Health Disparities and Health Equity: The Issue Is Justice

Eliminating health disparities is a *Healthy People* goal. Given the diverse and sometimes broad definitions of health disparities commonly used, a subcommittee convened by the Secretary's Advisory Committee for *Healthy People 2020* proposed an operational definition for use in developing objectives and targets, determining resource allocation priorities, and assessing progress.

Based on that subcommittee's work, we propose that health disparities are systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups; they may reflect social disadvantage, but causality need not be established. This definition, grounded in ethical and human rights principles, focuses on the subset of health differences reflecting social injustice, distinguishing health disparities from other health differences also warranting concerted attention, and from health differences in general.

We explain the definition, its underlying concepts, the challenges it addresses, and the rationale for applying it to United States public health policy. (*Am J Public Health.* 2011;101:S149–S155. doi:10.2105/AJPH.2010.300062)

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ONE OF 2 OVERARCHING goals of *Healthy People 2010*[1] was "to eliminate *health disparities* among different segments of the population." A similar goal to "achieve health equity and eliminate health disparities" was proposed by the Health and Human Services Secretary's Advisory Committee (SAC) for *Healthy People 2020*.[2] *Healthy People 2010* noted that health disparities "include differences that occur by gender, race or ethnicity, education or income, disability, living in rural localities, or sexual orientation."[1] However, the rationale for identifying disparities in relation to these particular population groups was not articulated. The National Institutes of Health defined health disparities as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States"[3,4]; several other federal agencies have similarly broad definitions.[5] The lack of explicit criteria for identifying disparities in *Healthy People 2010*[1] and the relatively nonspecific definitions of disparities used by federal agencies[3,4] leave considerable room for ambiguity as to what other groups might also be relevant.

Furthermore, there has been controversy as to whether definitions of health disparities should imply injustice or simply reflect differences in health outcomes that might apply to any United States population segment.[6–8] Different ethical, philosophical, legal, cultural, and technical perspectives may generate different definitions of health disparities or inequalities (the most comparable term outside the United States).[9–21] For example, in the United Kingdom, Whitehead defined health inequalities as differences that are unnecessary, avoidable, and unfair.[21] This definition is widely used internationally, where "health inequalities" are assumed to be socioeconomic differences unless otherwise specified; in the United States, however, "health disparities" more often refer to racial or ethnic differences.

Effective public policies require clear and contextually relevant operational definitions to support the development of objectives and specific targets, determine priorities for use of limited resources, and assess progress. The need for clear definitions is particularly compelling given the lack of progress toward reducing racial/ethnic and socioeconomic disparities in medical care[22] and health.[23–25] Recognizing the practical implications of lack of clarity on this critical issue, the SAC convened a subcommittee to define "health disparity" and "health equity" for use in *Healthy People 2020*.[2] The subcommittee members, including both SAC members and external experts, wrote this paper to elaborate on the definitions and explain their rationale.[2,26] These definitions (see the box on the next page) and the rationale presented are substantively consistent with those adopted by the SAC and recently published in *Healthy People 2020*,[2] but reflect some changes in wording. Clarifying these concepts will enable medical and public health practitioners and leaders to be more effective in reducing disparities in medical care and in advocating for social policies (e.g., in child care, education, housing, labor, and urban planning) that can have major impacts on population health.[27]

UNDERLYING VALUES AND PRINCIPLES

The concepts of health disparities and health equity are rooted in deeply held American social values and pragmatic considerations, as well as in internationally recognized ethical and human rights principles.[9] Drawing on ethical and human rights concepts, key principles underlying the concepts of health disparities and health equity include the following:

All people should be valued equally. This concept was articulated by Jones et al.[28] as foundational to the concept of equity. Equal worth of all human beings is at the core of the human rights principle that all human beings equally possess certain rights.[29,30]

Health has a particular value for individuals because it is essential to an individual's well-being and ability to participate fully in the workforce and a democratic society. Ill health means potential suffering, disability, and/or loss of life, threatens one's ability to earn a living, and is an obstacle to fully expressing one's views and engaging in the political

process. The Nobel Laureate economist Amartya Sen[31] viewed health as a fundamental capability required to function in society; similarly, ill health can be a barrier to fully realizing one's human rights. Because ill health can be an obstacle to overcoming disadvantages, health disparities, which further disadvantage socially disadvantaged groups, seem particularly unfair.

