review

What is health equity?

Paula Braveman, Elaine Arkin, Tracy Orleans, Dwayne Proctor, Julia Acker, & Alonzo Plough

abstract

Policymakers and others concerned about public health often speak of the need to achieve health equity. Yet the term can mean different things to different people. For government, other organizations, and communities, lack of shared understanding can be a serious obstacle to effective action. This lack of understanding makes it difficult to agree on concrete goals and criteria for success and can lead to wasted efforts, with policies and practices that work at cross-purposes. This article provides a carefully constructed definition of *health equity* and discusses the definition's implications both for action and for assessing progress toward health equity.

Braveman, P., Arkin, E., Orleans, T., Proctor, D., Acker, J., & Plough, A. (2018). What is health equity? *Behavioral Science & Policy, 4*(1), 1–14.

Core Findings

What is the issue?
Different audiences tend to understand *health equity* differently. This can frustrate attempts to achieve desired health outcomes. Public health stakeholders need a common understanding of health equity in order to guide decision-making and resource allocation while maintaining respect for social groups of concern.

How can you act?
Selected recommendations include:
1) Simultaneously emphasizing the benefit of health equity measures to society at large and not only targeted groups
2) Constant monitoring of overall levels of health and health determinants within and across given populations

Who should take the lead?
Researchers, policymakers, and stakeholders in public health

Over the past two decades, the term *health equity* has been used with increasing frequency in public health practice and research. But definitions for this term vary widely. Some differ inconsequentially. Others, however, reflect deep divides in values and beliefs and can be used to justify and promote very different policies and practices. Clarity is particularly important when health equity is at stake because pursuing equity often involves a long uphill struggle against considerable resistance; in most cases, this struggle must strategically engage diverse stakeholders who have their own agendas. Under those circumstances, lack of clarity about the desired goal can put efforts to achieve health equity at risk of failure.

In this article, based on a report published by the Robert Wood Johnson Foundation,[1] we aim to stimulate discussion and promote greater consensus about the meaning of *health equity* and the implications this meaning has for action and research. In recommending a definition of the term, we are not aiming to have everyone use exactly the same words to define health equity. Rather, our goal is to identify crucial elements that can guide action in both public and private spheres. (The Robert Wood Johnson Foundation report, written by five of us—Braveman, Arkin, Orleans, Proctor, and Plough—includes content not in this article, such as examples of health equity efforts and resources for undertaking health equity initiatives.)

Throughout this article, the term *health* refers to health status or outcomes, distinct from *health care*, which is only one of many important influences on health. The term *social* encompasses economic, psychosocial, and other societal domains, although at times we refer separately to *social* and *economic* domains for emphasis. The Appendix provides definitions of many terms that are used in this article and often arise in discussions of health equity.

Criteria for a Definition

The following criteria were key to developing the definition of *health equity* that we share in this article. The definition had to:

- be conceptually and technically sound and consistent with current scientific knowledge;
- reflect the importance of fair and just practices across all sectors, not only the health care sector, because health is a product of conditions and actions occurring in virtually all social domains;
- be actionable and sufficiently unambiguous to substantively guide decisions about resource allocation priorities (some definitions may be meaningful or even inspiring to a segment of the public health community with experience in thinking about and pursuing health equity, but not specific or concrete enough to guide action, especially for a wider audience);
- be capable of being operationalized for the purpose of measurement, which is crucial in assessing whether interventions are working; and
- reflect respect for the social groups of concern.

The Definition

Application of the criteria led to a two-part definition. The first part is geared toward a broad, nontechnical audience; the second is needed to guide measurement and monitoring of how well efforts to improve health equity are working:

> *Health equity* means that everyone has a fair and just opportunity to be as healthy as possible. Achieving this requires removing obstacles to health—such as poverty and discrimination and their consequences, which include powerlessness and lack of access to good jobs with fair pay; quality education, housing, and health care; and safe environments.
>
> For the purposes of measurement, *health equity* means reducing and ultimately eliminating disparities in health and in the determinants of health that adversely affect excluded or marginalized groups.[2–5]

Different Definitions for Different Audiences

For many audiences or settings, the above definition will be too long or complex. The following are briefer and generally less complex alternatives, to be used with the understanding that they are backed up by the full definition:

An 8-second version for general audiences (defining *health equity* as a goal or outcome): **Health equity means that everyone has a fair and just opportunity to be as healthy as possible.**

Another 8-second version for general audiences (defining *health equity* as a process): **Health equity means removing social and economic obstacles to health, such as poverty and discrimination.**

A 15-second version for audiences concerned with measurement: **Health equity means reducing and ultimately eliminating disparities in health and in the determinants of health that adversely affect excluded or marginalized groups.**[2–5]

A 30-second definition for general audiences (consisting of the first part of the full definition above, minus the second part about measurement): **Health equity means that everyone has a fair and just opportunity to be as healthy as possible. Achieving this requires removing obstacles to health such as poverty and discrimination and their consequences, which include powerlessness and lack of access to good jobs with fair pay; quality education, housing, and health care; and safe environments.**

A 20-second definition to clarify the relationship between health equity and health disparities: **Health equity is the ethical and human rights principle that motivates people to eliminate disparities in health and in the determinants of health that adversely affect excluded or marginalized groups. Progress toward health equity is measured by reductions in health disparities.**

