THEORY AND METHODS

Defining equity in health

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Study objective: To propose a definition of health equity to guide operationalisation and measurement, and to discuss the practical importance of clarity in defining this concept.

Design: Conceptual discussion.

Setting, Patients/Participants, and Main results: Not applicable.

Conclusions: For the 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/disadvantage—that is, wealth, power, or prestige. 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 disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health; health is essential to wellbeing and to overcoming other effects of social disadvantage. Equity is an ethical principle; it is also consonant with and closely related to human rights principles. The proposed definition of equity supports operationalisation of the right to the highest attainable standard of health as indicated by the health status of the most socially advantaged 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.

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.1 That influential, articulate, and well-conceived paper was “...not meant to be a technical document, but ...aimed at raising awareness and stimulating debate in a wide, general audience...” in Europe.1 The document succeeded in its stated aim and has been useful in many settings on other continents. Valuable contributions also have been made by other discussions of the concept of equity in health or in health care, or both.2–13 Accumulated experience now permits a fresh look at the question of how to define equity in health in a conceptually rigorous fashion that can guide measurement and hence accountability for actions at the policy and programmatic levels. This question is of particular relevance given the growing interest in equity among national and international health organisations.14–16 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 Organisation17–18 and at a number of academic institutions19–20; this debate is discussed below (see Do 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 terms of consequences 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.21–24 Equity in health can be—and has widely been—defined as the absence of socially unjust or unfair health disparities.1 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 groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige. 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 disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health; health is essential to wellbeing and to overcoming other effects of social disadvantage. 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 receipt/utilisation 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 or disadvantage refers to wealth, power, and/or prestige—that is, the attributes that define how people are grouped in social hierarchies. Disadvantage also can be thought of as deprivation,25,26 which can be absolute or relative27; the concept of human poverty developed by the United Nations Development Program reflects severe disadvantage.28 Thus, more and less advantaged social groups are groups of people defined by differences that place them at different levels in a social hierarchy. Examples of more and less advantaged social groups include socioeconomic groups (typically defined by measures of income, economic assets, occupational class, and/or educational level), racial/ethnic or religious groups, or groups defined by gender, geography, age, disability, sexual orientation, and other characteristics relevant to the particular setting. This is not an exhaustive 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 associations must be significant and frequent or persistent, not just occasional or random.\(^{13}\)

**EQUITY IS NOT THE SAME AS EQUALITY**

The concept of equity is inherently normative—that is, value based\(^ {13}\); while equality is not necessarily so.\(^ {13, 14, 15, 16}\) Often, the term *health inequalities* is used as a synonym for *health inequities*, perhaps because *inequity* can have an accusatory, judgmental, or morally charged tone. However, it is important to recognise 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.\(^ {13}\) 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 do not. It would be difficult, however, to argue that any of these health inequalities is unfair. However, differences in nutritional status or immunisation levels between girls and boys, or racial/ethnic differences in the likelihood of receiving appropriate treatment for a heart attack, would be causes for grave concern from an equity perspective.

**EQUITY AND HUMAN RIGHTS: EQUAL RIGHTS AND OPPORTUNITIES TO BE HEALTHY**

The concept of equity is an ethical principle; it also is consonant with and closely related to human rights principles. The *right to health* as set forth in the WHO Constitution\(^ {17}\) and international human rights treaties is the right to “the highest attainable standard of health.” Although this notion has sometimes been criticised by public health practitioners for being vague and difficult to operationalise, accumulating experience suggests itsutility.\(^ {18, 19}\) We believe that the highest attainable standard of health can be understood to be reflected by the standard of health enjoyed by the most socially advantaged group within a society. One could argue that, given sufficient resources, the highest attainable standard could be far greater than that currently experienced even by the best-off group in a society. The health levels of the most privileged groups in a given society at least reflect levels that clearly are biologically attainable, and minimum standards for what should be possible for everyone in that society within a foreseeable future. The proposed definition of equity in health thus is useful in operationalising the concept of the right to health.

While it is important, as noted above, to be clear about the distinction between health inequalities and health inequities, the concepts of equality and equal rights are none the less central and indispensable. The concept of equality is indispensable for the operationalisation and measurement of health equity and is important for accountability under the human rights framework. Equality can be assessed with respect to specified measurable outcomes, whereas judging whether a process is equitable or not is more open to interpretation. Furthermore, in practical terms, it is generally those who are in positions of power who are likely to be determining at a societal level what is equitable and what is not, with respect to the allocation of resources necessary for health. For example, in some countries where women are particularly disenfranchised, those in power have argued that conditions for women in their countries are not unfair but rather are appropriate given the different capacities and roles of men and women; similar arguments have been used to justify racial/ethnic discrimination.\(^ {20, 21}\) In such contexts, equality is a crucial reference point in attempts to achieve greater equity in health.

