Socioeconomic Disparities in Health: A Symposium on the Relationships Between Poverty and Health

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FOREWORD

Socioeconomic Disparities in Health: A Symposium on the Relationships Between Poverty and Health

Lawrence O. Gostin*

There is a social gradient in health that runs from the top to the bottom of society and affects all of us. A way to understand this link between status and health is to think of three fundamental human needs: health, autonomy and opportunity for full social participation. All the usual suspects affect health—material conditions, smoking, diet, physical activity and the like—but autonomy and participation are two other crucial influences on health; and the lower the social status, the less autonomy and the less social participation.

Michael Marmot (2005)1

This annual symposium of the Georgetown Journal on Poverty Law and Policy (GJPLP) focuses on ill health, perhaps the most adverse consequence of being poor in America and in most other countries in the world. The disparities in health between the rich and poor are so striking, and the results so dire, that reducing the gap is an ethical imperative.

A strong and consistent finding of epidemiological research is that socioeconomic status (SES) is correlated with morbidity, mortality, and functioning.2 SES is a complex combination of income, education, and occupation. Theorists posit that material disadvantage, diminished control over life’s circumstances, and lack

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of social acceptance all contribute to poor health outcomes. The relationship between SES and health often is referred to as a “gradient” because of the graded and continuous nature of the association; health differences are observed well into the middle ranges of SES. These empirical findings have persisted across time and cultures and remain viable today.

Some researchers go further, concluding the overall level of economic inequality in a society correlates with (and adversely affects) population health. That is, societies with wide disparities between rich and poor tend to have worse health status than societies with smaller disparities, after controlling for per capita income. These researchers hypothesize that societies with higher degrees of inequality provide less social support and cohesion, making life more stressful and pathogenic. Drawing upon this line of argument, some ethicists contend, “social justice is good for our health.”

There is some persuasive anecdotal evidence for this societal inequality theory. Health disparities in the United States, for example, are vast even by international standards, and cannot be explained by race, income, or health care access alone. The United States ranks twenty-ninth in the world in life expectancy—behind countries with half the income and half the health care expenditures per capita.

Among countries with available data, all but four of the twenty-eight preceding the U.S. have more equal income distributions. The authors of a meta-analysis, however, cast doubt on the theory that more equal societies are necessarily healthier, while acknowledging that raising the incomes of the least advantaged will improve their health and thereby increase society-wide health:

Overall, there seems to be little support for the idea that income inequality is a major, generalizable determinant of population health differences within or between rich countries. Income inequality may, however, directly influence some health outcomes, such as homicide... in the United States, but even that is somewhat mixed. Despite little support for a direct effect of income inequality on health per se, reducing income inequality by raising the incomes of the most disadvantaged will improve their health, help reduce health inequalities, and generally improve population health.12

Opponents of redistributive policies—including health care reforms such as universal health insurance and programs to benefit the poor—challenge this last claim, arguing such policies punish personal accomplishment, thereby discouraging economic growth. Pointing to the correlation between population-wide health and national per capita income, they say redistribution reduces population-wide health over the long run by suppressing the growth of per capita income. Redistribution of private wealth, they contend, is a political matter, outside the appropriate scope of the public health enterprise.13 Critics of the public health case for redistributive policies also note that the explanatory variables for the relationship between SES and health are not entirely understood. Some recharacterize the causal relationship between SES and health, suggesting instead that people who are ill tend not to attain high SES.

The SES gradient probably does involve multiple pathways. These include material disadvantages (e.g., diminished access to food, shelter, and health care), toxic physical environments (e.g., poor conditions at home, work, and community), psychosocial stressors (e.g., financial or occupational insecurity and lack of control), and social contexts that influence risk behaviors (e.g., smoking, physical inactivity, poor diet, and excessive alcohol consumption). Finding the exact pathways or causal relationships presents many challenges, but available data support the conclusion that SES is, in the main, a cause, not a consequence, of health status.14

Perhaps more importantly, the notion advanced by some free market advocates that health is a consumer good that should be distributed according to individuals' ability to pay is ethically troublesome. Perhaps it is better to conceptualize health as a basic human right, which at the very least should include the right to the basic necessities of life. Although the right to health may

be in part aspirational, subject to realization over time, it conveys the fundamental importance of seeking to ensure the conditions in which people can be healthy.

