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The Normative Dimensions of Health Disparities

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ABSTRACT

Understanding what conditions must be satisfied for a health inequality to be a health inequity (disparity) is crucial for health policy makers. The failure to understand what constitutes a health inequity, and confusing health inequalities with health inequities threatens the successful creation of health policies by diverting needed attention and resources away from addressing health inequalities that are health inequities. More generally, the failure threatens to undercut our ability to tell what research is relevant to the creation of health policies that aim to mitigate or eliminate health inequities. With this in mind, the principal aim of the present paper is to provide a framework within which to understand the relationships of concepts such as health difference, health inequality and health inequity to one another. Under the umbrella heading of “health disparities”, which is often used as a catch-all expression to refer to various, sometimes very different concepts of health, health outcomes and health determinants, the paper draws attention to two important axes in this framework; the axis of health inequalities (the empirical dimensions) and the axis of health inequities (the normative dimensions). Using the writings of John Dewey on valuation and value judgments, the paper explores how it is possible for a claim about the existence, prevalence or scope of health disparities to have both an empirical dimension and a normative dimension.

Keywords: Health Disparities; Health Inequalities; Health Inequities; Health Policy; Dewey; Ethics

INTRODUCTION

The 2003 Institute of Medicine (IOM) report, *The Future of the Public's Health in the 21st Century*, concludes that compared with U.S. residents living in 1900, those in 2003 “are healthier, live longer, and enjoy lives that are less likely to be marked by injuries, ill health, or premature death.” (Institute of Medicine, Committee on Assuring the Health of the Public in the 21st Century, Board on Health Promotion and Disease Prevention, 2003) Unfortunately, even with these improvements and benefits, health inequalities between subpopulations continue to exist. Moreover, there are statistically significant differences amongst subpopulations in the U.S. relative to how close they come to achieving health targets such as those established by Healthy People 2020. The presence of these health inequalities means that it is likely that there are differences amongst the subpopulations in health outcomes (e.g., infant mortality), and in having opportunities to attain or maintain opportunities for good health. If the differences are unfair or unjust, they constitute health inequities (often referred to, especially in the U.S., as *health disparities*).

A principal goal of health policies is to either maintain a fair and just distribution of health resources, or change the distribution of health resources to bring about fair and just distributions of health opportunities and outcomes. Thus, understanding what conditions must be satisfied for a health inequality to be a health inequity (disparity) is crucial for health policy makers. In this connection, Paula Braveman writes that “How one defines ‘health disparities’ or ‘health inequity’ can determine not only which measurements are monitored by national, state/provincial, and local governments and international agencies, but also which activities will receive support from resources allocated to address health disparities/inequalities and health equity.” (Paula Braveman, 2006) The failure to understand what constitutes a health inequity (disparity), and confusing health inequalities with health inequities threatens the successful creation of health policies by diverting needed attention and resources away from addressing health inequalities that are, in fact, health inequities. More generally, the failure threatens to undercut our ability to tell what research is relevant to the creation of health policies that aim to mitigate or eliminate health inequities.

With this in mind, the principal aim of the present paper is to provide a framework (Taylor, 2001) within which to understand the relationships of concepts such as health difference, health inequality and health inequity to one another. Under the umbrella heading of “health disparities”, which is often used as a catch-all expression to refer to various, sometimes very different concepts of health, health outcomes and health determinants, the paper draws attention to two important axes in this framework; the axis of health inequalities (the empirical dimensions) and the axis of health inequities (the normative dimensions). Using the writings of John Dewey on valuation and value judgments, the paper explores how it is possible for a claim about the existence, prevalence or scope of health disparities to have both an empirical dimension and a normative dimension. Thus, the present paper is not an empirical investigation of how one or more populations differ relative to some well-defined quantitative health related metric. Instead, in what follows we seek to provide a “conceptual space” (framework) within which it is possible to understand the relationships of empirical investigations and policy deliberations regarding health disparities to one another, and how they can, and do, and should inform one another.

