

What Are Health Disparities and Health Equity? We Need to Be Clear

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ABSTRACT

“Health disparities” and “health equity” have become increasingly familiar terms in public health, but rarely are they defined explicitly. Ambiguity in the definitions of these terms could lead to misdirection of resources. This article discusses the need for greater clarity about the concepts of health disparities and health equity, proposes definitions, and explains the rationale based on principles from the fields of ethics and human rights.

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If you look up the word “disparity” in a dictionary, you will most likely find it defined simply as difference, variation, or, perhaps, inequality, without further specification. But when the term “health disparity” was coined in the United States around 1990, it was not meant to refer to all possible health differences among all possible groups of people. Rather, it was intended to denote a specific kind of difference, namely, worse health among socially disadvantaged people and, in particular, members of disadvantaged racial/ethnic groups and economically disadvantaged people within any racial/ethnic group. However, this specificity has generally not been made explicit. Until the release of Healthy People 2020 in 2010, federal agencies had officially defined health disparities in very general terms, as differences in health among different population groups, without further specification.^{1,2} This article argues for the need to be explicit about the meaning of health disparities and the related term “health equity,” and proposes definitions based on concepts from the fields of ethics and human rights.

WHY EXPLICIT DEFINITIONS ARE NEEDED

Not all health differences are health disparities. Examples of health differences that are not health disparities include worse health among the elderly compared with young adults, a higher rate of arm injuries among professional tennis players than in the general population, or, hypothetically, a higher rate of a particular disease among millionaires than non-millionaires. While these differences are unlikely to occupy prominent places in a public health agenda, there are many health differences that are important for a society to address but are not health disparities. For example, if the health of an entire population seemed to be getting worse over time, or if there were a serious disease outbreak in an affluent community not seen in less affluent communities, these health differences would merit attention, but for reasons other than relevance to health disparities or equity. None of these examples reflects what is at the heart of the concept of health disparities: concerns about social justice—that is, justice with respect to the treatment of more advantaged vs. less advantaged socioeconomic groups when it comes to health and health care.

Ambiguity about the meaning of health disparities and health equity could permit limited resources to be directed away from the intended purposes. For example, if these terms remain vaguely defined, socially and economically advantaged groups could co-opt the terms and advocate for resources to address their advantaged social group’s health needs.

DEFINING HEALTH DISPARITY AND HEALTH EQUITY

Recognizing the need for clarity, Healthy People 2020 defined a health disparity as:

“... a particular type of health difference that is closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”³

In this definition, economic disadvantage refers to lack of material resources and opportunities—for example, low income or lack of wealth, and the consequent inability to purchase goods, services, and influence. Social disadvantage is a broader concept. While it includes economic disadvantage, it also refers more generally to someone’s relative position in a social pecking order—an order in which individuals or groups can be stratified by their economic resources, as well as by race, ethnicity, religion, gender, sexual orientation, and disability. These characteristics can influence how people are treated in a society. In the Healthy People definition, environmental disadvantage refers to residing in a neighborhood where there is concentrated poverty and/or the social disadvantages that often accompany it.

Health equity is the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.

What is the basis for these definitions? More specifically, what is the basis for singling out a certain category of health differences, those linked with economic/social disadvantage, for special attention? There are multiple reasons. First, a massive body of evidence strongly links economic/social disadvantage with avoidable illness, disability, suffering, and premature death.⁴⁻⁹ Another article in this supplement¹⁰ discusses some of that evidence. Second, economic/social disadvantage can be ameliorated by social policies, such as minimum wage laws, progressive taxation, and statutes barring discrimination in housing or employment based on race, gender, disability, or sexual orientation.

In addition, these definitions have a basis in principles from the fields of ethics and human rights.¹¹

Daniels and other ethicists have pointed out that health is needed for functioning in every sphere of life. Therefore, the resources needed to be healthy—including not only medical care¹² but also health-promoting living and working conditions¹³—should not be treated as commodities such as designer clothing or luxury cars. Rather, they should be distributed according to need. An aversion to health disparities reflects widely held social values that call for everyone to have a fair chance to be healthy, given that health is crucial for well-being, a long life, and economic and social opportunity.

