May 2017

What Is Health Equity?

And What Difference Does a Definition Make?

UCSF
University of California
San Francisco

Robert Wood Johnson
Foundation

Authors

Paula Braveman
Elaine Arkin
Tracy Orleans
Dwayne Proctor
Alonzo Plough

Acknowledgements

We sincerely thank the following individuals who provided comments on drafts:

Deborah Austin, PhD, ReachUp Inc.
Stephanie V Boarden, MPH, PolicyLink
Karen Bouye, PhD, MPH, MS, CDC Office of Minority Health and Health Equity
Renee B Canady, PhD, MPA, Michigan Public Health Institute
Naima Wong Croal, PhD, MPH, National Collaborative for Health Equity
Ana Diez Roux, MD, PhD, MPH, Drexel University School of Public Health
Tyan Parker Dominguez, PhD, University of Southern California
Mary Haan, PhD, University of California, San Francisco
Erin Hagan, PhD, MBA, Evidence for Action
Robert Hahn, PhD, MPH, Centers for Disease Control and Prevention

Suggested Citation

Content from the publication may be reproduced without permission provided the following citation is referenced:
Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What Is Health Equity? And What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

Introduction

Health equity is a cornerstone of the Robert Wood Johnson Foundation's (RWJF) Culture of Health Action Framework, which aims to achieve a society in which everyone has an equal opportunity to live the healthiest life possible.[1] Equity surrounds and underpins all of the Culture of Health Action Areas, as depicted in the diagram on this page. A recent report *(The Road to Achieving Equity)* commissioned by RWJF concluded, however, that although the term health equity is now used widely, a common understanding of what it means is lacking.

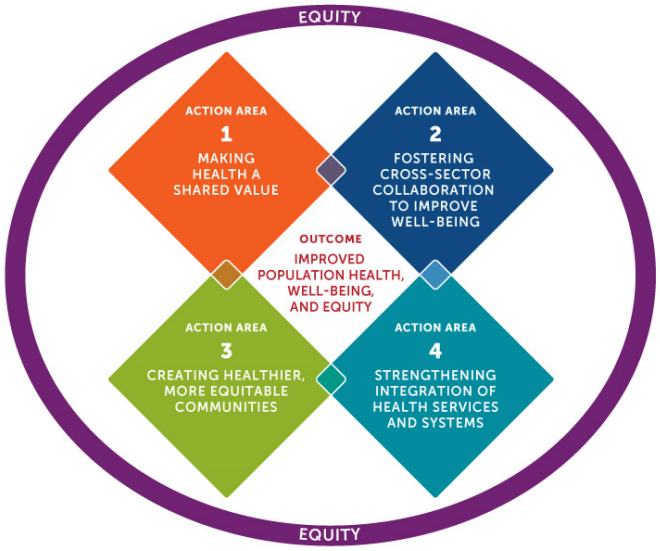
The purpose of this report is to stimulate discussion and promote greater consensus about the meaning of health equity and the implications for action within the Culture of Health Action Framework. The goal is not for everyone to use the same words to define health equity, but to identify crucial elements to guide effective action.

This report is the first in a series examining important issues faced in advancing health equity. Throughout this report, the term "health" refers to health status itself, distinguished from health care, which is only one of many important influences on health. The concepts presented here are based on widely recognized ethical and human rights principles and are supported by knowledge from health sciences.

Definitions can matter. While differences between some definitions may represent stylistic preferences, others can reflect deep divides in values and beliefs that can be used to justify and promote very different policies and practices. Clarity is particularly important in the case of health equity because pursuing equity often involves a long uphill struggle that must strategically engage diverse stakeholders, each with their own agenda. Under those circumstances, if we are unclear about where we are going and why, we can more easily be detoured from a path toward greater equity; our efforts and resources can be co-opted, and we can become lost along the way.

Contents

Culture of Health Action Framework



What Is Health Equity? A Definition

For general purposes, health equity can be defined as follows:

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

The following should be added when the definition is used to guide measurement; without measurement, there is no accountability:

For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.[2,3,4,5]

Many of the concepts in the definition are complex. A later section on "Terms That Often Arise in Discussions of Health Equity" may be useful to consult while reading this and subsequent sections.

Defining Health Equity for Different Audiences

A 30-second definition for general audiences: Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

A 15-second definition for technical audiences: For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.

A 20-second definition for audiences who ask about the difference between equity and disparities: Health equity is the ethical and human rights principle that motivates us to eliminate health disparities; health disparities—worse health in excluded or marginalized groups—are how we measure progress toward health equity.

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

Explaining Key Concepts in the Definition

- **Health** means physical and mental health status and well-being, distinguished from *health care*.

- **Opportunities to be healthy** depend on the living and working conditions and other resources that enable people to be as healthy as possible.[6,7,8,9,10,11,12,13] A population's opportunities to be healthy are measured by assessing the determinants of health—e.g., income or wealth,[14] education,[15,16] neighborhood characteristics,[17,18] or social inclusion[19]—that people experience across their lives. Individual responsibility is important, but too many people lack access to the conditions and resources that are needed to be healthier and to have healthy choices.[6,7,10,11]

- **A fair and just opportunity** to be healthy means that everyone has the opportunity to be as healthy as possible.[20] Being as healthy as possible refers to the highest level of health that reasonably could be within an individual's reach[20,21,5] if society makes adequate efforts to provide opportunities.

- **Achieving health equity requires actions to increase opportunities to be as healthy as possible. That requires improving access to the conditions and resources that strongly influence health**—including good jobs with fair pay,[22] high-quality education,[15,16] safe housing,[23] good physical and social environments,[17,24] and high-quality health care—***for those who lack access and have worse health.***[25,26] While this should ultimately improve health and well-being for everyone,[27] the focus of action for equity is with those groups who have been excluded or marginalized.[26] A wide array of actions can be used to advance health equity.[28,29] (See later sections on Examples of Advancing Health Equity and Resources.)

