and gender discrimination, communities must strategize at all levels. This suggests uniting many social movements, with national and international links, similar to the civil rights, women's, and environmental justice movements in the United States or the movement for public health in the Victorian era in England. Beyond prevention and protection, the elimination of health inequities will depend on new forms of community activism. The challenge is to develop a common agenda among diverse cultural groups and organizations with differing identities but similar experiences, based on a commitment to social justice (Carlisle, 2000). It is therefore important not only to transcend identity politics, which facilitates a divide-and-conquer strategy, but also not to medicalize the issue of health inequities or create health movements. The latter cannot substitute for the identification of the common interests connected to social justice values that lead people to mobilize around the root causes of inequities more broadly (Scambler, 2002). Strong partnerships can address a much broader array of social needs and issues that affect health and well-being.

Although such an agenda may seem overwhelming, it can be pursued in small steps. These steps may lead in a different direction—toward major social transformations in the conditions of life that reduce inequalities, rather than only activities directed toward reform, regulation, technological advances, or advances in medical care that leave inequities in the social system untouched. These steps must aim at solutions that disturb political power relations. However, because the consequences of political power function everywhere in society, so must struggles for social justice and health justice be everywhere, not just within the realm of public policy or state institutions. Many locations, cultural practices, social institutions, and even personal relations remain sites of struggle for collective action to challenge health inequities, from universities

and the mass media to workplaces and corporate boardrooms. The public's health is a site of contestation that can challenge basic assumptions about what society and the future can be. The contributors to this book provide the context, the research, and the framework to rethink how we might achieve health equity by enabling people to create their own history.

## Notes

1. Documentation of the relationship between health inequalities and income inequality was developed in the 1970s. See, for example, Wagstaff and Van Doorslaer (2000) and Bartley, Blane, and Davey Smith (1998). For a summary of research in the 1980s, see Feinstein (1993).
2. Two examples are the Labor Community Strategy Center, a multiracial, anticorporate think tank in Los Angeles, and the Association of Community Organizations and Reform Now (ACORN), a community organization of low- and moderate-income families in forty-five cities.

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