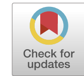
Nursing Outlook 71 (2023) 102032

Contents lists available at ScienceDirect

Nursing Outlook

journal homepage: www.nursingoutlook.org

Health equity: A concept analysis



Chrystal L. Lewis, PhD, RN [a,*], Alice Yan, PhD [a], Michelle Y. Williams, PhD, RN [a,b], Lynette V. Apen, DNP, RN, CNS [a], Cecelia L. Crawford, DNP, RN, FAAN [a], Lisa Morse, MSN, RN [a], Anna M. Valdez, PhD, RN, FAEN [c], G. Rumay Alexander, EdD, RN, FAAN [d], Ernest Grant, PhD, RN, FAAN [e], Claire Valderama-Wallace, PhD, MPH, RN [f], Dale Beatty, DNP, RN, NEA-BC [g]

[a] *Department of Research and Health Equity, Stanford Health Care, Menlo Park, CA*
[b] *Division of Primary Care and Population Health and Nursing Research Section, Department of Medicine, Stanford University School of Medicine, Palo Alto, CA*
[c] *Department of Nursing, Sonoma State University, Rohnert Park, CA*
[d] *School of Nursing, University of North Carolina at Chapel Hill, Chapel Hill, NC*
[e] *Duke University School of Nursing, Durham, NC*
[f] *Department of Nursing, California State University, East Bay, Hayward, CA*
[g] *Executive Administration, Stanford Health Care, Palo Alto, CA*

A R T I C L E I N F O

Article history:
Received 9 February 2023
Received in revised form 28 July 2023
Accepted 9 August 2023
Available online 6 September 2023

Keywords:
Health equity
Concept analysis
Health care organization
Health care system
Payor
Policymaker

A B S T R A C T

Background: Although health equity is critically important for healthcare delivery, there are inconsistencies in its definitions or lack of definitions.
Purpose: Develop a comprehensive understanding of health equity to guide nursing practice and healthcare policy.
Method: Walker and Avant's concept analysis method was used to establish defining attributes, antecedents, consequences, and empirical referents of health equity.
Findings: Health equity defining attributes are grounded in ethical principles, the absence of unfair and avoidable differences, and fair and just opportunities to attain a person's full health potential. Health equity antecedents are categorized into environmental; financial or economic; law, politics, and policy; societal and structural; research; and digital and technology.
Discussion: Health equity's antecedents are useful to distinguish health disparities from health outcomes resulting from individual preferences. To achieve health equity, organizations need to focus on addressing the antecedents.
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Background

In 2021, health spending in the United States (U.S.) grew 2.7% to $4.3 trillion, $12,914 per person, and comprised 18.3% of the nation's gross domestic product (Centers for Medicare & Medicaid Services (CMS), 2023). Despite outspending all other developed nations in healthcare, the U.S. lags behind in nearly all measures of health status, indicating that higher healthcare expenditure does not guarantee better health outcomes or equity (Papanicolas et al., 2018). Medical care contributes to only 10 to 20% of variations in health outcomes, while the broader socioeconomic context (i.e., social determinants of health) [SDoH]) accounts for half of these variations (De Lew & Sommers, 2022; Woolf, 2017). Therefore, to enhance the health of the U.S. population, a focus on health equity and the broader SDoH is essential (Hood et al., 2016). Health equity encompasses pursuing the "best health possible" for all, including freedom from harm, exploitation, hazards, and suffering (Allen et al., 2011). U.S. stakeholders, including policymakers, health system leaders, insurers, and researchers, have intensified their focus on addressing health disparities and advancing health equity. This focus is further solidified by the Joint Commission's (TJC) (2022) requirements, which positions health equity as a cornerstone of healthcare improvement and a quality and safety priority (Perlin & Lee, 2022; TJC, 2022). While the TJC primarily views health care disparities as a quality of care issue, it is crucial to recognize the role of social justice in addressing these disparities. Addressing health disparities is not just about improving health care; it is a commitment to a more just society, as these disparities exacerbate social disadvantage and vulnerability (Braveman et al., 2011; Velasco & Reed, 2023).

