


# The Health Equity Framework: A Science- and Justice-Based Model for Public Health Researchers and Practitioners

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*In this article, we describe a science- and justice-based framework for promoting health equity designed for researchers and practitioners working across public health and social science fields. We developed the health equity framework (HEF; [etr.org/healthequityframework](http://etr.org/healthequityframework)) in two phases of iterative development. Building on existing models, the HEF illustrates how health outcomes are influenced by complex interactions between people and their environments. The framework centers on three foundational concepts: equity at the core of health outcomes; multiple, interacting spheres of influence; and a historical and life-course perspective. Health equity is defined as having the personal agency and fair access to resources and opportunities needed to achieve the best possible physical, emotional, and social well-being. By centering population outcomes, the HEF encourages researchers and practitioners to think beyond traditional approaches that focus on individual behaviors and choices to assess and identify their gaps in acknowledging and addressing factors from multiple spheres of influence. We identified four, interacting spheres of influence that represent both categories of risk and protective factors for health outcomes as well as opportunities for strategies and interventions that address those factors. The HEF highlights the explicit and implicit interactions of multilevel influences on health outcomes and emphasizes that health inequities are the result of cumulative experiences across the life span and generations. The*

*HEF is a practical tool for leaders and professionals in public health research and practice to reflect on and support a shift toward addressing health inequities resulting from the interplay of structural, relational, individual, and physiological factors.*

**Keywords:** health equity; social determinants of health; framework; health disparities

## ► BACKGROUND

Health equity is a public health priority. Yet some market research suggests current social determinants approaches do not yield public support for addressing health disparities and may be challenging for practitioners to apply (Robert Wood Johnson Foundation et al., 2010). Simultaneously, there is criticism that current public health strategies fail to reduce disparities because they do not acknowledge the systemic roots of inequity (Hogan et al., 2018). Clarity of health equity approaches is needed to ensure collaborative efforts reflect shared assumptions and practices that will effectively reduce disparities and promote greater equity (Braveman et al., 2017). It is critical that the public health field identify applied frameworks that can support both researchers and practitioners in

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applying a health equity approach. This article describes a science- and justice-based framework for promoting health equity that is designed for researchers and practitioners working across public health, health promotion, and social science fields.

## ► **METHOD**

Development of ETR's health equity model was conducted in two phases. The first phase was a review of theoretical and conceptual frameworks that examined influences on health at different levels, such as sociopolitical, neighborhood and community, family and relationships, and development and biology. A team of applied researchers and health professionals met to discuss the benefits and limitations of the models. As no single model met our criteria, we adapted elements of several models (Center for Population Health and Health Disparities, 2007; Law et al., 1996) into one simple framework for articulating and exploring strategies for addressing social determinants of health. The second phase consisted of iterative development of the framework based on 12 interviews with stakeholders in health equity, public health, and social science. The interviews centered on conceptual understanding of the framework and its functionality in application in research and practice. The framework underwent several revisions, each followed by internal and external stakeholder reviews.

## ► **RESULTS**

As a result of theory synthesis and multiple rounds of iterative development, ETR established the Health Equity Framework (HEF; Figure 1; [etr.org/healthequity-framework](http://etr.org/healthequity-framework)). The HEF builds on approaches from public health, education, and social science to illustrate how health outcomes are influenced by complex interactions between people and their environments. The visual design is intentionally simple and representative of a holistic view of health to support action across disciplines (e.g., public health, social work, education, etc.) and job functions (e.g. frontline providers, program managers, researchers, etc.). The framework is designed to facilitate the translation of science to practice and to encourage emerging research questions informed by practice. The HEF centers on three foundational concepts described below.

### ***Equity at the Core of Health Outcomes***

The framework defines “health equity” as having the *personal agency* and *fair access to resources and opportunities* needed to achieve the best possible

physical, emotional, and social well-being. Many traditional public health interventions aim to modify an individual's *personal agency* to improve outcomes. These interventions may focus on increasing knowledge, skills, and self-efficacy among individuals to adopt and maintain health-promoting behaviors. These approaches on their own, however, fail to address the upstream social determinants that prevent individuals and communities from achieving optimal health outcomes.