Health Differences and Health Inequalities

In the literature on health disparities, the expressions ‘health disparities’, ‘health differences’, ‘health inequities’, and ‘health inequalities’ are sometimes used interchangeably. (Kindig, 2007; Krieger, 2005) This unfortunate conflation often creates confusion about the character of health measures and their monitoring undertaken by health services research as well as by governments and agencies. (Paula Braveman, 2006; Carter-Pokras & Baquet, 2002; Murray, Gakidou, & Frenk, 1999) Equally important, the conflation obfuscates what conditions warrant judgments that empirical variations in distributions of health outcomes or opportunities to attain or maintain good health are ethically unacceptable. To that end, we begin with the expression about which there is general agreement that its content is principally empirical – viz., ‘health difference’. (Paula Braveman & Gruskin, 2003; Gakidou, Murray, & Frenk, 2000; Gwatkin, 2000; Kawachi, Subramanian, & Almeida-Filho, 2002; Krieger, 2005; Norheim & Asada, 2009; Raphael, 2000) A health difference is an empirically measurable variation in the health characteristics or determinants of health characteristics in one or more populations relative to some reference measure.

Because of the multiple dimensions of the concept of inequality (and equality) (Gakidou et al., 2000; Gwatkin, 2000; Sen, 2002), there are various ways to characterize health inequalities. Nevertheless, we can say generally that a health inequality is a summary measure that captures one or more specific differences in the overall distribution of a chosen health metric among populations or between one or more populations and some reference measure. (Carter-Pokras & Baquet, 2002; Kawachi et al., 2002; Norheim & Asada, 2009; Truman et al., 2011) Characterized in this way, it follows that all health differences entail the existence of a health inequality. For example, the mortality rate in the U.S. Non-Hispanic White subpopulation is different from the mortality rates in the U.S. Hispanic subpopulation and the U.S. Non-Hispanic Black subpopulation. Thus, as a function of the mortality rate, the health of the U.S. Hispanic and Non-Hispanic Black subpopulations is not equal to the health of the U.S. Non-Hispanic White subpopulation. Significantly, not only is the mortality rate in the U.S. Hispanic subpopulation not the same as the U.S. Non-Hispanic White subpopulation, it is also not the same as the mortality rate in the U.S. Black subpopulation. This difference in the mortality rates between the U.S. Hispanic subpopulation and the U.S. Non-Hispanic Black subpopulation is also a health inequality.

While the mortality rate in the U.S. Hispanic subpopulation is not the same as the mortality rate in the U.S. Non-Hispanic Black subpopulation, disparities researchers typically compare both the U.S. Hispanic and the Non-Hispanic Black subpopulations to the U.S. Non-Hispanic White subpopulation. One reason for comparing the U.S. Black and Hispanic subpopulations to the U.S. Non-Hispanic White subpopulation is that the Non-Hispanic White subpopulation has been the majority (numerically) population while the Non-Hispanic Black and Hispanic subpopulations have been the minority (numerically) populations. A second reason is that, historically, the U.S. Non-Hispanic White subpopulation has had better health outcomes, better health access and better access to needed health care than most other U.S. subpopulations. A third reason underlying the comparison is the widely held claim that the U.S. Non-Hispanic White subpopulation has treated the U.S. Non-Hispanic Black and Hispanic populations unjustly or unfairly, resulting in institutionally embedded social disadvantages and injustices for these two U.S. subpopulations. (Jones, 2010; Paula Braveman, 2006)

By themselves, claims about the presence of health inequalities do not have any normative content. (Krieger, 2005) As Iris Young writes, claims regarding equality or inequality are, in themselves, “simply factual comparisons of amounts or degrees of some variables between or among entities.” (Young, 2001) For example, surveys such as the American Community Survey (ACS) and the Current Population Survey (CPS) reveal that the percentage of the U.S. Non-Hispanic Black subpopulation with health insurance is less than 100 percent. Similarly, the percentage of the U.S. Hispanic subpopulation with health insurance is less than 100 percent. Based on these surveys, we may claim that the percentages for both subpopulations are less than the stipulated objective/target of 100 percent set by Healthy People 2020. This is a claim (statement of fact) about how the percentages of people with health insurance in two U.S. subpopulations are not equal to the stipulated target in Healthy People 2020. What is important, though, is that it does not immediately follow from this claim (even assuming that it is true) that there is anything ethically objectionable in the two subpopulations falling short of the Healthy People 2020 target. There is something more needed to justify the inference from the factual, descriptive claim about health insurance coverage to the normative judgment that it is ethically objectionable that the percentages of people with health insurance in two U.S. subpopulations are not equal to the Healthy People 2020 target.