- Health equity and health disparities are intimately related to each other. **Health equity is the ethical and human rights principle that motivates us to eliminate health disparities,** which are differences in health or its key determinants (such as education, safe housing, and freedom from discrimination) that adversely affect marginalized or excluded groups. **Disparities in health and in the key determinants of health are the metric for assessing progress toward health equity.**

- **Health equity can be viewed both as a *process***[30] (the process of reducing disparities in health and its determinants) **and as an *outcome*** (the ultimate goal: the elimination of social disparities in health and its determinants).

- **Progress toward health equity is assessed by measuring how these disparities change over time,** in absolute and relative terms.[31,32,33] The gaps are closed by making special efforts to improve the health of excluded or marginalized groups, not by worsening the health of those who are better off.[34]

Criteria for Defining Health Equity

A definition of health equity should:

- Reflect a commitment to fair and just practices across all sectors of society
- Be sufficiently unambiguous that it can guide policy priorities
- Be actionable
- Be conceptually and technically sound, and consistent with current scientific knowledge
- Be possible to operationalize for the purpose of measurement, which is essential for accountability
- Be respectful of the groups of particular concern, not only defining the challenges they face but also affirming their strengths
- Resonate with widely held values, in order to garner and sustain broad support
- Be clear, intuitive, and compelling without sacrificing the other criteria, in order to create and sustain political will

- **Excluded or marginalized groups** are those who have often suffered discrimination or been excluded or marginalized from society and the health-promoting resources it has to offer. They have been pushed to society's margins, with inadequate access to key opportunities.[35,6] They are economically and/or socially disadvantaged.[36] Examples of historically excluded/marginalized or disadvantaged groups include—but are not limited to—people of color;[19] people living in poverty, particularly across generations;[37,38,39] religious minorities; people with physical or mental disabilities;[40,41] LGBTQ persons;[42,43] and women.[44]

  - This list includes many groups and people. To be effective, an organization may choose to focus on selected disadvantaged groups. The depth and extent (multiple versus single disadvantages),[45,46,20,37] of disadvantage faced by a group, as well as judgment about where maximal impact could be achieved, are legitimate considerations in choosing where to focus.[25,26, 20]

  - Excluded or marginalized groups must be part of planning and implementing the actions to achieve greater health equity.

  - 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.

- **Social exclusion, marginalization, discrimination, and disadvantage can be measured,** for example, by indicators of wealth (such as income or accumulated financial assets),[47,14,48] influence,[6,49] and prestige or social acceptance[50] (for example, educational attainment and representation in high executive, political, and professional positions). They also can be measured by well-documented historical evidence of 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 criminal justice).

- **A commitment to health equity requires constant monitoring** not only of overall (average) levels of health and the resources needed for health in a whole population, but also **routinely comparing how more and less advantaged groups within that population are faring** on those indicators. Average/overall levels of health are important but they can hide large disparities among subgroups within a population.

  - It is important to measure the gaps in health and in opportunities for optimal health, not only to document progress but also to motivate action and indicate the kinds of actions needed to achieve greater equity.

- **Discrimination is not necessarily conscious, intentional or personal; often it is built into institutional policies and practices,** for example, policing and sentencing practices, bank lending procedures, and school funding that depends

Health equity and health disparities are intimately related to each other. Health equity is the ethical and human rights principle that motivates us to eliminate health disparities, which are differences in health or its key determinants (such as education, safe housing, and freedom from discrimination) that adversely affect marginalized or excluded groups. Disparities in health and in the key determinants of health are the metric for assessing progress toward health equity.

heavily on local property taxes. These can have inequitable effects whether or not any individual now consciously intends to discriminate. This is called *structural* or *institutional* discrimination.[51]

- Racial residential segregation is an example. Racial segregation is the product of deliberate discriminatory policies enacted in the past. Even though it is no longer legal to discriminate in housing, many people of color continue to be tracked into neighborhoods with limited opportunities for health based on poor quality schools, housing, and services in general; poor employment prospects; and exposure to physical and social health hazards, including social norms and role models that can kill hope. These places lack the assets required for optimal health.[19]

- Voter registration requirements used in some states, such as showing a birth certificate, may discriminate against immigrants, who are less likely to have the necessary documentation despite meeting federal voter qualifications.

