

What's in a Name?

Untangling Health Disparities, the Social Determinants of Health, and Health Equity

Health disparities...social determinants of health...health equity. Funders, researchers, and advocates routinely use these phrases to talk about differences in health, but what do they mean by them? This essay is intended to shed some light on the subject and in the process to help grantmakers think about their funding priorities and how best to communicate them.

When we look at the health of groups, it becomes apparent that people who belong to certain groups are more at risk for illness, disease, and death than members of other groups are. In this country, as in many, the poor and members of racial and ethnic minorities are the groups at greatest risk. These health inequalities are the frame of reference for health disparities, social determinants of health, and health equity. The terms are different ways of explaining why health inequalities exist, what should be done about them, and who should be involved (Nathanson 2010). The entry point for health disparities work is the most superficial level – which is not to underestimate the difficulty of the task. These programs typically work with individuals, hoping to alter disease and death trends. They generally do not address the larger factors that give rise to disease. At the other end of the spectrum, health equity work focuses on groups rather than individuals, and addresses conditions like poverty and discrimination that are known to be the fundamental causes of health and disease.

HEALTH DISPARITIES

The 1985 U.S Department of Health and Human Services *Report of the Secretary's Task Force on Black and Minority Health* first called widespread attention to major racial and ethnic differences in the health of Americans. The report galvanized efforts to document disparities and to explain their origins. Since the 1980s, racial and ethnic disparities in health and health care have been the primary focus of research and interventions, but some also use disparities to refer to gender differences in health or to rural-urban differences.

There is no universally accepted definition of health disparities, but it is important to understand that a difference in health does not necessarily indicate the existence of a disparity. For example, young people are healthier than the elderly, but that is not a disparity (Braveman and Gruskin 2003). Paula Braveman (2006) defines health disparities in terms of advantage, namely that disadvantaged social groups systematically experience worse health or greater health risks than more advantaged social groups.

Disparities are as disturbing a problem today as they were 25

years ago. Like racial disparities in infant mortality, many trends have shown little improvement over time. The causes of health disparities are not completely understood, but it is evident that their source lies in multiple factors that include genetics, behavior, and community factors, as well as in factors related to health care access and quality of care. Research consistently finds that race and socioeconomic status play important roles.

Efforts to reduce disparities in health status and health care typically focus on primary prevention, improvements in the delivery of health care, and use of data to track trends and outcomes. The focus of intervention is usually individuals. Examples include:

- community programs to improve the health status of at-risk populations (such as screenings and health education),
- programs to improve care in clinical settings (such as cultural competency training, workforce diversity), and
- data collection to build the evidence base.

THE SOCIAL DETERMINANTS OF HEALTH

The framework of the social determinants of health, which is closely related to the concern for health equity, developed in Europe and gained traction through the work of the World Health Organization (WHO) Commission on the Social Determinants of Health (WHO 2008). Michael Marmot, the commission chair, points to a 1985 article that opened his eyes to the “profoundly simple and simply profound” insight that the primary determinants of disease are not individual but environmental (Marmot 2001). In its 2008 final report, the WHO Commission defined the social determinants of health as the structural determinants and conditions of daily life that create health inequalities, such as the distribution of power, income, goods and services, access to health care, schools and education, as well as conditions of work, leisure, housing, and the environment. From the social determinants perspective, clinical care is a minor influence on health relative to social, economic, and individual factors.

In comparison to the narrower focus of the health disparities approach, the social determinants framework provides a more comprehensive understanding of the reasons why low-income communities and communities of color experience disproportionately higher rates of disease and death. From this perspective, what puts people at risk for or protects them against disease is the environment in which they are born, grow, live, and work. These conditions shape people’s options, choices, and behavior. Consequently, polluted environments,

inadequate housing, lack of educational and employment opportunities, and unsafe working conditions are understood to damage the physical and mental health and well-being of low-income communities and communities of color.

The strength of the social determinants approach is its comprehensiveness, but there are concerns that in the United States this approach runs the risk of glossing over the fundamental role of race and ethnicity in shaping social and economic opportunity. As Camara Jones (2009) of the Centers for Disease Control and Prevention puts it, “We need to do both: address the social determinants of health, including poverty, in order to achieve large and sustained improvements in health outcomes [and] address the social determinants of equity, including racism, in order to achieve social justice and eliminate health disparities.”

Action on the social determinants of health requires a broad grantmaking scope and a willingness to fund outside of traditional health arenas. Possible areas of action include:

- reducing the levels of poverty in the population,
- reducing intervening factors between socioeconomic status and health, and
- increasing awareness of nonhealth policies that can have decisive consequences for the health of economically vulnerable populations (GIH 2008).

HEALTH EQUITY

The push to achieve health equity is part of a global movement fueled by the WHO Social Determinants Commission. The movement is committed not just to identifying the social determinants of health that create health disparities, but also to taking action to change them. Driven by values of social justice, there is a focus on outcomes (achieving equity) rather than problems (ending disparities), a focus on population health rather than individuals, and a focus on structural and institutional change to address the conditions that produce illness and disease (DRA Project 2009).

A decade ago, the groundbreaking Institute of Medicine report *Crossing the Quality Chasm* was one of the first to link health equity and disparities, and identify health equity as one of the six aims of a quality health care system. Reflecting the broader goals of the current movement, a more recent definition states, “Health equity is achieving the highest level of health for all people. Health equity entails focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices” (Virginia Department of Health 2010).

From the health equity perspective, improving the health of minority communities is a social and moral imperative because it is socially just and will benefit society as a whole. “We must address and remove obstacles and biases based on income, race, gender and other aspects of who we are. There is ample evidence that people of color and those in low-income areas don’t have the same access to quality health care as others. It’s only sensible, fair and right that we find solutions that offer quality

care to everyone” (The Opportunity Agenda 2009).

Several health departments and government agencies are involved in the health equity movement. Often their goal is not only to change the ways public health agencies operate, but also to empower communities. Examples are the Health Equity and Social Justice initiatives of the National Association of County and City Health Officials, and the King County Equity and Social Justice Initiative in Seattle. The goal of the latter is for all King County residents to live in communities of opportunity. The initiative aspires for all communities to be equipped with the means to provide individuals with access to livable wages, affordable housing, quality education, quality health care, and safe and vibrant neighborhoods (King County 2010).

King County’s goals mirror the guidance of the WHO Commission, which recommended three actions to achieve health equity:

- Improve the circumstances in which people are born, grow, live, work, and age.
- Tackle the inequitable distribution of power, money, and resources – the structural drivers of conditions of daily life – globally, nationally, and locally.
- Measure the problem, evaluate action, and expand the knowledge base (WHO 2008; Marmot and Bell 2010).

Others recommend working on structural and institutional change in the political, economic, and social-cultural systems that are the environments and contexts of biological susceptibility and behavioral risk (APHA 2010).

It is possible to support the goals of health equity without taking on the challenge of broad social change. Programs under the rubric of health equity that focus primarily on health status and health services include efforts to:

- improve access to health care;
- increase risk reduction and disease prevention;
- increase minority participation in the health professions;
- integrate health literacy, disparities reduction, and quality improvement; and
- understand the relationship between health and other sectors, such as infrastructure and economic development.

CONCLUSION

In practice, many use the terms health disparities, social determinants of health, and health equity loosely and interchangeably. In fact, it is clear that they have different implications for the focus and scope of a foundation’s grant-making. Being clear about the approach they are taking will help grantmakers decide where they want to put their energy, define their goals, and assess their success in achieving them.

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