To say that claims about health equalities and inequalities do not have any normative content is different from saying that no value judgments underlie the identification and measurement of the inequalities. Everything that we measure is interpreted – the experiential data about which measurements are made “are not raw experiences but rather beliefs about what we experienced.” (Misak, 2008a) In this connection, Julian Le Grand writes that since “Atkinson’s path-breaking article on [economic] inequality measurement (1970) it has been generally accepted that the use of statistical measures of inequality, such as the Gini coefficient or the coefficient of variation, implies the acceptance of certain values.” (Le Grand, 1991) Nevertheless, Le Grand continues, the inference from the fact that the use of statistical measures of inequality implies the acceptance of certain values to the claim that “inequality (and therefore equality) is itself normative” (Le Grand, 1991) is not a legitimate inference. The fact “that the choice of summary measures of inequality involves value-judgments”, writes Le Grand, “does not imply that the concept itself is normative.” (Le Grand, 1991)

Although Le Grand’s remarks refer to methods for measuring economic inequality, an inequality that is often a social determinant of health (Raphael, 2000), the same point applies to measures used in determinations of purported health inequalities (e.g., population attributable risk, the concentration curve and index). (Paula Braveman, 2006; Wagstaff, Paci, & Doorslaer, 1991) Moreover, that we should be interested in race, ethnicity or functional status and not eye color or hair length reflects value judgments (sometimes explicit but more often implicit) about which inequalities are important when studying health inequalities or creating health policies. In the U.S., for instance, a principal focus has been on racial and ethnic inequalities, while internationally, inequalities due to differences in socioeconomic status (SES) have been a principal focus. (P. A. Braveman et al., 2011; Dehlendorf, Bryant, Huddleston, Jacoby, & Fujimoto, 2010; Dehlendorf et al., 2010; Krieger, 2005) Thus, while claims about health equalities and inequalities lack normative content, it is nonetheless true that to arrive at a notion of health inequality we must already have made value judgments “about what kinds of considerations ought to count when judging when health is (un)equal.” (Harper et al., 2010)

Health Inequalities and Health Inequities

Yukiko Asada writes that while health science researchers “have increasingly distinguished health inequity from health inequality ... confusion over the terminology still persists”. (Asada, 2005) The principal distinction is that unlike the concepts of equality and inequality, the concepts of equity and inequity are explicitly normative. (Chang, 2002; P. Braveman & Gruskin, 2003; Williams, 2005; Le Grand, 1991) As Margaret Whitehead writes, “The term inequity has a moral and ethical dimension.” (Whitehead, 1991; Also, see Carter-Pokras & Baquet, 2002) To claim that a health inequality is also a health inequity is to claim that the inequality is, in some important sense, ethically unfair or unjust. (Murray et al., 1999; P. A. Braveman, 2003; Marchand, Wikler, & Landesman, 1998) The qualification of ‘ethically’ to the concepts of unfairness and injustice is crucial. For instance, Williams and Cookson write that in “economics the term ‘equity’ is usually taken to refer to fairness in the distribution of a good ... and ‘fairness’ is taken almost unthinkingly to mean *reducing inequalities*.” (Williams & Cookson, 2000) When applied to health inequalities, this unqualified, economic account of equity assumes that all health inequalities are ethically unfair and, as a result, are health inequities. This assumption, which is tantamount to making equity claims independent of ethical judgments (Goddard & Smith, 2001), is not correct.

To understand why not, suppose that a portion of a given population deliberately underutilizes, relative to the rest of the population, “some or all traditional (mainstream) health care services” because of informed, freely made “religious, esthetic, or cultural reasons”. (Daniels, 1982) In such a case, there is a health inequality between the subpopulation and the rest of the population in terms of access (although, perhaps not in terms of availability) to some or all mainstream health care. However, insofar as the inequality in utilization rates is not due to some exogenous factor (e.g., the unwillingness of physicians to provide medical treatment to people having the religious, esthetic or cultural characteristics in question) but is, instead, the result of informed, freely made choices by a portion of the population, the inequality is not a health inequity. (Daniels, 1988) The general point is that because not all health inequalities are ethically unfair (P. Braveman & S. Gruskin 2003; S. Anand 2002; Oliver et al. 2002), the existence of a health inequality is not a sufficient condition for the existence for a health inequity. (Williams, 2005) Therefore, following Fabienne Peter, the problem a theory of health equity faces is how to go from empirical identifications of health inequalities, such as inequalities in mortality or access to care, to the normative judgment that those inequalities are also health inequities. (Peter, 2011)