Health Disparities and Health Equity

Health disparities are health differences that adversely affect socially disadvantaged groups.

Health disparities are systematic, plausibly avoidable health differences according to race/ethnicity, skin color, religion, or nationality; socioeconomic resources or position (reflected by, e.g., income, wealth, education, or occupation); gender, sexual orientation, gender identity; age, geography, disability, illness, political or other affiliation; or other characteristics associated with discrimination or marginalization. These categories reflect social advantage or disadvantage when they determine an individual's or group's position in a social hierarchy (see the box on the next page).

Health disparities do not refer generically to all health differences, or even to all health differences warranting focused attention. They are a specific subset of health differences of particular relevance to social justice because they may arise from intentional or unintentional discrimination or marginalization and, in any case, are likely to reinforce social disadvantage and vulnerability.

Disparities in health and its determinants are the metric for assessing health equity, the principle underlying a commitment to reducing disparities in health and its determinants; health equity is social justice in health.

Nondiscrimination and equality. Every person should be able to achieve his/her optimal health status, without distinction based on race or ethnic group, skin color, religion, language, or nationality; socioeconomic resources or position; gender, sexual orientation, or gender identity; age; physical, mental, or emotional disability or illness; geography; political or other affiliation; or other characteristics that have been linked historically to discrimination or marginalization (exclusion from social, economic, or political opportunities). The groups represented by these characteristics substantively agree with those specified by the United Nations Committee on Economic, Social and Cultural Rights as vulnerable groups whose rights are at particular risk of being unrealized, due to historic discrimination.[32] This directly reflects the human rights principles of nondiscrimination and equality; nondiscrimination includes not only intentional but also unintentional or de facto discrimination, meaning discriminatory treatment embedded in structures and institutions, regardless of whether there is conscious intent to discriminate.[32,33] The late philosopher John Rawls[19] advanced the concept of a society's ethical obligation to maximize the well-being of those worst off. An aversion to discrimination is also firmly rooted in United States policies, as exemplified by the Civil Rights Act of 1964 prohibiting discrimination on the basis of race, color, or national origin; the 1954 Brown *vs.* Board of Education decision desegregating schools; the Hill Burton Act of 1946 prohibiting hospitals receiving federal funds from discriminating on the basis of race, color, or creed; and the Americans with Disabilities Acts of 1990 and 2008 prohibiting discrimination on the basis of physical or mental disability.

Health is also of special importance for society because a nation's prosperity depends on the entire population's health. Healthy workers are more productive and generate lower annual medical care costs.[34–36] A healthier population has more workers available for the workforce. Health can facilitate political participation, which is essential for democracy.

Rights to health and to a standard of living adequate for health. International human rights agreements, to which virtually all countries are signatories, obligate governments to respect, protect, fulfill, and promote all human rights of all persons, including the "right to the highest attainable standard of health" and the right to a standard of living adequate for health and well-being. Governments must demonstrate good faith in progressively removing obstacles to realizing these rights.[29] The United States signed but did not ratify the International Covenant on Economic, Social, and Cultural Rights, which articulated the right to health. Signing a treaty, however, is considered an endorsement of its principles and reflects acceptance of a good faith commitment to honor its contents. The "right to health" (i.e., "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"[37]) is "not to be understood as a right to be *healthy,*" because too many factors beyond states' control influence health. Rather, it is "the right to a system of health protection which provides equality of opportunity to enjoy the highest attainable level of health." It includes the right to equal access to cost-effective medical care as well as to child care, education, housing, environmental protection, and other factors that are also crucial to health and well-being.[38]

