

In Pursuit of Health Equity:

Comparing U.S. and EU Approaches to Eliminating Disparities

Timely Analysis of Immediate Health Policy Issues

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Introduction

Significant health differences across population subgroups have persisted for nearly 30 years since first officially documented in the United States. These differences have been subject to attention in health policy and philanthropy circles for more than a decade.

Despite the activity focused on this problem in the United States and other developed countries, there remains surprisingly little consensus about the meaning of terms such as “health disparities,” “health inequalities,” and “health equity.”¹ Consequently, some in the field emphasize the practical implications of the terms we use, as in the case of the updated definition proposed by Braveman and Gruskin specifying that a disparity must be potentially amenable to redress via policy solutions:²

“A health disparity/inequality is a particular type of difference in health or in the most important influences on health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups (such as the poor, racial/ethnic minorities, women, or other groups that have persistently experienced social disadvantage or discrimination) systematically experience worse health or greater health risks than more advantaged groups.”

Beyond the issue of definition, there are evident differences in approaches used to assess and address health disparities. Notably, health disparities measurement has reflected an implicit assumption that relevant differences are those between better- and worse-off social groups, selected a priori based on who has been more- or less-advantaged in society.³ A major difference in assessing disparities relates to how policy-makers focus on the health disparities of particular disadvantaged groups—in the case of the United States, racial and ethnic minorities—or take a broader view of

the range of (often interrelated) socioeconomic factors that contribute to producing disparities. Based on the definition adopted above, either formulation of the disparities problem would qualify for policy attention.

However, in the United States, the large differences in health between the economically successful and unsuccessful have been largely ignored, at least as part of the disparities agenda.⁴ Moreover, we are at risk of allowing the shortcomings of our health care system to distract us from attending to the most important causal determinants of health disparities.

In this paper, we compare and contrast the U.S. public policy approach to tackling the problem of health disparities with the European approach. We begin by providing an overview of the ways in which the issue of health disparities has been framed in American and European policy discourse. We next compare how health disparities have been addressed in policy statements produced by the U.S. Department of Health and Human Services (HHS) and by the European Commission, the executive body of the European Union (EU). In so doing, we seek to illuminate implicit choices that stand to have a bearing on the outcomes of these initiatives.

Disparities and Inequalities: A Brief Overview of Recent History

In European countries, health differences across socioeconomic groups defined by income, education, material deprivation, and the like are most often referred to as inequalities. They are framed as a matter of policy concern in that health differences perceived to be unwarranted or unfair threaten to undermine social solidarity.⁵ Health inequalities between citizens of different European countries and between socially advantaged and disadvantaged groups are seen as challenges to the EU’s commitment to solidarity, social and economic cohesion, human rights, and equality of opportunity.⁶

During the 1990s, the European office of the World Health Organization worked to highlight the problem of health inequalities across socioeconomic groups, helping to birth and fuel policies aimed to reduce inequalities or, by eliminating disparities across groups with different levels of social advantage, achieve health equity in countries including Finland, the Netherlands, Norway, Sweden, and the United Kingdom.^{7,8}

Implemented policies included those focusing on health care as well as those stressing nonmedical determinants of health such as working conditions and behavioral factors.⁹ A study group convened by the European Commission concluded that European policies to reduce health inequalities were largely intuitive and would benefit from incorporation of more rigorous, evidence-based approaches, as well as the international exchange of experiences with development, implementation, and evaluation of policies.¹⁰

After a period of about five years in which the health equity issue was a less prominent part of European policy discussions, the cause was taken up again in 2009 by the European Commission, subsequent to expansion of the Union to include a large number of new member states from Central and Eastern Europe.¹¹ Since announcing its renewed policy focus on health inequalities, the Commission charged a consortium led by Sir Michael Marmot to study the state of inequalities in Europe.¹² This study provided insight into determinants of certain health inequalities, noting, for instance, that income-related inequalities in Europeans' health are largely due to differences in noncommunicable diseases and health risks and behaviors, reflecting the influence of lack of control, stress, and reduced capabilities that are associated with social disadvantage. The study also found that EU member states with lower levels of social protection (i.e., lower per capita spending on welfare programs) had lower levels of self-reported health status.

