DEFINING EQUITY IN HEALTH

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Abstract

For purposes of measurement and operationalisation, equity in health is the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage. The term equity in health care or population health includes inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disadvantaged racial, ethnic, or religious group) at further disadvantage with respect to their health; health is essential to well-being and to overcoming other effects of social disadvantage. Equity is an ethical principle; it also is consonant with and closely related to human rights principles. The defined concept of equity supports operationalisation of the right to the highest attainable standard of health as indicated by the health status of the most socially disadvantaged group. Assessing health equity requires comparing health and its social determinants between more and less advantaged social groups. These comparisons are essential to assess whether national and international policies are leading toward or away from greater social justice in health.

Introduction

In a widely cited 1992 paper on The concepts and principles of equity in health, Whitehead defined health inequities as differences in health that are unnecessary, avoidable, unfair and unjust. That influential, articulate, and well-conceived paper on health equity — meant to be a disciplinary stimulus and source of evidence... — succeeded in its stated aim and has been useful in many settings on other continents. Valuable contributions in health have been made by other discussions of the concept of equity in health or in health care, or both (Anand, 2002). Accumulated experience now permits a fresh look at the question of how to define equity in a conceptually rigorous way that may guide measurement and hence accountability for actions at the policy and programmatic levels. This paper is of particular relevance given the growing interest in equity among national and international health institutions (Evans 2001, Acchion, 1998, Braveman, 2002). The need for a more precise definition of equity in health also has arisen in the context of a recent debate between researchers at the World Health Organization (Monsey 1995, Glauberman 2000, Braveman 2000) and at one of the academic institutions (Braveman 2001, Njema, 2000); this debate is discussed below (see On the definitions matter? This paper is primarily addressed to the research community, proposing a definition of health equity to guide measurement and, hence, accountability; we also discuss the practical importance of clarity in defining this concept in its application for both policies and measurement. We are not aware of other literature addressing this issue.

Equity Means Social Justice

Equity means social justice or fairness; it is an ethical concept, grounded in principles of distributive justice (Beauchamp, 1994, Rawls 1985, Daniels, 1998). Equity in health can be—and has widely been—defined as the absence of social unjust or unfair health disparities. However, because social justice and fairness can be interpreted differently by different people in different settings, a definition is needed that can be operationalised based on measurable criteria.

For the purposes of operationalisation and measurement, equity in health can be defined as the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage—this is different positions in a social hierarchy. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disadvantaged racial, ethnic, or religious group) at further disadvantage with respect to their health; health is essential to well-being and to overcoming other effects of social disadvantage.

Health represents both physical and mental wellbeing, not just the absence of disease (WHO, 1948). Key social determinants of health include household living conditions, conditions in communities and workplaces, and health care, along with health policies and programmes affecting any of these factors. Health care is a social determinant in so far as it is influenced by social policies; we use the term broadly here to refer not only to the operationalisation of health services, but also to the allocation of health care resources, the financing of health care, and the quality of health care services.

Underlying social advantage/disadvantage refers to wealth, power, and/or prestige—this is the attributes that define how people are grouped in social hierarchies. Disadvantage also can be thought of as deprivation, which can be measured by factors such as income, education, employment, or living conditions.

While it is important, as noted above, to be clear about the distinction between health inequities and health disparities, the concepts of equity and equality re none the less central and indispensable. The concept of equity is indispensable for the operationalisation and measurement of health equity and is important for accountability under the human rights frameworks. Equality can be assessed with respect to specified measurable outcomes, whereas judging whether a particular health outcome is equitable or not is more open to interpretation. Furthermore, it is generally not possible for everyone in society at a societal level to be equal in what is equally possible to achieve at a societal level. This is not an unrealistic list, but social advantage is distributed along these lines virtually everywhere in the world.

A health disparity must be systematically associated with social advantage; that is, the association must be significant and frequent or persistent, not just occasional or random.

Equity is not the same Quality

The concept of equity is inherently normative—that is, value necessarily follows from (Oliver, 2002). Often, the term health inequalities is used as a synonym for health inequalities, perhaps because inequality can have an accusatory, judgmental, or morally charged tone. However, it is important to recognize that, strictly speaking, these terms are not synonymous. The concept of health equity focuses attention on the distribution of resources and other processes that drive a particular kind of health inequality—that is, a systematic inequality in health (or in its social determinants) between more and less advantaged social groups, in other words, a health inequality that is unjust or unfair.