Health differences adversely affecting socially disadvantaged groups are particularly unacceptable because ill health can be an obstacle to overcoming social disadvantage. This consideration resonates with common sense notions of fairness, as well as with ethical concepts of justice, notably, the concept that need should be a key determinant of resource allocation for health, and Rawls' notion of the obligation to maximize the well-being of those worst off.[39] Sen noted as a "particularly serious . . . injustice . . . the lack of opportunity that some may have to achieve good health because of inadequate social arrangements. . . ."[40] Sen argued that health is a prerequisite for the capability to function normally in society.[31] It is therefore particularly unjust that those who are socially disadvantaged should also experience additional obstacles to opportunity based on having worse health. Ratifying human rights agreements obliges governments to direct special effort toward

equalizing the rights of vulnerable groups facing more obstacles to realizing their rights. A nonexhaustive list of vulnerable groups is specified in human rights documents on nondiscrimination and equality.[32,37,41,42]

The resources needed to be healthy (i.e., the determinants of health, including living and working conditions necessary for health, as well as medical care) should be distributed fairly. To do so requires considering need (along with capacity to benefit[16] and efficiency[17]) rather than ability to pay or influence in society.[17] This principle, along with principles cited previously, reflects the ethical notion of distributive justice (a just distribution of resources needed for health) and the human rights principles of nondiscrimination and equality, as well as the right to a standard of living adequate for health. Investments in medical care intended to reduce disparities must be weighed against other potentially more effective investments that address disparities in other health determinants.[38]

Health equity is the value underlying a commitment to reduce and ultimately eliminate health disparities. It is explicitly mentioned in the *Healthy People 2020*[2] objectives. Health equity means social justice with respect to health and reflects the ethical and human rights concerns articulated previously. Health equity means striving to equalize opportunities to be healthy. In accord with the other ethical principles of beneficence (doing good) and nonmalfeasance (doing no harm), equity requires concerted effort to achieve more rapid improvements among those who were worse off to start, within an overall strategy to improve everyone's health. Closing health gaps by worsening advantaged groups' health is not a way to achieve equity. Reductions in health disparities (by improving the health of the socially disadvantaged) are the metric by which progress toward health equity is measured.

HEALTH DISPARITIES: DEFINITION AND RATIONALE

We briefly define health disparities and health equity (see the box on the previous page), elaborating further and explaining in this section. We also discuss social disadvantage, a key concept for understanding disparities and equity (see the box on this page). Health disparities are systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups. They may reflect social disadvantage, although a causal link need not be demonstrated. Differences among groups in their levels of social advantage or disadvantage, which can be thought of as where groups rank in social hierarchies, are indicated by measures reflecting the extent of wealth, political or economic influence, prestige, respect, or social acceptance of different population groups.

Systematic But Not Necessarily Causal Links With Social Disadvantage

As noted by Starfield,[45] health disparities are systematic, that is, not isolated or exceptional findings. Health disparities are systematically linked with social disadvantage, and may reflect social disadvantage, although a causal link does not need to be demonstrated. Whether or not a causal link exists, health disparities adversely affect groups who are already disadvantaged socially, putting them at further disadvantage with respect to their health, thereby making it potentially more difficult to overcome social disadvantage. This reinforcement or compounding of social disadvantage is what makes health disparities relevant to social justice even when knowledge of their causation is lacking. It is important to define health disparities without requiring proof of causality, because there are important health disparities for which the causes have not been established, but which deserve high priority based on social justice concerns. For example, the large Black–White disparity in low birth weight and premature birth strongly predicts disparities in infant mortality and child development, and likely in adult chronic disease.[46] Although the causes of racial disparity in birth outcomes are not established,[46] credible scientific sources have identified biological mechanisms that plausibly contribute to the disparities,[46–50] which reflect phenomena shaped by social contexts and thus are, at least theoretically, avoidable.

Social Disadvantage

Health disparities and health equity cannot be defined without defining social disadvantage.

