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Editorial

What we don't talk about in health inequalities: Value judgements

Most definitions of health inequalities, or health inequities, focus on health gaps which are avoidable and unfair [1]. Hundreds of pages of journals are filled every year describing health inequalities, but few discuss why these differences are unfair and avoidable. These value judgements raise important philosophical and ethical questions. But, more pragmatically, the lack of engagement with these value judgements may be part of the reason that more progress on addressing health inequalities is not made.

It is straightforward to identify avoidable health outcomes caused by, for example, unhealthy diets or physical inactivity. Over the past 30 years, public health has built a robust evidence base that unhealthy lifestyles are driven by the social determinants of health; also avoidable through political choice. However, the difference between avoidable and unavoidable is a value judgment. An unavoidable health outcome, one that could not be prevented or mitigated, is difficult to identify and operationally of limited use. In reality there are few such outcomes, especially in the context of policy development. Historically public health taught about modifiable (e.g. diet and lifestyle) and non-modifiable risk factors (e.g. age, gender, genetics). While this may be relevant for health professionals with a patient in front of them, it is not relevant at a collective, policy level. We cannot change an individual's age, but we can target policies and services to age groups. We now know there are a plethora of gene-environment interactions, meaning that an individual's genes are not as non-modifiable as we once thought. For example, adverse child events influence gene expression and subsequently development [2].

One could consider rare genetic conditions which lead to early mortality as unavoidable difference. Take for example Hutchinson-Gilford progeria, a rare genetic condition that causes children to age rapidly with an average life expectancy of 14.6 years [3]. We may argue that it is unavoidable that someone with this condition will die before those without it and therefore should not be considered an inequality. But these distinctions are abstract to policy makers who are much more pragmatic and utilitarian in their approach – seeking the maximum benefit to as many as possible. The risk with the concept of avoidablity is in making inappropriate judgements about what is avoidable. For example, taking an unconscious and fatalistic approach to certain health problems and communities – such as the high prevalence of diabetes in people who are south Asian.

Fairness is even more subjective than avoidablity. For many members of the public (and many policy makers) fairness is concerned with deservedness; those who make healthy choices deserve to live longer, healthier lives. For example, a large proportion of the general public may view differences in life expectancy between smokers and non-smokers as fair; if an individual chooses to smoke despite repeated health warnings and offers of support it is not unfair if their health is worse than non-smokers. At the heart of this argument is a belief that the individual is primarily responsible for their own health, rather than society. The British Attitudes Survey (BSA) found that 61% of people thought individuals had a greater responsibility for their own health than the government [4].

For most public health practitioners, policy makers and researchers fairness is about equal health outcomes irrespective of, for example, wealth, ethnicity or region. The underlying reason for any differences is the unequal distribution of the wider determinants of health – education, income, employment, etc. The deservedness perspective does not hold up for those in public health who believe that health is the product of the structures within society. Many in public health see it as a mission to highlight the impact of the unequal distribution of the social determinants of health and advocate for structural change. However according to the BSA, only 9% of the public think the government has a greater responsibility than individuals.

Before public health take the moral high ground, we must acknowledge our own value judgements about fairness. For example, women consistently have a higher life expectancy than men. Yet, we do not see public health claiming this as an injustice or public health campaigns aiming to close the gender gap in life expectancy. Rather there is an implicit acceptance that women face many disadvantages in society and prioritising policy action to raise the life expectancy of men in line with women would not be fair.

Does it matter if avoidablity and fairness are inherent, subjective value judgements at the heart of health inequalities? The vagueness of these terms is convenient because it allows a disparate group of policy makers and health organisations to coalesce and advocate for a more equitable society. However, it is also inconvenient because it leaves health inequalities as a nebulous concept, meaning different things to different people, with the gap between the beliefs and values of the public health community and the general public particularly wide. It also leads to assumptions; some politicians and policy makers may not engage with health inequalities because they assume it is pushing a particular view of what is unfair and avoidable. If we are to make meaningful progress on health inequalities and build cross party consensus, we must acknowledge and engage the general public, politicians and policy makers with these big questions about fairness and avoid ability.

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