

Review Article

The History of Health Equity: Concept and Vision

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ABSTRACT

Health equity has long been an ideal, with roots in social medicine reaching back into the mid-nineteenth century when visionary public health leaders and social critics recognized that social and class inequalities led to inequities in health. The Constitution of the World Health Organization states that "the highest standards of health should be within reach of all, without distinction of race, religion, political belief, economic or social condition". The Universal Declaration of Human Rights of the United Nations states that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family" and that "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status". Various organizations-the Rockefeller Foundation, the World Bank, and many non-governmental organizations (NGOs) have frequently used the terms "health equity" and "inequity" in their statements of mission and purpose. In 1971, Julian Tudor Hart coined the Inverse Care Law: "The availability of good medical care tends to vary inversely with the need of the population served." Other analysts have pointed out that medical care is only one of the requirements for good health, with income, education, nutrition, sanitation, and living and working conditions all being essential determinants of health. Margaret Whitehead has emphasized the difference between health differentials that are unavoidable, and those that are avoidable and preventable; the latter were health inequities and recognized as injustices. This essay traces the history of the idea of health equity and raises questions about the translation of the concept into practice.

Keywords: Equity; Health equity; History; Human rights; Health disparities; Inequalities; World Health Organization

What is known about this topic?

Although there is a considerable literature on health equity, we are not aware of any existing historical analysis. We believe that this paper is thus an entirely original contribution to the literature.

Introduction

There is an African proverb that says "Until the lions have their historians, tales of the hunt shall always glorify the hunter."

The intention to eliminate unfair and avoidable differences between disadvantaged groups that have poorer survival rates, life conditions, and health status - that perpetuate their disadvantage – is at the core of health equity. It is not entirely clear when and who coined this concept, but many health care systems, health organizations, and thought leaders have considered health equity as the North Star of health care. Practice, however, has been far from the ideal; and the ideal has failed to translate into equitable and equally healthy societies.

Early Declarations and Discussions of Health Equity

The origins of the concept of health equity can be found in the history of social medicine, especially since the mid-nineteenth century. Men such as Rudolf Virchow, Friedrich Engels, Andrija Stampar, and others clearly recognized that social and class inequalities led to inequities in health. This essay traces the subsequent history of the concept of health equity, and poses questions about the translation of this idea into practice.

The World Health Organization (WHO) Constitution (1946) proclaimed that "the highest standards of health should be within reach of all, without distinction of race, religion, political belief, economic or social condition [1]." Two years later, in 1948, the United Nations, in a response to the Nazi holocaust, adopted the Universal Declaration of Human Rights [2] which set a standard by which the human rights activities of all nations, rich and poor alike, were to be measured. It states that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." It also states that "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" [3].

Twenty-three years later, in 1971, Julian Tudor Hart coined what he termed "the inverse care law" in his article about the British National Health System (NHS). As he described the inverse care law: "the availability of good medical care tends to vary inversely with the need of the population served." [4]. This was, of course, a play on the inverse square law of physics. Hart said that the inverse care law could be observed at its fullest extent when medical care was exposed to market forces, and argued that "a just and rational distribution of the resources of medical care should show . . . at least a uniform distribution."

Referring to a publication by Richard Titmuss on the 15 first years of the British National Health System [5], Hart noted that "the higher income groups know how to make better use of the service; they tend to receive more specialist attention; occupy more of the beds in better equipped and staffed hospitals; receive more elective surgery, have better maternal care, and are more likely to get psychiatric help and psychotherapy than low income groups -- particularly the unskilled [4]." Hart argued that the large social inequalities of mortality and morbidity, and the equally large differences in the quality and accessibility of medical resources, could not be solved by simply improving care for everyone, but that a redistribution of resources was necessary. He also stated that "medical services are not the main determinant of mortality or morbidity; these depend most upon of standards of nutrition, housing, work environment, and education, and the presence or absence of war" [4].

The concept of health equity was strongly endorsed by the participants in the World Health Organization's (WHO) Conference on Primary Health Care in Alma-Ata in 1978. The launch of "Health for All" campaign (HFA), implicitly made health equity a priority for all countries [6]. The Alma-Ata Declaration viewed health as part of and an impetus for development, with every social sector needing to collaborate in the production and maintenance of "health for all." Clean water and sanitation systems were necessary to control diarrheal diseases; improved conditions of housing and shelter were needed to contain tuberculosis and respiratory disorders; good nutrition was an important foundation of good health; and poverty was the foundation of much illness. The Alma-Ata Declaration highlighted the inequality between the developed and the developing countries and termed it politically, socially, and economically unacceptable [7].