Social disadvantage refers to the unfavorable social, economic, or political conditions that some groups of people systematically experience based on their relative position in social hierarchies. It means restricted ability to participate fully in society and enjoy the benefits of progress. Social disadvantage is reflected, for example, by low levels of wealth, income, education, or occupational rank, or by less representation at high levels of political office. Criteria for social disadvantage can be absolute (e.g., the federal poverty threshold in the United States is based on an estimate of the income needed to obtain a defined set of basic necessities for a family of a given size)[43] or relative (e.g., poverty levels in a number of European countries are defined in relation to the median income, e.g., less than 50% of the median income).[44]

Not all members of a disadvantaged group will necessarily be (uniformly) disadvantaged, and not all socially disadvantaged groups will necessarily manifest measurable adverse health consequences. The extent (whether in a single or multiple domains), depth (severity), and duration (e.g., across multiple generations) of disadvantage matter. Social disadvantage is different from unavoidable physical disadvantage due to, for example, an unavoidable physical disability. However, when disabled persons are put at an unnecessary disadvantage in society due to lack of feasible supports (e.g., accessible public buildings and transportation) or to discrimination against them in hiring for work that they could perform, this would constitute social disadvantage, reflecting discriminatory treatment, whether intentional or unintentional.

Plausibly Avoidable Differences in Health Given Sufficient Political Will

It must be plausible, but not necessarily proven, that policies could reduce the disparities, including not only policies affecting medical care but also social policies addressing important nonmedical determinants of health and health disparities, such as a decent standard of living; a level of schooling permitting full social participation, including participation in the workforce and political activities; health-promoting living and working conditions, including both social and physical environments; and respect and social acceptance.[23,51] This criterion addresses the issue of avoidability, which is central to Whitehead's definition of health inequalities; it strives for more specificity about avoidability and to clarify the burden of proof regarding causality.[21]

Avoidability can be highly subjective. For example, one person may believe that ill health caused by poverty is avoidable; another, however, may believe that both poverty and ill health among the poor are inevitable; hence, these disparities are unavoidable. According to the proposed definition, the criterion is whether the given condition is theoretically avoidable, based on current knowledge of plausible causal pathways and biological mechanisms, and assuming the existence of sufficient political will. The more solid the knowledge, the more reasonable and politically viable it will be to invest resources in interventions; feasibility, costs, and potentially harmful unintended consequences must be considered. Without firm knowledge to guide specific interventions, pursuing health equity would require supporting research on how to intervene effectively and efficiently to reduce important disparities.

Worse Health Among Socially Disadvantaged Groups

Socially disadvantaged groups are defined a priori, according to criteria consistent with human rights principles regarding nondiscrimination and equality. Health disparities and equity should be central considerations for public policy relevant to health, but they are not the only considerations. Other legitimate considerations include the magnitude of impact and proportion of the population affected, as well as efficiency in the use of resources. If a more socially advantaged group happens to fare worse on a particular health indicator, this may be a very important issue that public health or other sectors should energetically address; but it is not part of a "health disparities" agenda, which focuses on improving the health of socially disadvantaged groups.

The Need to Reduce Disparities in the Determinants of Health

Health determinants include not only medical care but also the quality of the social and physical conditions in which people live, work, learn, and play.[23,51,52] Evidence of disparities in health determinants is thus relevant to assessing disparities in health. Society will generally be more motivated to address health differences that appear to result from modifiable circumstances over which individuals may have little control[21,53]; for example, the quality of local schools, exposure to pollution or crime, or absence of stores selling nutritious food in one's neighborhood.

Disadvantaged Groups Are Not Necessarily Uniformly Disadvantaged

Internationally recognized human rights documents provide guidance on which groups are disadvantaged. Although health disparities are systematic, a socially disadvantaged group will not necessarily fare worse on all health indicators, and might fare better on some. For example, non-Hispanic European American or White (hereafter "White") women over age 40 have higher incidence of breast cancer than non-Hispanic African American or Black (hereafter "Black") women,[54] and babies born to Hispanic immigrant women often have more favorable birth weights than those born to non-Hispanic Whites.[55] Neither of these differences—although both deserve public health attention—would be a health disparity by the proposed definition. Regardless of this type of exception in relation to a health outcome, Whites as a group are more socially advantaged than Blacks and Hispanics, as data on income, wealth, education, occupations, and political office have documented.[56–58] Furthermore, on most health indicators, including breast cancer mortality, White women are healthier than Black women.[59] Similarly, higher rates of a preventable illness in 1 of 2 affluent geographic regions would warrant public health action, but not as a health disparities concern.

