Bundesgesundheitsbl - Gesundheitsforsch - Gesundheitsschutz 2008 · 51:151–157
DOI 10.1007/s00103-008-0443-7
Online publiziert: 7. Februar 2008
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Health inequities and social justice

The moral foundations of public health

Recently we developed an account of social justice that defends the view that considerations of justice provide the moral foundation for public health [1]. For us, social justice is concerned with human well-being, which is best understood as involving plural, irreducible dimensions, each of which represents something of independent moral significance. Health is one of these distinct dimensions of well-being, as is personal security, the development and exercise of cognitive capacities for reasoning, living under conditions of social respect, developing and sustaining deep personal attachments, and being able to lead self-determining lives. In this paper, we begin first by locating our theory in relation to a number of theoretical competitors, and second, by addressing why considerations of justice, and not utilitarian aims, are most foundational to public health. We then discuss some of the central claims of our theory by showing how the differing aims or points of social justice frame the pursuit of public health and help shape its priorities.

Theoretical alternatives

Utilitarianism is in our view the main competitor among theoretical alternatives discussed among public health theorists and practitioners. However, a first step toward a discussion of how our theory compares to utilitarian views in specific detail is to locate our approach within the larger context of the alternative theoretical approaches to social justice.

Our theory falls within the broadly egalitarian camp. Egalitarian theories differ among themselves, but they differ most fundamentally from both utilitarian theories and libertarian approaches. Egalitarian theories are directly concerned with distributive outcomes, while utilitarians care about distributive matters only indirectly. For example, providing more public health [2] and health care resources to those groups whose well-being is lower than other groups may be endorsed by utilitarians only if doing so is the most effective means to raise aggregate utility while egalitarians may endorse such a policy for reasons that have nothing to do with impact on aggregate utility.

Libertarians, by contrast, are indifferent to distributive inequalities even as an indirect concern. The sole aim is to make sure that public policies do not violate anyone's rights, and especially objectionable are redistributive tax policies that are said to violate the rights to property. Inequalities in wealth, health or any other measure are not morally objectionable as long as they do not result from the violations of rights that protect against interference with property or state coercion. Libertarian theories have considerably less adherents outside of the United States and they have limited influence in public health circles throughout the world. Utilitarianism remains the major competitor, and proponents of various economic approaches to distribution in public health often favor some form of cost-benefit analysis or cost-effectiveness analysis that are themselves rooted in utilitarian commitments [2].

Among broadly egalitarian theories, the main division is between theories that focus on distributive inequalities in the means to human well-being and those that take certain measures or aspects of well-being to be the direct object of distributive concern. The leading example of the former is the theory of John Rawls [3]. His theory takes as its focus the need to guarantee both fair equality of social and economic opportunities within a competitive society and tax and other policies designed to ensure the maximization of the distributive share of wealth and income for the worst-off segment of society. Rawlsians who adapt the theory to the health policy context, for example, argue that policies that provide access to health care and adequate levels of public health services are necessary for fair equality of opportunity [4]. Similarly, some now argue that to the extent that inequality of income is itself a causal contributor to health inequalities, then a policy focus on income support will have the effect of reducing health inequalities [5].

Influential critics of the Rawlsian approaches, including Amartya Sen and Martha Nussbaum, argue that health itself, along with positive outcomes with regard to other aspects of human well-being are, in fact, direct objects of egalitarian concern [6, 7]. The real focus of justice is not

the means to the desired outcomes, but the outcomes themselves. Moreover, there are multiple dimensions of well-being for which a theory of justice ought to have direct concern. Our theory falls within this camp of outcome-oriented theories, but we differ in emphasis, both in respect to the way we conceptualize the relevant outcomes and in the way we understand the point of the task of inequality reduction.

Nussbaum and Sen argue that justice is concerned with each individual's capability to choose to function in the desirable way, including, for example, the capability to be healthy, to reason, to be self-determining and to form attachments, if they choose to do so.

For us, the object is successful functioning of these basic dimensions of well-being, or the actual existence of the desirable states of affairs, and not just the individual's potential capability for achieving them should they choose. Because self-determination is also an essential dimension of human well being, there are limits on the extent of permissible interference with individuals in order to make them healthy, but the end remains health (or self determination) itself.

