

Addressing Social Inequities to Create a More Just, Fair and Equitable World

A Conversation with Dr. Nancy Krieger, Professor of Social Epidemiology at Harvard School of Public Health

The Harvard Public Health Review (HPRH) recently sat down with Dr. Nancy Krieger, Professor of Social Epidemiology in the Department of Social and Behavioral Sciences, and Director of the Interdisciplinary Concentration on Women, Gender and Health, at HPSH. Drawing on her extensive body of research, she outlined how populations ultimately embody their social and ecologic experiences, which, under inequitable conditions—like those related to poverty to global climate change—can result in unfair and unjust distributions of disease and suffering. Far from deeming these distributions a given, Krieger argues that academics, public health professionals, policymakers, and informed constituencies have a right and an obligation to mobilize evidence in their efforts to address health inequities head on and create a better world for all.

Harvard Public Health Review The public health arena often refers to both health disparities and health inequities. What is the difference, if any, between the two terms?

Dr. Nancy Krieger The U.S. is unique in its discussion of health disparities. The definition of the term has evolved over time, initially referring only to differences between groups, and today often encompassing unjust, unfair, and preventable conditions that undermine health outcomes.

Yet it is really important to bring in the equity and inequity perspective, because it highlights what is fair and unfair, and helps us speak more directly to what we're aspiring to, which is health equity. For

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instance, Healthy People 2020 recognizes that health inequities are tied to economics, exclusion, and discrimination that prevent groups from accessing resources to live healthy lives.

From your experience, what do you see as the most pressing issues threatening health equity in the U.S. today?

What stands out are those areas where the U.S. lags considerably still, as it does in infant mortality compared to almost all other economically prosperous nations.

We've had different periods in this country, between the mid-1960s and 1980, in which a fair number of health inequities, including infant mortality, declined and then, after 1980, opened up, widened, or stagnated. So historical context is really important, because it points to what is modifiable, and reveals the consequences of social arrangements and policies and priorities. It's also important not to simply think that health inequities increase over time, because better off people have more access to the latest in technology. That's not necessarily true. That can happen. But you also can have arrangements, which make that not the case.

The thing that is important to take into consideration about health equity and health inequity is that they're all encompassing. No matter the area of interest—younger people or older people, global climate change and air pollution, education and cognitive development—there is always an entry point through which to examine how people embody their societal and ecologic contexts, and whether there are unequally distributed exposures that can be prevented.

How might policymakers ensure more equitable access to care for all?

There are issues in the health system related to ensuring equitable access to health care—yet addressing access cannot resolve the broader determinants of health. You need to address how to prevent disease in the first place and create conditions for people to live healthier their lives with dignity. This extends beyond the health system. That's why there is attention to the built environment; regulating industry, in terms of coal and the amount of air pollution; and so on.

In the U.S., we have begun using the frame, Health in All Policies, to consider the public health implication of any given policy: zoning, transportation, education, commerce, trade agreements, taxation, and so on. What matters is not only the health impact of a policy, but also the health equity impact. That means looking beyond the on-average rate of a given outcome to consider the impact on inequities and which groups are most harmed. You don't want situations where you change the on-average rate, but do not address inequities. Or that the on-average rate

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changes because things are so much better for the better off, yet still are worse for the worst off. So I think there is a renewed emphasis on understanding the magnitude of inequities, relative and absolute, and the trends over time, to get a sense where efforts need to be targeted.

We also have to consider that policymakers are not acting based on evidence alone. Informed constituencies use evidence to push for change. The major health care changes we have had in this society, including Medicaid and Medicare, resulted from very active mobilization of concerned people who themselves represented affected communities. That's been true in HIV/AIDS, and in many other issues.

How can these leaders work, for instance, with an elected official who represents a constituency whose support actually reflects a resistance to evidence, whether related to women's health or global warming?

Reality has a way of biting back ultimately, despite ideological posturing. People in academia and in professions that produce scientific evidence have an obligation to speak up. That's not to say that evidence rules by itself. There are always issues of power and politics, but that's all the more reason to speak up. Then it becomes a question of debate and engagement.

It doesn't mean that it's easy or quick—and there's no shortcut on the politics. Anyone who thinks you can have a completely rational, “evidence based”-led society isn't living in the real world. But we can do the best we can to produce credible scientific evidence that's rigorous and deals with the competing claims as to what causes health inequities and make the difference that way.

Do you have any thoughts you'd like readers to keep in mind when addressing health inequities and equity, whether they are researchers or community advocates?

Issues of health inequity and equity are matters of concern for everyone, and not only the groups affected, even as these groups most likely will be the ones to raise their voices about what the harms are. Therefore it applies to every single outcome. Societal arrangements of power, property, wealth, and industry have major implications for the health and wellbeing of people and other species on this planet. They affect the translation of ideas into the field—and the very ideas people have in the first place.

Also, there are certain themes that will continue to emerge. For example, there continues to be new debates around scientific racism. Even though evidence continues to mount as to why it's not helpful to say that people are *a priori* genetically different, we still see research that looks at differences in health by race/ethnicity that does not consider the

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impact of discrimination and economic inequities.

I think it is important to know that doing work in public health, by definition, engages us with the societies in which we live, so there's bound to be disagreements and conflict. That's part of the work. But what we can add to that work is again rigorously testing our ideas and not being beholden to have to defend any particular interest other than the principles of health equity.