The core goal of individuals working in the population health enterprise should be to improve health for all. There are many formulations of this fundamental aspiration, but it is unlikely that there is much disagreement about this general notion among researchers and practitioners in medicine or in public health. Over the past few decades there has been a growing awareness of the health gaps between groups, often characterized as health disparities or health inequities across the axes of race and ethnicity, socioeconomic status, and sex among others.

Black US residents live shorter lives than their White counterparts, and they are sicker throughout life. The richest quintile of US residents can expect to live 1 decade or more longer than the poorest quintile. Despite improvements in health over the past several decades for the richest 20%, many measures of health have worsened for the poorest 80%. The focus on health inequities has grown and sharpened during the past year as issues of racial justice more broadly have risen in the public consciousness, triggered by the killing of George Floyd and the subsequent civil protests that followed—the largest such protests in US history.

In an unusual confluence of theory and hard reality, the national COVID-19 vaccination effort came to be during this moment of growing reckoning with health inequity. Informed by several academic efforts to produce guidance on the topic, the Biden administration, as well as state governments, created equity-based guidelines for vaccine distribution, aiming to make sure that it would be fair, first reaching those individuals and communities who were most susceptible to COVID-19 before becoming available to those who were less vulnerable.

Although the US and individual state efforts have largely done what they were intended to do—keep health equity in the foreground—these efforts also, predictably enough, encountered difficulties. Trying to find, reach, and vaccinate specific groups quickly is challenging and it is a slower process than offering vaccination to everyone at the same time, a scenario that would undoubtedly play out with groups that are wealthier and better connected moving quickly to the front of the line. This recognition has, predictably, led to concern that vaccination is not happening quickly enough because of efforts to prioritize equity in the vaccination efforts.

The COVID-19 vaccination efforts highlight the trade-offs that sometimes have to be made between equity and efficiency. This balance is not particularly new, although seldom has it been so plainly visible and part of the public conversation. The concept of equity-efficiency trade-offs comes from the field of economics, but also has long been discussed in academic public health. These trade-offs arise from the observation that it is easier to deliver care and services to groups that already have assets and resources. These assets include social and technological connections along with having access to regular care providers, all of which make privileged populations easier to reach and hence more efficiently accessible during efforts to deliver health resources. Aiming to deliver services to health-disadvantaged groups requires making more of an effort, incurring more costs and time, and introducing inefficiencies. The COVID-19 pandemic has taken a concept that was theoretical and perhaps marginal to the mainstream public health conversation and given it full-bore visibility.

This challenges population health experts to then ask: How does society reckon with these trade-offs? How does society reckon with the price needed to be paid to achieve health equity both during the COVID-19 pandemic and in the future? Population health equity should focus on the following 3 main concepts.
First, at the heart of any equity-efficiency discussion are matters of values. There is no escaping this. It is entirely possible that focusing on health equity exacts a real price in terms of delayed availability of treatment (e.g., vaccines) for particular groups, such as younger, healthier, or more affluent people. Achieving equitable health indicators often rests on unequal approaches. This is eminently justifiable when society recognizes that the unequal approaches are needed because of a history of inequality of assets and resources that has historically disadvantaged particular groups. Any unequal approach therefore aims to rectify unfairness and level the playing field on health to make sure there are no health have-nots. However, doing so requires society to value the goals of achieving health for all and to recognize that fairness may compel individuals—at least in the short term—to compromise on efficient marginal rates of return on the effort, motivated by a higher-order value. Although this has been implicit in the vaccine rollout national conversation, it has not been explicit, suggesting that there is limited political tolerance for a discussion that honestly addresses the compromises that have to be made to live in accord with shared principles.

Second, and building on the concept of values, the success of any effort to promote equity while potentially reducing efficiency rests on the political support that is possible for any such efforts. Again, distribution of the COVID-19 vaccine offers a paradigmatic example. The presence and extent of political support for achieving equity has determined how well efforts to address this goal have succeeded. If the general public perceives that delays in delivering vaccines to many are excessive and overly onerous, their pressure on elected officials will almost certainly be enough to overwhelm even the best-intentioned policy makers. The different pace at which states have moved to vaccinate members of the general public, reflects the varying political pressure in the individual states. This argues for building long-term political support for health equity, and this post-George Floyd moment creates a window of opportunity to do so, to ramp up education about the importance and centrality of health equity to a moral society.

Third, society needs to ensure that the definition of efficiency that is in wide circulation reflects the full manifestation of health over the life course. It is easy to suggest that absolute number of vaccinations delivered is the more efficient approach. With that metric, it is clear that the most efficient approach would be to distribute vaccines to high-income communities where it would be easier to reach those eager to be vaccinated. However, if efficiency is defined on a longer time horizon, it may indeed be more efficient to first target low-income communities, which face greater risk of infections, more severe disease due to greater underlying comorbidity, and higher health care costs. Hence, the equity-efficiency balance is driven by what is considered to be most efficient, and a longer-term view of efficiency may often align more with the goals of equity than a short-term perspective.

There is a price to pay for health equity—one that is abundantly justifiable by the fundamental aspirations of health and of a fair society that invests in ensuring that all of its members are healthy enough to realize their potential. However, recognizing that there is such a price to pay should focus the attention of anyone concerned with health and achieving health equity as well as on the forces that militate against it, which requires sharper thinking on the topic than what has occurred in recent public conversations.
REFERENCES


