Cigarette manufacturing interests responded with an effort to pass explicit state preemption. During the 2007 and 2008 legislative session, 11 neutral to strong clean indoor air bills were introduced; three were co-opted to include weak clean indoor air provisions and preemptive language as a result of tobacco manufacturer lobbying. Tobacco control advocates stopped all weak bills with preemption and convinced legislators to delay state laws, which could become vehicles for preemption.[7]

The trajectory of South Carolina clean indoor air ordinance progress provides a strong counterpoint to Ferketich et al.'s conclusion that there is a lack of motivation among tobacco control advocates at the local level in tobacco-growing states and that clean indoor air ordinance efforts should focus at the state level. Developing clean indoor air laws at the state level without strong local support provides an opportunity for cigarette manufacturers to preempt more comprehensive local activity, where tobacco manufacturers have less sway.[3,9] In contrast, developing the capacity of local advocates can result in a strong smoke-free movement through local smoke-free ordinance adoption. ■

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Contributors

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BERMAN AND FERKETICH RESPOND

Contrary to Sullivan and Glantz's assertion, our article never stated that "there is a lack of motivation among tobacco control advocates at the local level in tobacco-growing states," nor did we intend any such implication. We have deep admiration and profound respect for the efforts of local tobacco control advocates, particularly those working in the challenging political environment of Appalachia.

Recognizing the limitations of a community-by-community approach identified in our research, we urged local tobacco control advocates to prioritize the adoption of comprehensive statewide smoke-free laws while not abandoning efforts to promote local smoke-free ordinances. Sullivan and Glantz fear that tobacco manufacturers may seek to weaken proposed statewide laws and insert preemptive provisions that would limit local authority. We have no doubt that tobacco companies will attempt such tactics. But, as the experience in South Carolina shows, well-organized tobacco control advocates are fully capable of defeating the tobacco industry at the state level.

Around the country, tobacco control advocates have been far more successful in pursuing the adoption of anti-preemptive state laws than the tobacco industry has been in seeking preemption. In just the last five years, explicit anti-preemptive language clarifying that local smoke-free ordinances can be broader than state law has been enacted (either as part of a smoke-free law or separately) in Arizona, Arkansas, Colorado, Georgia, Hawaii, Idaho, Illinois, Louisiana, Maryland, Minnesota, Nevada, New Jersey, New Mexico, North Dakota, and Ohio.[1]

Preemptive statewide laws are an appropriate area of concern, but as tobacco control advocates around the country have demonstrated, the best defense is a good offense. ■

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M. Berman drafted the letter. A.K. Ferketich worked with M. Berman on the content.

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RELATIVE MEASURES ALONE TELL ONLY PART OF THE STORY

In their article on HIV/AIDS mortality, Rubin et al. approvingly cite Braveman's definition of a health inequality as "a difference in which disadvantaged social groups . . . systematically experience worse health or greater health risks than more advantaged social groups."[1(p1053)] Later in her work, Braveman discusses two common effect measures used when comparing two groups, the rate ratio and the rate difference, and observes that "both absolute and relative

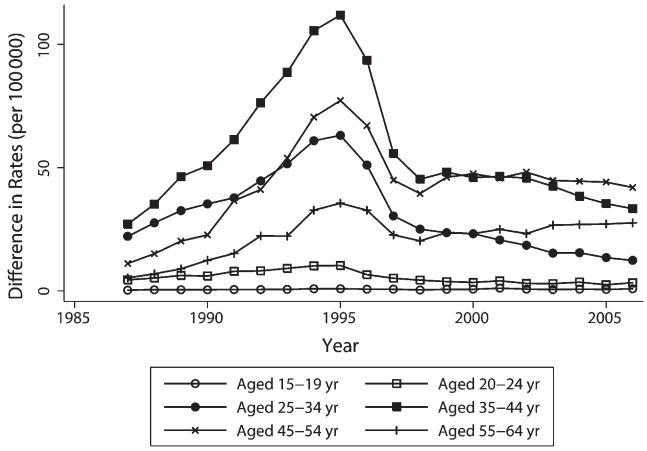

FIGURE 1—Black–White rate difference in HIV/AIDS mortality: United States, 1987–2005.

differences can be meaningful."[2(p178)] She also recommends that any systematic approach to studying health inequalities should calculate both rate ratios and rate differences, and examine how they change over time.

Rubin et al. only partially followed Braveman's recommendations in their research, concluding that the introduction of highly active antiretroviral therapy (HAART) led to "significant exacerbations of inequalities in HIV/AIDS mortality by both SES [socioeconomic status] and race."[1(p1057)] Although this is true for the rate ratios, as Figure 1 demonstrates, the introduction of HAART reduced absolute mortality inequalities by race, particularly among those aged 25 to 54 years, the group with the highest pre-HAART mortality. One can observe similar reductions in absolute inequalities by SES.

While Rubin et al. note that socioeconomic and racial rate differences decreased during this time period, they argue that

> we are concerned about relative rates, which grew much larger between the pre- and post-HAART periods . . . because we think policy and practice should address inequalities by ensuring everyone benefits equally from treatments like HAART.[1(p1057)]

This contention is supportable only if one already defines inequality exclusively in relative terms. If inequality is defined in absolute terms, then the introduction of HAART had a greater beneficial impact on Blacks and the socioeconomically disadvantaged. Although there has been some debate on the matter,[3,4] there is no definitive epidemiologic or statistical reason to prefer one measure to another, nor do Rubin et al. attempt to provide one.[5]

Rubin et al. also conclude that

> if similar patterns are replicated for other life-saving discoveries, the cumulative effect of the maldistribution of such benefits will leave our society with enduring, perhaps even growing, health inequalities.[1(p1057)]

Again, this contention is supportable only if one looks at relative inequality alone. By contrast, one might conclude that the introduction of HAART led to a net gain in terms of social justice, reducing mortality among all groups, harming none, reducing the number of excess deaths among Blacks and low-SES groups, and reducing absolute inequalities. To be sure, unacceptable levels of inequality are still present, but only in an exclusively relative sense have they "grown."

We agree with Rubin et al.'s recommendation that public health policies strive for an equitable distribution of resources, but we disagree with the assertion that HAART has unambiguously increased inequalities. This interpretation requires strict allegiance to the relative comparison without any attention to the actual number of lives saved or lost. As such, it is at best only half of the story. Like Braveman, we recommend that health inequalities researchers strive for transparency by presenting their data in both absolute and relative terms and by explicitly stating the philosophical or political values that underlie their preference for one or another.[5] Doing so will make for a clearer and more complete representation of the data, and therefore better health policy. ■

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RUBIN ET AL. RESPOND

King et al. are concerned about our use of relative measures to gauge progress toward health equality in HIV mortality. Prior work by some of these same authors suggests,[1] and we concur, that values and moral issues are involved and that explicit consideration of these is essential. Their comment is useful as it spurs us to think more deeply and provides an opportunity to report why, in this situation, relative measures more adeptly address moral concerns.

To begin, consider a situation in which human knowledge concerning how to prevent or treat a disease is absent. We may find absolute or relative differences between groups but, as a society, we bear no culpability for these differences, as we cannot do anything about