The beginning of an answer is, in a broadly Deweyan sense, that a health inequality becomes a health inequity when, because of some problem or conflict in thinking otherwise (Dewey, 2008a), people come to “perceive and interpret” the inequality as a problem of unfairness or injustice and “come to some shared understanding that they want to change the situation.” (Stone, 2006) When this happens, the inequality is attributed a normative value relevant for health policy choices (P. A. Braveman et al., 2011; Aday, Andersen, & Fleming, 1980), where the connotation of ‘policy’ includes the creation of laws, regulations, and rules whose purpose is to exercise some degree of social control. Because the transformation of an inequality into an inequity is a function of the values held by specific communities at particular times, it follows that there is no single, universally applicable answer to the question of what inequalities are attributed a normative value relevant for policy choices. In this respect, the transformation runs counter to what Arthur Caplan calls “the engineering model of applied

ethics”. (Caplan, 1983) According to that top-down model, “there is a body of knowledge concerning ethics that persons can be more or less knowledgeable about”, and that knowledge becomes applied, transforming inequalities into inequities, by deducing conclusions for the appropriate ethical theories “in light of relevant empirical facts and descriptions of circumstances.” (Caplan, 1983) This, though, is precisely what Dewey denies; for Dewey, each moral situation is unique, and rather than the present being subservient “to a rigid yet abstract future” (Dewey, 1988) outlined by the “true” or “correct” ethical theory and the principles that constitute that theory, each “moral situation is unique”, created by people attempting to interpret and address situations of conflict. (Dewey, 1988) Ethical theories, principles and public policies are instruments of action whose purpose “is to converge all the instrumentalities of the social arts, of law, education, economics, and political science upon the construction of intelligent methods of improving the common lot.” (Dewey, 1997)

Nevertheless, while the details may vary from community to community, it is possible to identify three general types of equality common to health policy discussions. In addition, since inequity is derivative of inequality (all instances of inequity are instances of inequality), it follows that there are three types of inequity. The first type of equality, equality of opportunity, requires that positions and possessions of goods (including welfare and well-being) are open to all people, and that when members of two or more populations have the same native talents and the same aspirations, they have the same realistic prospects for success in acquiring some objective. (Roemer, 2003) To the degree that the prospects of members of two or more populations to acquire some objective vary only by the “foreseeable, avoidable” results of the members’ “own responsible choices” (Elford, 2012), any differences in the prospects for acquiring some objective are fair and just. In contrast, when the variance in prospects is a function of native talents or circumstances into which the members are born, when the prospects vary by “brute luck” (Dworkin, 1981, 2001), then any differences in the prospects for acquiring some objective are unfair or unjust. Thus, building on a remark by Braveman et al., (P. A. Braveman, Egerter, Cubbin, & Marchi, 2004) every person should have the same realistic prospect of achieving his or her “optimal health status” without distinction based on characteristics such as race or ethnic group, nationality, skin color, age, or disability status.

For example, suppose that the objective in question is possession of health insurance. In the United States, there are subpopulations such as males, ages 30 to 35 having incomes that fall below the federal poverty limit, whose members typically cannot afford to purchase health insurance. Because of their socio-economic status, these people have no realistic opportunity to purchase health insurance. Since few, if any government programs provide public health insurance for members of this population, the prospects of this subpopulation to acquire health insurance coverage is generally not equal to those other U.S. subpopulations whose members have the financial resources to purchase health insurance or whose members are covered by government programs (e.g., Medicaid). Thus, it is not the case that everyone in the population who wants health insurance coverage has the realistic prospect of acquiring such coverage. On the assumption that the political and socio-economic conditions that prevent males ages 30-35 from acquiring insurance are due to circumstances over which they have no direct control, then the inequality of opportunity is also an inequity of opportunity.

The second type of equality, substantive equality, refers either to the equal occurrence of some good in two or more populations, or to the fact that the occurrence of some good in one or more populations is at least equal to some stipulated target/objective. In the context of health

and health care, an example of substantive equality is the Healthy People 2020 target of no more than 160.6 cancer deaths per 100,000 people in the U.S. When the population meets the target, then there is substantive equality in the population relative to cancer deaths. This category captures differences in health outcomes or health status, as well as differences in the quality of health and received health care. For example, following Healthy People 2020, suppose that we assume that for all U.S. racial subpopulations, the number of new cases of diabetes per 1,000 population aged 18 to 84 years that occur within the a given calendar year should be equal to or less 7.2 cases. In this case, if the number of new cases of diabetes per 1,000 Non-Hispanic Black subpopulation aged 18 to 84 is greater than 7.2 cases, then the difference between the reality and the stipulated Healthy People 2020 target is both a substantive inequality and a substantive inequity.