In the United States, policy attention has focused on health care disparities across racial and ethnic groups as contributors to differential health outcomes. HHS officials trace the department's work on racial and ethnic disparities back to a 1985 report, the *Report of the Secretary's Task Force on Black and Minority Health*.¹³ Much of the ongoing U.S. policy activity can be linked to the Institute of Medicine (IOM)'s 2003 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, which compiled compelling evidence of variation in the rates of medical procedures by race and poorer access to services and quality of care, even when insurance status, income,

age, and severity of conditions were comparable. The report recommended steps including increasing public awareness, promoting use of evidence-based guidelines, and increasing representation of minorities among health care providers.¹⁴ Since 2003, the U.S. Agency for Healthcare Research and Quality (AHRQ) has published annually a congressionally mandated report on disparities in health care delivery as it relates to “racial factors and socioeconomic factors in priority populations.”¹⁵ In its 10th edition of the report—reflecting the state of affairs before implementation of most elements of the Affordable Care Act (ACA)—AHRQ reported that overall, quality of care is improving, access to care is getting worse, and disparities in health care “are not changing.”¹⁶

Meanwhile, public health experts have built a convincing case that nonmedical factors—including economic, environmental, behavioral, and education-related conditions—far outstrip health care as determinants of health. Researchers estimated that improvements in health care access and quality offered the potential to reduce preventable mortality by only as little as 10-15 percent, raising questions as to why such a small share of health spending has been devoted to prevention and promotion of public health.¹⁷ In the United States, experts have pointed to some policy interventions to address nonmedical health determinants that were considered to be politically feasible. These include public education and leadership by the surgeon general and other government actors; development of mechanisms to further collaboration across sectors; expanded monitoring and reporting on nonmedical determinants of health; and developing new knowledge about how these factors affect health and successful interventions to address them.¹⁸ Concurrently, British experts have pointed to evidence suggesting that policies to address income inequality and poverty through income redistribution could be justified on health grounds in light of the strength of evidence linking economic deprivation, social isolation, and poor health.¹⁹

More recently, the National Research Council produced a report documenting an alarming trend in U.S. health status relative to other high-income countries.²⁰ Over the past three decades, the U.S. health disadvantage has grown as a pervasive pattern of poorer health over Americans' lifespans, with Americans dying at younger ages than people in almost all other high-income countries. Notably, the report asserted that this shortfall in U.S. population health status cannot be fully explained by the health disparities that disadvantage

people who are uninsured or poor, because several studies have shown that even advantaged Americans—those who are White, insured, college-educated, or upper-income—are in worse health than their peers in other countries. The report study committee attributed the U.S. health disadvantage to factors including the large uninsured population and more limited access to primary care found in the United States; the prevalence of certain high-risk health behaviors, such as high calorie-intake and firearm use; and social and economic conditions including high levels of poverty (especially child poverty), income inequality, and lower rates of social mobility.

From this brief history it is evident that disparities or inequalities in health have been a concern to policy makers in both the United States and Europe, although the framing of these issues has differed in important respects, as has the emphasis. The striking conclusion that economic inequality is an important factor contributing to the poor health of disadvantaged groups has currently driven few policy changes on either side of the Atlantic, though, as will be further seen in our analysis to follow, Europeans seem to be a step ahead in framing this issue.

Comparing Today's U.S. and EU Policy Approaches

To assess how the issues of health disparities are being tackled in U.S. and EU policy, we consulted two prominent policy statements. We analyzed an April 2011 paper by HHS, *HHS Action Plan to Reduce Racial and Ethnic Disparities*.²¹ We compared that report to a communication issued in October 2009 by the European Commission, *Solidarity in Health: Reducing Health Inequalities in the EU*.²² While the publications and the public agencies that produced them are not strictly equivalent, both set forth an action plan for addressing the problem of health disparities or inequalities. In both cases, the authors are executive government actors with a fairly diffused and circumscribed scope of authority relative to the scale and scope of the problem addressed.