**GLOBAL HEALTH DISPARITIES**

It is well known that the poor suffer, and suffer more than the rich, and these disparities result in disease and early death for the poor throughout the world. What is less often known is the degree to which the poor suffer unnecessarily and why this occurs. With respect to health, the global burden of disease is not just shouldered by the poor, but disproportionately so, such that health disparities across continents render a person’s likelihood of survival drastically different based on where she is born. These inequalities have emerged as one of the defining problems of our time, and have captured the attention of social epidemiologists, social justice theorists, and economists. However, while awareness of these problems is rising, and despite resulting funding increases by states and foundations, these disparities have been stubbornly resistant to change.

The current global distribution of disease has led to radically different health outcomes in developed and developing countries. Disparities in life expectancy among rich and poor countries are vast, with the highest rates of early death in sub-Saharan Africa. Average life expectancy in Africa is nearly 30 years less than in the Americas or Europe. Life expectancy in Zimbabwe or Swaziland is less than half that in Japan; a child in born in Angola is 73 times more likely to die in the first few years of life than a child born in Norway; and a woman giving birth in sub-Saharan Africa is 100 times more likely to die in labor than a woman in a rich country. While life expectancy in the developed world has consistently increased throughout the twentieth century, it actually has been decreasing in the least developed countries and in transitional States such as Russia. Infectious disease epidemics, particularly HIV/AIDS (which kills on average 6,000 Africans, but only 49 North Americans, each day), and increased chronic disease have erased hard-won gains in life expectancy that took decades

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18. See id.
21. See World Health Statistics, Supra note 16.
Chances of living just to the age of five are low among the world’s poor compared with the wealthy. The poorest 25 percent of children in the world are two-and-a-half times more likely to die before age five than the wealthiest 25 percent. In fact, of the 9.7 million children under five who die each year, 90% of the deaths occur in just 42 countries. Just one example offers perspective on the global health gap between the rich and the poor. The World Bank reports that in one year alone, 14 million of the poorest people in the world died, but only four million would have died if the death rate for this population had been the same as for the global rich.

The health gap between the worst and best-off groups, moreover, is growing. In wealthier nations, the population is increasingly healthier and living longer, while in the least developed countries, the population is getting sicker and dying younger. The population in countries with the highest child and adult mortality rates suffer multiple deprivations when compared with their low-mortality counterparts: they are four times more likely to live on less than one dollar per day; have two times the female illiteracy rate; and have a 20 (adults) or 65 (children)-fold difference in per capita health spending.

The causes of death and disability vary greatly between developing and developed countries. Developed countries suffer primarily from chronic, non-communicable diseases because they have technologies to prevent and treat most communicable diseases. Meanwhile, developing countries suffer a high burden of communicable, preventable, and treatable diseases, while simultaneously experiencing growth in rates of chronic illness—a double-edged sword of sorts. In poor areas such as Africa and India, communicable diseases account for 59 percent of years of life lost, compared with 12 percent for the Americas and 5 percent for Europe. At the same time, non-communicable diseases now

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24. See World Health Statistics, Supra note 16.
28. Id.
29. Cf. Abdallah Daar et al., Top Ten Biotechnologies for Improving Health in Developing Countries, 32 NATURE GENETICS 229, 229-32 (2002); Peter Singer & Abdallah Daar, Harnessing Genomics and Biotechnology to Improve Global Health Equity, 294 SCIENCE 87, 87–89 (2001).
comprise more than half the disease burden in low- and middle-income countries.  

ARE PROFUND HEALTH INEQUALITIES FAIR?