The third type of equality is related to what Alan Gewirth calls an equality of generic rights, viz., “equality between the agent and his recipients with regard to their severally having the necessary conditions of agency.” (Gewirth, 1978) On the assumption that having access to needed health care is a necessary condition of agency, we can refer to this subset of Gewirth’s equality of generic rights as access equality. Such equality requires either that two or more populations are equal in terms of their access to needed health care, or that the access one or more populations have to needed health care is equal to or greater than that specified by some stipulated objective. For example, suppose that we assume that all adults in the U.S. population ought to have access to needed health care. As established by a variety of surveys, adults in the U.S. with restricted mobility capabilities (e.g., people who must use a wheelchair) do not always have access to needed care (even though the resources to provide the needed care may be available). The inability to access needed care may be due to social determinants such as obstacles of the built environment, or inadequate transportation, or to some other source over which people with restricted mobility capabilities have no direct control. If we assume that all adults in the U.S. population ought to have access to needed health care, it follows that the health care inequality of access to needed health care that exists between the mobility challenged portion of the adult U.S. population and the standard set by the assumption is an access inequity.

Although the expression ‘health disparities’ is sometimes used to refer to only health inequalities, typically, and especially in the United States, it is used more specifically to refer to health inequities. Two simple examples illustrate the use of health inequities in identifications of health disparities. The first example comes from comparing the population of people ages 80 and over with the population of people ages 18 to 65. All other things being equal, the mortality rate for the first population is greater than the mortality rate for the second population. Thus, there is a substantive inequality between the first population and the second population. However, insofar as the inequality is due to natural biological (dis-) functions associated with age and not to exogenous factors such as inferior healthcare for people ages 80 and over, the health inequality is not a health inequity (health disparity).

The second example concerns Glucose-6-phosphate dehydrogenase (G-6-PD) deficiency, which is a “hereditary condition in which red blood cells break down when the body is exposed to certain drugs or the stress of infection.” (A.D.A.M. Medical Encyclopedia, 2010) At least in the United States, men are more likely to have a G-6-PD deficiency than women are, and Blacks are more likely to have the deficiency than Non-Hispanic Whites are. Thus, relative to the U.S. population, there is a substantive inequality between the Black, male subpopulation in terms of the prevalence of G-6-PD deficiency and the Non-Hispanic White, female subpopulation. (Frank,

2005) Nevertheless, because the difference is due to inherited biological characteristics, the health inequality is not a health inequity (health disparity). A health inequality between a reference population and two or more other populations, or between a specific characteristic of one or more populations and a stipulated target, is a health disparity only if the health inequality is a health inequity in one of the three senses identified above.

Assessing the Normative Dimensions

Based on the remarks and arguments made in the previous section, there is a centrally important question for those interested in health inequities (disparities). “What warrant do we have for the judgment that a specific metric for one or more populations ought not be *less than* (or *greater than*, depending on the metric) the same metric for either the reference population or a stipulated health objective/target?” There are many ways one could answer this question. Some authors try to answer the question by referring to health inequalities caused by social status. For example, Braveman et al. write that we “use the term “social disparities in health” broadly here to refer to differences in health – or likely determinants of health – that are systematically associated with different levels of underlying social advantage or position in a social hierarchy.” (P. A. Braveman, Egerter, Cubbin, & Marchi, 2004) Similarly, Kilbourne et al. define health disparities “as observed clinically and statistically significant differences in health outcomes or health care use between socially distinct vulnerable and less vulnerable populations that are not explained by the effects of selection bias.” (Kilbourne, Switzer, Hyman, Crowley-Matoka, & Fine, 2006) In both cases, the idea is that any health inequality resulting from a difference in social status is a health inequality that results from unjust or unfair social institutions (and their effects on groups of people) and so a health inequity. (Daniels, Kennedy, & Kawachi, 1999)

Apart from the difficulty in operationally defining “social status”, such characterizations have at least two problems. First, the claim that a health inequality is a health inequity depends on whether the inequality in social position is an ethically acceptable one. If the inequality in social position is an ethically acceptable one, then, presumably, any attendant health inequalities are ethically acceptable. It follows that this approach to identifying health inequities is dependent upon a full account of what inequalities in social position are ethically acceptable and what differences are not ethically acceptable. For example, suppose that one’s economic status is a (social) determinant in a population of having health insurance. Furthermore, suppose that the society is one in which differential levels of economic status (e.g., income) are an ethically acceptable determinant of social position. These suppositions lead to several alternatives. On the one hand, it may be that the health inequality of having insurance is not a health inequity. On the other hand, it may be that there is some tacit belief that either social status based on economic status is not acceptable or the acceptability of differential social status based on economic status is not relevant to the ethical assessment of the health difference.

