

Health Equity

The concept of health equity, or equal opportunity for optimal health, captures the idea that no one should be hindered from achieving his or her full health potential due to social position or socially determined circumstances (1). Good health, which is considered the attainment of physical, mental, and social well-being and the absence of disease, is vital for individuals to fully engage in society, overcome personal adversities, and realize their full potential as human beings (2). The opportunity for every person to achieve his or her full health potential is widely recognized as a fundamental human right (2, 3).

Health Disparities and Health Inequities

The terms “health disparities” and “health inequities” are often used interchangeably, but in fact represent two distinct concepts, which at times overlap. Health disparities are differences in the rate of disease incidence, prevalence, morbidity, mortality, or survival in certain populations compared to other populations (4). Disparities can be attributed to variations in individual biology and genetics, such as when health changes occur due to the normal course of aging, or if a genetic variation causes the onset of disease (5). For instance, we would expect a higher incidence of heart disease among older adults than among younger adults. When the underlying cause of health differences is socially produced and avoidable, the health disparities are termed health inequities due to their lacking “fairness or justice”(6). Inequities occur when unfair social policies and practices deny groups of individuals the opportunity for optimal health, either through a lack of resources that promote health or through increased exposure to risk factors for disease (7). Building a waste plant in a low-income area, for instance, places that area’s residents at increased risk of exposure to toxic environmental agents. Placing the waste plant in a low-income area rather than a more affluent area is a socially produced, modifiable, and unjust decision. Therefore, the resulting poorer health outcomes experienced by the low-income residents are examples of health inequity. The concept of health disparities, on the other hand, does not imply that differences are associated with unjust societal influences (8).



Social Determinants of Health (SDOH)

Although individual-level choices and genetics do play a role in the health outcomes individuals experience, health is profoundly influenced by underlying structural influences that exist prior to individual choice and that may even influence individual choice. Underlying factors that consistently create variability in health status are referred to as social determinants of health. They include the presence or absence of safe environments, opportunities for high-quality education, access to nutritious and affordable foods, convenient spaces for physical activity, social support, employment opportunities, health-supporting community norms, resources for disease prevention and management, and access to quality healthcare (9). The unequal distribution of these social determinants of health can contribute to the health inequities among populations that have less access to these health-promoting resources (10).

A large body of evidence indicates that social and societal factors, based on social determinants of health, exert a major influence on population health that is greater than the combination of health behaviors, genes and biology (11, 12). We also know that the social determinants of health impact the types of health behaviors people choose (11, 12).

Determinants of Health and Examples (11, 12)

- Genes and biology: sex, age, etc.
- Health behaviors: drinking alcohol, diet, physical activity, smoking, etc.
- Social Determinants of Health (SDOH): where someone lives, income, educational attainment, employment status, discrimination (sexism, racism, ageism), access to medical care, etc.
- Medical Care (an important SDOH): access to quality health care and having or not having insurance, etc.

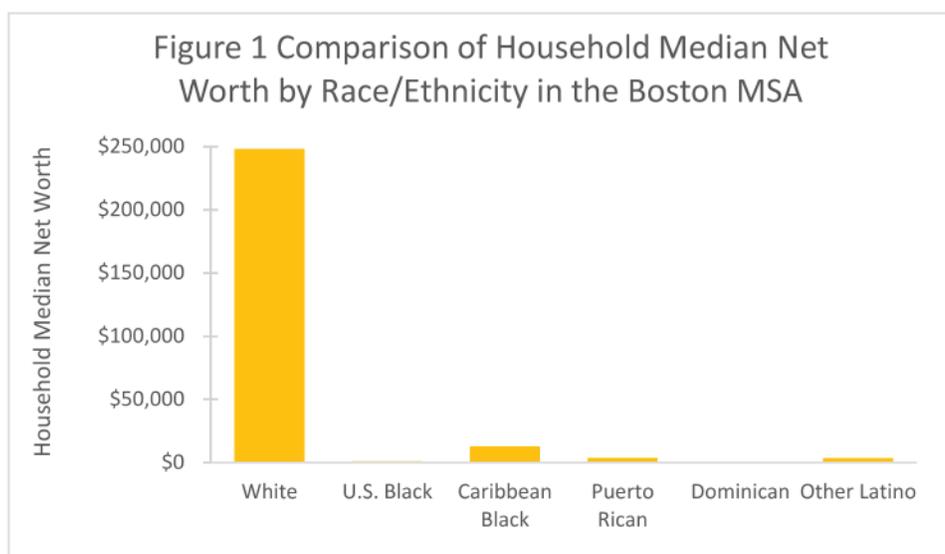
Influence of Racism and Discrimination

The influence of racism and other exclusionary practices may contribute to an unequal distribution of critical health-promoting resources among racial/ethnic groups. Social inequities, such as poverty and a lack of educational and employment opportunities, often have origins in discriminatory laws, policies, and practices that have historically denied people of color an equal right to earn income, own property, and accumulate wealth. These types of practices have existed well after the end of slavery in the United States. For example, practices that promoted housing segregation were formalized within federal law with the establishment of the Federal Housing Administration (FHA) in 1934. The FHA was originally founded to provide affordable, long-term loans to eligible buyers to purchase property during the Great Depression. FHA's initial zoning policies reflected prevailing attitudes of racial discrimination at the time, utilizing a discriminatory rating system called "redlining" to guarantee that any residential areas housing non-White individuals would be rated "red" to designate low property worth and unstable community investments (13).