Communities must also have *fair access to resources and opportunities* that facilitate positive physical, emotional, and social health, including education, health services, and housing as well as support systems, safe environments, and social capital. The HEF recognizes that resources and opportunities are not distributed equally across populations and access is impeded by institutional and interpersonal biases, such as racism, sexism, classism, homophobia, transphobia, and ableism. Left unmitigated, unequal access to resources and opportunities leads to health inequities, defined as the systematic and preventable differences in health outcomes closely linked to social, economic, and environmental conditions.

The HEF intentionally centers on health outcomes at a population-level—rather than the individual—in order to elevate and shift our understanding of and attention to health equity. Targeting the factors that affect both access to resources and opportunities and the personal agency to act on those opportunities are crucial for achieving health equity. Framed this way, the HEF encourages researchers and practitioners to think beyond traditional individual-level approaches to assess and identify their gaps in acknowledging and addressing factors from multiple spheres of influence.

### ***Multiple, Interacting Spheres of Influence***

Where many models stack influencing factors or illustrate pathways from factors to health behaviors, the HEF is designed to highlight the explicit and implicit interactions of multilevel influences on outcomes. We identified *four spheres of influence* that represent categories of risk and protective factors for health outcomes as well as strategies to address those factors.

*Systems of Power.* Systems of power refer to policies, processes, and practices that determine the distribution and access to resources and opportunities needed to be healthy. Systems of power—as opposed to social conditions such as poverty—contribute to the systematic and differential treatment of groups and include

## ETR's Health Equity Framework.

Health and education outcomes are influenced by complex interactions between people and their environment.

### Relationships and Networks

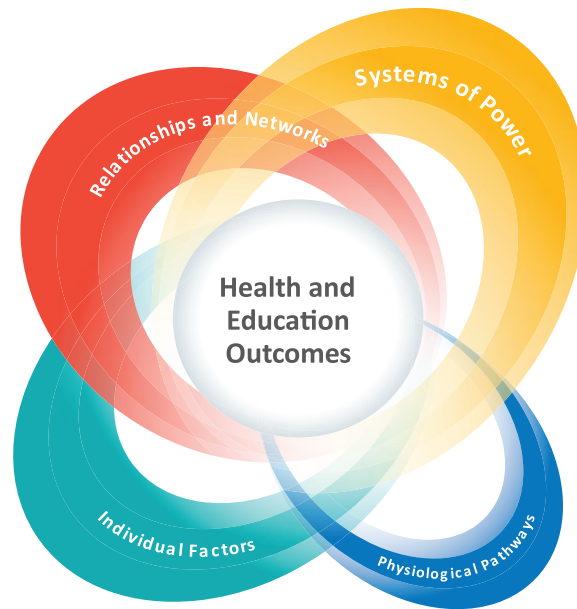
Connections with family, friends, partners, community, school and workplaces that:

- + Promote health equity through support systems that encourage health-promoting choices
- Intensify health inequities through social networks that enable health-harming behaviors

### Individual Factors

A person's response to social, economic and environmental conditions that:

- + Promotes health equity through attitudes, skills and behaviors that enable their personal and community's health
- Intensify health inequities through attitudes, skills or behaviors that cause harm to their personal or community's health



### Systems of Power

Policies, processes, practices that:

- + Promote health equity through fair access to resources and opportunities that enable healthy lives
- Intensify health inequities by allowing unfair social, economic or environmental advantages for some groups over others

### Physiological Pathways

Factors that:

- + Promote health equity when a person's physical, cognitive and psychological abilities are maximized
- Intensify health inequities when a person's environment or experiences has impaired their physical, cognitive or psychological functions

### Health Equity

Having the personal agency and fair access to resources and opportunities needed to achieve the best possible physical, emotional and social well-being.

