

HEALTH EQUITY AND HEALTH DISPARITIES: DEFINING AND ADDRESSING THE EQUITY DEFICIT

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Many articles have been written about the health care industry's desire to address disparities and eliminate gaps in the quality and delivery of health care. These gaps often exist in historically disadvantaged groups and populations that are underserved and vulnerable.¹ These discussions can sometimes overlook the underlying systemic causes of poor health outcomes.² In order to respond appropriately to health disparities, society must acknowledge and confront the historical legacy of oppression in the United States.

Traditionally disenfranchised groups include people who have suffered at the hands of racism, internment, genocide, exclusion laws, and Jim Crow laws. In the United States, these groups include African Americans, Asian Americans, Pacific Islanders, Native Americans, and Hispanic Americans. All of these groups suffer significant health disparities.³ Many of these communities begin their journey toward health in an equity deficit. This equity deficit is not a gap, it's a hole. While a gap can be attributed to social conditions, the hole may be attributed to the political reality, or to the lack of political will needed to recognize and address systematic, ongoing oppression in society.⁴

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1. AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., 2008 NATIONAL HEALTHCARE DISPARITIES REPORT CH. 3 (2008).

2. D.J.P. Barker, *Developmental Origins of Chronic Disease*, 126 PUB. HEALTH 185, 188 (2012) (discussing the importance of human development in curing chronic adult diseases).

3. See, e.g., OR. HEALTH AUTH. & DEP'T. OF HUMAN SERVS., STATE OF EQUITY REPORT 16 (2013).

4. Michael Marmot & Jessica J. Allen, *Social Determinants of Health Equity*, 104 AM. J. PUB. HEALTH 517, 517-18 (2014).

DEFINING THE TERMS RELATED TO HEALTH EQUITY

Health equity is the quest to close avoidable health gaps. It is the opportunity for all people to arrive at their full health potential, unencumbered by social disadvantage. Social disadvantage has historically been maintained through a “social hierarchy.”⁵ This hierarchy has rendered certain groups, particularly racial minorities, to be regarded as inherently inferior.⁶ While individual choices and genetic factors are barriers to achieving the full health potential, the concept of health disparities focuses on the social and political factors that have historically disadvantaged certain groups.⁷ These disparities are linked to social and economic disadvantages stemming from race and ethnicity, national origin and language, gender, sexual orientation, gender identity, disability status, and geographic location.⁸ People of color suffer worse health outcomes than white people.⁹ This suggests that health disparities have a social, not a genetic, origin.¹⁰ Racism systematically limits access to education, job opportunities, affordable housing, health services, and fresh food. These issues, combined with the increased exposure to environmental pollution and community violence, cause more chronic diseases and stress for ethnic minorities than they do for ethnic majorities. African Americans and other populations of color generally have poorer health than the white population. Discrimination, prejudice, and other dynamics of social exclusion contribute to poorer health outcomes.¹¹

EQUITY VERSUS EQUALITY

Distinguishing between equity and equality is critical to

5. P. Braveman & S. Gruskin, *Defining Equity in Health*, 57 J. EPIDEMIOLOGY & COMMUNITY HEALTH 254, 254 (2003) (“[E]quity in health can be defined as the absence of systematic disparities in health . . . between social groups who have different levels of underlying social advantage/disadvantage—that is, different positions in a social hierarchy.”).

6. David R. Williams & Ruth Williams-Morris, *Racism and Mental Health: The African American Experience*, 5 ETHNICITY & HEALTH 243, 246 (2000).

7. *Social Determinants of Health*, CENTERS FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/socialdeterminants/Definitions.html> (last visited July 23, 2015).

8. Office of Disease Prevention & Health Promotion, *Disparities*, U.S. DEP’T OF HEALTH & HUMAN SERVS., <http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities> (last visited July 23, 2015).

9. *What is Health Equity?*, BOSTON PUB. HEALTH COMMISSION, <http://www.bphc.org/whatwedo/health-equity-social-justice/what-is-health-equity/Pages/what-is-health-equity.aspx> (last visited July 23, 2015).