The WHO is organized by regions, each having some commonality of geography, culture, and epidemiological pattern of disease [8]. After the Alma-Ata Conference, the WHO Regional Office for Europe established a program on Equity in Health to examine issues of unemployment, poverty, and health, with reference to several vulnerable groups. A strong network of experts provided a wealth of information and insights into the problem and put equity firmly on the political agenda in member states. In 1990, the Regional Office commissioned Margaret Whitehead to write a document articulating and explaining the concept of health equity. Her report was later published as a highly influential article, "The Concepts and Principles of Equity and Health," published in 1991 in Health Promotion International [9].

Whitehead noted that although the health targets of the World Health Organization's European Region referred directly or indirectly to health equity, the meaning of health equity was often unclear. In part, the confusion was caused because inequity in health was often conflated with inequity in the provision of health services. From a policy point of view, of course, it was easier to deal with unequal access to health care than inequality in health status per se.

Whitehead set out to clarify the concepts and principles involved in health equity with the aim, she said, of raising awareness and stimulating debate, and to educate those, within or outside the health sector, whose policies could have an influence on health. She outlined consistent evidence showing that disadvantaged groups had poorer survival chances, and died at a younger age than more favored groups [10]. In every part of the European Region, in every type of political and social system, there were marked differences in health between different social classes, different geographical areas in the same country, and notably large gaps in mortality rates between urban and rural populations, the young and the elderly, and diverse ethnic groups. Furthermore, those who were most in need of medical care, including preventive care, were the least likely to receive it. National health policies could hardly claim to be concerned about the health of all the people if the heaviest burden of ill-health borne by the most vulnerable was not addressed.

Whitehead [10] addressed seven main determinants of health where differentials could be identified:

- Natural, biological variation
- Health-damaging behavior if freely chosen, such as participation in certain sports and pastimes
- The transient health advantage of one group over another when that group is first to adopt a health-promoting behavior (if other groups had the means to catch up)
- Health-damaging behavior where the degree of choice of lifestyles was severely restricted
- Exposure to unhealthy, stressful living and working conditions
- Inadequate access to essential health and other public services; and
- Natural selection or health-related social mobility involving the tendency for sick people to move down the social scale

Whitehead [10] pointed out that some of these differences and differentials were unavoidable and, although they were "inequalities," they were therefore not "inequities." Use of the term "inequity" implied a moral judgment. Health inequities were avoidable and preventable; these were therefore injustices and recognized as such. In the last category, for example, the original ill-health in question may have been unavoidable, but nonetheless the resulting low income of sick people was both preventable and unjust.

Whitehead has continued to work and publish extensively on inequalities in health. She is now Dame Margaret Whitehead, having received the Order of the British Empire for her services to public health. As professor of public health at the University of Liverpool, she is head of a World Health Organization Collaborating Center for Policy Research on the Social Determinants of Health. Emphasis on the social determinants of health has been a clear move away from thinking of ill-health only in biological terms or the assumption of the centrality of medical and health care services.

The Regional Office for the Americas, the Pan American

Health Organization (PAHO), identified the reduction of health inequities as a major goal. [11]. The Health Equity Interprogrammatic Group of PAHO stated that "The issue of health inequities and their relation to living conditions is now in the mainstream of public health thinking" and that "pronouncing these inequalities as inequities makes a forceful claim about justice." [12]. The PAHO document argues that philosophical and pragmatic meanings of "health equity" needed to be distinguished. Health equity is both an ideal and a policy goal. Equality is sameness, but equity is a matter of morality, fairness, and justice. Inequities in health were morally unacceptable. The PAHO Director, Sir George Alleyne, stated that "Equity refers to differences that are unnecessary or reducible and are unfair and unjust. The concept of fairness obviously involves a moral judgment and is, therefore, intrinsically difficult. As is the case with health outcomes, similarly the inequities in health determinants are those that should not exist. Every person should, in terms of equity, be able to access those sanitary and social measures necessary to protect, promote and maintain, or recover health" [12]. Equal access to medical services was only one part of equity, the part that was easiest to measure, whereas health status was affected by "living conditions, working conditions, environmental issues such as air quality, education level, and access to cultural, social, and political participation." This was an admirably broad definition; the improvement of health status was "part of the larger work of human development" [12].

Equity in health was also a cornerstone of the Millennium Development Goals (MDGs) launched in 2005 by the WHO, and the Countdown to Equity Working Group established to determine how countries were advancing on health equity in relation to the MDGs. The Working Group collected and analyzed country data and provided key reproductive, maternal, newborn, and child health indicators of different dimensions of equity: wealth, maternal education, and geographic location, among others. [13]. In 2005, WHO also established the Commission on Social Determinants of Health (CSDH) to address the social factors leading to ill health and health inequities, and to draw the attention of government agencies and policy makers to the social determinants of health. The commission delivered its final report to the World Health Organization in July 2008; its overarching recommendations were to improve living conditions; to tackle the inequitable distribution of power, money and resources; and by measuring the problem, be able to assess the impact of actions. This was a tall order and, like many WHO reports, was more an ideal statement than a practical plan of action [14].