Explaining the Definition

Both *fairness* and *justice* are invoked in this definition to signify that achieving health equity in a population (for example, of a city, county, state, nation, or globally) involves not only meeting widely held standards of fairness, but also addressing broader ethical concerns and adhering to human rights laws and principles. Before people can achieve health equity, they must first be able to fully realize their human rights in all domains essential for health, dignity, and participation in society. They must be able to freely exercise not only civil and political rights—such as freedom of speech, assembly, and religion—but also social, economic, and cultural rights, including rights to education, decent living conditions, and freedom from avoidable obstacles to good health.[6]

A large and growing literature demonstrates that opportunities to be healthy depend on living and working conditions and other resources that vary across social groups.[7–13] The extent of a population's opportunities to be healthy, therefore, can be measured by assessing the social determinants of health—such as income, wealth,[14] education,[15,16] neighborhood characteristics,[17,18] or social inclusion[19]—that people experience across their lives. This concept acknowledges that individual responsibility is important, while recognizing that too many people lack access to the opportunities, conditions, and resources needed to make healthy choices and live the healthiest possible lives.[7,8,11,12] Societal action is needed to address these obstacles.

Health equity and health disparities are intimately related to each other. *Health equity* is the ethical and human rights principle that motivates people to eliminate *health disparities*, which are presumably avoidable differences in health or in its key determinants (such as good jobs with fair pay; quality education, housing, and health care; and safe environments) that adversely affect marginalized or excluded groups. Disparities in health and its key determinants are the metrics used to assess the extent

"Lack of political will does not justify considering a health disparity to be unavoidable"

of health equity and how it changes over time for different groups of people.

Being *as healthy as possible* refers to the highest level of health that could be within an individual's reach[5,20,21] if society makes adequate efforts to provide opportunities to achieve it. This notion acknowledges and takes into account the existence of some unavoidable variations in genetic endowment that may limit an individual's health potential. Even if someone has serious unavoidable biological disadvantages, the best health possible for people with those biological disadvantages could be achieved if societal efforts addressed that goal. For example, a person with a disability that makes her unable to walk can achieve better health if she has a properly designed wheelchair and if access to fixtures at home, on buses, and at work enable her to be more physically active, less isolated, and less dependent on others. Adequate societal efforts often depend on political will. Lack of political will does not justify considering a health disparity to be unavoidable. A health disparity should be considered avoidable if current scientific knowledge indicates that it could potentially and plausibly be reduced or eliminated if political will were present.

This definition implies that advancing health equity requires societal actions to increase opportunities to be as healthy as possible, particularly for the groups that have suffered avoidable ill health and encountered the greatest social obstacles to achieving optimal health. Workers in the health sector and much of the public will be motivated to take action for greater health equity by seeing evidence of significant health disparities—that is, presumably avoidable health differences on which excluded or marginalized groups fare worse than socially better-off groups. If one looks beneath the surface, however, and examines the results of extensive scientific research, it becomes apparent that most disparities in health are tenaciously rooted in profound inequities in the opportunities and resources that are needed to be healthier. The literature reveals that social inequities produce health inequities, which cannot be addressed effectively or in a lasting way without addressing their underlying causes.

A large body of knowledge indicates that pursuing health equity requires addressing equity not only in health care but also in a range of social determinants of health, particularly poverty,[10–12,14,22,23] discrimination,[11,19,24,25] and their consequences, including powerlessness and lack of access to a range of resources, services, and conditions needed for optimal health. Achieving health equity calls for removing obstacles and improving access to the conditions and resources known to strongly influence health, including good jobs with fair pay;[26] high-quality education,[15,16] housing,[27] and health care; and health-promoting physical and social environments,[17,28] particularly for those who lack access to these conditions and resources and who have worse health.[29,30] Although this strategy should ultimately improve health and well-being for everyone,[31] the systematic focus of action for equity should be on groups that have been excluded or marginalized.[30] The definition explicitly points to poverty and discrimination as underlying causes of health inequity. We wrote it this way to make the definition concrete and to reduce the ambiguity of more abstract and less specific definitions, which could be misused, perhaps unwittingly, to justify directing resources away from health equity.

Discrimination refers to adverse treatment of members of a social group based on prejudicial assumptions about the group as a whole. Discrimination may be based on any number of characteristics, such as race, ethnic group, religion, national origin, disability status, skin color, gender or gender identity, or sexual orientation. Discrimination or oppression is not necessarily conscious or intentional. Evidence has revealed that unconscious bias in interpersonal interactions is strong, widespread, and deeply rooted. Whatever the cause of the bias, it can

take a heavy toll on the health of its victims. This conclusion is partly based on an understanding of the physiological mechanisms involved in responding to stress, particularly chronic stress.[24]

Discrimination does not occur only on the interpersonal level, though. It is often systemic, that is, built into institutional structures, policies, and practices—consider policing, bail, and sentencing practices that put people of color at a profoundly unfair disadvantage in the justice system; bank lending procedures that make it difficult or even impossible to build wealth in low-income, largely minority communities; and the underfunding of schools in racially segregated, poor communities, which denies children from these neighborhoods a good education and hence a good, decently paying job. These built-in features can have inequitable effects regardless of whether any individual consciously intends to discriminate. This systemic form of discrimination is also known as *structural* or *institutional discrimination*[32] or *systemic oppression*.