Despite the growing emphasis on health equity, the definition of "health equity" remains ambiguous across many healthcare

* Corresponding author: C.L. Lewis, Department of Health Equity and Research, Stanford Health Care, 301 Ravenswood Avenue, Menlo Park, CA 94025.
E-mail address: CLewis@stanfordhealthcare.org (C.L. Lewis).

https://doi.org/10.1016/j.outlook.2023.102032
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organizations. For example, HCA Healthcare and UVA Encompass Health incorporate the term in their strategic initiatives but lack a clear, identifiable definition on their public-facing websites (HCA Healthcare, n.d.; Minda, 2022; UVA Encompass Health, n.d.). This ambiguity extends to healthcare payors and insurers, with some providing explicit definitions (Anthem Blue Cross Blue Shield, 2022; CMS, n.d.; Kaiser Permanente Division of Research, n.d.), while others allude to the concept (Hiles, 2022; United Health Group, n.d.). The absence of a standardized definition for health equity can lead to inconsistencies in how health equity is addressed, challenges in measuring progress toward health equity, and difficulties in implementing effective strategies to promote it (Evans, 2020).

There are persistent and pervasive health disparities in populations that are minoritized based on race and ethnicity compared to White/non-Hispanic people in the United States. Although race is a social construct (Flanagin et al., 2021), it is frequently used to classify health outcomes. For instance, the burden of cancer falls disproportionately on Black/African Americans, Native Americans and Alaska Natives, Asians, Native Hawaiians/other Pacific Islanders, and Hispanics. These groups endure not only higher incidence rates but also grapple with more aggressive disease presentations and poorer survival outcomes across various types of cancer (Zavala et al., 2021). The health disparities are equally stark in maternal health, with Black/African American women being three to four times more likely to die from pregnancy-related causes than White women, and Native American and Alaska Native women facing a 2.5 times higher risk of death (Petersen et al., 2019).

The COVID-19 pandemic has further amplified the critical importance of health equity. People who are minoritized based on race and ethnicity, including Black/African Americans, Hispanics, and Native Americans, have disproportionately suffered from COVID-19 infections, hospitalizations, and deaths (Baptiste et al., 2020). These health disparities are the consequences and constitutive of broader societal issues, such as food and housing insecurity, educational gaps, employment instability, and systemic injustice, highlighting the urgent need to address structural racism (Lewis et al., 2022). Structural racism is characterized by societal systems and policies that perpetuate inequities, further marginalize people who are racialized as non-White, and is a fundamental driver of health disparities in the U.S. In response, the American Nursing Association (ANA) issued a racial reckoning statement acknowledging its role in perpetuating systemic racism in nursing through the exclusion of Black/African American, Native Americans, and other nurses of color, while also failing to support and care for communities and people who have been minoritized and marginalized (Grant & Cole, 2022). According to Lett et al. (2022), extant amplification of health equity has given a fresh lens to its tourism by those otherwise "not previously engaged in the work" notwithstanding decades of underresourcing and disregard. Lett et al. further suggest health equity tourists risk mischaracterizing health inequities and obfuscating salient solutions. For health care organizations, understanding structural racism as a core determinant of health inequities is crucial. This understanding forms the basis for advocating for policy and practice changes aimed at eradicating these health inequities (Kapadia & Borrell, 2023).

Nurses are at the forefront of health care delivery and are uniquely positioned to address health inequities (National Academies of Sciences, Engineering, and Medicine NASEM, 2021). Their close contact with patients, understanding of community needs, and holistic approach to care make them crucial agents of change (NASEM, 2021). The *Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity* report underscores this role, emphasizing the need for nurses to serve as change agents in bridging health care delivery and social needs care in the community (NASEM, 2021). Therefore, the authors propose a comprehensive concept analysis of health equity. This analysis is not merely an academic exercise; it is a crucial step toward a more equitable health care system. Since the work of health equity exists beyond the health care system, cocreation and emergence of a more just society would require a transformed approach to health, wellness, safety, wholeness, and care. By providing a nuanced understanding of health equity, the authors aim to illuminate the various pathways forward for current and future health care providers to lead, follow, and partner with the most directly impacted communities with the knowledge and tools necessary to dismantle structural racism and promote health equity in their practice.