10. See Office of Disease Prevention, *supra* note 8.

11. UNNATURAL CAUSES (California Newsreel 2008).

understanding the concept of health equity. One image that is commonly used to explain this distinction is a depiction of three children peeking over a fence to watch a baseball game.¹² In this image, each child is a different height.¹³ In order to see over the fence, two kids need a box to stand on. But, because of the children's varying heights, each box must be a different size to accommodate the child. With each child standing on the appropriately sized box, or no box at all, all of the children can enjoy the baseball game beyond the fence.¹⁴ If every child stood on a box of equal height, then the shortest child would be shortchanged, and only the tallest child would be able to watch the game; this is an equal result. An equitable result is each child standing on an appropriately sized box to see over the fence. The concept of equity can also be applied to health disparities. When a disadvantaged person is given the same health opportunities as a person who has societal advantage, the result may be equal, but it is not equitable. The group at a disadvantage is still in an inferior position because nothing has been done to eliminate the gap between them and the advantaged group.

DISPARITY VERSUS INEQUITY

Health disparities are specifically tied to overall outcomes.¹⁵ Health disparities are defined as “differences in health that are avoidable, unfair, and unjust,” and are “affected by social, economic, and environmental conditions.”¹⁶ Health disparities are much more commonly discussed than health inequities. Inequities are specifically impacted by social, economic, and environmental conditions or influences.¹⁷ A health disparity exists as a result of inequities. The

12. See, e.g., Office of Equity & Human Rights, *The Problem with “Equality,”* CITY OF PORTLAND OR., <https://www.portlandoregon.gov/oehr/article/449547> (last visited Aug. 7, 2015) (using the image to explain the difference between equality and equity).

13. *Id.*

14. *Id.*

15. Office of Disease Prevention, *supra* note 8.

16. Braveman & Gruskin, *supra* note 5, at 255 (citing Margaret Whitehead, World Health Org., *The Concepts and Principles of Equity and Health*, WORLD HEALTH ORG. 5 (1990), <http://publicaciones.ops.org.ar/publicaciones/piezas%20comunicacionales/cursosDDS/cursoseng/Textos%20Completos/the%20concepts%20and%20principles%20of%20equity%20and%20health.pdf> (“The term inequity has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable, but in addition, are also considered unfair and unjust. [I]n order to describe a certain situation as inequitable, the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society.”)).

17. *Id.* at 255.

conversation centers around a perceived need to address health disparities when the dialogue and response should actually focus on addressing health inequities which are the cause. The dynamic is more than an exercise in semantics; it is rooted in politics.¹⁸ There is a lack of political will to address the behaviors and systems that have created the health inequities.¹⁹

THE SOCIAL DETERMINANTS OF HEALTH

“[A] health disparity is inequitable if it is systemically associated with social disadvantage”²⁰ These disadvantages are typically linked to factors beyond biology and individual behavior and are attributed to circumstances such as social environment, physical environment, and access.²¹ The effects of discrimination are part of the social environment.²² Social exclusion, along with poverty and other manifestations of inequality, widens the health gap and deepens the hole.²³ Additionally, the failure to address the need to develop opportunity and level the distribution of wealth eventually is more of a reflection of policy and political priorities than any other potential cause or source.²⁴

THE EFFECTS OF OPPRESSION ON HEALTH

Prevalent culture and media in the United States often promotes the message that responses to social issues are equal or fair if everyone is treated the same. Dominant U.S culture is grounded in this sense of justice and fair play.²⁵ While it may be noble, it does not provide the appropriate equitable response necessary in many situations.

A variety of studies on health behaviors or chronic disease speak to the physical and psychological deficits created by stress and trauma. Studies have found that adverse or traumatic childhood

18. Marmot & Allen, *supra* note 4, at 517–19.

19. *Id.*

20. Braveman & Gruskin, *supra* note 5, at 255.

21. *Id.*

22. WORLD HEALTH ORG., CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 182 (2008).

23. Marmot & Allen, *supra* note 4, at 517.

24. *Id.* at 519.

25. TRACY NOVINGER, INTERCULTURAL COMMUNICATION: A PRACTICAL GUIDE 89 (2001).

experiences can impact behavior and health in the adolescent and adult phases of life.²⁶ People who suffered abuse and other conditions of adverse childhood exposure may be more likely to smoke, use and abuse alcohol and drugs, engage in risky sexual behavior, suffer from depression or obesity, and attempt suicide.²⁷ These behaviors lead to increased risk and presence of heart, lung, or liver disease, cancer, and skeletal fragility.²⁸ Other studies indicate that the predisposition to chronic disease has a deeper origin. Stress experienced by the fetus in the womb can also be a predictor of health in adult life.²⁹ Not only can poor maternal nutrition impact the health of a fetus, other fetal stressors, such as higher levels of stress hormones in the mother and low oxygen levels in the womb, can impact the structure of organs in the fetus and change the nature of regulatory genes in the body over a lifetime. In other words, stress in the mother can impact development of the fetus, leading to a potential deficit in health at birth and rendering that person at greater risk for chronic illness.³⁰ External stimuli which induce a stress reaction in the human body can affect human physiology over time, keeping the system in a constant heightened state.³¹ The anger and anxiety caused by racism leads to increased levels of chronic stress.³² It follows that racism and the stress that it causes in women of color and other socially disadvantaged groups could compromise fetal development and increase susceptibility to chronic disease.