A substantial body of literature attempts to explain why these global health disparities are unethical, but no single theory has gained traction. Perhaps the strongest claim that health disparities are unethical is based on what I call a theory of human functioning. Health has special meaning and importance to individuals and the community as a whole. Health is necessary for much of the joy, creativity, and productivity that a person derives from life. Individuals with physical and mental health recreate, socialize, work, and engage in family and social activities that bring meaning and happiness to their lives. Every person strives for the best physical and mental health achievable, even in the face of existing disease, injury, or disability.

Health also is essential for the functioning of populations. Without a minimum level of health, a person cannot fully engage in social interactions, participate in the political process, exercise rights of citizenship, generate wealth, create art, or provide for the common security. A safe and healthy population builds strong roots for a country’s governmental structures, social organizations, cultural endowment, economic prosperity, and national defense. Population health becomes a transcendent value because a certain level of human functioning is a prerequisite for activities that are critical to the public’s welfare—social, political, and economic.

Amartya Sen famously theorized that the capability to avoid starvation, preventable morbidity, and early mortality is a substantive freedom that enriches human life. Depriving people of this capability strips them of their freedom to be who they want to be and “to do things that a person has reason to value.” Other ethicists have expanded on this theory, claiming that health, specifically, is important to the ability to live a life one values—one cannot function who is barely alive. Under a theory of human functioning, health deprivations are unethical because they unnecessarily reduce one’s ability to function and the capacity for human agency. Health, among all the other forms of disadvantage, is

32. See Lopez, supra note 29; see also Benjamin Caballero, A Nutrition Paradox – Underweight and Obesity in Developing Countries, 352 NEW ENG. J. MED. 15, 1514-16 (2005).
37. Id. at 36-37.
special and foundational, in that its effects on human capacities impact one’s opportunities in the world and, therefore, health must be preserved to ensure equality of opportunity.\textsuperscript{39}

THE GJPLP SYMPOSIUM ON POVERTY AND HEALTH

The GJPLP partnered with a new Institute at Georgetown University devoted to impactful scholarship at the intersection of poverty and health. The mission of the O’Neill Institute for National and Global Health Law is to find innovative solutions for the most pressing health concerns facing the nation and the world through research, scholarship, and reflective engagement with partners in the public and private sectors. The O’Neill Institute approaches the major problems of national and global health from multiple innovative perspectives—breaking down barriers between disciplines and changing traditional ways of thinking. In keeping with Georgetown University’s mission of social justice, the Institute seeks to reduce health disparities and improve health in the United States and globally.\textsuperscript{40} The GJPLP also worked with the Georgetown Center on Poverty, Inequality, and Public Policy. The Center on Poverty is a joint initiative of the Georgetown University Law Center and the Georgetown Public Policy Institute. At a time of unacceptably high poverty and growing inequality in the United States, the Center seeks to serve as a bridge between researchers, policymakers, and policy advocates in Washington and at state and local levels. The Center seeks to elevate attention to the nature and extent of poverty and inequality and the costs and consequences for the nation; to identify emerging issues that are—or should be—prominent in efforts to address poverty and economic opportunity, mobility, and security; and to work with policy-oriented researchers and other experts in and outside of Washington in efforts to identify innovative and implementable policy solutions.

The Georgetown Journal on Poverty Law and Policy, the O’Neill Institute, and the Center on Poverty brought together leading academics, policymakers, and practitioners in multiple fields, including public health, health policy, and health law for the 2008 annual Symposium, “The First Wealth is Health: The Nexus of Health, Poverty, and the Law.” The authors, who also spoke at a major conference at Georgetown Law on March 28, 2008, were asked to creatively identify disparities in health and health care, explain the reasons for these disparities, and propose innovative strategies for improving health outcomes among the most disadvantaged populations. The authors brought both domestic and global perspectives to their presentations and papers. The articles in this issue cover four broad sections: disparities, access to care, global health, and practical approaches to health and poverty.