Racial segregation in housing in the United States is an example of systemic discrimination based on race or skin color. It is the product of deliberately discriminatory policies enacted in the past, including the Jim Crow laws that enforced segregation of dark-skinned people in the United States and practices affecting the sale and rental of housing.[33] Even though housing discrimination is no longer legal, many people of color continue to be relegated into neighborhoods that pose multiple challenges to health by exposing residents to a range of physical hazards (such as air pollution, other toxins, and unsafe housing conditions) and social hazards (such as concentrated poverty, absence of local employment, inadequate transportation to work and to better job prospects, poor schools, crime, an unhealthy food environment, hopelessness, and powerlessness). These places also lack the assets required for optimal health, such as good schools, optimism, clean air, green spaces, traffic patterns that minimize pedestrian danger, a feeling of safety, and the presence of many role models who set positive norms for healthy behaviors.[19]

Systemic discrimination has many other guises as well. Voter registration requirements in some states, such as the need to show a birth certificate, may discriminate against immigrants and homeless persons, who are less likely to have the necessary documentation even when they meet federal voter qualifications. People of limited financial means, meanwhile, face discrimination in the judicial system. A nonviolent, first-time criminal offender may qualify for a diversion program, which would allow the offender to avoid going to jail and to have the offense expunged from records, but only if the offender pays substantial fees. Thus, people with low incomes are far more likely to serve jail time and have criminal records than are more affluent people who have committed similar or worse offenses.[34] People of color are more likely than White people to be incarcerated for the same offenses, and a history of incarceration is a formidable obstacle to future employment, housing, and participation in society.[35]

Powerlessness is both an objective and a subjective phenomenon. Poverty and discrimination deprive people of economic and political power and make them less able to gain control of their lives and to access resources. Powerlessness becomes internalized when people perceive their inability to influence outcomes as a personal failure rather than a result of discrimination or systemic oppression.[36] Repeated or persistent experiences of powerlessness may lead to feelings of hopelessness and, subsequently, immobilization and an inability to assert one's rights or needs.

Excluded or *marginalized groups* are made up of people who have often suffered discrimination or been pushed to society's margins, with little or no access to society's health-promoting resources and key opportunities.[7,24] They suffer economic or social disadvantages or both,[37] and they lack privilege. Examples of historically disadvantaged groups who have been excluded or marginalized include—but are not limited to—people of color;[19] people living in poverty, particularly across generations;[22,38,39] religious minorities; people with physical or mental disabilities;[40,41] LGBTQ persons;[25,42] and women.[43]

Health Disparities
Avoidable differences in health or in its key determinants that adversely affect marginalized or excluded groups

Healthy As Possible
Highest level of health that could be within an individual's reach

Structural/ Institutional Discrimination
Systemic form of discrimination built into institutional structures, policies, and practices

"A key feature of the definition of health equity is that it deliberately avoids the need to establish a causal role for any given factor in creating a health inequity"

A key feature of the definition of *health equity* is that it deliberately avoids the need to establish a causal role for any given factor in creating a health inequity. According to the definition, differences in health are inequitable if members of an excluded or marginalized group experience poor health that could plausibly have been avoided, given political will. It is important not to require proof of causation. The causes of some important health disparities—for example, racial disparities in premature birth—may be unknown or contested, making some people reluctant to call them inequities. These disparities should nevertheless be addressed in a health equity agenda because they put people who are part of a socially disadvantaged group at further disadvantage with respect to their health, regardless of the causes. If the disparities are known to be rooted in social inequities in access to the opportunities and resources needed for health, they can be referred to as *health inequities*. If the causes are not known, we prefer to emphasize the distinction by using a different term: *disparities* or *inequalities* (a term generally used outside the United States). Both *disparity* and *inequality* imply more than just a neutral difference, though: they suggest that there is something suspect about an observed difference and that discrimination may be involved.

This definition of *health equity* treats it as both a process[44] and an outcome, and it can be measured as either. The process is removing obstacles to health, particularly among those who have been excluded and marginalized. It also can be thought of as the process of reducing and ultimately eliminating disparities in health and health's determinants that adversely affect excluded or marginalized groups. Health equity also can be viewed as an outcome, namely, the ultimate goal of achieving fair and just opportunities to be healthy for everyone, or the elimination of health and health-determinant disparities that adversely affect disadvantaged groups.

Implications for Action

The definition presented here deliberately restricts what can be called an effort for health equity. Many actions may be worthwhile public health endeavors but not health equity efforts. For example, it could be important to address a health problem that primarily affects a high-income community; this, however, would not be a health equity endeavor, which prioritizes actions disproportionately benefiting those who have been socially disadvantaged. Similarly, an initiative to improve nutrition for the entire population of a state or nation might be worthwhile but would not be a health equity effort unless it devoted considerably more resources to improving nutrition among the disadvantaged. Likewise, an initiative to expand green spaces and recreational areas in solidly middle-class communities could be worthwhile from a public health perspective, but it, too, would not be a health equity initiative. Health equity should be one of the most central considerations driving policies that influence health, but not the only principle; other key principles that must also be considered are effectiveness, efficiency, overall population impact, and sustainability.