The importance of focusing on states of well being and not merely the capacity for well-being is most obvious in the case of children. From our point of view, the demands of justice are best understood when thinking about well being across the life course. What children require to thrive is actual health and personal security, states of well being that must be provided for them by caring adults and societies. Moreover, securing health and the other essential dimensions of well being for children is critical not only for the welfare of children but also for the welfare of the adults we hope these children will become. If sufficient levels of well being during developmentally critical points in childhood are not secured, the prospects for well being in adulthood are substantially diminished. Thus, when we argue that children should be given priority in health and social policy as we do in more detail later in this paper, it is not because children have enjoyed fewer years of life and are in this sense worse off compared to people who have lived more years. The ultimate end is not only secure, loved and healthy children but also healthy, self-determining adults with strong personal attachments, and who enjoy the respect of others. It is this more comprehensive goal of social justice that justifies a commitment to a focus on the desired outcomes starting in early childhood, rather than simply a set of social policies that make it possible that adults later achieve a level of functioning along these dimensions, if they so choose.

The second departure from other well-being oriented approaches lies in the way we think of the task of inequality reduction. We do not necessarily argue, as Sen does, for equality in all dimensions of well-being. Nor are we content, however, with the claim that some measure of sufficiency of each dimension of well-being is adequate as an approximation of the ultimate ideal of inequality reduction. In addition, we argue, as developed in more detail below, that the most immediate task in the context of non-ideal, real world patterns of inequality is vigilance against systematic disadvantage of the sort that involves overlapping and mutually reinforcing determinants of loss of well-being in all of its dimensions, resulting in greatly diminished futures for those thus affected.

Utilitarianism, justice theory, and public health

Theoretical discussions of the moral foundations of public health are much less well-developed than the arguments found in the more extensive literature addressing the practice of medicine. Public health focuses on the health of populations rather than individual patients, and it relies upon a range of primary prevention strategies and public policies that include potential modifications of environmental and occupational causes and vectors of illness and injury rather than targeted therapeutic interventions. These differences in focus and interventions suggest possible moral differences as well. One plausible way of capturing that difference has been to suggest that public health is concerned with the broadly utilitarian aim of maximizing the aggregate health of the population.

Two related problems arise if we take this utilitarian suggestion seriously. First, utilitarian maximizing is famously indifferent to distributive concerns; the imperative to maximize aggregate health, for example, leaves out concern for how benefits and burdens are distributed. Public health is not, however, indifferent to the poor health outcomes of some so long as overall health is increased. Second, public health is not and has never been so narrowly concerned with health in isolation from other dimensions of well-being that its ends have been defined indifferent to such things as the need to secure for all members of the population a rich measure of social respect, conditions conducive to leading self-determining lives, and a host of other goods such as personal security and cognitive development, both of which matter to the end of improved health and matter independently of their causal roles in health promotion. The history of public health as it is revealed in practice and its most articulate theoretical expressions of professional aims demonstrates both the inherent concern for distributive implications of public policy and its commitment to practical attention to a plurality of morally salient concerns other than health when crafting public health policies and interventions [8–13].

Our theory of social justice easily accommodates what the standard view – to the extent that a broadly utilitarian view is the standard view – gets right about the moral justification for public health. Social justice as we understand it is in its positive aim about well-being and about outcomes. Justice in our view requires ensuring for everyone a sufficient amount of each of the essential dimensions of well-being, of which health is one. Thus, in our account, bringing about health is a specific objective of social justice.

What the standard view about public health gets wrong is that it frames public health as if the enterprise is solely concerned with outcomes. Unlike either beneficence-based or utilitarian justifications for public health, by situating the focus on well-being within a theory of social justice, we capture what we believe are the twin moral impulses that animate public health – to improve human well-being by improving health and to do so in

particular by focusing on what we take to be the morally most urgent aspect of the inherent concern of distributive justice. A commitment to social justice, expressed negatively, attaches a special moral urgency to remediating the conditions of those whose life prospects are poor across multiple dimensions of well-being. Placing a priority on those so situated is a hallmark of public health.