\textsuperscript{39} See Norman Daniels, Justice, Health, and Healthcare, 1 AM. J. BIOETHICS 2 (2001).
Howard K. Koh, Harvey V. Fineberg Professor of the Practice of Public Health at the Harvard School of Public Health, and colleagues argue that the global burden of cancer, which will become the leading cause of death worldwide in the 21st century, demands a coordinated worldwide approach. However, this challenge first requires understanding the disproportionate burden falling upon poor and low socioeconomic position (SEP) populations around the world. In this paper, Professor Koh explores the links between poverty, the closely related concept of SEP, and cancer disparities from both a global and national perspective. He offers a framework to explain these links and describes a range of policy approaches to address modifiable determinants of health, particularly focusing on the prevention and early detection phases of the cancer control continuum.

Disparities in health and access to health care are manifest on the domestic scale as well as on the global scale. As Dania A. Palanker, a student at the Georgetown Law, explains, African Americans have poorer access to care, receive lower quality healthcare treatment, and have poorer health outcomes than whites. In recent years, it has become clear that African Americans also receive poorer pain treatment. The problem of disparities in pain is worsened by current and past policies within the U.S. public health system. Her article, in particular, discusses the war on drugs and how drug policies may be reducing access to necessary pain medications for African Americans by creating prejudices about African Americans as drug abusers that unconsciously impact physician decisions.

Wendy C. Perdue, Associate Dean for Graduate Programs at Georgetown Law, discusses the growing concern about obesity and associated chronic diseases among the poor. There is now a rapidly growing literature on the relationship between physical spaces and behaviors associated with obesity—specifically food consumption and levels of physical activity. Obesity is a particular health concern for the poor. Not only are obesity rates generally higher among those with lower SES, but the chronic conditions caused by obesity may also present a particular challenge for the poor who often lack access to necessary ongoing medical supervision. Although the reasons for overeating and insufficient physical activity are complex and include a wide range of factors, there is growing evidence to suggest that a partial explanation can be found in the built environment. The physical characteristics of many of our communities, and particularly poorer communities, encourage obesity-generating behaviors including a sedentary lifestyle and unhealthy eating habits. Although changes in the physical environment may not yield the quick and dramatic results that such changes yielded a hundred years ago, they still offer some promise as part of a more comprehensive public health effort.

Larry I. Palmer, O'Neill Visiting Professor of National and Global Health Law, ties together the diverse research findings on health disparities by asking the basic question: “What is Urban Health Policy and What’s Law Got To Do With It?”
The demographic shift from rural to urban modes of living has implications for the structure of global social and economic institutions. Professor Palmer proposes to enrich the reality of the global, national and state focus of scholarship and discourse on health policy by shifting our focus to that which is most local—the neighborhood, the community, and the city.

**ACCESS TO HEALTH CARE: THE CRISIS OF THE UNINSURED**

Karen Davenport and Meredith King, Director of Health Policy and Health Policy Research Analyst (respectively) at the Center for American Progress, point out that almost two-thirds of all Americans without health insurance—more than 30 million people—live in households with incomes that fall below 200 percent of the Federal Poverty Level. These individuals and families have few options for obtaining health coverage. Lower-income workers and their families typically do not have access to employer-sponsored coverage, nor do they have adequate income or assets to purchase coverage on their own. In addition, many (particularly childless adults) do not qualify for Medicaid coverage by nature of their family structure, age and disability status. Ms. Davenport and Ms. King argue that, practically speaking, proposals that seek to expand various forms of group coverage for lower-income Americans—whether public or private group coverage—have the greatest potential for increasing health insurance participation among this group of vulnerable Americans. Group coverage offers two important advantages. First, because of economies of scale and the concomitant ability to spread risk across a large and stable collection of insured lives, large groups have greater negotiating clout with insurers and health care providers. They are thus able to secure favorable rates. Second, a large group is generally able to reflect a balanced cross-section of risks—healthy enrollees who use few health services and are low risk alongside unhealthy enrollees who heavily use health services and are high risk. This balance smooths out expected costs across the group, thus creating a stable insurance pool and easily predictable insurance costs.