Policies, systems, and environmental improvements can prevent and reduce health inequities, but, in most cases, only if they explicitly and energetically focus on health equity and are well designed and implemented; otherwise, even well-meaning interventions may inadvertently widen health inequities. For example, in the early decades of anti-smoking efforts, messages about the health dangers of tobacco use were disseminated across entire populations. At some point, however, it became clear that the messages were primarily reaching White people of higher education levels. Smoking was declining among all groups, but the decline was far slower among people of color and less educated people. The understanding emerged that different messages and different methods for transmitting them were needed for

"Equity is not the same as equality. Those with the greatest needs and fewest resources require more, not equal, effort and resources to equalize opportunities."

anti-smoking communications to be effective among less privileged groups.

Achieving health equity requires societal action to remove obstacles to health and increase opportunities for everyone to be healthier, while focusing particularly on those who have worse health, face more social obstacles to health, and have fewer resources to improve their health. In line with basic ethical concerns (such as for autonomy and respect for persons) and human rights principles (such as participation in society and in making decisions that affect one's well-being), advancing health equity requires engaging excluded or marginalized groups in planning and implementing the actions needed to achieve greater health equity. Equity is not the same as equality. Those with the greatest needs and fewest resources require more, not equal, effort and resources to equalize opportunities.

Although those who advocate for health equity will necessarily focus on the health needs of excluded or marginalized groups, they will garner support if they simultaneously call attention to the ways that achieving greater health equity will benefit all of society. For example, greater health equity should result in a more productive workforce and reduced spending on medical care for preventable conditions. Furthermore, advancing health equity requires achieving a more generally equitable society, and it has repeatedly been observed that overall health is better in more equal societies.[31] Some scholars have hypothesized that this pattern arises because more equal societies enjoy greater social cohesion and trust, which benefits everyone.[31]

Achieving health equity requires more than identifying and addressing overt discrimination. It also requires addressing unconscious and implicit bias and the discriminatory effects—intended and unintended—of systemic structures and policies created by historical injustices, even when conscious intent to discriminate is no longer present.

Ideally, a health equity effort would aim to improve the fundamental and structural causes of ill health, notably poverty and discrimination, as opposed to addressing only the consequences of those causes. It may not always be possible in the foreseeable future to alter the underlying causes, however. In those circumstances, it would be desirable, while alleviating suffering by addressing the consequences of the root problems, to also raise awareness (among the public, policymakers, and those most affected) of the need to address the root causes, thus paving the way for more effective action targeting the root causes in the future. For example, the problem of obesity is an important health equity issue, with a disproportionate burden of obesity among people of lower income and education and among people of color. A policymaker will probably not want to wait until all the upstream determinants of obesity and effective solutions for them are identified before putting in motion some downstream efforts—such as making it easier and more appealing for low-income people to engage in physical activity, increasing funding for physical education at schools, requiring that the caloric content of all foods be clearly noted, or taxing sugary sodas—that could have at least some impact in the short or intermediate term. But if the policymaker is aware of the more fundamental factors that are strongly suspected to be at the root of the problem—factors related to poverty and discrimination—a more long-term and ultimately more effective strategy addressing poverty and discrimination and why they often, but do not always, intersect can be pursued at the same time, with the understanding that the results may not be seen for quite a while.

Many groups of people are socially disadvantaged. To be effective, an organization may

choose to focus on one or a select few disadvantaged groups. The depth and extent of disadvantage faced by a group (such as multiple versus single disadvantages),[20,23,38,45] as well as where maximal impact could be achieved, are legitimate considerations in choosing where to focus.[20,29,30] In addition, it should be noted that some individuals in an excluded or marginalized group may have escaped from some of the disadvantages experienced by most members of that group; these exceptions do not negate the fact that the group as a whole is disadvantaged in ways that can be measured.

Implications for Accountability: Measuring & Monitoring Health Equity

As the definition of *health equity* implies, measurement is not a luxury: it is crucial for documenting disparities and inequities and for motivating and informing efforts to eliminate them. Without measurement, there is no accountability for the effects of policies or programs.

A commitment to health equity requires constant monitoring of overall (average) levels of health and health determinants in a population, as well as routine comparisons of how more and less advantaged groups within that population are faring on relevant measures of health and health determinants. Overall levels of health are useful to know and are important, but they can hide large disparities among subgroups within a population. Measuring gaps in health and in opportunities for optimal health is important not only to document progress, but also to motivate action and identify the kinds of actions needed to achieve greater equity.

The definition of *health equity* calls for examining how well socially disadvantaged (excluded or marginalized) groups in a population fare on health and its determinants compared with advantaged or privileged groups.[46–48] Making this assessment requires having information on both (a) important measures of health and its determinants, including social determinants, and (b) the distribution of social advantage and disadvantage (inclusion versus exclusion or marginalization, or privilege versus lack of privilege); the information must identify which groups are most and least advantaged and define who should be compared. Because health equity is concerned with fairness and justice, gaps should be assessed using both measures that are absolute (such as differences between groups in the percentage of infants who survive until their first birthday) and measures that are relative (such as infants in Group X are twice as likely as infants in Group Y to die in their first year of life). The gaps between the advantaged and disadvantaged are closed by making concerted efforts to improve the health of excluded or marginalized groups, not by worsening the health of those who are better off.[49] For example, the relative gap between Black and White infants in the incidence of low birth weight narrowed during the period 1990–2010 in the United States; however, that trend did not represent the achievement of greater health equity, because it instead reflected an increase in the incidence of preterm birth among Whites rather than real improvement in that measure among Blacks.[50]

Disadvantaged groups should be compared with those who are most advantaged, not with the whole population (or the population average). Comparing the disadvantaged with the general population is not appropriate unless information on advantaged groups is unavailable, for a simple reason: when disadvantaged groups represent a sizable portion of the population—as is increasingly occurring in the United States—this approach compares the disadvantaged groups largely with themselves, thereby substantially underestimating the size of the gap between the disadvantaged and the advantaged.