The destinations and the roadmaps

In its action plan, HHS puts forward an aspirational vision of achieving “a nation free of disparities in health and health care,” while the European Commission set the relatively more modest goal of “reducing health inequalities.” The U.S. report provides an overview of racial and ethnic disparities and unveils a plan for HHS to reduce those disparities. The

European Commission report sets forth the commission’s plans to initiate actions to support its member states and other actors in reducing the extent and consequences of health inequalities. Neither publication established specific dates by which the goals are to be met, although both provide timelines and mechanisms for reporting on progress, and the U.S. plan provides timelines for implementing specific actions outlined.

The EU report concerns itself primarily with two types of disparities: inequalities in health between people living in different parts of the European Union and inequalities between the most advantaged and disadvantaged sections of the population. The latter includes populations with lower education, a lower occupational class, or lower income. The EU report also acknowledges—and recommends targeted actions to address—the problems of vulnerable and socially excluded groups, including people from some migrant or ethnic minority backgrounds, the disabled, and the homeless.

The U.S. report, by contrast, presents health disparities associated with race and ethnicity as the primary focus of its drive to increase health equity, noting that many of the strategies it will advocate and implement can also serve to increase health equity for vulnerable populations as defined by income, geography, disability, sexual orientation, or other characteristics. The U.S. report affirms the role of underlying determinants of poor health—such as poverty, low socioeconomic status, and lack of access to health care—and observes that marked differences in these social determinants exist along racial and ethnic lines. Notably, there is no attempt to explain the rationale for the decision to focus on racial and ethnic disparities and provide relatively limited attention to health disparities associated with socioeconomic status as otherwise defined.

The U.S. report delineates 11 so-called strategies for eliminating racial and ethnic health disparities (see [table 1](#)). The report names 34 specific actions, many of which are further delineated into subcomponent actions (not presented in the table), to be undertaken by the department and its agencies to implement the strategies identified.

The European Commission’s report identifies five broad challenges to be addressed in order to reduce health inequalities across and within EU member states (see [table 2](#)). The report points to a collaborative approach between EU member states and the European

Commission in addressing health inequities. The report also puts forward 20 specific actions to be implemented by the Commission to support the efforts of EU nations in reducing inequalities in health within their countries, and to address cross-national inequalities in health.

Different approaches to identify the disadvantaged populations

One of the most notable distinctions between the U.S. and EU publications lies in the population focus. As previously described, the U.S. report approaches the problem of health disparities with a focus on the experience of racial and ethnic minorities, whereas the EU report concerns itself both with socioeconomically disadvantaged groups as defined by a range of variables and with differences across populations based on geographic area of residence.

There are cultural, political, and historical reasons for these markedly different lenses through which the U.S. and the EU view health disparities. With a history marked by the legacy of slavery and discrimination, the United States has adopted a racially oriented perspective on certain social concerns to ensure equitable treatment under the law and safeguard civil rights. The legacy of social disadvantage has repercussions in that poor Blacks have far less wealth and live in more severely impoverished neighborhoods than do poor Whites, while poorly educated Blacks earn less income than their poorly educated White counterparts.²³ In Europe, by contrast, experience with ethnic group genocide during World War II has caused great reluctance to segment or even identify populations on racial or ethnic grounds. Consequently, authorities in many European countries have made a deliberate decision not to collect data on race and ethnicity.²⁴

Cultural differences also contribute to differences in the propensity to frame issues through the lens of economic status. Europeans are characterized by a widespread historical acceptance of the value of social solidarity, stretching back to the postwar era when many European countries implemented strong social welfare protections and other provisions reflecting a commonly held perspective. In the United States, efforts to discuss the problems of economically disadvantaged persons or groups are subject to being denounced as socialism or incitements to class warfare.²⁵

Furthermore, the U.S. policy focus on racial and ethnic health disparities may reflect a “chicken and egg” problem around what studies are funded and

undertaken domestically. In European-based academic research literature studies of health inequalities have focused on health differences between better- and worse-off socioeconomic groups—typically measured by indicators of socioeconomic position such as educational attainment, occupational characteristics, income/wealth, place of residence or living conditions—and have given less attention to racial and ethnic inequalities than has literature from the United States.²⁶