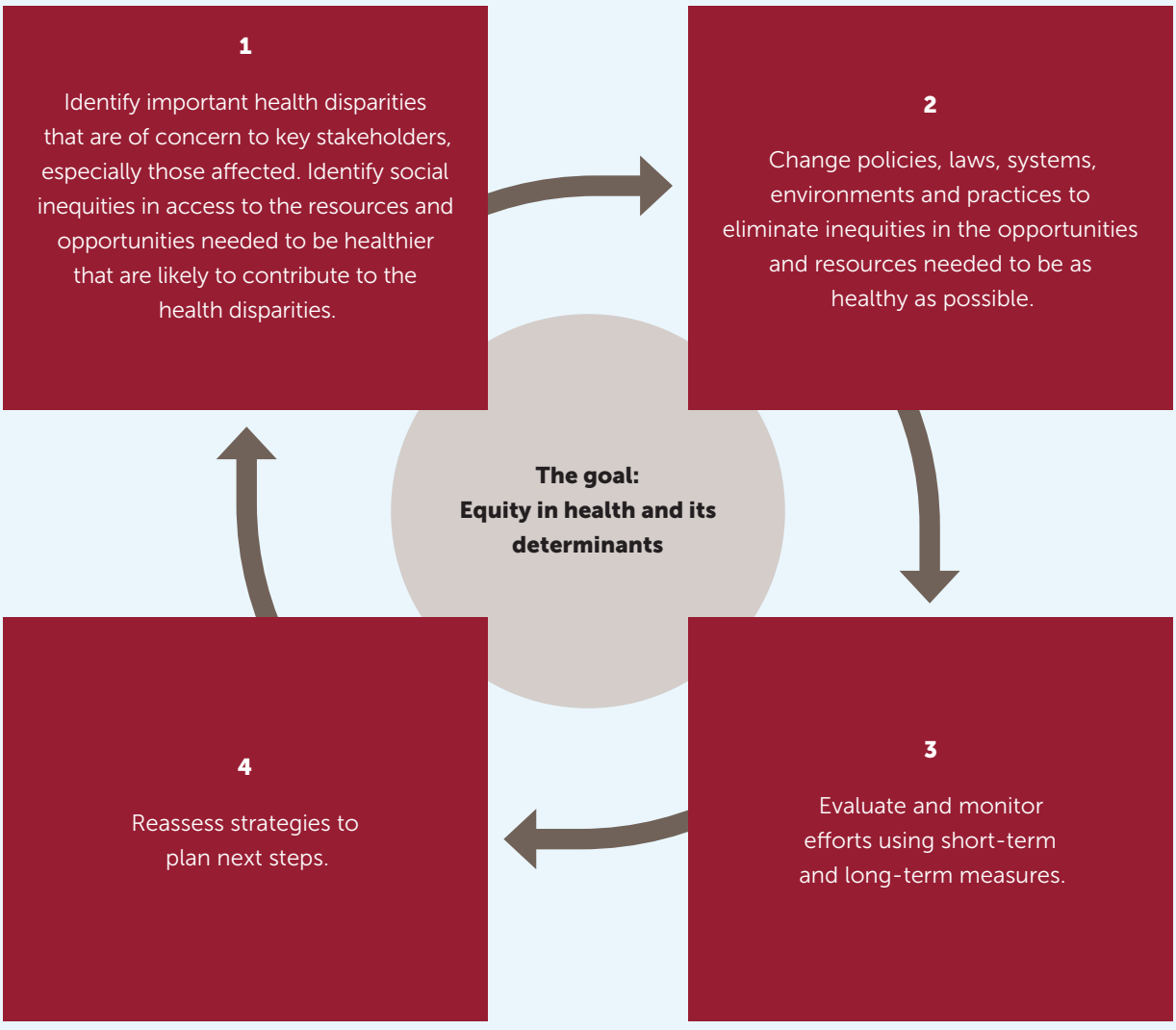
- Non-violent, first-time criminal offenses may qualify for "diversion," resulting in not going to jail and having the offense expunged from records, but only if the offender pays substantial fees. This means that people with low incomes are far more likely to serve jail time and have criminal records than more affluent people who have committed similar or worse offenses.

- Evidence has revealed that unconscious bias in interpersonal interactions is strong, widespread and deeply rooted, and could potentially take a heavy toll on health, considering current knowledge of physiological mechanisms involved in responding to stress, particularly chronic stress.[35]

Measuring the gaps in health and in opportunities for optimal health is important not only to document progress but also to motivate action and indicate the kinds of actions needed to achieve greater equity.

Key Steps to Advancing Health Equity

A strategy to achieve greater health equity may be most effective when it includes steps moving systematically from identifying health disparities to action to achieve greater health equity. *(The steps may not always occur in the order depicted below.)*



Explaining the Key Steps to Advancing Health Equity

1. **Identify important disparities in health (including disparities known to be inequities and disparities whose causes are unknown or contested) that are of concern to key stakeholders, especially those affected. Identify social inequities in access to the resources and opportunities needed to be healthier that are likely to contribute to the health disparities.**

   - The causes of some important health disparities—for example, disparities in premature birth—may not be known, making some reluctant to call them inequities. These important disparities should nevertheless be addressed in a health equity agenda because they put 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 to be healthier, they can be referred to as health inequities. *(See further discussion in section on Terms.)*

   - For those working in the health sector, the observable problem motivating action generally will be evidence of significant disparities in health—that is, health differences on which excluded or marginalized groups have worse health than socially better-off groups.

   - If we look beneath the surface, however, and examine the results of more than a century of research, we realize that those disparities in health generally are tenaciously rooted in profound inequities in the opportunities and resources that are needed to be healthier. These opportunities and resources include, for example, employment at a fair wage in health-promoting conditions; good education from preschool on; safe and affordable housing; safe and clean environments; and good medical care. Social inequities produce health inequities, which cannot be addressed without addressing their root causes.[52,6]

2. **Change and implement policies, laws, systems, environments, and practices to reduce inequities in access to the opportunities and resources needed to be as healthy as possible.**

   - If we are serious about eliminating unfair, preventable differences in health outcomes, we must eliminate the unfair social conditions that give rise to them. This will require meaningful changes not only in programs and individuals' attitudes and practices, but in policies, laws, systems, and institutional practices that keep social inequities in place, leading to health inequities.

3. Evaluate and monitor efforts using short-, intermediate-, and long-term measures.

- The ultimate goal is to eliminate disparities in health and its determinants while improving health for everyone. Only by reducing economic and other social inequities in the conditions needed for health can we succeed in reducing inequities in health in deep and lasting ways. That is not easy. It may take decades or generations to achieve reductions in some health disparities, yet most funders and the public want to see measurable gains from investments of resources within three to five years or less. That is why it is crucial to identify short- and intermediate-term outcome indicators that could be improved within the timeframe for a given initiative. The short- and intermediate-term indicators should be shown by previous research to be linked to health—that is, to be on pathways toward better health, particularly for socially disadvantaged populations. Not all indicators will be feasible to measure in all settings.

- The chosen indicators must be measured among the socially (including economically) disadvantaged groups and compared with the corresponding indicators among those who are better off. Gaps should be assessed in measures that are both absolute (e.g., differences between groups in the percentage of infants who survive until their first birthday) and relative (e.g., infants in Group X are twice as likely as infants in Group Y to die in their first year of life). Disadvantaged groups are sometimes compared with the whole population (the population average) rather than with more advantaged groups. Comparing the disadvantaged with the general population is not acceptable, however, unless information on advantaged groups is unavailable. When the disadvantaged groups represent a sizable proportion 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.