The fact that not all members of a disadvantaged group (e.g., Blacks) appear to be severely disadvantaged (e.g., we have a Black United States President, and some Blacks are highly educated, in high professional positions, and/or wealthy) does not contradict considering that group as generally disadvantaged. The issue is whether the group has been on the whole more disadvantaged than Whites. Ample evidence has documented a longstanding pattern of less wealth,[60,61] lower incomes, lower educational attainment, and under-representation in positions of high occupational rank[56] and financial and political power[62] among Blacks as a group compared with Whites. Despite an end to legal racial segregation decades ago, racial residential segregation persists and with it, de facto educational segregation, condemning many Black children to poor quality schools. This reduces their chances of obtaining good jobs with adequate income as adults, perpetuating social disadvantage across generations.[63,64]

Similarly, although many United States women are affluent and some now hold high professional and political offices, as a group, they are more likely than men to be poor,[65] to earn less at a given educational level,[66] and to be underrepresented in high political office.[67] Human rights documents on nondiscrimination explicitly name women as a vulnerable group warranting special protection from discrimination. Patterns suggesting clinically unjustified underreceipt of certain cardiac treatments by women compared with men[68] would reflect a gender disparity in a determinant of health (medical care, in this instance). Shorter life expectancy among men in general, if likely avoidable, would clearly be an issue of public health importance based on the magnitude of potential population impact. However, men as a group have more wealth, influence, and prestige, so this difference would not be a social injustice and, therefore, not a health disparity or equity issue.

Health Disparities as the Metric to Assess Progress Toward Health Equity

The stated criteria permit the assessment of measurable progress toward greater health equity. Systematic associations with social disadvantage can be identified by observing a repeated pattern of correlations between measures of social disadvantage and a health outcome. Social advantage and disadvantage can be measured by comparing populations on factors such as levels of wealth, income, educational attainment, or occupational rank, for example (see the box on page S151). Demonstrating that a given disparity is plausibly avoidable and can be reduced by policies requires being able to describe, at least in general terms, 1 or more potential causal pathways that are consistent with current scientific knowledge; it does not require definitively establishing either the causation of the disparity or proving the effectiveness of existing interventions to reduce it. Guidelines for measuring health disparities are available.[9,69–73]

Increasingly, the term "health inequity"[21,74,75]—the opposite of health equity—is being used instead of "health disparity" to capture explicitly the moral dimension and differentiate health differences thought to reflect injustice from health differences in general. Examples of health differences that would not be considered health disparities according to our definitions (see the box on page S150) include: elderly adults generally having worse health than nonelderly adults; skiers being at higher risk of long-bone fractures than nonskiers; and men not having obstetric problems, whereas women do. Both "health disparity" and "health inequity" have their place in the public health lexicon. Health inequity, however, is a forceful term tending to imply a strong judgment about causality, which may be difficult to support in many cases that nevertheless deserve attention as health disparities (i.e., health differences adversely affecting socially disadvantaged groups) regardless of their causation. As with health equity, measuring health inequity relies on health disparities as the metric.

Health Disparity: Not Just a Health Difference

Interpreting the term "health disparities" as any health differences among any population group, as has been done by some federal agencies, encompasses the entire domain of epidemiology, which is the study of the distribution of diseases and risk factors across different populations. We have argued that the term health disparities should be used advisedly, in the spirit of the movement for social justice from which the term emerged, to refer to a particular subset of differences in health that meet well-specified criteria of specific relevance to social justice. The definitions proposed here were designed to clarify the concepts of health disparities and health equity in ways that could stand up to rigorous conceptual scrutiny as a basis for guiding policy and practice and ensuring accountability, which requires clear criteria for measurement.[9,69,70] To achieve the desired rigor, the full versions of the proposed definitions are complex and technical and will not be suitable for all audiences; for many audiences, it may be most appropriate to define health disparities simply as worse health among socially disadvantaged groups and then elaborate as necessary, drawing on the more comprehensive form of the definitions.