By contrast, in the United States, research on racial and ethnic disparities in health and health care far outstrips that on shortfalls in health and health care experienced by other socially disadvantaged groups. This emphasis carries through to government reports on health and health care.²⁷ The predominance of research on racial and ethnic disparities serves to reinforce the choice to focus policy attention on this manifestation of the health inequity problem, in turn begetting further research. Moreover, a recent assessment of progress in addressing racial and ethnic disparities in health care noted that experts see a potential trade-off in expanding the focus from racial and ethnic disparities to a broader equity agenda. While expansion could help to increase relevance to more of the population, it could also reduce the attention and resources available to address the problem of racial and ethnic disparities.²⁸

Of course the importance of framing lies primarily in the implications for action. If the large health disparities documented by the IOM and others are driven by discrimination in health care or cultural factors related to racial or ethnic differences, they might best be addressed through efforts targeted directly at those issues. If racial differences in health outcomes are driven largely by environmental or behavioral factors associated with economic disadvantage, place of residence, or living conditions, addressing racial disparities in health care will be less effective than addressing the underlying social conditions that contribute to relatively poor health outcomes.

In fact, although apparent discrimination or other factors²⁹ play an important role in explaining disparities relating to certain health conditions, a growing body of evidence shows that race and ethnicity are not nearly as important in explaining health disparities as are underlying factors such as socioeconomic status, place of residence, and living conditions. In 1995, researchers undertaking a comprehensive review of the evidence concluded that “socioeconomic differences between

racial groups are largely responsible for the observed patterns of racial disparities in health status.”³⁰ Later research confirmed the importance of socioeconomic factors in explaining differences in mortality between Black and White men.³¹ In 2011, Hicken and colleagues found that social and environmental factors explained much of the difference in the rates of hypertension found between Black and White populations.³² LaVeist and colleagues found that Black–White health disparities in the prevalence of diabetes, hypertension, obesity among women, and in use of health services dissipated when living conditions were comparable. This led the researchers to conclude that “policies aimed solely at health behavior change, biological differences among racial groups, or increased access to health care are limited in their ability to close racial disparities in health.”³³

Health care systems as perpetrator or victim of disparities?

The European and U.S. health disparity policy publications cited here each take a widely different stance in setting out the role of health care systems in relation to the disparities problem.

As framed in the European Commission report, inequalities are a problem, in part, because the more significant health problems experienced by disadvantaged groups puts an economic burden on socially financed health systems that provide universal coverage. In general, the report does not point to health care systems as important contributors to inequalities in health. However, it acknowledges that poorer people may face more barriers to accessing services, particularly in newer EU member states that are struggling to provide adequate services in the face of the economic downturn. Accordingly, the report presents a plan of action (see [section IV.A](#), in table 2) to improve access and appropriateness of health services for migrants, ethnic minorities, and other vulnerable groups and to stimulate initiatives to encourage health promotion and preventive care for these populations.

While the U.S. report does acknowledge the importance of the social determinants of health, it portrays health disparities as deriving from health system failures to a greater degree than in the European Commission’s assessment. A sizeable share of the strategies proposed to address disparities—six of the 11 strategies—relate to improvements in health insurance and health care delivery to be implemented as means to address racial and ethnic health disparities. Notably, the first strategy

and related plan of action delineated pertain to expansion of insurance coverage and the patient protections afforded therein. This emphasis presumably reflects an appreciation of the role of health insurance in securing access to health care and the disproportionately high rate of uninsured persons among minority populations, as well as evidence that racial and ethnic minorities experience poorer access to services and worse quality of care.

One explanation for the differing emphasis on health care in the two reports may relate to different experiences across countries in how well health care delivery systems serve disadvantaged populations. Studies evaluating service use across income groups indicate that the United States has levels of access inequity across income groups that exceed the level of inequity in many European countries.³⁴ However, recent research sheds light on the types of health care disparities that are most significant in the United States, demonstrating that disparities in access to and quality of care between groups of different races and ethnicities are dwarfed by the disparities identified between high- and low-income populations within each racial or ethnic group.³⁵