4. Reassess strategies to plan next steps.

- A critical reassessment should be made of strategies in light of both process and outcome measures. Achieving equity is not a finite project that will be implemented and completed in a predictable period of time. It requires a constant process and ongoing cycle of improvement that actively engages those most affected in the identification, design, implementation, and evaluation of promising solutions. Regular reassessments should be part of these efforts, which may involve repeating the whole cycle or proceeding to any of the steps.

Guiding Principles

The following principles are fundamental to guide action to achieve health equity:

1. Achieving health equity requires societal action to remove obstacles to health and increase opportunities to be healthier for everyone, focusing particularly on those who face the greatest social obstacles and have worse health. It also requires engaging excluded or marginalized groups in identifying and addressing their health equity goals.

2. Policy, systems, and environmental improvements have great potential to prevent and reduce health inequities, but only if they explicitly focus on health equity and are well designed and implemented. Otherwise, such interventions may inadvertently widen health inequities. For example, public health anti-smoking campaigns inadvertently led to widened socioeconomic disparities in smoking because the untargeted messages were picked up and applied more rapidly by more educated, affluent people.

3. Opportunities to be healthy depend on the living and working conditions and other resources that enable people to be as healthy as possible. A population's opportunities to be as healthy as possible are measured by assessing the determinants of health—social and medical—that people experience across their lives.

4. Pursuing health equity entails striving to improve everyone's health while focusing particularly on those with worse health and fewer resources to improve their health. Equity is not the same as equality; those with the greatest needs and least resources require more, not equal, effort and resources to equalize opportunities.

5. Approaches to achieving health equity should build on and optimize the existing strengths and assets of excluded or marginalized groups.

6. Piecemeal approaches targeting one factor at a time are rarely successful in a sustained way. Approaches are needed that both increase opportunities and reduce obstacles. Successful approaches should address multiple factors, including improving socioeconomic resources and building community capacity to address obstacles to health equity.

7. Achieving health equity requires identifying and addressing not only overt discrimination but also unconscious and implicit bias and the discriminatory effects—intended and unintended—of structures and policies created by historical injustices, even when conscious intent to discriminate is no longer clearly present.

8. Measurement is not a luxury; it is crucial to document inequities and disparities and to motivate and inform efforts to eliminate them. Without measurement, there is no accountability for the effects of policies or programs.

9. The pursuit of equity is never finished. It requires constant, systematic, and devoted effort. A sustained commitment to improving health for all—and particularly for those most in need—must be a deeply held value throughout society.

Terms that Often Arise in Discussions of Health Equity

Discrimination

- Discrimination is a broad term that includes but is not limited to racism (see below). Prejudicial treatment has been based on a wide range of characteristics, including not only racial or ethnic group but also low income, disability, religion, LGBTQ status, gender, and other characteristics that have been associated with social exclusion or marginalization.

Ethnicity or ethnic group

- Ethnicity or ethnic group refers to belonging to a group of people who share a common culture (beliefs, values, or practices such as modes of dress, diet, or language). This usually involves sharing common ancestry in a particular region of the world. Some people use the term ethnicity or ethnic group to encompass both racial and ethnic group, based on recognition that race is fundamentally a social rather than biological construct. (See "Race or Racial Group" below.)

Health

- In this report, health refers to health status, that is, physical and mental health and well-being, distinguished from health care.

Health disparity and health inequality

- Health disparity and health inequality are synonyms; disparity is used more often in the United States, while other countries use inequality. For over 25 years in the fields of public health and medicine, they have referred to plausibly avoidable, systematic health differences adversely affecting economically or socially 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 (including economically) disadvantaged groups. Health disparities/inequalities are ethically concerning even if we are not certain of the causes because they affect groups already at underlying economic or social disadvantage, and further disadvantage them with respect to their health; this seems especially unfair since good health is needed to escape social disadvantage.

- Health disparities/inequalities are how we measure progress toward health equity. Health equity is the underlying principle that motivates action to eliminate health disparities/inequalities.

- It may seem reasonable to use disparities and inequalities to refer only to descriptive or mathematical differences, without any normative judgment. However, social movements in the United States and other countries for over 25 years have treated these terms as indicating differences that are concerning from an ethical and human rights perspective. In the United States, health disparities have often referred

to racial or ethnic differences in health, while in Europe and other regions, health inequalities have generally referred to socioeconomic differences. Legislation and policies have been written based on this understanding of disparities/inequalities. Re-defining these terms is tempting because it might simplify some discussions, but it could have unintended consequences that could unwittingly threaten the achievements and momentum of initiatives gained over almost three decades.

- Health disparity and health inequality are broader terms that include health inequity and signify more than just difference or variation; they signify a morally suspect health difference. These terms are very useful in that they signify reason for concern (an avoidable health difference that puts a socially disadvantaged group at further disadvantage on health) and they are measurable, but do not necessarily imply definitive knowledge of the causes.

Health equity

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

- For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its 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 (see above) that is not only of concern for being potentially unfair, but which is believed to reflect injustice. There will be different views of what constitutes adequate evidence. Some will argue that to call a disparity an inequity, it is essential to 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, because it puts an already socially disadvantaged group at further disadvantage on health, and good health is 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, needlessly exposing health equity efforts to potentially harmful challenges. It should be used thoughtfully.

Opportunity

- Opportunity means access to goods, services, and the benefits of participating in society. There are many different kinds of obstacles to access in addition to financial barriers and geographic distance; obstacles can include past discrimination, fear, mistrust, and lack of awareness, as well as transportation difficulties and family caregiving responsibilities. To measure not only potential access but the real opportunities that different social groups have, that is, their realized access,[53] we need to assess 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 places often correspond to very different opportunities to be as healthy as possible.