Social advantage, privilege, inclusion, disadvantage, discrimination, exclusion, and marginalization can be measured in various ways, including by assessing indicators of wealth (such as income or accumulated financial assets),[14,51,52] influence,[7,36] and prestige or social acceptance (for example, educational attainment and representation in high executive, political, and professional positions).[53] They also can be measured by well-documented historical

evidence of oppression or discrimination (such as slavery; displacement from ancestral lands; lynching and other hate crimes; denial of voting, marriage, and other rights; and discriminatory practices in housing, bank lending, and justice system).

Final Remarks

Health equity may seem to be a complex and elusive concept. The essence, however, consists of two basic elements: (a) reducing health disparities by improving the health of socially disadvantaged groups, and (b) addressing the social determinants of health disparities, including poverty and discrimination. It is important to be clear about what health equity is and what it is not; for example, it is a core aspect of public health, but it is not the only aspect that needs to be considered in public health actions. Clarity is important because efforts to move toward health equity will inevitably face powerful challenges. If those of us who wish to contribute to achieving greater health equity are not clear about where we are headed and why, we can be detoured from promising paths and perhaps even lose our way.

author affiliation

Braveman: University of California, San Francisco. Arkin: independent consultant. Orleans and Proctor: Robert Wood Johnson Foundation. Acker: University of California, San Francisco. Plough: Robert Wood Johnson Foundation. Corresponding author's e-mail: paula.braveman@ucsf.edu

author note

We thank the following individuals who provided comments on drafts of the report on which this article is based. The authors are solely responsible for the contents of this article:

Deborah Austin, ReachUp Inc.
Stephanie V. Boarden, PolicyLink
Karen Bouye, CDC Office of Minority Health and Health Equity
Renee B. Canady, Michigan Public Health Institute
Ana Diez Roux, Drexel University
Tyan P. Dominguez, University of Southern California
Mary Haan, University of California, San Francisco
Erin Hagan, Evidence for Action
Robert Hahn, Centers for Disease Control and Prevention
George Kaplan, University of Michigan (Emeritus)
Mildred Thompson, PolicyLink
Naima Wong Croal, National Collaborative for Health Equity

Appendix. Definitions of terms used in the article

discrimination

This is a broad term that includes but is not limited to **racism**. (Bold type indicates words defined in this appendix.) Prejudicial treatment, social exclusion, and marginalization have been based on a wide range of characteristics, including not only racial or ethnic group but also poverty, disability, religion, LGBTQ status, gender, and other characteristics.

ethnicity or ethnic group

These terms refer to belonging to a group of people who share a common culture (which may consist of beliefs, values, or practices, such as modes of dress, diet, or language) and usually a common ancestry in a particular region of the world. Some people use the term *ethnicity* or *ethnic group* to encompass both racial and ethnic groups, based on the recognition that race is fundamentally a social rather than biological construct. (See **race** or **racial group** below.)

health

Throughout the article, *health* refers to health status, that is, to physical and mental well-being, distinguished from health care, which is only one of many important influences on health.

health disparity and health inequality

These terms are synonyms; *disparity* is used more often in the United States, whereas other countries use *inequality*. Progress toward health equity is measured by assessing health disparities/inequalities. The concept of health equity is the underlying principle that motivates action to eliminate health disparities.

The terms *disparity* and *inequality* do not necessarily imply that social disadvantage is the cause of or a contributor to worse health, but they suggest that such a causal link should be considered. For over 25 years in the fields of public health and medicine, the terms *health disparity* and *health inequality* have referred to plausibly avoidable, systematic health differences adversely affecting socially or economically disadvantaged groups. This definition does not require establishing that the disparities/inequalities were caused by social disadvantage; it requires only observing worse health in socially or economically disadvantaged groups. Health disparities/inequalities are ethically concerning even if their causes are not clear, because they affect groups already at underlying economic or social disadvantage (due to poverty, discrimination, or both) and they indicate that these socially disadvantaged groups are further disadvantaged by having ill health on top of social disadvantage; this double whammy seems especially unfair because good health often is needed to escape social disadvantage.

It may seem reasonable to use the term *disparities* or *inequalities* to refer to only descriptive or mathematical differences without implying any judgment about whether they suggest cause for moral or ethical concern. However, social movements in the United States and other countries for nearly 30 years have treated these terms as indicating differences that are worrisome from ethical and human rights perspectives (although the groups of concern are not always the same). In the United States, health disparities have often referred to racial or ethnic differences in health, whereas in Europe and other regions, health inequalities have generally referred to health differences among people of different socioeconomic means. In theory, one might want to bring the definitions into alignment to simplify discussions of how to achieve health equity. But legislation and policies have been written based on the existing understandings of the terms, so redefinitions might have unintended consequences that could unwittingly threaten the achievements and momentum gained over decades. For example, some have proposed using the term *disparity* only to mean a difference, without any implication regarding whether the difference is morally suspect, and using the term *inequity* for racial or socioeconomic differences in health. If that change were made, then the resources now directed to national, state, and local efforts to reduce health disparities could be used for virtually any health improvement effort, including efforts focused on privileged groups. Furthermore, indiscriminately calling any racial or socioeconomic difference in health unfair

(inequitable) would be unwise from a communications perspective, because there are some health differences whose etiology we do not know; the term *health disparity* is convenient to use for these differences, signaling reason for concern but not necessarily proof of a **health inequity**.