These findings suggest that initiatives to increase access to health services for low-income persons by reducing financial and other barriers to care (e.g., local availability of services) and initiatives to improve health care delivery in areas where low-income people live through health programs and providers that serve the poor stand to have an important effect on disparities in health care in the United States. Nevertheless, it is unclear as to whether the level of emphasis on health care versus population health and intersectoral strategies is consistent with the findings from research on the role of health care as a determinant of health status, and the relatively small contribution of improvements in health care access and quality to avertable mortality.*

Pursuit of intersectoral action

The third of the five overarching challenges discussed by the European Commission refers to developing broad social commitment to reduce health inequalities. This is described as working with different levels of

* Having health insurance and adequate access to health care provides benefits for individuals and society beyond potential health improvements, including an increase financial security (protection against catastrophic costs associated with illness or injury) and reduced stress.

government and across sectors (health care, employment, social protection, environment, education, youth, and regional development), to influence how people live their lives, including their experiences at work, school, and leisure in their communities. Specific actions to be utilized by the European Commission include making use of policy coordination mechanisms (see [section III.B.](#) in table 2) and facilitating the exchange of information on best practices through EU platforms and forums on health-related topics (e.g., alcohol, diet, and physical activity) (see [section III.A.](#) in table 2).

While much of the HHS plan pertains to health system strengthening, the report includes references to intersectoral action. Notably, the report includes a pledge (see [section IV.B.1.](#) in table 1) to develop and implement strategies to conduct collaborative health disparities research across federal departments to address social determinants of health in multiple settings. It also notes a plan to evaluate the prospective use of health disparity impact assessments for proposed national policies and programs (see [section III.B.2.](#) in table 2). Presumably, the use of such an impact assessment tool—should testing demonstrate feasibility and value—would introduce “impact on health disparities” as a factor in decision-making regarding policies and programs administered across government departments.

Addressing the link between wealth and health

The European Commission’s report prominently, if delicately, discusses the matter of economic measures as instrumental to achieving equitable health and related objectives. The first overarching action area in the EU health equity policy agenda points to equitable distribution of health as a component of overall social and economic development, noting that not all groups have benefited equally from economic progress. The report text points to EU structural funds (resources the EU deploys to reduce regional disparities in income, wealth, and opportunities) as having a vital role to play in creating a pattern of overall economic and social development that leads to greater economic growth, as well as greater solidarity, social cohesion, and health.

Although the HHS report states unequivocally that health disparities are closely linked with social, economic, and environmental disadvantages, the report does not put forward any specific actions that would explore use of economic policy or social protection programs as tools to address disparities in health.

The differences between the two policy agendas in addressing socioeconomic roots of health problems likely reflect the variation in whether addressing such roots through policy is considered politically feasible (or even desirable). In comparison with European countries, the United States permits a higher share of its population to live in poverty and experiences a much larger chasm between the richest and poorest tiers.³⁶ Unlike in Europe, the concept of social solidarity is rarely discussed and not widely accepted, as evidenced by the contentious and continuing debate over health insurance coverage expansion, with some criticizing the ACA expressly because it involves income redistribution as a means of assuring health insurance coverage.³⁷ In Europe, however, a focus on social solidarity has led to different choices regarding interventions in the labor market and working conditions policy as a means of promoting health equity. Such policies were implemented in Sweden, France, and the Netherlands during the 1990s.³⁸

A shared strategy to improve information and evidence

Both the HHS and EU plans set forward strategies and related actions to improve the information and evidence basis for work on health disparities. The second of the five overarching strategies for reducing inequalities in the EU report is “improving the data and knowledge base, and mechanisms for measuring, monitoring, evaluating, and reporting on health inequalities.” The plan calls particularly for support of policy evaluation, so as to expand the base of knowledge on what mechanisms for increasing equity are most effective. The U.S. plan devotes two of its 11 strategies to strengthening the knowledge base, announcing its intent to increase the availability and quality of data collected and reported on racial and ethnic minority populations, and to conduct and support new research to inform disparities reduction initiatives.

Conclusions

The findings from our analysis of the policy positions taken in the United States and Europe in pursuit of health equity goals raise important questions about the direction of U.S. policy.