Race or racial group

- Race or racial group generally refers to belonging 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 very unlikely to be associated with fundamental, widespread, underlying differences in biology. This does not rule out the possibility of there being some highly specific genetic differences associated with ancestry that could affect susceptibility to particular diseases (for example, sickle cell disease, other hemoglobinopathies, Tay-Sachs disease) or treatments. These highly specific differences, however, are not fundamental and do not define biologically distinct racial groups; they generally occur in multiple racial groups, only at different frequencies. The primary drivers of health inequities are inequitable differences in opportunities to be healthier. Scientists, including geneticists, concur that race is primarily a social—not a biological—concept.[54,55,56]

Racism

- Racism refers to prejudicial treatment based on racial or ethnic group and the societal institutions or structures that perpetuate this unfair treatment. Racism can be expressed on interpersonal, structural/institutional, or internalized levels.[51]

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

- Internalized racism occurs when victims of racism internalize the 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.

- Structural or institutional 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 tracked people of color into residential areas where opportunities to be healthier and to escape from poverty are limited.

Social

- Unless specified otherwise, the term "social" encompasses (but is not limited to) economic issues. In this document, at times "economic" is specified separately in addition to "social," for clarity.

Social determinants of health

- The social determinants of health are nonmedical factors such as employment, income, housing, transportation, child care, education, discrimination, and the quality of the places where people live, work, learn, and play, which influence health. They are "social" in the sense that they are shaped by social policies. The World Health Organization Commission on the Social Determinants of Health[6] chose to include medical care among the social determinants, presumably because the provision of medical care is the responsibility of social policy. Generally, however, and in this report, the term refers to determinants of health outside of medical care.

Social exclusion or marginalization

- Social exclusion or marginalization refers to barring or deterring particular social groups—based, for example, on skin color, national origin, religion, wealth, disability, sexual orientation, gender identity, or gender—from full participation in society and from sharing the benefits of participation. Socially excluded or marginalized groups have less power and prestige and generally less wealth. Because of that, the places where they are able to live often have health-damaging and/or non-health-promoting conditions, such as pollution, lack of access to jobs and services, and inadequate schools.

Structural racism

- Defined under "Racism" above.

Examples of Advancing Health Equity

The Civil Rights Act of 1964: a policy intervention linked with greater equity in infant survival. The Civil Rights Act of 1964 prohibited hospitals from denying care to people based on skin color. A team of economists observed a marked narrowing of the Black-White gap in infant mortality in the rural South and Mississippi, beginning in the mid-1960s and continuing into the early 1970s. They have made a compelling case for that improvement in health equity being attributable in large part to the desegregation of hospitals, especially in the rural South, and other elements of the Civil Rights Act.[57]

Advancing health equity through greater economic equity: New Orleans' Economic Opportunity Strategy, launched in 2014, aimed to ensure that everyone had the opportunity to benefit as the city grew. Economic assets are critical social determinants of individual and population health. Focusing on the hardest to employ, the Strategy included partnerships between social services, training and community advocates and collaboration with community anchor institutions to help disadvantaged individuals and businesses. In less than three years, the African American male under-employment rate dropped from 52 percent to 44 percent, with 1,000 newly employed in New Orleans. *http://nola.gov/mayor/press-releases/2017/20170126-pr-mayor-landrieu-honors-businesses-for-c/* (Accessed January 9, 2017)

Advancing health equity through greater equity in opportunities for physical activity and play: California's Statewide Park Development and Community Revitalization Act of 2008 made available $400 million for new parks in communities identified as "critically underserved" and where community-based groups would be actively involved in planning and would receive technical assistance if needed. These were neighborhoods where families had no backyards and children had no safe places to play. Green space may be important to health by providing opportunities for physical activity and places for people to gather. Families, youth and seniors participated in deciding what they wanted these spaces to be, and more than 100 new parks are now under development. *www.parks.ca.gov/?Page_id=26025* (Accessed January 10, 2017)

Achieving health equity by focusing early in life: The Children's Services Council (CSC) of Palm Beach, Florida, (now in nine Florida counties), was funded by an ordinance approved by local voters. CSC invests property taxes to improve birth outcomes, reduce abuse and neglect, improve readiness for kindergarten and increase access to summer and afterschool programs. Universal screening identifies needs for a range of more than 50 services and programs, provided by a network of nonprofit groups and agencies. Results attributed to participation in CSC programs include: reduced low birthweight rates; a 20-year low in the county's teen birth rate; near-zero rates of child abuse or neglect; and higher rates of kindergarten readiness (which shapes educational attainment and therefore health in adulthood). *www.cscpbc.org/cscfacts* (Accessed January 10, 2017)

Achieving greater health equity by transforming a community in many domains: Villages of East Lake, Atlanta, Georgia, transformed a community that had experienced a cycle of economic neglect, extreme poverty, violent crime, high unemployment and low educational achievement; all of these factors are tightly linked with ill health. A partnership led by a local real estate developer included local business leaders, East Lake residents, the Atlanta Housing Authority, Atlanta Public Schools, and the YMCA, among others. They envisioned a comprehensive transformation that would provide high-quality mixed-income housing, a "cradle-to-college" educational pipeline, and wellness resources. Results associated with the transformation include: lower rates of childhood asthma and obesity; a 90 percent reduction in violent crime; a reduction from 59 percent to 5 percent of subsidized housing residents on welfare; 100 percent of nondisabled, nonelderly residents of subsidized housing working or in job training (up from 13 percent employment); and 98 percent of charter school students in grades 3 through 8 meeting or exceeding state standards in core subjects. East Lake's success and its comprehensive, inclusive partnership model led to the creation of Purpose Built Communities, a nonprofit that works to replicate successful elements of this model in other low-income communities across the country. *http://purposebuiltcommunities.org/* (Accessed January 11, 2017)