Furthermore, the notion of equal opportunities to be healthy is fundamental to the concept of equity in health and closely linked with the concept of equal rights to health. The notion of equal opportunities to be healthy is grounded in the human rights concept of non-discrimination and the responsibility of governments to take the necessary measures to eliminate adverse discrimination—in this case, discrimination in opportunities to be healthy in virtue of belonging to certain social groups. A selective concern for worse-off social groups is not discriminatory; it reflects a concern to reduce discrimination and marginalisation. Equal opportunity to be healthy refers to the attainment by all people of the highest possible level of physical and mental wellbeing that biological limitations permit, noting that the consequences of many biological limitations are amenable to modification. For example, the functional limitations associated with many physical handicaps can be markedly changed with basic measures (such as providing wheelchairs, installing protective railings, or providing physical training to increase mobility and strength); similarly, the degree of impairment associated with many psychological and physical conditions is highly related to the degree of social stigmatisation or acceptance of people with those conditions.\(^ {22, 23}\)

According to human rights principles, all human rights are considered inter-related and indivisible.\(^ {24, 25}\) Thus, the right to health cannot be separated from other rights, including rights to a decent standard of living and education, or freedom from discrimination and freedom to participate fully in one’s society. Equalising opportunities to be healthy requires addressing the most important social and economic determinants of health, including, as stated earlier, not only health care but also living conditions in households and communities, working conditions, and policies that affect any of these factors. Concern for equal opportunities to be healthy is the basis for including within the definition of equity in health the absence of systematic social disparities not only in health status but in its key social determinants.

**EASE OF AVOIDABILITY SHOULD NOT BE A CRITERION FOR INEQUITY**

The 1990 *Concepts and principles* paper\(^ {26}\) defined inequity in health as inequalities in health that are unjust, unfair and avoidable. That definition has been very helpful in giving the abstract notion of equity meaning in terms that most people understand and recognise as a widely shared social value. However, we recommend that avoidability not be used as a criterion to define equity in health, for two reasons. Firstly, including this criterion is unnecessary, because unjust and unfair imply avoidability. Second, certain health inequities may be extremely challenging to tackle because they require fundamental changes in underlying social and economic structures; one would not want the ease of avoidability to be a measure of the degree of inequity. Furthermore, using avoidability as a criterion introduces but begs the question: avoidable by whom? Is a given health disparity that adversely affects already disadvantaged groups in a poor country considered to be avoidable by the groups adversely affected, by their community, by government—and at what level—and/or by the international community?

Thus, in defining equity in health, avoidability should only be invoked in so far as injustice and unfairness imply avoidability. The degree to which an inequitable health disparity is avoidable does, however, have important practical implications for efforts to achieve greater equity, in that it will generally be easier to mobilise public opinion and policies to address disparities that are more clearly and easily recognisable as avoidable, particularly those that can be achieved more quickly, at lower cost and with less challenge to underlying
social and economic structures. This is a pragmatic considera-
tion and should not be considered a fundamental component
of the definition of equity.

CAUSAL ASSUMPTIONS
According to the definition of equity proposed here, a health
disparity is inequitable if it is systematically associated with
social disadvantage in a way that puts an already disadvan-
taged social group at further disadvantage. In addition, it must
be reasonable based on current scientific knowledge to believe
that social determinants could play an important part in that
disparity at one or more points along the causal pathways
leading to it; that is, that at least one factor associated with
social disadvantage is causally connected with at least one
factor associated (directly or indirectly) with the specified
health condition or determinant. This does not, however,
require definitive understanding of the most proximate—that
is, immediate cause(s), the causes most amenable to interven-
tion, or the entire causal pathway(s) explaining a health dis-
parity between social groups. The causes of health disparities
between more and less advantaged groups are likely to be
complex and multifactorial, and may not be clearly or imme-
diately linked to underlying differences in social advantage. A
health disparity between more and less advantaged popula-
tion groups constitutes an inequity not because we know the
proximate causes of that disparity and judge them to be
unjust, but rather because the disparity is strongly associated
with unjust social structures; those structures systematically
put disadvantaged groups at generally increased risk of ill
health and also generally compound the social and economic
consequences of ill health.

Given the complex and multifactorial nature of the causal
pathways leading from underlying social determinants to
most health disparities, causal assumptions should not be
made based on observed associations between particular
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
causal 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 equalising 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 substan-
tially different paradigms, and the implications of adopting
these different paradigms in particular contexts. As noted ear-
erlier, 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 inequities. Health inequalities is less
cumbrous than social inequalities in health, 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 not be 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 abbreviated expressions, one must be clear
that equity, at least as understood here and in the vast major-
ity 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 inequities put disadvantaged groups at further
disadvantage with respect to health, diminishing opportuni-
ties to be healthy.
- Health equity, an ethical concept based on the principle of
distributive justice, is also linked to human rights.

The World Health Organisation’s (WHO) World Health Report
for the year 2000 made a welcome argument for the import-
ance 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 is assessed, but there are no compari-
sons 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 simi-
lar 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. If countries or organisations use this WHO measure rather
than established measures of health equity (reviewed comprehen-
sively 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,
will not be known who is benefiting most or least from poli-
cies 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.

CONCLUSION
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 systemati-
cally associated with social advantage/disadvantage. Health
inequities systematically put populations who are already
socially disadvantaged (for example, by virtue of being poor,
female, or members of a disenfranchised racial, ethnic, or reli-
gious 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 health

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health and its social determinants among more and less necessarily reflect inequity in health, which implies unfairness in health, which underscores the importance of addressing the social determinants of health.

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