### Health Inequities

The preventable differences in health outcomes closely linked to social, economic and environmental conditions.

FIGURE 1 The Health Equity Framework

institutionalized and interpersonal manifestations of bias (Raymond, 2016). Where systems of power have been restructured to repair the historical and current causes of health disparities, they may promote health equity by ensuring fair access to resources and opportunities. Where systems of power are left unchecked, they may perpetuate health inequities through unfair social, economic, and environmental advantages for some groups over others. The HEF views these systems as functioning at varying levels in both political (federal, state, and local) and institutional (school, private companies, health care systems) spaces. While “big policy” issues (e.g., health care, housing) are often discussed as drivers of population health, there is also substantial need for ensuring health equity policies are

enacted at the institutional level, including practices in institutions that mitigate the effects of “big” policies on disparities. For example, there is current research interest in how school environment and restorative justice strategies work to improve adolescent health outcomes by shifting school practices toward repairing harm, elevating student voice, and improving school climate (Patton et al., 2016).

*Relationships and Networks.* Relationships and networks include the many connections and support structures made up of family (biological, adopted, or chosen), friends, romantic partners, and people within cultural communities, neighborhoods, schools, and workplaces. These connections may simultaneously

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serve as protective influences from health-harming behaviors as well as sources that contribute to stigma, discrimination, or pressure that lead to poorer health outcomes. Relationships and networks may promote health equity through support systems that mitigate the social disadvantage produced by systems of power. This is consistent with extensive research suggesting that social relationships are critical for maintaining health (Holt-Lunstad et al., 2010). Social networks may also intensify poorer health outcomes by enabling health-harming behaviors, either by the negative effects of these relationships (e.g., intimate partner violence, identity stigma) or by the explicit or implicit social pressure to engage in risk behavior. For example, young people may engage in health-risk behaviors to maintain social status in a peer group, even if peer pressure is only perceived (Patton et al., 2016).

*Individual Factors.* Individual factors concern a person's response to social, economic, and environmental conditions through their attitudes, skills, and behaviors. For example, childhood development of social and emotional skills—such as self-control, self-regulation, self-efficacy, relationship skills, and coping skills—are associated with better mental and physical health outcomes, life satisfaction, and life expectancy in adulthood (Goodman et al., 2015). The HEF emphasizes the interaction of individual factors with other spheres of influence. A person's attitudes, skills, and behaviors are shaped by their personal experiences, including their relationships with others and access to opportunities, often driven by systems of power. While a person's demographic characteristics (e.g., gender, race, socioeconomic status) and other aspects of their identity are closely related to their experiences and opportunities, the HEF underscores individual factors (i.e., skills and behaviors) that contribute directly to health outcomes.

*Physiological Pathways.* Physiological pathways refer to a person's biological, physical, cognitive, and psychological abilities. The HEF recognizes that these factors contribute substantially to health outcomes but cannot be easily, or in some cases ethically, modified by intervention. This sphere of influence also concerns how the timing and intensity of other determinants might change developmental, biological, and cognitive trajectories that lead to poorer health outcomes. For example, extreme or extended activation of the physiological stress response that results from early childhood adversities (e.g., extreme poverty, interpersonal, or community violence) disrupts development of brain architecture and function,

neuroendocrine stress response, and immune system function; these disruptions are precursors to impairments in social and emotional behaviors and physical and mental illness over the life span (Johnson et al., 2013). When applying physiological pathways in practice, we focus on (1) increasing awareness of how physiological responses can be driven by other spheres of influence and (2) how interventions can maximize and support the resilience of physiological functions and abilities after exposure.