Health equity, despite its widespread use, is more than just a term. It is an abstract, complex, and multifaceted concept that encompasses a broad range of interacting factors and dimensions. A concept is an understanding from experiences and reasoning using a particular set of instances or occurrences, while a definition states the word's meaning as in a dictionary definition (Merriam-Webster, n.d.-a, n.d.-b). To fully comprehend and apply health equity in practice, a rigorous concept analysis is essential. This process clarifies the concept's meaning, defines its attributes, identifies its antecedents and consequences, and elucidates its various interpretations and applications in different contexts (Walker & Avant, 2019). It also establishes an operational definition, enhancing the understanding and promoting effective health equity strategies.

Methods

The Walker and Avant (2019) concept analysis format follows a prescribed step-by-step process to bring clarity to the concept under consideration and was utilized for this health equity concept analysis. Walker and Avant consider concept analysis a continually evolving process. Once more information is known about a concept, the results of the original concept analysis may change. This method begins with reviewing dictionary definitions, reviewing concept usage in other disciplines, identifying defining attributes, and establishing an operational definition of the concept. Once those steps are completed, a model case is constructed and may be followed by a borderline case, related case, contrary case, invented case, and illegitimate case. For the purposes of this concept analysis, model and contrary cases were included for comparison and contrast of the selected concept. These cases help clarify what the concept is and is not, enabling the defining of the concept's antecedents and consequences.

To complete the concept analysis of health equity, the review of the literature involved electronic database searches over two time periods. The initial November 2022 search strategy included searching CINAHL, PubMed, and online dictionaries for the terms "health equity," "health inequity," and "concept analysis" either alone or in combination. Searches were individualized for each database with open years and yielded 26 citations, which was reduced to 21 after deduplication. The team was also particularly interested in how health equity is used by healthcare organizations, healthcare payors and insurers, as well as healthcare policy drivers and makers. A search of select healthcare systems and professional organizations yielded 36 citations, with 26 lacking a definition or vaguely alluded to health equity. The 10 remaining citations, combined with the database searches and exclusions, resulted in a final total of 21 relevant sources. Several review rounds by five independent reviewers resulted in 100% consensus for 18 final references specific to the concept of health equity.

After careful analysis, the investigators determined that a second comprehensive search was needed. The second literature review was conducted from April 4 to June 15, 2023, and is reported in Figure 1 using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses reporting guidelines. The search strategy was developed in consultation with a medical librarian information specialist. Search phrases included ("health equity" OR "healthcare equity" OR "health care equity" OR "health inequities") AND (concept* OR defin* OR mean* OR