According to the first FHA Underwriter's property manual, property ratings were automatically diminished by a number of "adverse factors" including the "ingress of undesirable racial or nationality groups" (13). Subsequent FHA financing support, approved only for property in highly rated (i.e., "non-red") areas, was then selectively allocated to White individuals who were considered "worthy" investments for properties. These exclusively White, highly-rated, and well-invested areas were often built away from smoke, smog, commercial development, railroads, and high-traffic noise pollution, providing their White residents with the benefits of healthier environmental conditions in their new communities (14).

At the same time, the FHA refused to underwrite loans for individuals from communities of color whom as a consequence they considered “second-class,” propagating widespread institutional racism through property owners, real estate boards, and community associations (14, 15). Redlining denied Black Americans the opportunity to sell or purchase property through racially restricted covenants that ultimately even reduced the market value of the property that they did own. The low market values, in turn, caused the economic worth of their communities to decline sharply. Home ownership tends to be the most important form of wealth accumulation, especially for low-income individuals. For this reason, property devaluation due to institutional racism created a barrier to the accumulation of wealth for people of color. The barrier to accumulating and passing on wealth to their children meant that these racist policies affected the socioeconomic status of multiple generations of Black Americans.

After decades of legalized discriminatory housing practices, the Fair Housing Act of 1968 was enacted to prohibit discrimination in housing rental or acquisition based on race, color, or national origin (16). However, the lasting consequences of these discriminatory practices on, among other things, homeownership, the accumulation of wealth, housing safety and stability, and subsequently health, among communities of color remain evident today (15, 17). The impact of these policies can be seen in the differences in net worth between White and Non-White residents of Boston’s Metropolitan Statistical Area (MSA). Net worth, the sum of the value of total assets minus the value of debts, describes a household’s financial well-being or wealth. Prominent racial differences are evident when looking at total household wealth. White households have a median net worth of \$247,500, while Dominican, Black, and Other Latino households in the U.S. have a median net worth close to zero. Of all Non-White groups for which estimates could be made, Caribbean Black households had the highest median net worth with \$12,000, which represents only 5% as much wealth as the White household median (see Figure 1) (18, 19).



NOTE: The Boston MSA (Metropolitan Statistical Area) includes the following counties: Essex, Middlesex, Norfolk, Plymouth, and Suffolk in Massachusetts; and Rockingham and Strafford New Hampshire.

Figure adapted from Muñoz et al. National Asset Scorecard for Communities of Color (NASCC) survey, 2015 (18).

The City of Boston experiences large inequities in the distribution of wealth. Of the city's approximately 667,137 residents, 10% are Asian, 23% are Black and 20% are Latino. There are persistent differences in income and poverty rates across these groups when compared with White Boston residents (20). In 2015, a higher percentage of White residents had a household income of \$50,000 or more (76%) compared with Asian, Black and Latino residents (50%, 55%, and 42% respectively). Also in 2015, White residents had a poverty rate of 13%, while the poverty rate for Asian, Black and Latino residents was higher in comparison (30%, 21%, and 32% respectively)(21).

Approaches to Achieving Health Equity

Health inequities will persist as long as social, economic, and environmental resources are distributed unfairly and unequally. Approaches to reducing health inequity should be built on the understanding that social, economic, and environmental inequities are root causes of health inequities. Strategies must address inequities in education, employment, income, housing, neighborhood safety, recreational opportunities, environmental hazards, healthcare, and healthy food access in order to be effective in improving the health and well-being of people of color. Strategies for change in policy, systems, and the environment should prioritize values of justice, equity, inclusion, transformation, sustainability, and integrity. Addressing the root causes of health inequities requires a long-term commitment to comprehensive multi-level and multi-sector strategies. Broad coalitions of public, private, nonprofit, and community stakeholders are required to change community structures (16). In order to do this work effectively, resident voices are essential. Residents should help to define the assets and challenges of their communities, identify the possible solutions, and participate in the implementation of those solutions (22). It is this model of building partnerships with community residents, community-based organizations, policymakers, and large institutions that is essential to promoting system and policy level changes to promote health in all of Boston's communities.



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