### ***Historical and Life-Course Perspective***

A life-course perspective is a critical component of the HEF, including the historical and developmental stages of the life span. Figure 2 illustrates the shifting and evolving importance of different systemic and relational influences from infancy to adulthood. For example, where family of origin is a key influencer as a child, an adolescent experiences greater exposure to relationships with peers, teachers, and employers that shape their attitudes, behaviors, and outcomes into adulthood (Patton et al., 2016). A life-course perspective also emphasizes that health inequities are the result of cumulative experiences across the life span and generations (Braveman, 2014). To achieve equity, it is critical to acknowledge and mitigate how systems of power have historically and currently work to undermine fair access to resources and opportunities to achieve optimal health outcomes.

## **► IMPLICATIONS FOR PRACTICE**

The HEF was developed as a unifying framework for ETR's diverse goals and approaches for improving health outcomes. In our experience applying the HEF, establishing a shared language was a critical first step toward implementing a health equity agenda. The HEF was designed as a tool with two main functions: (1) reflecting on the multilevel influences of priority health outcomes and (2) identifying strategies to improve inequities of priority health outcomes resulting from multilevel factors. We have used the HEF to

- map projects across the organization according to primary spheres of influence to assess level of resource allocation by sphere, content area, and strategy;
- organize reviews of research on the determinants of priority health outcomes and identify feasible and relevant multilevel determinants to address; and

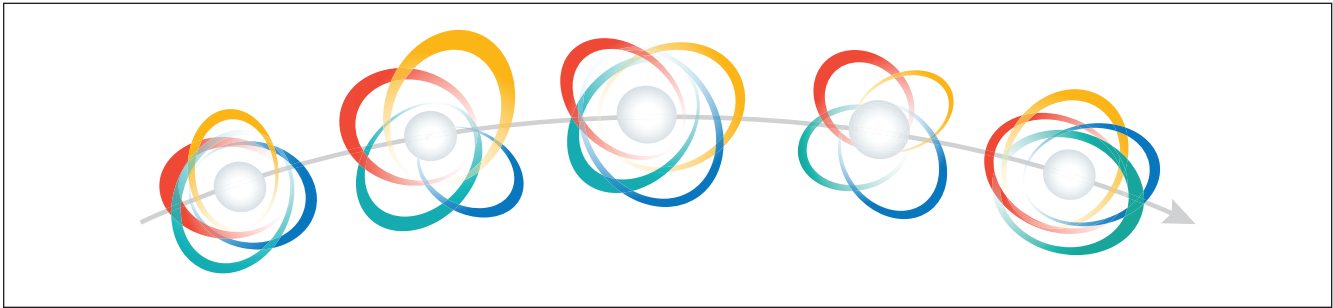


FIGURE 2 The Health Equity Framework Across the Life-Course

- identify and prioritize new funding opportunities that increase the number of projects addressing multilevel influences with an emphasis on systems of power and relationships and networks.

For example, ETR's large portfolio of sexual health programs for adolescents historically focused on addressing individual-level factors, such as attitudes, skills, and behavior. The HEF provided a framework for expanding on a traditional sexual health education program (individual factors) by developing young people's skills within a relationships-context (relationships and networks) and employing neuroscience principles, such as autonomy and social-emotional processes, in activities and messages (physiological pathways). The program was also delivered in a youth-friendly, health service setting to increase participants' comfort with and access to sexual health services (systems of power).

ETR's HEF is part of a growing discourse within the public health and health promotion fields, calling attention to the urgent need to address the interrelated, complex factors that influence health equity. The HEF shares similarities with other recent frameworks, including a new research framework from the National Institute on Minority Health and Health Disparities (Alvidrez et al., 2019). Both frameworks recognize the limitations of a historical focus on individual-level factors, call attention to the relational- and systems-level determinants of health and adopt historical and cumulative life-course perspectives. Our complementary emphasis on creating tools for the public health field provides users of these frameworks a way to see and do their work differently and with potentially greater impact on equity outcomes. As we continue to evaluate the HEF, we look forward to opportunities to work collaboratively with those who have developed frameworks on health equity, to share lessons learned and reflect on refinements of these tools for the field.

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