It is clear that over the years, U.S. policy has prioritized closing racial and ethnic disparities gaps in health over attention to health disparities experienced by disadvantaged persons who are not members of racial or ethnic minorities, including those who are disadvantaged by virtue of their low income and

material disadvantage. The rationale for attention to the plight of racial and ethnic minorities is clear; persistent and self-perpetuating inequities, as are seen in education and residential segregation, mean that race and social class remain closely intertwined in this country. Nevertheless, while important differences in health and health care by race and ethnicity are evident, much of the disparities seen in health and health care are due to underlying socioeconomic differences across racial and ethnic groups. This raises an important policy question as to whether the goal of health equity across racial and ethnic groups can be achieved absent concurrent and equivalent attention to the full range of socioeconomic drivers of health inequality. Joining the group of analysts who have drawn similar conclusions—including Isaacs and Schroeder³⁹ and Woolf and Braveman⁴⁰—we believe that the U.S. policy focus should be expanded to include more attention to disparities associated with socioeconomic class, defined by factors such as income, education, occupation, and residence, in addition to race and ethnicity.

Our review also indicates that the United States continues to focus on health system transformation as a mechanism to pursue access and quality of care improvements intended to close health disparities. As the United States makes sizeable strides in moving toward universal coverage through provisions of the ACA, the importance of health care as a driver of health disparities will be further dwarfed by social, environmental, and behavioral health determinants.^{41†} In order to pursue the most effective disparity-reduction policies, it will be important to re-evaluate the relative importance of strengthening the health care delivery system as opposed to investing in population health and nonmedical health determinants. We must periodically question whether health equity goals would be better served by a significant shift in resources to public and community health initiatives and by prioritizing intersectoral work to address upstream health drivers. Evidence of high levels of inefficiency in U.S. health spending suggests the feasibility of capturing savings for redirection through such steps as eliminating overuse of wasteful or discretionary services.⁴²

Presuming that U.S. health policy-makers have established positions informed by the relevant research literature, a question emerges as to whether the current policy focus was adopted because of a belief that shifting course was undesirable or politically infeasible. Is our U.S. commitment to eliminating racial and ethnic disparities inadvertently serving as a distraction facilitating avoidance of confronting the economic injustice at the root of health inequity problems? Should U.S. policy-makers follow the Europeans' lead to act on the growing evidence about the role of material deprivation on health through policies designed to reduce the severity of disparities in socioeconomic status?

While some may argue that political action to address economic injustice is impractical given the state of American values and public opinion, there are voices of disagreement. In their 2009 book, Benjamin Page and Lawrence Justice analyzed decades of polling data and concluded that, contrary to what is expressed in the mainstream media, the views of a majority of Americans—including affluent Americans—can be described as conservatively egalitarian, in that they are concerned about inequality to the point of being willing to make personal sacrifices to address it.⁴³ If this view is correct, it may be the case that political decision-makers are failing to act in accordance with the views of those they represent when they abstain from enacting policies that would entail further redistribution in pursuit of greater equity. Is America's skittishness in facing the real costs of economic hardship and deprivation comparable to the Europeans failing to prioritize matters of racial and ethnic disparities?

Both the United States and Europe have identified the achievement of reductions in health inequities as an important policy objective, but are pursuing quite different strategies to meet this common goal. Perhaps some public discussion of the types of questions raised in this paper might help to ensure that our resources are deployed effectively and in accordance with our core values as a society.

† Notably, the fact that uninsured Blacks are disproportionately affected by the decisions of states not to expand Medicaid will slow or diminish the projected impact of the ACA on disparities. Nearly 60 percent of uninsured Blacks with incomes below the Medicaid expansion limit resided in states that had not pursued Medicaid expansion, as of late June 2013.