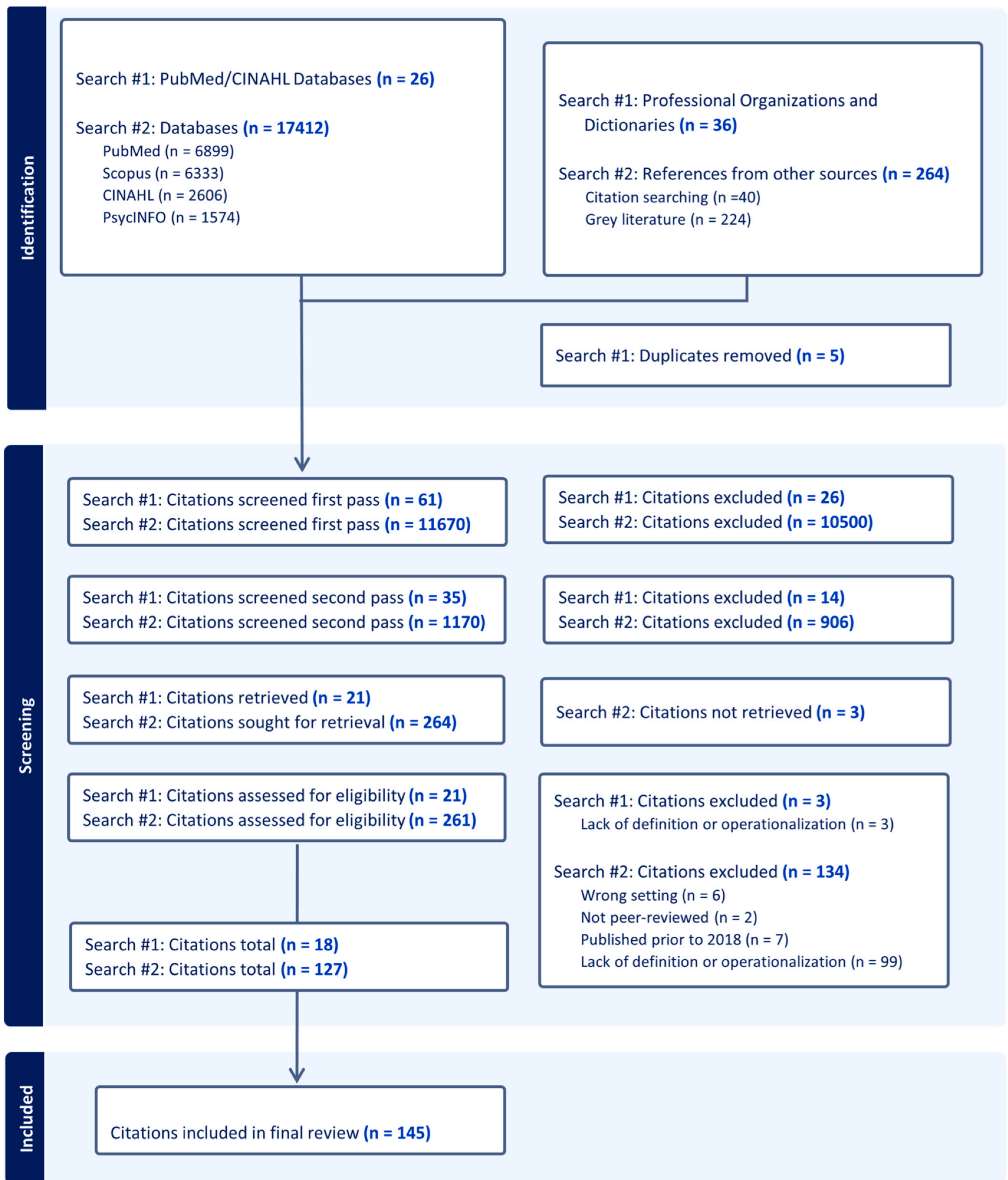

Figure 1. PRISMA diagram. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

explain* OR determinant* OR factor* OR character* OR outcome* OR impact* OR effect*). Four electronic databases (i.e., PubMed, Scopus, CINAHL, and PsycINFO) were included. The second database search produced 17,412 articles, with 264 additional sources identified from searching grey literature and citation searching. After initial deduplication, titles and abstracts of the remaining 11,670 citations were screened for eligibility by a team of two authors and three clinical research associates using Covidence systematic review software (Covidence, Melbourn VIC Australia). Studies and reports were included if they were peer-reviewed, defined, conceptualized, or operationalized health equity, and were U.S.-centric. Using the Covidence platform, five authors independently conducted additional title and abstract screening of the

remaining 1,170 publications. After removing publications that did not meet inclusion criteria, the remaining 264 studies and citations were retrieved for full-text review and screened by five authors independently. A total of 127 articles were deemed eligible for inclusion. In all, 145 citations from the two searches were included in the final review results. Supplement 1 provides an overview of the definitions derived from these final articles. The definition of web in Supplement 1 illuminates how few organizations are ultimately the primary sources defining health equity, and thus it is noted how those who are marginalized or under-resourced maybe overlooked.

Definitions

At the time of this writing, there are no dictionary definitions for "health equity." Oxford English Dictionary (OED) (n.d.-b) defines *health* as "By extension, the general condition of the body with respect to the efficient or inefficient discharge of functions: usually qualified as good, bad, weak, delicate, etc." The OED (n.d.-a) defines *equity* as "The quality of being equal or fair; fairness, impartiality; even-handed dealing." Importantly, the Merriam-Webster (n.d.-c) adds an additional explicit context to its definition of *equity* "justice according to natural law or right specifically: freedom from bias or favoritism." The added context of "freedom from bias" deserves special emphasis in defining health equity. Merriam-Webster (n.d.-c) also includes, as a second definition, "the money value of a property or of an interest in a property in excess of claims or liens against it." The OED does not include a definition related to monetary value in its definition of *equity*.