This negative point of justice requires the policing of patterns of systematic disadvantage that profoundly and pervasively undermine prospects for well-being across multiple dimensions. Inequalities in health that are a part of such systematic patterns of disadvantage are the inequalities that are most morally urgent to address. Justice here demands aggressive public health intervention to document and help remedy existing patterns of systematic disadvantage and their detrimental consequences. Justice also, however, imposes prospective obligations to ensure that, at very least, public health policies do not exacerbate such patterns and that they contribute to preventing new disadvantaging patterns from arising.

One critical moral function of public health is thus to monitor the health of those who are experiencing systematic disadvantage as a function of group membership, to be vigilant for evidence of inequalities relative to those in privileged social groups, and to intervene to reduce these inequalities insofar as possible. Disparities in health statistics take on different moral meaning when those disparities identify differences between socially dominant groups and socially disadvantaged groups. Whether the term used is oppression, domination, or subordination, patterns of systematic disadvantage linked to group membership are among the most invidious, thorough going, and difficult to escape.

Put another way, for public health as for justice, groups matter. Social justice is not only a matter of how individuals fare; it is also about how groups fare relative to one another whenever systematic disadvantage is linked to group membership. Depending on the context, the groups of particular concern may be defined by different characteristics such as gender, ethnicity, race, religion, caste, citizenship,

Zusammenfassung · Abstract

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Health inequities and social justice. The moral foundations of public health

Abstract

Recently we argued that social justice is concerned with human well-being, which is best understood as involving plural, irreducible dimensions, each of which represents something of independent moral significance. Health is one of these distinct dimensions of well-being, as is personal security, the development and exercise of cognitive capacities for reasoning, living under conditions of social respect, developing and sustaining deep personal attachments, and being able to lead self-determining lives. In this paper, we address why considerations of justice, and not utilitarian aims as applied narrowly to health outcomes, are most foundational to public health. In particular, we argue that the aspiration for improvement of the health of populations defines the positive aim of justice in public health, along with the negative aim of reducing or combating systematic disadvantage that affects adversely historically situated social groups and, more generally, children across the normal life span when their well-being is not assigned a special priority in the development of public health policies.

Keywords

social justice · public health · systematic disadvantage · poverty · children · well-being

Gesundheitliche Ungleichheit und soziale Gerechtigkeit. Die moralischen Grundlagen von Public Health

Zusammenfassung

Vor kurzem haben wir ausführlich dargelegt, dass soziale Gerechtigkeit sich mit menschlichem Wohlergehen befasst. Wohlergehen umfasst einige, nicht reduzierbare Dimensionen, von denen jede etwas von unabhängiger moralischer Bedeutung darstellt. Gesundheit ist eine dieser verschiedenen Dimensionen des Wohlergehens, wie auch persönliche Sicherheit, die Entwicklung und das Training kognitiver Urteilsfähigkeiten, Leben unter den Bedingungen sozialer Beziehungen, Entwicklung und Erhalt persönlicher Bindungen und die Fähigkeit, ein selbstbestimmtes Leben zu führen. In dieser Arbeit befassen wir uns damit, warum Gerechtigkeitserwägungen und nicht utilitaristische Ziele, wie sie sehr eng gefasst auf die Ergebnisse gesundheitlicher Parameter angewandt werden können, grundlegend für Public Health und das öffentliche Gesundheitswesen sind. Insbesondere argumentieren wir, dass das Streben nach Verbesserung der Gesundheit der Bevölkerung das positive Ziel der Gerechtigkeit in Public Health definiert, komplementär zu dem negativen Ziel, eine systematische Benachteiligung zu vermindern oder zu bekämpfen, die schlecht gestellte soziale Gruppen betrifft. Dies schließt generell auch Kinder und ihre normale Lebensspanne mit ein, wenn ihrem Wohlergehen nicht besondere Priorität bei der Entwicklung politischer Strategien für das öffentliche Gesundheitswesen zugewiesen wird.