Why would President Bush veto bipartisan legislation that does precisely what he insisted on—namely, aggressively enroll the poorest children? One might blame the poisonous atmosphere that pervades Washington, but other important social policy reforms have managed to get through. Sara Rosenbaum, Professor of Health Policy at the George Washington School of Public Health and Health Services, and Mary E. Harty, a student at the George Washington School of Law, explain that the answer lies in a far larger dimension of SCHIP that is basic to any health insurance legislation—namely, the legislative architecture of the reform plan, its structural and operational approach. Viewed from this vantage point, the SCHIP battle turns out not to have been about family-income assistance levels or the mechanism for financing coverage subsidies (although both the Medicare managed-care industry and the tobacco companies weighed in noisily on the latter question). Instead, the issue became the role of government in organizing and overseeing the health care marketplace.
Building on theories about ensuring access to health care, John Bouman, President of the Sargent Shriver National Center on Poverty Law, asks the practical question, "What can a public interest lawyer bring to campaigns to expand or protect access to care for low income people?" The traditional lawyer skills involve technical expertise in the governing legal framework, drafting statutes and rules, and litigation. In campaigns to expand or protect access to care, public interest lawyers who intend to be involved in leadership of the campaigns must think about multiple and multi-forum strategies, and a variety of skills and capacities. In addition to traditional legal skills, attorneys must also develop new capacities, including lobbying and forming relationships with policymakers, media relations, message development, grass roots contacts and organizing, academic research, access to religious leaders and groups, relationships with health care provider organizations, and contacts in the business community. Bringing all of these factors together into an effective strategy is the challenge for a successful campaign.

**Health and Poverty in the Global Development Context**

Rudolf V. Van Puymbroeck, former legal adviser to the World Bank Group, examines global health inequality through the prism of HIV/AIDS. He argues that the HIV/AIDS pandemic has had such significant economic and social consequences that it constitutes a major threat to development in many countries. Although HIV/AIDS strikes rich and poor alike, the poor suffer the greatest impact. Conversely, poverty is itself a driver of HIV/AIDS: under-nutrition, unsanitary conditions and parasite infections, inadequate primary health care, illiteracy, economic insecurity and precarious ability to cope with the financial repercussions of illness and death, all increase poor people's susceptibility to HIV. Law and legal reform have two important roles to play in a complete response to HIV/AIDS. First, the legal system must provide a supportive framework for a country's HIV/AIDS program. Second, as poverty enables HIV/AIDS, those who prepare and direct national HIV/AIDS programs must have a keen appreciation of the larger development effort within which their work fits. Some of the institutional and social issues that must be addressed for national poverty reduction are also of vital importance for an effective and lasting response to HIV/AIDS, including gender inequality, child vulnerability, and intellectual property protection.

William McGreevey, Adjunct Professor at the Georgetown School of Nursing and Health Studies, and colleagues, argue that the key to reduced exposure to infectious diseases, particularly in urban areas, is a strong water-and-waste infrastructure. That infrastructure has nowhere been developed wholly by private action. Its successful construction in the main cities of Europe and the 'neo-Europes' of overseas expansion depended on recognition that better health care, extended to all urban residents, is a public good that must be purchased with public resources. The advantages of propinquity only accrue when barriers to
good health are broken by efficient public services that extend to rich and poor alike. For two billion or more poor people in low- and middle-income countries, the task of combining better health with urbanization and productivity improvement is a key task that lies ahead.