Advancing health equity by addressing causes of homelessness: Homestretch, Falls Church, Virginia, focuses on building self-sufficiency among homeless families by systematically addressing the multiple obstacles they encounter. Homestretch tackles multiple root causes of homelessness such as domestic violence, sudden loss of a loved one, unexpected medical calamity, human trafficking, natural disaster, and political unrest in a client's home country; all of these limit access to critical assets and opportunities required for security, stability, safety, and health. All clients receive safe housing, a case manager, and financial counseling. A comprehensive set of services is provided to adult, teen and child family members. Serving more than 1,000 families since 1990, results associated with Homestretch include: 147.5 percent average increase in income for graduating families; 92 percent of graduates remaining employed a year after graduation; $681,352 in debts repaid over the last six years; and 62 percent of adult clients enrolled in college or vocational training. All of these influence health. *http://homestretchva.org/about-us/* (Accessed January 9, 2017)

Preventing youth violence with a multi-pronged, supportive strategy: Blueprint for Action, Minneapolis, Minnesota, was launched in 2008 to counter youth violence. Homicide was the leading cause of death among 15- to 24-year-olds, with repercussions across neighborhoods such as business disinvestment, declines in property values, and a sense of hopelessness. The Blueprint strategy is multipronged, multiyear and partnership-based to address youth violence in public health terms—an approach that includes participation, collaboration, measurement, and communication. Through resource allocation and systems changes, eligible youth in targeted neighborhoods receive a variety of prevention services including mentoring, employment and recreational opportunities. Support is also available to families and parents. By 2011, results attributed to this effort included a: 59 percent reduction in juvenile violent crime; 66 percent reduction in incidents involving guns and

What are essential features of an effort to achieve health equity?

1. It addresses the underlying social inequities in opportunities and resources needed to be healthy—such as good jobs with fair pay, quality education and housing, safe environments and medical care—that contribute to worse health in excluded or marginalized groups of people. This will almost always require cross-sector efforts.

2. Ultimately it should benefit everyone's well-being, but it is systematically targeted to produce the greatest health benefit for socially disadvantaged groups, who are worse off both on health and on opportunities to be as healthy as possible.

3. It evaluates its efforts not by measuring average impact or health in a whole population, but by measuring both: (a) change in the selected outcomes among disadvantaged groups; and (b) the size of gaps—in absolute and relative terms—between disadvantaged and advantaged groups.

juveniles; 39 percent reduction in firearm-related injuries in youth and young adults; 57 percent increase in youth in city jobs programs; and a significant drop in the teen pregnancy rate. Blueprint for Action views their "upstream" work as a long-term effort, continuing to coordinate across programs and mobilizing community support. *www.minneapolismn.gov/health/youth/yvp/blueprint* (Accessed January 9, 2017)

Advancing health equity by interrupting the school-to-prison pipeline: Success Courts in Kansas City, Missouri, schools are working to change the culture to counter the school-to-prison pipeline and its lifelong effects on opportunities for healthy, meaningful, and productive lives. Rather than automatic suspension, students who violate rules attend a "Success Court" before school. There, a Circuit Court judge serves as a mentor, helping to identify students' needs which, when addressed, will help avoid school infractions and absences. Truancy officers have been renamed "attendance ambassadors," reframing the culture from penalties to supports for high-risk students. Two years into this "culture change," attendance is up, as are grades; educational attainment is a powerful influence on health later in life. *www.kcpublicschools.org/site/default.aspx?PageID=1* (Accessed January 9, 2017)

Greater equity in maternal health through a policy intervention: Expansion of the Earned Income Tax Credit (EITC). The Earned Income Tax Credit gives tax refunds to low-income working people. Expansions of EITC in 1993 gave higher benefits to families with two or more children. Researchers with the National Bureau of Economics Research used national data to gauge the impact of the EITC expansion on mothers with two children vs. those with one child. They concluded that the EITC expansions contributed to improvements in maternal health overall, mental health, and biological markers of risk for chronic disease.[58] *www.nber.org/papers/w16296* (Accessed January 11, 2017)

Resources for Achieving Health Equity

The following organizations—and many others—have produced practical tools and resources designed to help practitioners and decision-makers design, implement, and evaluate initiatives to achieve greater health equity. (Relevant resources can generally be found by searching for an organization's name and adding "equity" as a search term.)

- **The Association of State and Territorial Health Officers (ASTHO)** provides tools to help state-level leaders formulate and implement promising strategies. *www.astho.org/Programs/Health-Equity/* (Accessed January 4, 2017)

- **Build Healthy Places Network** supports "collaboration across the health and community development sectors, together working to improve low-income communities and the lives of the people living in them" with a focus on health equity. *www.buildhealthyplaces.org/resources/* (Accessed January 4, 2017)

- **CDC's National Center for Chronic Disease Prevention & Health Promotion** created A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease, which "provides lessons learned and innovative ideas on how to maximize the effects of policy, systems and environmental improvement strategies—all with the goal of reducing health disparities and advancing health equity." *www.cdc.gov/NCCDPHP/dch/pdf/HealthEquityGuide.pdf* (Accessed January 9, 2017)

- **The Center for Global Policy Solutions** has launched its Allies for Reaching Community Health Equity initiative to "advance equity-centered strategies that strengthen families and communities." The website has a range of tools and resources. *http://healthequity.globalpolicysolutions.org/* (Accessed February 24, 2017)

- **The National Association of County & City Health Officers (NACCHO)** created the Health Equity and Social Justice Toolkit for local health departments. *http://toolbox.naccho.org/pages/index.html* (Accessed January 9, 2017)

- **National Collaborative for Health Equity (CHE)** is a national initiative designed to empower leaders and communities to identify and address social, economic, and environmental conditions that shape health and life opportunities. *www.nationalcollaborative.org/* (Accessed January 12, 2017)