The second problem is that the characterizations assume that all health inequalities resulting from differences in social status or position in a social hierarchy are instances of inequity. This seems to be too strong a claim. Suppose that public health insurance offered to those whose incomes are sufficiently low (e.g., Medicaid in the United States) will not pay for cosmetic surgeries such as liposuction, whereas at least some private health insurance will pay for such procedures. On the assumption that these kinds of procedures are costly, it follows that people with low incomes whose only health insurance is public have fewer opportunities for cosmetic health procedures than do people whose private health insurance will pay for the procedures. Presumably, this is a health inequality in terms of opportunities for health services

due to social status based on income. Thus, according to the definitions above, this is an example of a health inequity. This, though, seems to widen, unacceptably, the scope of what counts as a health inequity. A differential in opportunities for health services related to cosmetic health procedures does not seem to rise to the level needed to make the health difference a health inequity.

Certainly, there are other ways to identify which health inequalities rise to the level of health inequities. Norman Daniels argues, using ideas drawn from the writings of John Rawls, that the “goal of public health and medicine is to keep people as close as possible to the ideal of normal functioning, under reasonable resource constraints.” (Daniels et al., 1999) When there are inequalities in attainment of the ideal of normal functioning under reasonable resource constraints, the inequality is also an inequity. In a health needs approach, the distribution of health resources that results in the health inequality is one in which the health needs of one or more segments of the target population are not satisfied. A distribution of health resources in which the health inequality was absent is one in which more health needs of the target population are satisfied. Although there are complexities associated with who determines what constitutes a health need and whether the relevant needs should be delimited to “basic needs” (Ward & Johnson, 2011), the concept is relatively clear; equitable health care is health care provided because of the health needs of a person. As Aday et al. write, “Equity is, in fact, said to exist when services are distributed on the basis of need rather than as a result of structural or individual factors such as a family’s income level, persons’ racial characteristics, or the distribution of physicians in an area.” (Aday, Andersen, & Fleming, 1980) In a human rights approach, the distribution of health resources that results in the health inequality is one in which there is a violation of one or more of the “human health rights” of people in a target population. A distribution of health resources in which the health inequality was absent is one in which fewer (or no) human health rights of people in the target population are violated. Thus, relative to the population in which there are fewer (or no) violations of human rights, there are health inequalities. Moreover, since the rights have normative value as human rights, the health inequalities are also health inequities.

This short list of approaches does not exhaust the possibilities of how to delineate health inequalities that rise to the level of health inequities from those that do not. Methodologically though, what is common to all these approaches is that the challenge of identifying which health inequalities are health inequities is one that comes from the prior acceptance of a specific ethical theory and then working out the implications of that theory. This, then, poses a dilemma of sorts. On the one hand, we believe that it is, at best, an open (and contested) question of whether there is a single best or correct ethical theory within which to frame the difference between health inequalities and health inequities. Indeed, some people would argue that there is something misguided in talking about an ethical “theory” at all. On the other hand, without some account of which health inequalities are health inequities, there is no principled way to create health policies to address health inequities (disparities), or to allocate limited resources to address such inequities, or to make decisions about whether proposed research is truly concerned with health and health care inequities (disparities).

Rather than trying to grasp the dilemma by either of its horns, we believe that the writings of Dewey offer a way to slip between the horns. Recall the Deweyan point made earlier that a health inequality becomes a health inequity when, because of some problem or conflict in thinking otherwise (Dewey, 2008a), people come to “perceive and interpret” the inequality as a

problem of unfairness or injustice and “come to some shared understanding that they want to change the situation.” (Stone, 2006) Although much of traditional, Western ethics starts with some theory in which there are clear definitions of the concepts of unfairness and injustice, and then attempts to justify normative claims based on those definitions, Dewey’s approach is different. For Dewey, discovery and reflective inquiry are the critical elements, not justification (Caspary, 2000); the conflicting and confused characteristics of actual, particular social situations lead to hypothetical judgments that they are situations of unfairness or injustice. (Dewey, 1991) In this respect, conflicting and confused situations exist before the problematization of situations that comes from the use of characterizations such as unfairness and injustice in value judgments about the situations. This is what Dewey means when he writes that, “The indeterminate situation becomes problematic in the very process of being subjected to inquiry.” (Dewey, 1991) Value judgments are hypotheses made in an effort to understand and eliminate the conflict and confusion; the values of justice and injustice, fairness and unfairness, are constructs (instruments, tools) to define and address conflicting and confused situations. (Festenstein, 1997)