Laws, treaties, and principles from the field of human rights also provide a basis for these definitions. By now, a vast majority of countries have signed (if not ratified) major human rights agreements that are of great relevance to health disparities; signing implies agreement in principle. While human rights agreements are all too often violated, this global consensus on fundamental values, developed over a period of years, greatly strengthens the basis for defining the concept of health disparities. Under international human rights laws and agreements, countries are obligated to protect, promote, and fulfill the human rights of everyone in their populations. Recognizing that many countries lack the resources to remove all obstacles to all rights for everyone immediately, human rights agreements require that countries demonstrate “progressive realization;” i.e., they are making gradual progress toward realizing the rights of their populations. Of particular relevance for understanding health disparities and health equity is the implicit obligation to pay particular attention to those segments of the population who experience the most social obstacles.¹⁴

Most likely, the principle that first comes to mind when considering human rights in relation to health is the “right to health,” defined as the right to attain the highest possible standard of health. I have argued elsewhere that, for the purpose of measurement, the highest possible standard of health can be reflected by the level of health among the most economically and socially privileged group in a society.¹¹ One could argue that this standard is conservative. The right to health, however, is not only a right to health care. A large body of knowledge, including sources cited previously, indicates that the resources needed to be healthy include not only quality medical care, but also education and health-promoting physical and social conditions in homes, neighborhoods, and workplaces. Human rights principles call for countries to remove obstacles to health in any sector—for example, in education, housing, or transportation—and they explicitly call for the right to a standard of living necessary to protect and promote health.^{15,16}

Equally relevant to health disparities are the human rights principles of nondiscrimination and equality. According to these principles, everyone has equal rights, and states are obligated to prohibit policies that have either the intention or the effect of discriminating against particular social groups. It is often very difficult to prove what a person’s (or institution’s) intentions—vs. actions—were. In addition, at a population level, greater harm to health may be done as a result of unintentionally discriminatory processes and structures,^{17,18} even when conscious intent to discriminate no longer exists or can be documented. Examples of such processes and structures—which persist as the legacy of slavery and “Jim Crow,” both of which were legal and intentionally discriminatory—include racial segregation, criminal justice codes and patterns of enforcing them, and tax policies that make schools dependent on local funding. These examples may no longer reflect conscious intent to discriminate, but nevertheless persist and transmit economic and social disadvantage—with health consequences—across generations.^{17,18} Because human rights agreements and principles prohibit *de facto* (unintentional or structural) as well as intentional discrimination, we do not have to know the causes of a health difference to call it a health disparity. Health disparities are inequitable, even when we do not know the causes, because they put an already economically/socially disadvantaged group at further disadvantage with respect to their health. Furthermore, health is necessary to overcome economic/social disadvantage.^{2,11}

Health equity and health disparities are intertwined. Health equity means social justice in health (i.e., no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged). Health disparities are the metric we use to measure progress toward achieving health equity. A reduction in health disparities (in absolute and relative terms) is evidence that we are moving toward greater health equity. Moving toward greater equity is achieved by selectively improving the health of those who are economically/socially disadvantaged, not by a worsening of the health of those in advantaged groups.¹⁹

The most intuitive and clear definition of health inequalities (the term used in most countries, where it is generally assumed to refer to socioeconomic differences in health) was developed by Margaret Whitehead in the United Kingdom. She defined health inequalities as health differences that are avoidable, unnecessary, and unjust.²⁰ The more technical definition presented here was developed in response to experience revealing that different people may have very different ideas of what is avoidable, unnecessary, and unjust, and that

additional guidance is often needed to keep policies and programs on track. The Whitehead definition, however, concisely and eloquently captures the essence of what health disparities and health equity are, and why we are committed to eliminating them.

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