WHO is not, of course, the only organization to adopt the term "health equity" as an ideal. The Rockefeller Foundation, the World Bank, and many non-governmental organizations (NGOs) are among those that frequently use the terms "equity" and "inequity." [15]. For the most part, however, the term "health disparities" tends to be used in the United States, whereas "health equity" is more commonly used in Europe and WHO. "Disparities" is the more neutral term, meaning differences in health status, and it does not necessarily, or so strongly, imply the moral judgment that such differences represent injustices that must be addressed and remedied.

Health disparities

The United States Public Law 106-525, also known as the "Minority Health and Health Disparities Research and Education Act," provides a legal definition of health disparities:

"Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States." A population is a health disparity population if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population as compared to the health status of the general population." [16].

With the launch of Healthy People 2010, the U.S. Department of Health and Human Services (DHHS) committed the nation to an overarching goal, to "eliminate health disparities." [17]. This initiative began with the publication of Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention [18]. As Green and Fielding explain, the growing interest in health promotion and disease prevention was at least in part due to increasing concern about the soaring costs of medical care, especially for chronic illness. Cost-containment became a pressing argument for making people healthy. The United States had standards for almost everything – including the number of stitches in a baseball's cover – but there were no generally accepted standards for community preventive health services. The Healthy People initiative was to remedy this failure.

The publication of 1990 objectives [19] brought many complaints. Setting out objectives for overall health and mortality statistics for the whole U.S. population masked vast discrepancies between the rich and poor, black and white, young and old. Average statistics would not do. Responses to the many and vociferous complaints focused on health differences or disparities between racial and ethnic groups; "disparities" came to mean racial disparities. This in turn, began to equate health "disparities" with "inequalities" and "inequities," bringing a clear judgment that these were unfair, unjust, and unacceptable. The Healthy People objectives were published each decade; by the time of the 2010 objectives, under Surgeon General David Satcher, the *reduction* of health disparities was replaced with a more aggressive set of objectives to *eliminate* health disparities [17].

In the United States, Paula A. Braveman has filled the role earlier held by Margaret Whitehead – that of clearly articulating, defining, and explaining the meanings of "health disparities" and "health equities" [20, 21, 22]. In her 2011 article, "Health disparities and health equity: the issue is justice," she and her coauthors – all of whom had participated in developing the recommendations to the Secretary Advisory Committee on Healthy People 2010 — stated that "health disparities are systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups" which might "reflect social disadvantage, but causality need not be established." Health disparities, they wrote, were "the subset of health

differences reflecting social injustice." The phrases "plausibly avoidable" and "causality need not be established" were undoubtedly end runs around controversies that were best avoided. Health disparities were further said to be "of particular relevance to social justice because they may arise from intentional or unintentional discrimination or marginalization and, in any case, are likely to reinforce social disadvantage and vulnerability." [21]. They stated that health disparities were the metric for assessing health equity, and "health equity is social justice in health." The need for clear definitions, they said, was "particularly compelling given the lack of progress toward reducing racial/ethnic and socioeconomic disparities in medical care and health."

Braveman and her co-authors argue that policies ("plausible, but not necessarily proven") could reduce health disparities, given sufficient political will. These included nonmedical policies such as "a decent standard of living; a level of schooling permitting full social participation, including participation in the workforce and political activities; health-promoting living and working conditions, including both social and physical environments; and respect and social acceptance." They laid out a convincing menu of policies to promote health equity but unfortunately, could not provide the recipe for "political will."

Conclusion

In tracing the history of health equity as concept and vision, we find that many –within and outside the World Health Organization (WHO) and its regional offices – have treated health equity as both an ideal and a moral necessity. The WHO has continued to express similar ideals through the Millennium Development Goals and the Commission on the Social Determinants of Health.

In the United States, the term "health inequities" has generally been supplanted by the more value-neutral term, "health disparities." The Advisory Committee on Healthy People 2010 has clearly stated that health disparities are the metric for assessing health equity and that "health equity is social justice in health."

Many have discussed, defined, and argued about the concept of health equity. Although clarity about the meanings of health equity and health disparities is essential, it cannot be the goal. A significant step forward lies in articulating the policies and practices that can lead us toward the ideal of health equity, and in being able to summon the social commitment and political will to turn this vision into reality.

Acknowledgements

Our gratitude to all who have pursued the ideal of health equity and those who continue to do so.

Source of funding:

One author is a member of the National Library of Medicine which supports her research and writing. It should be noted, however, that the views expressed here are solely those of the authors and do not necessarily represent the positions of the National Library of Medicine, the National Institutes of Health, or any other institutions with which the authors may be affiliated.

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Special issue title: Community-based Research
Handled by Editor(s): Dr. Okafor Innocent Igwebueze, Esut College Of Medicine, Nigeria

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Submitted: April 25, 2017; Accepted: May 15, 2017; Published: May 22, 2017