According to Dewey, “No existing situation can be modified without counteracting obstructive and deflecting forces that render a given situation confused and conflicting” (Dewey, 1991), and a necessary condition for such counteracting is that the situation be conceptualized by judgments using value characterizations. Dewey refers to these judgments as “valuations”. (Dewey, 1922) To the extent that valuations using specific characterizations (the specifics of unfairness and injustice) provide a conceptual framework that is successful in mitigating, reducing or eliminating the conflict and confusion, the valuations have warranted assertability and are retained. This is the “pragmatic”, experimental character of Dewey’s approach to ethics. However if the valuations using the characterizations are not successful in mitigating, reducing or eliminating the conflict and confusion, the valuations, and the characterizations they incorporate, are modified or eliminated. Judgments that situations are unfair or unjust are, therefore, instruments applied to a conflicted and confused situation to problematize it and to offer a means of resolving the conflict and confusion.

In Dewey’s view, problems (conceptualized confused and conflicted situations) which “induce inquiry grow out of the relations of fellow beings to one another ... [and] the meanings which have developed in the course of living, together with all the ways of forming and transmitting culture with all its constituents of tools, arts, institutions, traditions, and customary beliefs.” (Dewey, 1991) Moreover, as noted by William Caspary, Dewey acknowledges that “Not every individual or group in a community will understand a problematic situation in the same way or bring the same purposes and values to it.” (Caspary, 2000) As a result, there will likely be different conceptions of justice and fairness used to problematize any conflicted and confused situation. It is not that one of these conceptions mirrors or otherwise appropriately corresponds to an “objective” ethical order and is, consequently, the “true one” while the others are “false”. Instead, the dialogical interplay between the clear and fully articulated expressions of these different ways of problematizing the conflicted and confused situation results in iterated conceptualizations of justice and fairness that lead to the mitigation, reduction or elimination of the conflict and confusion in the situation. It is this “moral deliberation”, with its tacit assumption that “one belief can be better than another, that we can improve our beliefs, [and] that we can realize that we were mistaken in believing something” (Misak, 2008a) that serves as the democratic framework within which health policies emerge. Indeed, as noted by Matthew

Festenstein, Dewey's purpose in "proposing an empirical science of value is to define a sense in which the various claims made by plural, and sometimes conflicting, values can be objectively appraised." (Festenstein, 1997) For Dewey, then, it is possible to think of the practice of ethics as an exercise in practical politics, albeit a practical politics that is reflective, deliberative and experimental in nature.

Relative to identifying which health inequalities are health inequities, this means that there is no *a priori* "correct" way to make the delineation; the delineation is always a fallible one that emerges out of the specifics involved in trying to resolve one or more conflicted and confused situations. Those who believe that health inequalities of opportunity (or substantive inequalities, or access inequalities) based on racial or ethnic characterizations are unfair or unjust will make judgments that characterize those inequalities as inequities. Similarly, those who believe that health inequalities of opportunity based on socio-economic status are unjust or unfair will make judgments that characterize those inequalities as inequities. Whatever warrants that judgments of either sort have depends, ultimately, on whether the characterizations they use permit a mitigation, reduction or elimination of the conflicted and confused situation that led to the use of those characterizations. This is the sense in which the judgments have instrumental value. Sometimes, the judgments will make use only of antecedently accepted characterizations of values. In these cases, the judgments are descriptive but are not "valuations". However, even in these cases what remains an open question is whether the accepted characterizations of values are correct or fully capture the nature of the situation. Thus, what is crucial both for valuations and for judgments that are descriptive is that anyone making the judgment that a health inequality is a health inequity must explicitly state what the reasoning is for the characterization. It is only when this information is provided and the opportunity for critical thoughtful discussion permitted that it is possible to assess the value of the characterization. As Dewey writes, tools such as value judgments "can be evolved and perfected only in operation; in application to observing, reporting and organizing actual subject matter; and this application cannot occur save through free and systematic communication." (Dewey, 2008b) The failure to share information about the reasoning behind treating certain health inequalities as health inequities undermines any effort to link research about health inequalities to health policies whose purpose is to address health inequities, as well as undermining the ability to assess the efficacy and efficiency of those health policies. What matters is not finding the correct "theory of justice" or theory of equality" on which to base the judgments we make that transform inequalities into inequities, and the policies we construct to address the inequities. Theories are instruments of action, and, for that reason, what is crucial to disparities research and policy formation is transparency (of assumptions, of intentions, of reasoning) and the willingness to engage in thoughtful, critical dialogue with others about the analyses conducted and the policies created.