Limitations

These definitions do not provide numerical cutoffs for determining disadvantage. Nor do they remove completely the need to exercise judgment based on values that are likely to vary across individuals and societies. It is difficult to imagine reasonable definitions of these concepts, however, that would provide rigid cutoffs, would completely preclude the exercise of judgment, and would leave no room for contention. The proposed definitions do not clarify whether the reference group for making equity/disparities comparisons should be the most advantaged group in one's country or in the world; using one's country as the reference point may ignore the better health achieved by advantaged populations in other parts of the world.

Challenges Addressed

The definitions address major challenges, such as identifying the social groups to be compared and specifying the general criteria for appropriate reference groups for these comparisons.[18] These challenges have arisen when considering health disparity or equity issues, with serious implications for resource allocation. These definitions remove the need to establish the causality and avoidability of each health difference for it to qualify as a health disparity worthy of special attention. To address the difficult issue of causality, our definitions acknowledge that a health disparity may or may not arise from social disadvantage, but it must adversely affect members of socially disadvantaged groups; this can be assessed using epidemiologic data revealing repeated and pervasive associations between health indicators and measures of social advantage. The causes need not be known definitively, if it is biologically plausible that the difference could be reduced by policies. These definitions also ground the concepts of health disparities and health equity in internationally recognized principles from the fields of ethics and human rights, giving them universality and durability. Although human rights are often honored more in the breach than in the observance, they are a powerful resource in that they represent a global consensus on values. This consensus can be an important point of reference in national and local debates on policies and practice in the United States. It would be naïve to think that achieving consensus on a definition would obviate the need for constant vigilance to ensure that the agenda for research and action on health disparities remains on track and true to the essence of the definition; however, having a clear definition is crucial.

The Issue is Justice

Could this approach—putting health disparities within the broader context of ethics and human rights—jeopardize the limited resources allocated to specifically address racial/ethnic disparities, by spreading these resources more thinly among other disadvantaged groups? Would broadening the definition make the concept too abstract and therefore less compelling to the public and policymakers? We concluded that the struggle for racial justice, in which efforts to eliminate racial/ethnic disparities in health are crucial, has far more to gain than to lose from making these principles explicit. The relevant ethical and human rights principles support prioritizing attention to those facing the greatest obstacles, and

ample evidence has documented the multiple and often crushing obstacles faced by members of disadvantaged racial/ethnic groups in the United States, in some cases for centuries. These principles can protect initiatives to address racial/ethnic as well as other disparities in health from a range of potential challenges that constitute real threats.

Previous official approaches to defining health disparities in the United States have avoided being explicit about values and principles, perhaps for fear of stirring political opposition, because of genuine differences in values or because of the prevailing ethos that enjoins researchers to avoid the realm of values that might compromise the integrity of their science. Scientists, like all others, should be guided by ethical and human rights values. The first decade of the 21st century has ended with little if any evidence of progress toward eliminating health disparities by race or socioeconomic status.[22] It is time to be explicit that the heart of a commitment to addressing health disparities is a commitment to achieving a more just society. ■

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Contributors

All the authors participated conceptually in developing the recommendations to the Secretary's Advisory Committee (SAC) on *Healthy People 2020,* which were the starting point for this article, and all authors contributed ideas, reviewed drafts, and made comments that shaped this article in important ways. P.A. Braveman conceived the initial idea for the article, wrote initial drafts, and wrote most revisions for coauthors' review, based on their comments. S. Kumanyika also played a major role in writing the text and a lead role in responding to external reviewer comments. J. Fielding, T. LaVeist, L.N. Borrell, R. Manderscheid, and A. Troutman also contributed conceptually and participated in substantive revisions throughout the process.

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