FROM SOCIAL TO POLITICAL INFLUENCE

Stress is indeed a factor that impacts health and health outcomes. To understand the origins of disease it is necessary to take a look at the history of the populations that suffer the greatest health inequities. First, one must consider enslavement, Jim Crow laws, exclusion laws, and institutionalized racism in the context of the United States'

26. Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, 14 AM. J. PREVENTIVE. MED. 245, 249 (1998).

27. *Id.* at 252.

28. *Id.* at 254.

29. Kent Thornburg, *A Very Brief Description of Development Origins of Health and Disease*, OR. HEALTH & SCI. U., http://www.ohsu.edu/xd/about/news_events/news/2011/08-29-dohad/history.cfm (last visited July 23, 2015).

30. *Id.*

31. UNNATURAL CAUSES, *supra* note 11.

32. *What is Health Equity?*, *supra* note 9.

history³³: Add genocide, internment, the immigration debate, the debate about LGBTQ rights, discrimination and harassment in the workplace, lack of physical access, social access and language access to that list.³⁴ Understand that at the root of such history and debate dwells the ugly truth that these acts, the human behavior and conditioning that led to them and justified each, call into question the basic humanity and human worth of the groups of people subjected to these atrocities. Think and feel in those aforementioned terms and then try to regard them from the standpoint of the people—the human beings—who have suffered and continue to suffer from these oppressive acts.³⁵

THE POLITICS OF OPPRESSION

The equity deficit in health care, housing, education, and other social institutions exists today because of inequities that have been created over generations.³⁶ Prenatal- and childhood-exposure issues combined with social determinants compound to create not only inequities and disparities, but also an insurmountable deficit. According to a report by the Oregon Health Authority, some of the largest health disparities in the state of Oregon exist in Native American and African American populations.³⁷ Out of thirty-three indicators of health measured by the United States Department of Health and Human Services, twenty-six indicated racial disparities.³⁸

33. JOY DEGRUY LEARY, POST TRAUMATIC SLAVE SYNDROME: AMERICA'S LEGACY OF ENDURING INJURY AND HEALING 111–112 (2005).

34. See JEAN L. CHIN, THE PSYCHOLOGY OF PREJUDICE AND DISCRIMINATION 218 (2004); Susan Stucchi-Duran, Transmission of Community Trauma in Latinos: Del Monte Raid 10 (Mar. 11, 2011) (unpublished Master's thesis, Pacific University), available at <http://commons.pacificu.edu/cgi/viewcontent.cgi?article=1343&context=spp>; Alaska Dep't of Health & Soc. Servs., *Creating Healthy Communities: An Alaskan Talking Circle* (2002), http://dhss.alaska.gov/dph/Pages/healthy_alaskans/volume-2.aspx; U.S. Dep't of Health & Human Servs., *National Standards for Culturally and Linguistically Appropriate Services Standards* (Sept. 24, 2013), available at <https://www.federalregister.gov/articles/2013/09/24/2013-23164/national-standards-for-culturally-and-linguistically-appropriate-services-clas-in-health-and-health>; *What is Health Equity?*, *supra* note 9.

35. DEGRUY LEARY, *supra* note 33, at 111.

36. Office of Disease Prevention & Health Promotion, *Healthy People 2020: Social Determinants of Health*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health> (last visited June 25, 2015); DEGRUY LEARY, *supra* note 33 at 117–20.

37. OR. HEALTH AUTH. & DEP'T. OF HUMAN SERVS., STATE OF EQUITY REPORT 33 (2011) (African Americans and Native Americans show disparities for almost all of the key performance measures).

38. AGENCY FOR HEALTHCARE RESEARCH & QUALITY, *supra* note 1, at 287.

Gains in areas like education have failed to mitigate racial disparities in health care.³⁹ It is more likely that an infant born to a college-educated person of color will die before the age of one than an infant who is born to a white woman who did not finish high school.⁴⁰ When you consider children of various heights trying to see the ballgame over the fence, you can envision the different height of box each child would need. Now imagine that one does not have a box and another is standing in a hole in the ground, a deficit, dug and picked away at over time.