Health disparity and *health inequality* are broad terms that include **health inequity** and signify more than just difference or variation: they signify a health difference that raises moral or ethical concerns. These terms are very useful in identifying problematic areas (that is, an avoidable health difference that puts a socially disadvantaged group at further disadvantage on health) and being measurable, but they do not necessarily imply definitive knowledge of the causes.

health equity

This phrase means that everyone has a fair and just opportunity to be as healthy as possible. Achieving health equity requires removing obstacles to health such as poverty, discrimination, and their consequences, which include powerlessness and lack of access to good jobs with fair pay; quality education, housing, and health care; and safe environments.

For the purposes of measurement, *health equity* means reducing and ultimately eliminating disparities in health and health determinants that adversely affect excluded or marginalized groups.

Health equity is the ethical and human rights principle motivating efforts to eliminate health disparities; health disparities are the metric for assessing progress toward health equity.

health inequity

A health inequity is a particular kind of **health disparity,** one that is a cause for concern in that it is potentially a reflection of injustice. Views of what constitutes adequate evidence of a health inequity can differ. Some will argue that to call a disparity an inequity, one must know its causes and demonstrate that they are unjust. Others would maintain that regardless of the causes of a health disparity, it is unjust not to take concerted action to eliminate it; failure to act is unjust because the situation puts an already socially disadvantaged group at further disadvantage on health, and good health is often needed to escape social disadvantage. Where there is reasonable (but not necessarily definitive) evidence that underlying inequities in opportunities and resources to be healthier have produced a health disparity, that disparity can be called a *health inequity*; it needs to be addressed through efforts to eliminate inequities in the opportunities and resources required for good health. *Inequity* is a powerful word; its power may be diminished if it is used carelessly, exposing health equity efforts to potentially harmful challenges. It should be used thoughtfully.

opportunity

This means access to goods, services, and the benefits of participating in society. Financial barriers and geographic distance are not the only obstacles to access; others can include past discrimination, fear, mistrust, and lack of awareness, as well as transportation difficulties and family caregiving responsibilities. Measuring the real (or realized) access to opportunities that different social groups have requires not just measuring their potential access[54] but also assessing which groups actually have the relevant goods, services, and benefits. Because of past and ongoing racial discrimination in housing, lending, and hiring policies and practices, there is great variation in the quality of the places where people of different racial or ethnic groups live, work, learn, and play; these differences in quality often affect the opportunities groups have to be as healthy as possible.

race or racial group

This generally refers to a group of people who share a common ancestry from a particular region of the globe. Common ancestry is often accompanied by superficial secondary physical characteristics such as skin color, facial features, and hair texture. Given the extensive racial mixing that has occurred historically, these superficial differences in physical appearance are highly unlikely to be associated with fundamental, widespread, underlying differences in biology. This low probability of an association

does not rule out the possibility that some highly specific genetic differences associated with ancestry could affect susceptibility to particular diseases (for example, sickle cell anemia, other hemoglobinopathies, or Tay-Sachs disease) or responsiveness to treatments. These highly specific differences, however, are not fundamental and do not define biologically distinct racial groups; they generally occur in multiple racial groups at different frequencies. The primary drivers of health inequities are differences in social and economic opportunities to be healthier. Scientists, including geneticists, concur that race is primarily a social—not a biological—construct.[55–57]

racism

This term refers to prejudicial treatment based on racial or ethnic group and the societal structures or institutions that systemically perpetuate this unfair treatment. Racism can be expressed on interpersonal, systemic, and internalized levels.[32]

Interpersonal racism is race-based unfair treatment of a person or group by individuals. Examples include hate crimes; name-calling; or the denial of a job, promotion, equal pay, or access to renting or buying a home on the basis of race.

Structural or *institutional racism* (also known as *systemic racism*) is race-based unfair treatment built into policies, laws, and practices. It often is rooted in intentional discrimination that occurred historically, but it can exert its effects even when no individual currently intends to discriminate. Racial residential segregation is an excellent example: it has steered people of color into residential areas where opportunities to be healthier and to escape poverty are limited.