Schlüsselwörter

Soziale Gerechtigkeit · Public Health · systematische Benachteiligung · Armut · Kinder · Wohlergehen

sexual orientation, tribe, or disability. Whatever the common characteristic, the members of the disadvantaged group are accorded less social respect which frequently translates into reduced self-respect, reduced expectations, and reduced capacity for self determination. They face numerous, overlapping obstacles to achieving a decent level of well-being that are rooted in any number of sources including social conventions and custom, legal constraints, and the structure of political systems.

Making the health needs of disadvantaged groups a public health priority advances the remedial aims of justice in at least two ways. Insofar as such policies actually improve the health status of dominated groups, the negative point of justice with regard to health is advanced. In addition, however, policies that target the inequalities of dominated groups may have positive effects on other elements of well-being. For example, such policies are public expressions of respect. Specifically, they are public expressions that members of the disadvantaged group are entitled to equal regard as full moral persons. They are public acknowledgment that the failures of respect that underpin a web of negative determinants and consequences, including health inequalities, are unjust and must be addressed.

In many contexts, it is arguably the case that the poor, especially the desperately poor, are a dominated group whose members suffer from the same kinds of systematic disadvantages associated with racism and sexism. It is not necessary to make this claim, however, to maintain that the inequalities in well-being associated with severe poverty are inequalities of particular moral urgency. Those who have a proportionately tiny share of available economic resources are worse-off, not simply in virtue of having a much reduced standard of living, but in having disproportionately little influence on public affairs and in the marketplace, all of which translates into their having little control over their own lives. The systematic patterns of disadvantage that flow from dramatic differences in material resources produce a cluster of deficiencies in well-being that makes it extremely unlikely that individuals can improve their life prospects through their own efforts.

Inequality and life expectancy

We live in a world of radical inequality [14]. Despite significant improvements in life expectancy in low-income countries since 1960 [15], there is currently as much as a 40 year differential in average life expectancy between those of us who live in G7 countries and those of us who live in Southern Africa. Even if mortality in early childhood is not considered (a topic we will address shortly), in 2000, the average fifteen year old boy living in the United States can expect to live well into his 70s, if not beyond, while the average fifteen year old boy living in Uganda will be lucky to reach his 50th birthday. With life prospects, indeed the very prospect of living at all, so radically different, it is hard to conceive of these two youths as in any respect walking the same path. The magnitude of this source of extraordinary injustice cannot be overstated. It is estimated that each year as many as 20 million people in severe poverty in the developing world die young, by the standards of the rest of the world, from malnutrition and diseases that can be inexpensively prevented or treated.

Whatever other inequalities are moral priorities for public health, none are more pressing than the inequalities associated with severe, life long poverty, which has such crushing, grinding effects on all the dimensions of well-being.

Thus, as we see it, the job of justice in its most pressing role looks first to conditions of the most profound disadvantage. Justice's first concern requires permanent vigilance and attention to determinants that compound and reinforce insufficiencies across multiple dimensions of well-being, in ways that make it difficult if not impossible to escape. For the dimension of health, it is not possible to specify with precision what sufficiency requires, nor is it possible to establish precise numerical targets. At an outer bound, sufficiency can be pegged to what is technologically feasible with regard to both length and health-related quality of life. The World Health Organization's Burden of Disease projects, for example, use the world's longest life expectancy, that of the Japanese, as the benchmark for measuring health burdens internationally. A less demanding account of sufficiency would require that each of us have enough health over a long enough life span to live a decent life.

Unlike the dimension of respect, where a sufficiency of well-being requires that each be accorded equal regard, our theory of social justice does not require for health that there be precise equality between persons. That some fare better in terms of health outcomes is not, for that reason alone, necessarily unjust. At the same time, however, our theory does provide guidance as to how to think about inequalities in health.

From the standpoints of both public health and the positive or aspirational point of justice, all inequalities in health between groups are potentially of interest. That one group fares better than another group suggests that it may be technically possible, now or in the future, to improve the health status of some people. Any inequality is thus potentially informative to justice with regard to its positive aim. Depending on why the inequalities exist, that some experience better health than others tells us something about what it is possible to achieve with regard to health. For example, if it is possible to reduce the burden of disease from cardiovascular disease in one locality, it may (and indeed likely should) be possible to do so in another.

