Health Care Industry

Equity and population health

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To the Editor: The passion with which Norman Daniels writes is matched only by the precision of his argument (July-August 2006). I share his passion, and I agree with much of his argument. But I want to make a general point on whether it is true that social justice is good for our health, and a specific point on health-workers from low-income countries. I am an empirical economist, and it is from that perspective that I argue.

According to Daniels, "there can be no equity in health without social justice" and "achieving the best level of population health by making all people healthy requires (causally) that we pursue social justice more broadly." The empirical support for this idea goes like this: individual health depends on command over resources (income, for short), and the effect of income on health is larger for the poor. As a result, redistribution of income from rich to poor improves the health of the poor with little or no harm to the health of the rich, and so improves population health. A country that decides to be more serious about a just distribution of goods will, as a by-product, improve its population health.

But is it true that income affects health in this way? One immediate problem is that poor health is just as much a cause of low income as its consequence. Many of the poorest people, in both rich and poor countries, are poor because they cannot work; they are disabled or suffer from poor physical or mental health. Indeed, the WHO's Commission on Macroeconomics and Health argued that poor health was the primary cause of poverty in Africa. In rich countries, middle-aged people often retire in response to deteriorating health, with an inevitable reduction in income. Poor health in childhood leads to lower income as an adult. While the issue is far from settled, my own best judgment is that income in and of itself has little effect on health. If so, there can only be a weak link from social justice to health through income redistribution. Yet all is not lost. There is good historical evidence that population health has improved in response to other improvements in social justice, such as improved agency for women, the extension of the franchise to working people, better access to education, or the extension of civil rights to health care.

As Daniels argues, the issue of global justice is particularly difficult. The shortage of nurses in the rich world has opened up new opportunities for African and Asian nurses. For a poor African country, the increased world demand for its nurses and doctors has effects similar to an increased demand for its diamonds or its coffee. We do not usually regard the latter extension of opportunity as a harm perpetrated on Africa by OECD consumers, even though the higher price of coffee will certainly hurt some local consumers. But what of the victims of HIV/AIDS in Africa who desperately need the health care, and who are giving it up to provide (less urgent) care to the citizens of the north? This increase in relative deprivation would certainly be an injustice if the world were a single state. But in the world as it is, the argument is unclear. The increased demand for nurses gives the African state the possibility of improving some lives while not harming others. For example, the state could allow nurses to go if they remit at least as much as their previous salary, and if their replacements are in place. The point is not that there will be no harm in practice, but that any actual harm is a consequence of the internal arrangements of the state. From the "statist" perspective, this is not an injustice--although as Thomas Nagel has reminded us, in such circumstances, justice may be a side issue relative to the requirements of humanitarian action.

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1 2