One of the earliest accessible and most concise definitions of equity in health came from Whitehead and the World Health Organization (Whitehead, 1991, 1992): "equity in health implies that ideally, everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential if it can be avoided," (Whitehead, 1992, p. 433). The Robert Wood Johnson Foundation (RWJF) short-version definition is: "Health equity means that everyone has a fair and just opportunity to be as healthy as possible," (Braveman et al., 2017, p. 2). Braveman (2022) discusses that only using the RWJF short version of the definition results in a loss of context. NASEM (2017) describes health equity as eliminating disadvantages from achieving health potential and emphasizes the inextricable connection between opportunity and health equity. The Future of Nursing 2030 (NASEM, 2021) adopted the NASEM definition and states that "health equity is the state in which everyone has the opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance"(p. 128). Many other federal agencies and public health organizations have their own definitions for health equity, including the Center for Disease Control and Prevention (CDC) (2022), Healthy People 2030 (n.d.), and CMS (n.d.).

Although definitions of health equity do exist, the lack of concept clarity leads to challenges in pursuing health equity, including the confounding societal debate regarding the distinction between actual health disparities versus differences based on personal preference. There are no shared definitions that reflect a collective understanding of key attributes of health equity (Gómez et al., 2021). In a recent commentary, Braveman (2019) pointed out that a lack of conceptual clarity may lead to inadequate guidance. Specifically, a lack of a common understanding of the concept may lead to operational challenges in measuring (a) progress toward health equity and (b) accountability among different organizations and health systems. Ambiguity in health equity definitions could further lead to misdirecting resources.

Concept Use in Other Disciplines

The Walker and Avant (2019) format discourages a singular nursing or medical focus of the concept. This strategy limits bias, fostering a true understanding of the concept. Since laws comprise the societal infrastructure that can either contribute to health equity or health inequity (Teitelbaum et al., 2019), and there is a significant economic impact caused by health inequities, this concept analysis explores health equity in the disciplines of law and economics.

Health Equity in Law

The discipline of law is inextricably linked to health equity (Teitelbaum et al., 2019). Laws and their enforcement impact health equity by influencing SDoH such as access to healthcare, housing, transportation, education, and employment (Hahn et al., 2018). Well-designed federal and state laws and health policies aim to support health equity by improving population health through reduced inequitable distribution of SDoH (Lynch, 2020). Examples of public health policies that have improved population health include tobacco control, motor vehicle safety, and immunization programs (Teitelbaum et al., 2019). The Civil Rights Act of 1964 is linked with greater equity in infant survival, while the California statewide park development and community revitalization Act of 2008 led to equitable opportunities for physical activity and outdoor play (Braveman et al., 2017). New California legislation, AB 1407, aims to address racism in healthcare by ensuring nurses complete implicit bias training during their prelicensure nursing programs, in hospitals with new graduate programs, and those working with perinatal patients (Bill Text, 2021).

In addition to the law serving as a remedy to foster health equity, health inequity may result from unjust application of the law (Teitelbaum et al., 2019). Teitelbaum et al. (2019) describe that racially discriminatory laws that are no longer in practice still have a powerful impact on health equity in communities of color. The authors attribute the negative impact on health equity to the history of enslavement and oppression that created institutional racism in social sectors, including education, housing, labor, financial, and the justice system, which have direct links to compromising population health (Teitelbaum et al., 2019). Examining the health and societal consequences of historical oppression is critical to righting the wrongs to improve SDoH and has been proven effective through the passage of civil rights laws, state regulations, and Supreme Court decisions (Hahn et al., 2018). Organization position statements such as the ANA's "Our Racial Reckoning Statement" (American Nurses Association, 2022) also progress this work by acknowledging their contributions to institutional racism.