Table 1. Strategies and Principal Actions to Address Racial and Ethnic Health Disparities, as Presented in a 2011 Action Plan by the U.S. Department of Health and Human Services

Strategy	Actions to be Undertaken by the U.S. Department of Health and Human Services
I.A. Increase the proportion of people with health insurance.	I.A.1. Increase the proportion of people with health insurance and provide patient protections in Medicaid, CHIP, Medicare, health insurance exchanges, and other forms of health insurance.
I.B. Reduce disparities in access to primary care services and care coordination.	I.B.1. Increase the proportion of persons with a usual primary care provider and patient-centered health homes.
I.C. Reduce disparities in the quality of care.	I.C.1. Improve the quality of care provided in the health insurance exchanges.
	I.C.2. Improve outreach for adoption of certified electronic health record technology to improve care through the Regional Extension Centers program and other federal grant programs.
	I.C.3. Develop, implement, and evaluate interventions to prevent cardiovascular diseases and their risk factors.
	I.C.4. Increase access to dental care for children in Medicaid and CHIP.
II.A. Increase the ability of health professions and the health care system to identify and address racial and ethnic health disparities.	II.A.1. Support the advancement of translation services.
	II.A.2. Collaborate with individuals and health professional communities to make enhancements to the current National Standards for Culturally and Linguistically Appropriate Services in Health Care.
II.B. Promote the use of community health workers and individuals who provide health education and support to their community members.	II.B.1. Increase the use of Promotoras to promote participation in health education, behavioral health education, prevention, and health insurance programs.
	II.B.2. Promote the use of community health workers by Medicare beneficiaries.
II.C. Increase the diversity of the healthcare and public health workforces.	II.C.1. Create a pipeline program for students to increase racial and ethnic diversity in the public health and biomedical sciences professions.
	II.C.2. Increase education and training opportunities for recipients of Temporary Assistance for Needy Families and other low-income individuals for occupations in healthcare fields through the Health Profession Opportunity Grants program.
	II.C.3. Increase the diversity and cultural competency of clinicians, including the behavioral health workforce.
	II.C.4. Increase the diversity of the HHS workforce.
III.A. Reduce disparities in population health by increasing the availability and effectiveness of community-based programs and policies.	III.A.1. Build community capacity to implement evidence-based policies and environmental, programmatic, and infrastructure change strategies.
	III.A.2. Implement an education and outreach campaign regarding preventive benefits.
	III.A.3. Develop, implement, and evaluate culturally and linguistically appropriate evidence-based initiatives to prevent and reduce obesity in racial and ethnic minorities.
	III.A.4. Reduce tobacco-related disparities through targeted evidence-based interventions in locations serving racial and ethnic minority populations.
	III.A.5. Increase education programs, social support, and home-visiting programs to improve prenatal, early childhood, and maternal health.
	III.A.6. Implement targeted activities to reduce disparities in flu vaccination.
	III.A.7. Implement targeted activities to reduce asthma disparities.
III.B. Conduct and evaluate pilot tests of health disparity impact assessments of selected proposed national policies and programs.	III.B.1. Adopt a “health in all policies” approach.
	III.B.2. Evaluate use of health disparity impact assessment for proposed policies and programs.
IV.A. Increase the availability and quality of data collected and reported on racial and ethnic minority populations.	IV.A.1. Implement a multifaceted health disparities data collection strategy across HHS.
IV.B. Conduct and support research to inform disparities reduction initiatives.	IV.B.1. Develop and implement strategies to increase access to information, tools, and resources to conduct collaborative health disparities research across federal departments.

Strategy	Actions to be Undertaken by the U.S. Department of Health and Human Services
	IV.B.2. Develop, implement, and test strategies to increase the adoption and dissemination of interventions based on patient-centered outcomes research among racial and ethnic populations.
	IV.B.3. Promote community-based participatory research approaches to increase cancer awareness, prevention and control to reduce health disparities.
	IV.B.4. Expand research capacity for health disparities research.
	IV.B.5. Leverage regional variation research in search of replicable success in addressing health disparities.
V.A. Increase efficiency, transparency, and accountability of HHS programs.	V.A.1. Streamline grant administration for health disparities funding.
	V.A.2. Monitor and evaluate implementation of the HHS Disparities Action Plan.
	V.A.3. Goal-level disparities monitoring and surveillance.
	V.A.4. Strategy-level evaluation.
	V.A.5. Action-level monitoring.