- **National Partnership for Action to End Health Disparities** provides a Compendium of Publicly Available Datasets and Other Data-Related Resources. *https://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=46* (Accessed January 12, 2017)

- **PolicyLink** offers an array of equity-focused tools to guide measurement and policy development strategies, *www.policylink.org/equity-tools,* including the National Equity Atlas, a "first-of-its-kind data and policy tool for the community leaders and policymakers who are working to build a new economy that is equitable, resilient, and prosperous." *http://nationalequityatlas.org/* (both sites accessed January 4, 2017)

- **Prevention Institute** provides health equity tools for practitioners, advocates, community groups, and policymakers. *www.preventioninstitute.org/tools* (Accessed January 4, 2017)

- **RacialEquityTools.org,** offers a "monthly compendium of resources from a wide array of sources… for people who want to increase their own understanding and to help those working toward justice at every level—in systems, organizations, communities and the culture at large." *www.racialequitytools.org/home* (Accessed January 4, 2017)

References

1. Plough AL. Measuring What Matters: Introducing a New Action Framework. Robert Wood Johnson Foundation 2015. *www.rwjf.org/en/culture-of-health/2015/11/measuring_what_matte.html* (Accessed February 2017).
2. U.S. Dept. of Health & Human Services, Healthy People 2020. Disparities. *www.healthypeople.gov/2020/about/foundation-health-measures/Disparities* (Accessed January, 2017).
3. Braveman P, Kumanyika S, Fielding J. LaVeist T, Borrell L, Manderscheid R, Troutman A. Health disparities and health equity: The issue is justice. American Journal of Public Health, December 2011;101(S1): S149-S155.
4. U.S. Department of Health and Human Services, Office of Minority Health, National Partnership for Action to End Health Disparities. Toolkit for Community Action. *https://minorityhealth.hhs.gov/npa/* (Accessed February, 2017).
5. Braveman P. Health disparities and health equity: concepts and measurement. Annual Review of Public Health 2006;27:167-194.
6. World Health Organization (WHO) Commission on the Social Determinants of Health Final Report. Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. 2008. *www.who.int/social_determinants/thecommission/finalreport/* (Accessed January 2017).
7. Berkman LF, Kawachi I, Glymour M. Social Epidemiology, Second Edition. New York: Oxford University Press, 2014. 640 pages.
8. Marmot, M. The health gap: the challenge of an unequal world. The Lancet 2015; 386(1011):2442-44.
9. Marmot, M., Friel, S., Bell, R., et al. Closing the gap in a generation: health equity through action on the social determinants of health. The Lancet 2008; 372(9650), 1661-1669.
10. Braveman P, Egerter S, Williams D. The social determinants of health: Coming of age. Annual Review of Public Health 2011;32:381-98.
11. Adler N & Stewart J, eds. The Biology of Disadvantage: Socioeconomic Status and Health. Annals of the New York Academy of Sciences 2010. 1186:1-275.
12. Berkman LF, Kawachi I. Social Epidemiology, First Edition. New York: Oxford University Press, 2000. 391 pages.
13. Daniels N, Kennedy BP, Kawachi I, Why justice is good for our health: the social determinants of health inequalities. Daedalus 1999;128(4):215-251.
14. Schroeder SL, Isaacs SA. Class – the ignored determinant of health. New England Journal of Medicine 2004; 351:1137-1142.
15. Cutler, D. M., & Lleras-Muney, A. Education and health: evaluating theories and evidence. National Bureau of Economic Research 2006; No. w12352. *www.nber.org/papers/w12352* (Accessed January 2017).
16. Egerter S, Braveman P, Sadegh-Nobari T, Grossman-Kahn R, Dekker M. Education Matters for Health. Robert Wood Johnson Foundation, April 2011, 17 pages. *www.rwjf.org/en/library/research/2011/05/education-matters-for-health.html* (Accessed January 2017).
17. Diez Roux AV, Mair C. Neighborhoods and health. Annals of the New York Academy of Sciences 2010;1186:125-45.
18. Acevedo-Garcia D, Osypuk TL, McArdle N, Williams DR. Toward a policy-relevant analysis of geographic and racial/ethnic disparities in child health. Health Affairs 2008; 27: 321-333.
19. Williams DR, Mohammed SA, Racism and health I: Pathways and scientific evidence. American Behavioral Scientist 2013; 57:1152.
20. Whitehead M, The concepts and principles of equity and health. International Journal of Health Services 1992;22:429-445.
21. Braveman P, Gruskin S. Defining equity in health. Journal of Epidemiology and Community Health 2003;57:254-258.
22. Burgard, S. A., & Lin, K. Y. Bad jobs, bad health? How work and working conditions contribute to health disparities. American Behavioral Scientist 2013; 57:1105-1127.
23. Edmonds A, Braveman P, Arkin E, Jutte D, Making the case for linking community development and health. Robert Wood Johnson Foundation, 2015, 60 pages. *www.buildhealthyplaces.org/content/uploads/2015/10/making_the_case_090115.pdf* (Accessed December 2016).
24. Gordon-Larsen P, Nelson MC, Page P, Popkin BM. Inequality in the built environment underlies key health disparities in physical activity and obesity. Pediatrics 2006;117:417-24.
25. Daniels N, Kennedy BP, Kawachi I. Justice is good for our health. Boston Review, Feb. 1, 2000. *bostonreview.net/forum/norman-daniels-bruce-kennedy-ichiro Kawachi-justice-good-our-health* (Accessed January 2017).
26. Rawls, J. A theory of justice. Cambridge, MA: Belknap/Harvard University Press, 1971. 560 pages.
27. Pickett KE, Wilkinson RG. Income inequality and health: a causal review. Social Science & Medicine 2015 Mar;128:316-26.