Robert S. Lawrence, Professor and Director, Center for a Livable Future at the Johns Hopkins Bloomberg School of Public Health, and his colleagues discuss the timely issue of poverty and food security from the perspective of the right to health. Food security includes the adequacy of the food supply as determined by nutritional adequacy, food safety and quality, and cultural acceptability along with the stability of the food supply and access as determined by environmental sustainability and social sustainability. Each of these components are essential to food security, and hence the right to food and the right to health can be assessed according to the obligations of the state to protect, respect, and fulfill. This approach to food security is “consistent with that of a ‘livelihood approach’ to food security, rather than a ‘food first’ approach.” The livelihood approach “fulfils the rights of people,” while the food first approach is used to meet “the needs of beneficiaries.” The right holder is then in a position to claim these rights from the duty bearer, usually the state. The duty bearer, in turn, fulfills its responsibility to the right holder through the processes of respect, protection and fulfillment. Through the use of a human rights framework of the state’s obligation to respect, protect, and fulfill the right to food and the right to health, the poor and their advocates can move from reactive to proactive methods of alleviating hunger and obtaining food security.

PUBLIC HEALTH LEGAL SERVICES

David Schulman, in the Legal Department of the City of Los Angeles, and colleagues, argue that the role of legal services in achieving important public health goals has emerged as a new and powerful idea in recent years. The authors call this emerging vision “public health legal services.” It encompasses those legal services provided by private sector attorneys to low-income persons, the outcomes of which when evaluated in the aggregate using traditional public health measures advance the public’s health. For providers of legal services to vulnerable individuals, this emerging vision raises intriguing questions about best practices and institutional funding. For public health officials, it suggests a new tool to add to the traditional armamentarium of vaccine, sanitation, community education, population studies, and the like. For example, an attorney who compels a landlord to abate mold in a child’s home is exercising individual rights on behalf of the child. She is also improving the child's health. If several such actions within the same community result in similar improvements, such outcomes might be aggregated and evaluated using traditional public health metrics. Such studies could document the public health value of such actions, as surely as studies of vaccine effectiveness or improved sanitation. And as Schulman and colleagues explain, if such legal services not only improved access
to justice but public health, should not that change the public debate about the value of legal services?

POVERTY AND HEALTH FROM THE VANTAGE POINT OF SOCIAL JUSTICE

Legal scholarship too often sees health and poverty as two separate fields. One body of scholarship examines health care and public health, while the other examines the systemic effects of poverty. But as this symposium so compellingly shows, the two fields are interrelated, even synergistic. Bringing together thoughtful scholars, as well as legal and public health activists, to describe the relationships between health and SES, and to generate creative ideas to reduce the inequalities, is vitally important.

At the same time, health law scholars should not continue to approach health care reform as if it were a problem that affects everyone equally. It is not a matter simply of creating the right market incentives or even ensuring maximum choice for individuals. Rather, the challenge is to attend to the unique needs of persons living in poverty. This requires not so much an understanding of economics, although that is important. Rather, it requires a compelling articulation of the demands of social justice.

A core insight of social justice is that there are multiple causal pathways to numerous dimensions of disadvantage. The causal pathways to disadvantage include poverty, substandard housing, poor education, unhygienic and polluted environments, and social disintegration. These, and many other causal agents, lead to systematic disadvantage not only in health, but also in nearly every aspect of social, economic, and political life. Inequalities of one kind beget other inequalities, and existing inequalities compound, sustain, and reproduce a multitude of deprivations in well-being. Taken in their totality, multiple disadvantages add up to markedly unequal life-prospects.

The account of social justice in this GJLP symposium views the totality of social institutions, practices, and policies that both independently and in combination deeply and persistently affect human well-being. It is interventionist, not passive or market-driven, vigorously addressing the determinants of health throughout the lifespan. It recognizes that there are multiple causes of ill and good health, policies and practices affecting health also affect other valued dimensions of life, and health is intimately connected to many of the important goods in life. It has the aim of identifying and ameliorating patterns of systematic disadvantage that profoundly and pervasively undermine prospects for well-being of oppressed and subordinated groups—people whose prospects for good health are so limited that their life choices are not even remotely like those of others.41