Internalized racism occurs when victims of racism adopt (perhaps unconsciously) race-based prejudicial attitudes toward themselves and their racial or ethnic group, resulting in a loss of self-esteem and potentially in prejudicial treatment of members of their own racial or ethnic group.

social

Unless specified otherwise, this term encompasses (but is not limited to) economic, psychosocial, and other societal domains. In this article, at times *economic* is specified in addition to *social*, for clarity.

social determinants of health

These are nonmedical factors that influence health, such as employment, income, housing, transportation, child care, education, discrimination, and the quality of the places where people live, work, learn, and play. *Social* refers broadly to society—that is, people, their actions, and relationships. Social determinants are social in the sense that they are shaped by social policies. The World Health Organization Commission on the Social Determinants of Health[7] chose to include medical care (the services provided by trained medical or health personnel, such as doctors, nurses, therapists, pharmacists, and their support staff) among the social determinants, presumably because the provision of medical care—including access to it and its quality—is under the control of social policy. Generally, however, and in this article, the term *social determinants* refers to factors outside of medical care that influence health.

social exclusion or marginalization

This term refers to barring or deterring particular social groups—for example, on the basis of skin color, national origin, religion, wealth, disability, sexual orientation, gender identity, or gender—from full participation in society and from sharing the benefit of participation. Socially excluded or marginalized groups have less power and prestige and, generally, less wealth. Because they lack those basic resources, the places where they are able to live often are characterized by health-damaging conditions or conditions that fail to promote health, such as pollution, lack of access to jobs and services, and inadequate schools.

structural racism

See **racism**.

references

1. Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. (2017). *What is health equity? And what difference does a definition make?* Retrieved from Robert Wood Johnson Foundation website: https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf437393
2. United States Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2018). Disparities. Retrieved from http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities
3. Braveman, P. A., Kumanyika, S., Fielding, J., LaVeist, T., Borrell, L. N., Manderscheid, R., & Troutman, A. (2011). Health disparities and health equity: The issue is justice. *American Journal of Public Health*, *101*(S1), S149–S155.
4. United States Department of Health and Human Services, Office of Minority Health, National Partnership for Action to End Health Disparities. (2010). *Toolkit for community action*. Retrieved from http://www.minorityhealth.hhs.gov/npa
5. Braveman, P. (2006). Health disparities and health equity: Concepts and measurement. *Annual Review of Public Health, 27,* 167–194.
6. Braveman, P., & Gruskin, S. (2003). Poverty, equity, human rights and health. *Bulletin of the World Health Organization, 81,* 539–545.
7. World Health Organization Commission on the Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health.* Geneva, Switzerland: World Health Organization.
8. Berkman, L. F., Kawachi, I., & Glymour, M. (2014). *Social epidemiology* (2nd ed.). New York, NY: Oxford University Press.
9. Marmot, M. (2015). The health gap: The challenge of an unequal world. *The Lancet, 386,* 2442–2444.
10. Marmot, M., Friel, S., Bell, R., Houweling, T. A., Taylor, S., & Commission on Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *The Lancet, 372,* 1661–1669.
11. Braveman, P., Egerter, S., & Williams, D. R. (2011). The social determinants of health: Coming of age. *Annual Review of Public Health, 32,* 381–398.
12. Adler, N. E., & Stewart, J. (2010). Preface to the biology of disadvantage: Socioeconomic status and health. In N. E. Adler & J. Stewart (Eds.), *Annals of the New York Academy of Sciences: Vol. 1186. The biology of disadvantage: Socioeconomic status and health* (pp. 1–4). New York, NY: New York Academy of Sciences.
13. Norman, D., Kennedy, B., & Kawachi, I. (1999). Why justice is good for our health: The social determinants of health inequalities. *Daedalus, 128*(4), 215–251.
14. Isaacs, S. L., & Schroeder, S. A. (2004). Class: The ignored determinant of the nation's health. *The New England Journal of Medicine, 351,* 1137–1142.
15. Cutler, D. M., & Lleras-Muney, A. (2006). *Education and health: Evaluating theories and evidence* (NBER Working Paper No. 12352). Cambridge, MA: National Bureau of Economic Research.
16. Egerter, S., Braveman, P., Sadegh-Nobari, T., Grossman-Kahn, R., & Dekker, M. (2011). *Education matters for health.* Princeton, NJ: Robert Wood Johnson Foundation.
17. Roux, A. V. D., & Mair, C. (2010). Neighborhoods and health. In N. E. Adler & J. Stewert (Eds.), *Annals of the New York Academy of Sciences: Vol. 1186. The biology of disadvantage: Socioeconomic status and health* (pp. 125–145). New York, NY: New York Academy of Sciences.
18. Acevedo-Garcia, D., Osypuk, T. L., McArdle, N., & Williams, D. R. (2008). Toward a policy-relevant analysis of geographic and racial/ethnic disparities in child health. *Health Affairs, 27,* 321–333.
19. Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. *American Behavioral Scientist, 57,* 1152–1173.
20. Whitehead, M. (1991). The concepts and principles of equity and health. *Health Promotion International, 6,* 217–228.
21. Braveman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology & Community Health, 57,* 254–258.
22. Wagmiller, R. L., & Adelman, R. M. (2009). *Childhood and intergenerational poverty: The long-term consequences of growing up poor.* New York, NY: National Center for Children in Poverty.
23. Evans, G. W. (2004). The environment of childhood poverty. *American Psychologist, 59,* 77–92.
24. Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine, 32,* 20–47.
25. Meyer, I. H., & Northridge, M. E. (Eds.). (2007). *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations.* New York, NY: Springer Nature.
26. Burgard, S. A., & Lin, K. Y. (2013). Bad jobs, bad health? How work and working conditions contribute to health disparities. *American Behavioral Scientist, 57,* 1105–1127.
27. Edmonds, A., Braveman, P., Arkin, E., & Jutte, D. (2015). *Making the case for linking community development and health.* Princeton, NJ: Robert Wood Johnson Foundation.
28. Gordon-Larsen, P., Nelson, M. C., Page, P., & Popkin, B. M. (2006). Inequality in the built environment underlies key health disparities in physical activity and obesity. *Pediatrics, 117,* 417–424.
29. Daniels, N., Kennedy, B. P., & Kawachi, I. (2000, February 1). Justice is good for our health. *Boston Review.* Retrieved from http://www.bostonreview.net/forum/norman-daniels-bruce-kennedy-ichiro-kawachi-justice-good-our-health
30. Rawls, J. (1971). *A theory of justice.* Cambridge, MA: Belknap Press.
31. Pickett, K. E., & Wilkinson, R. G. (2015). Income inequality and health: A causal review. *Social Science & Medicine, 128,* 316–326.
32. Jones, C. P. (2000). Levels of racism: Theoretic framework and a gardener's tale. *American Journal of Public Health, 90,* 1212–1215.
33. Rothstein, R. (2017). *The color of law: A forgotten history of how our government segregated America.* New York, NY: Liveright.
34. Looney, A., & Turner, N. (2018). *Work and opportunity before and after incarceration.* Washington, DC: Brookings Institution.
35. Wildeman, C., & Wang, E. A. (2017). Mass incarceration, public health, and widening inequality in the USA. *The Lancet, 389,* 1464–1474.
36. Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. *American Journal of Health Promotion, 6,* 197–205.
37. United Nations General Assembly. (1966). *International covenant on economic, social and cultural rights*. Retrieved from http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