Improving health status, and thus narrowing inequalities, is not always a morally urgent matter, however. Whether an inequality in health assumes the sort of moral priority attached to the negative point of justice is a separate issue. We cannot tell simply from the numbers which disparities in health are the sort of inequalities that, as a matter of justice, should become public health priorities. That the life expectancies of some are as much as a decade less than that of others is concerning, and a differential of almost 50 years is alarming. The size of the disparity is not by itself, however, sufficient to determine whether an inequality in health should be a moral priority. Without knowing anything about who the different groups are and why they differ, it is not possible to make judgments about which

inequalities are the most morally important to address.

An easy moral case is the nearly fifty year differential in average life expectancy between countries such as Japan and Sierra Leone. The people of Sierra Leone are desperately poor; the people of Japan are among the most prosperous in the world. Inequalities in well-being associated with severe poverty are inequalities of highest moral urgency. By contrast, the inequality in life expectancy associated with a disease like cystic fibrosis is more morally complicated. If, contrary to fact, the disease was preventable or easily and effectively treated, and people were still dying young for lack of medical care, then this inequality would rival that experienced by the people of Sierra Leone in its moral urgency. However if all patients with cystic fibrosis were receiving the finest medical care and social services (which they are not), then the dramatic inequality in life expectancy experienced by people with cystic fibrosis, however tragic, has different implications for justice. It remains a matter of moral importance, but for biomedical research as compared to public health.

Nor do we consider the differential in average live expectancy between men and women observed in most countries in the world to constitute a priority in justice for public health. Although in some countries women may live on average as much as five or more years than men, in the world's wealthy nations male life expectancy still approximates any reasonable account of what constitutes a "sufficient" life span. Moreover, in almost all other dimensions of life, men fare at least as well and frequently far better than do women. Our point is not that we should be unconcerned about male life expectancy, or that we should not mount research and clinical programs to extend men's lives. Once again, we underscore that any inequality is of interest to public health and to the positive point of justice. Our position is merely that in the developed world gender inequalities in life expectancy, or even in disability-adjusted life expectancy, are not matters of relative moral urgency [16].

Children and the life course focus of justice

The vast differences in life expectancy, both between and within nations, together with the extent that health inequalities are associated with the full range of disadvantages in all dimensions of well-being across a complete life, highlight another crucially important implication of our theory. Social justice demands that, insofar as possible, all children achieve a sufficient level of health. With adults, depending on the context and the particular dimension of interest, we may be as concerned with securing for them the capability to achieve a sufficient level of well-being as with the state itself. By contrast, with children, what matters most in terms of justice is that the social order secure for them sufficient levels of each dimension of well-being. As a developmental matter, unless children experience a state of sufficient well-being in their young years, their capabilities as adults, and thus what they will be able to do with their lives, will be compromised. We are concerned about the actual health, reasoning abilities and attachment of children, in part, because these dimensions of well-being will develop properly, if at all, only if they are nurtured and secured in appropriate developmental stages. Moreover, the value of the dimensions of well-being to children does not depend on what children can do for themselves, as it sometimes does for adults. Securing the well-being of children can be achieved only through the actions of others and through the existence of a social order conducive to their development. Thus, for our non-ideal theory of social justice, and we think for public health, children matter differently than do adults. Social justice is not only a function of how individuals and groups that suffer systematic disadvantage fare, it is also in special ways about the actual well-being of children across childhood's developmental stages.

Our theoretical position on the privileged status of childhood in social justice provides a line of justification for human rights documents and conventions that accord special status to children. In 1990, these documents were concretized in writings emerging from the United Nations' World Summit for Children, which affirmed the principle mandating 'first call for children.' A decade later, in 2001, this principle was reaffirmed at a global summit: "(Leaders) also promised to uphold the far-reaching principle that children had 'first call' on all resources, that they would always put the best interests of children first – in good times or in bad, in peace or in war, in prosperity or in economic distress" [17].