Not all health disparities are unfair. For example, we expect young adults to be healthier than the elderly population. Female newborns tend to have lower birth weights on average than male newborns. Men have prostate problems, while women are less likely to have prostate problems. However, to argue that any of these health inequalities is unfair, one must be able to show that the differences in birth weights or in prostate problems are not due to social factors. Differences in birth weights or in prostate problems are not due to social factors. Differences in birth weights or in prostate problems are not due to social factors.
measures of social advantage and any given health outcome. For example, when a particular health disparity in a society is systematically seen across income groups, the underlying causals differences could be in factors associated with income rather than in income itself, thus, it would be a mistake to assume that efforts focused only on equalizing income would necessarily be effective in reducing that particular inequity.

Do the definitions really matter?

In practice, different social, political, economic and cultural contexts, will undoubtedly suggest the need for different ways of defining and explaining equity. However, clarity is required to determine when different definitions represent substantially different paradigms, and the implications of adopting these different paradigms in particular contexts. As noted earlier, people often use the term health inequalities in what may be an effort to avoid the judgmental or moral connotations that may be associated with health inequalities. Health inequalities is less cumbersome than social inequalities in health, in the latter term also often used as a more succinct way of referring to inequalities in health between more and less advantaged social groups. We believe that using these more concise terms will be more problematic so long as there is clarity as to how they are being used - that is, that both health inequalities and social inequalities in health mean inequalities in health or its social determinants, between more and less advantaged social groups, favouring the already more advantaged groups. When using the more abbreivated expressions, one must be clear that equity, at least so understood here and in the vast majority of the literature, cannot be assessed without comparing how better off and worse off social groups are faring in relation to each other. The importance of clarity regarding these concepts is illustrated by a recent debate.

Key points

- A definition of equity in health is needed that can guide measurement and hence accountability for the effects of actions.
- Health equity is the absence of systematic disparities in health (or its social determinants) between more and less advantaged social groups.
- Social advantage means wealth, power, and/or prestige - the attributes defining how people are grouped in social hierarchies.
- Health inequalities put disadvantaged groups at further disadvantage with respect to health, diminishing opportunities to be healthy.
- Health equity, an ethical concept based on the principle of distributive justice, is also linked to human rights.

The World Health Organization's (WHO) World Health Report for the year 2000 (WHO 2000) made a welcome argument for the importance of assessing health not only by average levels but also by examining its distribution. However, the report examines the distribution of health by measuring what it refers to as "pure health inequalities," disparities in health between ungrouped individuals, in contrast with examining differences between social groups. The total magnitude of health differences among all individuals assessed, but there are no comparisons of health among different social groups. Thus, the WHO measure compares the health of healthier people with the health of sicker people within a country, but does not, for example, compare the health of wealthier people with the health of poorer ones, the health of different ethnic groups with each other, or health care for men and women with similar health conditions. Nevertheless, most audiences naturally assume that work on health inequalities is work on health equity.

The measurement of health disparities without respect to how the disparities are distributed socially is not a measure of equity and does not reflect fairness or justice with respect to health (Akyeampong 2000, Wagstaff 2001). If countries or organisations use this WHO measure rather than established measures of health equity (reviewed comprehensively in Mackenbach and Kunst and Wagstaff et al), they will be unable to monitor differences in health and health care between the rich and the poor or between more and less privileged racial/ethnic groups or to make appropriate comparisons with respect to gender. Without such comparisons between identifiable social groups, it will not be known who is benefiting most or least from policies affecting health and therefore how best to target interventions or redistribute resources to achieve greater health equity. Thus, the choice of definition for equity in health matters because of the implications for the utility of measurement.

Conclusions

Equity in health is an ethical value, inherently normative, grounded in the ethical principle of distributive justice and consonant with human rights principles. Like most concepts, equity in health cannot be directly measured, but we have proposed a definition of equity in health that can be operationalised based on meaningful and measurable criteria. In operational terms, and for the purposes of measurement, equity in health can be defined as the absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage/disadvantage. Health inequalities systematically put populations who are already socially disadvantaged (for example, by virtue of being poor, female, or members of a disadvantaged racial, ethnic group) at further disadvantage with respect to their health.

While equity and equality are distinct, the concept of equality is indispensable in operationalising and measuring equity. Equity in health means equally opportunity to be healthy, for all population groups. Equity in health thus implies that resources re-distributed and processes re-designed in ways most likely to move toward equalizing the health outcomes of disadvantaged social groups with the outcomes of their more advantaged counterparts. This refers to the distribution and design not only of health care resources and programmes, but of all resources, policies, and programmes that play an important part in shaping health, many of which are outside the immediate control of the health sector.

Awareness of the need for greater clarity about the definition of health equity has arisen in the context of a recently proposed approach to the measurement of health inequalities that does not reflect how health is distributed across different population groups. Not all health inequalities necessarily reflect inequity in health, which implies unfair processes in the distribution of resources and other conditions that affect health. Assessing health equity requires comparing health and its social determinants among more and less advantaged social groups. Without this information, we will be unable to assess whether policies and programmes are leading toward or away from greater social justice in health.

References

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