38. Reeves, R., Rodrigue, E., & Kneebone, E. (2016). *Five evils: Multidimensional poverty and race in America.* Washington, DC: Brookings Institution.

39. Cheng, T. L., Johnson, S. B., & Goodman, E. (2016). Breaking the intergenerational cycle of disadvantage: The three generation approach. *Pediatrics, 137,* 1–14.

40. United States Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2018). *Disability and health.* Retrieved from http://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health

41. World Health Organization. (2018). *Disabilities.* Retrieved from http://www.who.int/topics/disabilities/en/

42. Ward, B. W., Dahlhamer, J. M., Galinsky, A. M., & Joestl, S. S. (2014). *Sexual orientation and health among U.S. adults: National Health Interview Survey, 2013* (National Health Statistics Report No. 77). Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf

43. Moss, N. E. (2002). Gender equity and socioeconomic inequality: A framework for the patterning of women's health. *Social Science & Medicine, 54,* 649–661.

44. Bluvas, E. (2016). Camara Jones inspires at the 9th Annual Clyburn Lecture with discussion on health disparities and racism. Retrieved from https://sc.edu/study/colleges_schools/public_health/about/news/2016/clyburn2016_recap.php

45. Ferraro, K. F., & Kelley-Moore, J. A. (2003). Cumulative disadvantage and health: Long-term consequences of obesity? *American Sociological Review, 68,* 707–729.

46. Harper, S., Lynch, J., Meersman, S. C., Breen, N., Davis, W. W., & Reichman, M. E. (2008). An overview of methods for monitoring social disparities in cancer with an example using trends in lung cancer incidence by area-socioeconomic position and race-ethnicity, 1992–2004. *American Journal of Epidemiology, 167,* 889–899.

47. Hosseinpoor, A. R., Bergen, N., Koller, T., Prasad, A., Schlotheuber, A., Valentine, N., . . . Vega, J. (2014). Equity-oriented monitoring in the context of universal health coverage. *PLoS Medicine, 11,* 1–9.

48. Mackenbach, J. P., & Kunst, A. E. (1997). Measuring the magnitude of socio-economic inequalities in health: An overview of available measures illustrated with two examples from Europe. *Social Science & Medicine, 44,* 757–771.

49. Whitehead, M., & Dahlgren, G. (2006). *Levelling up (part 1): A discussion paper on concepts and principles for tackling social inequities in health.* Copenhagen, Denmark: WHO Regional Office for Europe.

50. Martin, J. A., Hamilton, B. E., Ventura, S. J., Osterman, M. J. K., Wilson, E. C., & Matthews, T. J. (2012). Births: Final data for 2010. *National Vital Statistics Reports, 61*(1).

51. Pollack, C. E., Chideya, S., Cubbin, C., Williams, B., Dekker, M., & Braveman, P. (2007). Should health studies measure wealth? A systematic review. *American Journal of Preventive Medicine, 33,* 250–264.

52. Yeung, W. J., Linver, M. R., & Brooks-Gunn, J. (2002). How money matters for young children's development: Parental investment and family processes. *Child Development*, *73,* 1861–1879.

53. Keyes, C. L. M. (1998). Social well-being. *Social Psychology Quarterly, 61*(2), 121–140.

54. Andersen, R., & Aday, L. A. (1978). Access to medical care in the US: Realized and potential. *Medical Care, 16,* 533–546.

55. Yudell, M., Roberts, D., DeSalle, R., & Tishkoff, S. (2016, February 5). Taking race out of human genetics. *Science, 351,* 564–565.

56. McCann-Mortimer, P., Augoustinos, M., & LeCouteur, A. (2004). 'Race' and the Human Genome Project: Constructions of scientific legitimacy. *Discourse & Society, 15,* 409–432.

57. Witherspoon, D. J., Wooding, S., Rogers, A. R., Marchani, E. E., Watkins, W. S., Batzer, M. A., & Jorde, L. B. (2007). Genetic similarities within and between human populations. *Genetics, 176,* 351–359.