In addition to examining the chronic effects of trauma, it is also necessary to acknowledge the lingering effects of social conditioning that have allowed majority groups to dominate over minority groups. One cannot enslave, intern, exterminate, or deny other people basic rights and decency without harboring the idea that at some level these other people either deserved the oppression or do not warrant anything more. Such conditioning around dehumanization does not dissipate without an intervention and deconditioning.⁴¹ Assumptions of the inherent inferiority of racial and ethnic minorities have become institutionalized into policies and systems, which subsequently limit access and opportunity.⁴² The dehumanizing factor is evident in studies on the Latino population and LGBTQ communities.⁴³ The political violence caused by raid and deportation practices against undocumented immigrants results in trauma that extends across families, communities, and even generations.⁴⁴ For LGBTQ communities, the social and political debate regarding laws that outlaw discrimination and provide equitable access to marriage can perpetuate stress as it relates to stigmatized identity, calling into question one's very humanity.⁴⁵ A behavioral effect known as insidious trauma can be passed intergenerationally from parent to child if the ongoing impact of being devalued as a person of color over a lifetime is never resolved.⁴⁶

39. *What is Health Equity?*, *supra* note 9.

40. *Id.*

41. DEGRUY LEARY, *supra* note 33, at 200.

42. Williams & Williams-Morris, *supra* note 6, at 247.

43. See Susan Stucchi-Duran, *supra* note 34, at 10; GLENDA M. RUSSELL ET AL., TRAUMA, RECOVERY AND COMMUNITY: PERSPECTIVES ON THE LONG-TERM IMPACT OF ANTI-LGBT POLITICS 1–2 (2010).

44. Susan Stucchi-Duran, *supra* note 34, at 10.

45. GLENDA M. RUSSELL ET AL., *supra* note 43, at 1–2.

46. Susan Stucchi-Duran, *supra* note 34, at 7.

INSTITUTIONAL ISSUES AND SOLUTIONS

Discrimination is a determinant of health as it relates to the social environment.⁴⁷ The pursuit of health equity is a social-justice endeavor.⁴⁸ The barriers to addressing the social determinants of health are largely political.⁴⁹ If social determinants and health disparities are described as a gap, as in avoidable health gaps, then health inequities spawned by generations of systemic oppression embedded in the United States' policy and institutions represent a hole, or an equity deficit.⁵⁰ Forward motion in multiculturalism and inclusion requires that any given organization or institution must address the discrimination and oppression that exists within it.⁵¹ The Civil Rights Act of 1964 established the policy-related groundwork required to address institutionalized oppression.⁵² An aspiration to address health disparities must be grounded in the want to address health inequity.⁵³ A desire to address inequity must be founded in a desire to address oppression and the fact that underserved, vulnerable, and historically disadvantaged populations or groups do not receive the benefits of equity and are still regarded in some respects as inferior.⁵⁴

In order to instill equity in institutions, the conversation and action must embrace the social-justice work, laws, and policies that address systemic inequity such as Title VI of the Civil Rights Act, the Age Discrimination Act of 1975, and the Americans with Disabilities Act.⁵⁵ The absence of health equity is, at its core, a civil-rights issue. The historical legacy of oppression in the United States has ultimately led to disparities in health outcomes; generations of inequities and the inequitable distribution of opportunity and wealth should be addressed.⁵⁶ Until policymakers and practitioners recognize the deficit, health equity will not be achieved.

47. *Disparities*, *supra* note 8.

48. Braveman & Gruskin, *supra* note 5, at 254–58.

49. Marmot & Allen, *supra* note 4, at 517–19.

50. *Disparities*, *supra* note 8; Williams & Williams-Morris, *supra* note 6, at 251.

51. Derald Wing Sue, *Multicultural Organizational Consultation: A Social Justice Perspective*, 60 CONSULTING PSYCHOL. J.: PRAC. & RES. 157, 160 (2008).

52. Steven Schwinn, *Civil Rights Act of 1964: Enduring and Revolutionary*, INSIGHTS ON L. & SOC'Y, Winter 2014, at 3.

53. Braveman & Gruskin, *supra* note 5, at 256–57.

54. Williams & Williams-Morris, *supra* note 6, at 256.

55. Braveman & Gruskin, *supra* note 5, at 255.

56. Marmot & Allen, *supra* note 4, at 519.