Nowhere is the impact of well-being in childhood on the prospects of well-being in adulthood more clear than with regard to the dimension of health. There is overwhelming evidence that compromised health in childhood has profound effects on health later in life. Diseases as diverse as cancer, lung disease, cardiovascular disease and arthritis have all been associated with poor health in childhood [18–21]. Compromised health in childhood also has profound effects on dimensions of well-being other than health, most notably on the potential to develop the skills necessary for reasoning. It has long been established that severe intrauterine growth retardation, maternal malnutrition, extreme prematurity, and prenatal exposure to toxins are associated with poorer cognitive performance later in life [22–26]. There is increasing evidence that growth and development in infancy and early childhood may be equally critical to the development of cognitive capacities [27]. Malnutrition in the early years as well as exposure to toxins such as lead can have a profound and permanent effect on brain development and cognitive capacity [28, 29]. Failure to diagnose and treat disorders such as phenylketonuria can result in permanent mental retardation.

Perhaps the most obvious way in which compromised health in childhood forecloses options in adulthood is through child mortality. Despite significant reductions in child mortality in the 1980s and early 1990s, in 2003 more than 10 million children under the age of five years died [30]. Almost all of these children lived in low-income countries or in poor communities in middle-income countries. Most of these deaths could have been prevented by interventions that were in 2003 available, reasonably cheap and in widespread use [31]. By any plausible account of social justice, and certainly by our own, these

deaths constitute injustices of the gravest sort [32]. Diarrhea, pneumonia, and malaria – the principal killers of young children, abetted by under-nutrition – are all eminently treatable or preventable conditions. Among the world's poorest, many children never survive long enough for us to even begin to speak meaningfully about their capabilities, well being or flourishing. Even those who survive past infancy face a staggering chance of dying by comparison to children born in high income countries. In 2000, 25 of every 100 children born in Angola and Niger died before the age of 5; in Europe, this rate was less than 1 in 100 [33]. The effect of poverty on child mortality is evident within low and middle-income countries as well. In Indonesia, children born in the poorest quintile of the population are four times more likely to die by age five than children born to the wealthiest quintile [34].

For all of these reasons, inequalities in the health of children are among the most morally urgent for public health to address. Without a sufficient level of health in childhood, systematic constraints on well-being that are inescapable are locked in at an early age. Although the most profound inequalities in child health are between the wealthy and poor nations of the world, many children living in rich countries fail to achieve a sufficient level of health. Amidst affluence, most of these children are poor. In the United States, for example, poor children are more likely than other children to die in childhood [35]. They are more likely to experience lead poisoning [36] and less likely to be immunized [37]. They are more likely to be obese, and thus at greater risk of developing diabetes and heart disease later in life than are affluent children [38]. Poor children have higher rates of asthma and of asthma-related complications, including hospitalizations and permanently decreased lung capacity. Some of America's poorest, and least healthy, children are also members of minority groups.

Conclusion

Thus, as we see it, the first job of justice is permanent vigilance and attention to determinants that create, compound and reinforce insufficiencies across multiple dimensions of well-being, in ways that make it difficult if not impossible to escape. Note that whether we are considering systematically oppressed groups, those in severe poverty or children, all of our judgments about the relative urgency of inequalities in health, and their relationship to the negative and positive points of justice, reflect not only the particular commitments of our theory but also the empirical particulars in which these inequalities occur. As relevant features of the world change, so also do the implications for justice and public health. While the positive aspiration of public health – to strive to achieve for all lives that are healthy and long – remains a constant, what it is possible to obtain in terms of health is ever changing. So too are the concrete demands of the negative aim of our theory for public health. Here also the moral job of public health remains constant – to document and help remedy existing patterns of disadvantage and their detrimental effects on oppressed groups and the poor and to ensure that children achieve sufficient levels of health so that well-being in adulthood is possible. However, as patterns of social organization and systematic disadvantage alter, and the greatest threats to health sufficiency and other dimensions of well-being shift, the specific moral priorities for public health also will shift. And that is as it should be. Our theory of justice offers a moral foundation for the theory and practice of public health that is informed by empirical research and that provides a framework to guide that research. Without on-going empirical investigation of the many social determinants of ill health and their multiple, causally interactive connections to the ways populations and sub-populations experience cumulative disadvantages across all of the essential dimensions of well-being, the particular commitments of social justice in public health cannot be specified. At the same time, however, a theory of social justice provides guidance as to the questions that need to be asked and the data that need to be collected if the moral commitments of public health are to be realized.