CONCLUSION

According to Amartya Sen, "health is among the most important considerations of human life and a critically significant constituent of human capabilities which we have reason to value." (Sen, 2002; Also, see Anand, 2002; Asada, 2005; Marchand, Wikler, & Landesman, 1998) However, disparities exist in the distributions of the opportunities to attain or maintain good health, and in the health outcomes for various populations. (Mayberry, Mili, & Ofili, 2000; Siegel & Nolan, 2009) The recognition of disparities in the distributions of opportunities to attain or maintain good health and in health outcomes for various populations has had a

significant impact on the creation of health policies in the United States. (Beal, 2011; National Partnership for Action to End Health Disparities, 2011) One example is Healthy People 2020. Although not an explicit topic area for Healthy People 2020, health disparities serve as one of four foundation health indicators to track success in meeting the goals of Healthy People 2020. Indeed, the Health and Human Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020 (Phase I Report from October 28, 2008) included, as one of their "overarching goals" for Health People 2020, the target of achieving health equity, eliminating disparities, and improving the health of all groups. (Secretary's Advisory Committee on National Promotion and Disease Prevention Objectives for 2020, 2008) This extends and expands on Healthy People 2000's goal of reducing health disparities, and on Healthy People 2010 in which elimination of health disparities was a key objective. (United States Department of Health and Human Services, 2010; Weisfeld & Perlman, 2005)

Traditionally, there are at least two assumptions made when the presence of health disparities is one of the principal driving factors in the creation of health policies. The first assumption is that it is not ethically fair or just that some populations have opportunities to attain or maintain good health, or have health outcomes that are, in one way or another, "better" than another population. (Marchand et al., 1998) As stated by the IOM's Committee on Quality Health Care in America, "the quality of care should not differ because of such characteristics as gender, race, age, ethnicity, income, education, disability, sexual orientation, or location of residence." (Committee on Quality Health Care in America, Institute of Medicine, 2001; Also, see Le Grand, 1991) The second assumption is that it is possible to affect, by policy choices, the distributions of at least some opportunities to attain or maintain good health, or health outcomes in a population. (Daniels et al., 1999) Although these two assumptions overlap one another in important ways, this paper has focused on what conditions warrant judgments that empirically established health differences are also health inequities (disparities).

Like Dewey, we believe that research agendas, as well as "policies and proposals for social action" should "be treated as working hypotheses, not as programs to be rigidly adhered to and executed." (Dewey, 2008b) Thus, because judgments about which health inequalities are also inequities are hypotheses whose value rests with their capacity to address specific conflicts and confusions of humans and their interactions with one another, "the free exchange of results, experiences, arguments and ideals" (Misak, 2008b) is a necessary condition for their accurate assessment. In this connection, Braveman et al. note that "Previous official approaches to defining health disparities in the United States have avoided being explicit about values and principles". (P. A. Braveman et al., 2011) However, for the reasons presented in this paper, it is only by fully and clearly stating the assumptions and reasoning that lead to judgments that specific health inequalities are also health inequities (disparities) that we can engage in the reflective, critical discussion needed to assess the value and importance of such judgments. The answer to whether a health inequality is a health inequity, and so a health disparity in the full ethical sense of that expression, cannot be answered *a priori* by conceptual analysis, or statistically by examining health difference. This latter point is worth emphasizing; No statistical analysis, by itself, is sufficient to demonstrate the existence of a health inequity. Instead, the answer emerges only within ongoing dialogical exchanges constituting the "public communicative infrastructure" (Jacobs & Townsley, 2011), where conflicting views about what is good, and fair, and just take place, and in which statements of facts become value claims.

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