28. Whitehead, M. A typology of actions to tackle social inequalities in health. Journal of Epidemiology and Community Health 2007; 61(6), 473-478.
29. Centers for Disease Control and Prevention (CDC), Division of Community Health. A practitioner's guide for advancing health equity: Community strategies for preventing chronic disease. U.S. Department of Health and Human Services 2013. *www.cdc.gov/NCCDPHP/dch/pdf/HealthEquityGuide.pdf* (Accessed 12/19/16).
30. Jones, C.P. Ninth Annual Clyburn Health Disparities Lecture, University of South Carolina, April 1, 2016. *www.sc.edu/study/colleges_schools/public_health/about/news/2016/clyburn2016_recap.php* (Accessed December 2016).
31. Harper S, Lynch J, Meersman SC, Breen N, Davis WW, & Reichman ME 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 2008; 167(8), 889-899.
32. Hosseinpoor AR, Bergen N, Koller T, et al., Equity-oriented monitoring in the context of universal health coverage. PLOS Medicine September 22, 2014. *www.Journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001727* (Accessed February 2017).
33. Mackenbach JP, Kunst AE. Measuring the magnitude of socio-economic inequalities in health: an overview of available measures illustrated with two examples from Europe. Social Science & Medicine 1997;44:757-71.
34. Whitehead M., Dahlgren G. Concepts and principles for tackling social inequities in health: Levelling up Part 1. WHO Collaborating Center, U. of Liverpool 2006. *www.apps.who.int/iris/bitstream/10665/107790/1/E89383.pdf* (Accessed February 2017).
35. Williams, DR, Mohammed SA. Discrimination and racial disparities in health: Evidence and needed research. Journal of Behavioral Medicine 2009, 32: 20-47.
36. United Nations International Covenant on Economic, Social, and Cultural Rights. *www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx* (Accessed February 2017).
37. Reeves R, Rodrigue E, Kneebone E. Five evils: Multidimensional poverty and race in America. The Brookings Institution, April 2016. *www.brookings.edu/wp-content/uploads/2016/06/ReevesKneeboneRodrigue_MultidimensionalPoverty_FullPaper.pdf* (Accessed February 2017).
38. Wagmiller RL, Adelman RM. Childhood and intergenerational poverty: The long-term consequences of growing up poor. National Center for Children in Poverty, 2009. *https://academiccommons.colombia.edu/catalog/ac:126233* (Accessed January 2017).
39. Cheng TL, Johnson SB, Goodman E. Breaking the intergenerational cycle of disadvantage: the three generation approach. Pediatrics 2016;137:e20152467.
40. U.S. Department of Health & Human Services, Healthy People 2020. Disability and Health. *www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health* (Accessed January, 2017).
41. World Health Organization (WHO). Disabilities. *www.who.int/topics/disabilities/en/* (Accessed January 2017).
42. Meyer, IH, Northridge, ME, eds. The Health of Sexual Minorities. New York: Springer Nature 2007, 731 pages.
43. Ward BW, Dalhammer JM, Galinsky AM et al. Sexual orientation and health among U.S. adults: National Health Interview Survey, 2013. *www.cdc.gov/nchs/data/nhsr/nhsr077.pdf* (Accessed February 2017).
44. Moss NE. Gender equity and socioeconomic inequality: a framework for the patterning of women's health. Social Science & Medicine 2002;54:649-661.
45. Evans GW. The environment of childhood poverty. American Psychologist 2004;59:77-92.
46. Ferraro, KF & Kelley-Moore JA. Cumulative disadvantage and health: long-term consequences of obesity? American Sociological Review 2003; 68(5): 707-729.
47. Pollack CE, Chideya S, Cubbin C, Williams B, Dekker M, Braveman P. Should health studies measure wealth? A systematic review. American Journal of Preventive Medicine 2007;33(3):250-264.
48. Yeung WJ, Linver MR, Brooks-Gunn J, How money matters for young children's development: parental investment and family processes. Child Development 2002;73:1861-79.
49. Wallerstein, N. Powerlessness, empowerment, and health: Implications for health promotion programs. American Journal of Health Promotion 1992; 6(3), 197-205.
50. Keyes CLM. Social well-being. Social Psychology Quarterly 1998;61:121-140.
51. Jones, C.P. Levels of racism: A theoretic framework and a gardener's tale. American Journal of Public Health 2000; 90:1212-15.
52. Phelan J, Link B, Tehranifar P. Social conditions as fundamental causes of health inequalities: theory, evidence, and policy implications. Journal of Health and Social Behavior 2010; Suppl:S28-40.
53. Andersen R, Aday LA. Access to medical care in the US: realized and potential. Medical Care 1978;16(7):533-546.
54. Yudell M, Roberts D, DeSalle R, Tishkoff S. Taking race out of genetics. Science 2016; 351(6273): 564-5.
55. McCann-Mortimer P, Augustinos M, LeCouteur A. "Race" and the Human Genome Project: constructions of scientific legitimacy. Discourse & Society 2004; 15(4): 409-432.
56. Witherspoon DJ, Wooding S, Rogers AR et al., Genetic similarities within and between human populations. Genetics 2007;176 (1): 351-9.
57. Almond D, Chay K, Greenstone M. Civil rights, the War on Poverty, and Black-White Convergence in Infant Mortality in the Rural South and Mississippi. MIT Dept. of Economics Working Paper No. 07-04, 2007, 36 pages. *https://papers.ssrn.com/sol3/papers.cfm?abstract_id=961021* (Accessed February 2017).
58. Evans WN, Garthwaite CL. Giving Mom a break: the impact of higher EITC payments on maternal health. National Bureau of Economic Research 2010 *www.nber.org/papers/w16296* (Accessed January 2017).

Photos: Cover—Lynn Johnson; page 2—Matt Moyer; page 5—Tyrone Turner; page 7—Janet Jarman; page 9—Matt Moyer; page 10—Tyrone Turner; page 14—Matt Moyer; page 17—Tyrone Turner; page 19—Matt Moyer.