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Buchbesprechung

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Kindernotfälle im Rettungsdienst

Heidelberg: Springer-Verlag 2007, 2. Aufl., 268 S., 51 Abb., 27 Tab. (ISBN 978-3-540-46567-6), 26.95 EUR

Im ohnehin oft stressgeprägten Notfallgeschehen steigern kindliche Notfälle die Anspannung von Notfallmedizinern und Rettungsdienstmitarbeitern zusätzlich. An diese Lesergruppe wendet sich das vorliegende Buch und scheint zu sagen: Steck' mich ein und nimm mich mit! Nicht nur das Format bietet dies an, auch der Bucheinband verspricht, den Inhalt wirksam vor Bibliotheks-untypischen Bedingungen zu schützen. Im Innern gliedert eine farbliche Kennzeichnung die Kapitel sofort nach Aufschlagen des Einbands. Ebenso erlauben die Register in der Innenseite des Einbands unverzüglichen Zugriff. Dies erleichtert das Suchen bestimmter Sachverhalte auch unter hohem Zeitdruck. Wer Einsatz-bezogen sein Wissen auffrischen möchte, wird sich auf die Tabellen, Übersichten, Flussdiagramme und Schemata beschränken. Hierbei unterstützen wechselnde Farbgebungen und Textformatierungen das Auge bei der raschen Orientierung. Aber auch der systematisch vorgehende Leser kommt – ganz in der Tradition des Springer-Buchs – auf seine Kosten. Besonders die zahlreichen, sorgfältig ausgewählten Fallbeispiele bieten einen enormen Kenntnisgewinn. Sorgfältig formulierte Texte und eingängige Bilder vermitteln tiefere Einblicke in eine Thematik, die immer schnelleren Änderungen infolge neuer Leitlinien und aktueller wissenschaftlicher Erkenntnisse unterliegt. ILCOR-Richtlinien sind besonders dort zitiert, wo sich relevante Änderungen ergeben haben.

Die 2. Auflage von „Kindernotfälle im Rettungsdienst" trägt somit auch besonders dem Umstand Rechnung, dass heute eine regelmäßige Wissensauffrischung in immer kürzeren Intervallen unerlässlich ist. Dabei lassen die zahlreichen eingestreuten Praxistipps die enorme praktische Erfahrung der Autoren und ihre Nähe zu den täglichen Problemen im Rettungsdienst erkennen. Die Ordnung nach Leitsymptomen sowie die Überschriften „Erster Blick – Was ist sofort zu tun – Was ist zu unterlassen" priorisieren in notfallmedizinisch typischer Weise Aktivitäten und präformieren gedanklich organisiertes und strategisches Handeln im Notfall. Die wesentlichen Details, wie die in der Kinderheilkunde besonders differenzierten Dosierungen von Notfallmedikamenten werden ebenso wie die Übersicht an verschiedenen Normwerten und Materialgrößen in Tabellenform angeboten. Insgesamt gestaltet sich der Gesamtumfang der Texte und Kapitel so, dass auch komplexe Sachgebiete unter Zeitdruck erfasst werden können. Gleichwohl sind alle wichtigen pädiatrischen Notfälle ebenso wie die Basistechniken der Untersuchung und Reanimation bis hin zu psychologischen und psychosozialen Hinweisen berücksichtigt. Erfreulich ist, dass auch die von vielen nicht-anästhesiologischen Rettungsmedizinern gefürchtete präklinische Narkoseeinleitung mit einer exponierten Position in der Innenseite des Einbands besonders gewürdigt wird.

Zusammenfassend kann das Lehrbuch Notärzten unterschiedlichster Fachrichtungen ebenso wie Rettungsdienstpersonal sehr empfohlen werden, da es gleichermaßen einen exzellenten Überblick über die verschiedenen kindlichen Notfälle gibt, detaillierte Informationen über spezielle diagnostische und therapeutische Vorgehensweisen vermittelt und dabei durchgehend höchste Praxisrelevanz aufweist.

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