Introduction

STUDIES IN RECENT DECADES SHOW AN INVERSE gradient between mortality and socioeconomic status (SES), even among those near the top of the socioeconomic distribution. They also demonstrate that the health of individuals is associated with the socioeconomic disparities that exist within their geographic region as well as their own socioeconomic circumstances. Thus, within the United States, people in states with greater income disparity tend to have worse health than people in other states.

Important aspects of these relations, however, are still being studied. For example, does it matter how disparities in socioeconomic status (SES) develop? Would a state that experienced an increase in social discrepancies because of improvement in the socioeconomic status of persons who were already relatively well off also experience a decline in health among some of its residents? If so, who would experience this decline?

The seven studies and reflections contained in this issue of the *Milbank Quarterly* address three questions:

1. What is the nature of the relation between SES disparities and the health of a community?
2. Why, and to what degree, are we concerned about disparities in health, particularly those reflecting personal differences and community disparities in SES?
3. What might be done? How do our politics, technology, economic institutions, and culture constrain what we can or should do?

Several papers examine the association between health and SES and test hypotheses about causal links. Mary Daly's group builds upon earlier analyses of state data to investigate which groups are most affected by SES disparities within states and also to assess the relative importance of economic disparities related to poverty versus those related to great wealth. Norman J. Waitzman and Ken R. Smith analyze the effects on mortality of inequality that comes about through geographic segregation. They examine the points along the income distribution

gradient where such effects are most keenly felt and conclude that the concentration of poverty in metropolitan statistical areas (MSAs) is related to mortality, even among groups that are not poor. Bruce G. Link and his colleagues analyze Pap smear and mammography screening to test the “fundamental cause” concept, which posits that even when established procedures become uniformly available, SES differentials in health persist because new technologies are used first, and most effectively, by persons with more income, knowledge, and resources. Michael G. Marmot’s group tests the hypothesis that differentials in health across SES are best explained by a combination of social, environmental, and individual factors rather than by a single factor.

Sarah Marchand, Daniel Wikler, and Bruce Landesman note that social inequalities in health strike many as unjust. They offer four alternative explanations, from the perspective of moral philosophy, of why many consider that these inequalities constitute an injustice:

1. Inequality fails to maximize total community health.
2. Unequal health is itself unfair.
3. Justice requires emphasizing improvement of the health of the least advantaged group.
4. Justice requires giving priority to the sickest individuals.

A consideration of these alternative explanations is important because they suggest different policy responses. For example, the third explanation would suggest that we improve the health of those at the bottom of the social scale, even if this does more to improve the health of others and thus aggravates the inequality cited in the second explanation. Adding to this challenge to our political capacity for making coherent public policy choices, the authors explore other questions of fairness, including the degree to which persons are responsible for their own health and the extent to which health is different from other aspects of human well-being.

Although it would be extremely difficult to achieve consensus on these issues, it is useful to examine possible responses to test whether agreement exists and to explore the practical feasibility and political acceptability of alternative policies. Some of the pieces directly address the links between research and policy and between theory and policy. Each suggests possible policy responses. S. Leonard Syme, for example, while noting the intractable nature of SES disparities, nevertheless urges incremental,

specific, immediate, and effective intervention, and he offers the California *Wellness Guide* as a model for accomplishing this. The research carried out by Marmot's group reveals the multiple factors underlying the link between health and SES, leading them to suggest that it may not be possible to identify the most important contributing factors, but, rather, that it may be necessary to attempt to improve the general social environment. Margaret Whitehead documents the emergence of socioeconomic disparities as a problem in Europe that is now recognized in official circles, although attention to the problem at that level manifests itself through an emphasis on research and monitoring and has not reached the point of exploring channels for effective intervention.

Six of the seven pieces published here were presented at a conference sponsored by the Governor Scott M. Matheson Center for Health Care Studies at the University of Utah, with financial assistance from the British Council and the Archstone Foundation in Long Beach, California. The article by Marmot and his colleagues was submitted, by coincidence, at the same time this issue was being developed.

Robert P. Huefner
Norman J. Waitzman
University of Utah
Salt Lake City