Source: U.S. Department of Health and Human Services, 2011.⁴⁴

Table 2. Challenges and European Union Actions to Reduce Health Inequalities, as presented in a 2009 Communication from the European Commission

Challenges to be Addressed	Actions to be Undertaken by the European Union
I. Achieve an equitable distribution of health as part of overall social and economic development.	None specified; the communication proposes consideration of whether monitoring of health inequalities indicators would be useful as a tool for monitoring EU progress in achieving economic growth and greater social cohesion.
II. Improve the data and knowledge base and mechanisms for measuring, monitoring, evaluating, and reporting on health inequalities.	II.A. Support the further development and collection of data and health inequalities indicators by age, sex, socio-economic status, and geographic dimension.
	II.B. Develop health inequality audit approaches through the health program in joint action with member states willing to participate.
	II.C. Orient EU research towards closing knowledge gaps on health inequalities—including activities under the themes of Health and Socio-Economic Sciences and Humanities of the 7 th EU Framework Program for Research.
	II.D. Emphasize research and dissemination of good practices relevant to addressing health inequalities by EU agencies.
III. Build commitment across society to the goal of reducing health inequalities.	III.A. Develop ways to engage relevant stakeholders at the European level to promote the uptake and dissemination of good practice.
	III.B. Include health inequalities as one of the priority areas within the ongoing cooperation arrangements on health between the European regions and the European Commission.
	III.C. Develop actions and tools on professional training to address health inequalities using the health program and other mechanisms.
	III.D. Stimulate reflection on target development in the Social Protection Committee through discussion papers.
IV. Take steps targeted to meet the needs of specific vulnerable groups (e.g., people in poverty, disadvantaged migrant and ethnic minority groups, people with disabilities, elderly people, or children living in poverty).	IV.A. Launch initiatives in collaboration with member states to raise awareness and promote actions to improve access and appropriateness of health services, health promotion, and preventive care for migrants and ethnic minorities and other vulnerable groups, through the identification and exchange of good practice supported by the health and other programs.
	IV.B. Ensure that the reduction of health inequalities is fully addressed in future initiatives on healthy aging.
	IV.C. Report on the use of community instruments and policies for Roma inclusion, including a section on health inequalities prepared for the 2010 Roma summit.
	IV.D. Examine how the Fundamental Rights Agency could, within the limits of its mandate, collect information on the extent to which vulnerable groups may suffer from health inequalities in the EU, particularly in terms of access to adequate health care, social, and housing assistance.
	IV.E. Carry out activities on health inequalities as part of the European Year for Combating Poverty and Social Exclusion 2010.

Challenges to be Addressed	Actions to be Undertaken by the European Union
V. Develop and improve the contribution of EU policies to directly or indirectly tackling health inequalities.	V.A. Provide further support to existing mechanisms for policy coordination and exchange of good practice on health inequalities between member states. such as the EU expert group on Social Determinants of Health and Health Inequalities, linking both to the Social Protection Committee and the Council Working Party on Public Health.
	V.B. Review the possibilities to assist member states to make better use of EU cohesion policy and structural funds to support activities to address factors contributing to health inequalities.
	V.C. Encourage member states to further use the existing options under the rural development and market policy (school milk, food for most deprived persons, school fruit scheme) to support vulnerable groups and rural areas with high needs.
	V.D. Hold policy dialogs with member states and stakeholders on equity and other key fundamental values in health, as set out in the EU Health Strategy.
	V.E. Provide funding under the EU's Employment and Social Solidarity program, including for peer reviews and a call for proposals in 2010 to assist member states in developing relevant strategies.
	V.F. Run a forum on health and restructuring to examine appropriate measures to reduce health inequalities.
	V.G. Commission an initiative on the EU role in global health.

Source: European Commission, 2009.⁴⁵

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Elizabeth Docteur is an independent health policy researcher and consultant to clients in government and in organizations working on behalf of the public interest to devise, support, and implement reforms. Robert A. Berenson, MD, is an Institute Fellow at the Urban Institute. For their helpful comments on this paper, the authors thank Paula Braveman, professor of Family and Community Medicine and director of the Center on Social Disparities in Health at the University of California, San Francisco, and Johan Mackenbach, professor of Public Health, and chair of the Department of Public Health at Erasmus University Medical Center, Rotterdam, the Netherlands, as well as Andrea Ducas and Susan Mende from the Robert Wood Johnson Foundation. The authors retain sole responsibility for the analysis presented in this paper and the conclusions drawn.

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