Health Equity in Economics

Given the economic significance of health inequities and the connection of cost-benefit analysis in informing policymakers, the authors explored the concept of health equity and economics. The instances of health equity discussed in economics were in journals that were affiliated with healthcare and focused on the societal cost and economic dimensions of health. The economic benefits of a healthier population include a more productive workforce by taking fewer sick days, cost savings in insurance-related spending, and improved life expectancy (Turner, 2018). LaVeist et al. (2023) estimated the economic burden related to failure to achieve health equity goals was over $1 trillion in 2018. LaVeist et al. estimated the annual costs of inequities in health to be $258.4 billion for extra medical care and $149.1 billion in lost productivity. In addition, LaVeist et al. estimated the annual cost of preventable premature death due to health inequities as $622.3 billion.

Healthcare is a business that impacts healthcare operations; these activities occur in a complex system-wise fashion rather than in a simple linear fashion (Weberg, 2009). The integration of health

equity can cause system disequilibrium that challenges traditional operational approaches. Cost-effectiveness analysis (CEA) is a modeling strategy that provides a method to determine if the value of the intervention justifies the cost (U.S. Department of Veterans Affairs, n.d.). Hoch et al. (2021) describe the use of CEA modeling to determine which health equity strategy addresses the greatest need and is most cost effective. Cookson et al. (2017) discussed an adapted CEA study that goes beyond a standard approach to an equity-informed economic evaluation. This includes an equity impact analysis quantifying the cost of equity with specific variables and an equity trade-off analysis to assess improving total health versus meeting equity objectives. The process includes plotting on a visual health equity impact plane chart to illustrate health benefit and tradeoffs to support policymakers' decision-making (Cookson et al., 2017).

Findings

Health Equity Defining Attributes

Defining attributes in a concept analysis are key components of the concept that appear throughout the multiple uses of the concept (Walker & Avant, 2019). To achieve health equity, the following defining attributes of health equity must be true (Braveman et al., 2017; National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979; Whitehead, 1992; NASEM, 2017):

(1) The ethical principles of respect for persons, beneficence, and justice, as defined within the Belmont Report, are upheld.
(2) There is an absence of unfair and avoidable differences.
(3) Every person has a fair and just opportunity to attain their full health potential.

Table 1 provides further elucidation on the synthesis of the defining attributes.

While the Belmont Report originated out of the need to address ethical considerations of human subjects research, the principles identified transcend human subjects research to clinical practice and are foundational for health equity (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). Although these ethical principles are embedded within the ANA Code of Ethics (American Nurses Association, 2015), there are opportunities to improve upholding these ethical principles in the U.S. healthcare system. Examples of U.S. healthcare perpetuating harm and not upholding beneficence include maternal morbidity and mortality rates for minoritized populations with noteworthy extremes for Black/African American women (MacDorman et al., 2021) as well as the harm of the integration of medical devices, such as pulse oximetry, that are only researched on lighter skin tones, resulting in measurement errors that impact treatment decisions for patients with darker skin tones (Sjoding et al., 2020). Respect for persons is not routinely upheld, as exemplified by medical mistrust and diminished patient autonomy (Griffith et al., 2021). Justice is not upheld, as evidenced by lead poisoning subsequent to unsafe water in Flint, MI (Griffith et al., 2021). Pauly et al. (2021) assert that the ethical principles of justice, beneficence, and respect for persons are foundational principles for public health ethics.

Health equity is multifaceted and must include a commitment to reduce and ultimately eliminate systematic, unfair, and avoidable differences in health outcomes. Race is a social construct, not a biological construct (Flanagin et al., 2021). The misuse of race as a biological construct can result in health disparities and avoidable differences in health outcomes for marginalized communities (Ahmed et al., 2021). For example, including the race coefficient in the equation for the estimated glomerular filtration rate (eGFR) results in higher eGFR values for Black/African Americans than non-Black/African Americans with the same serum creatinine concentrations, age, and gender (National Institute of Diabetes and Digestive and Kidney Diseases, n.d.). Until recently, race-based algorithms to evaluate kidney function had been used for two decades based on limited studies that found Black/African Americans had, on average, higher serum creatinine concentrations than non-Black/African Americans due to increased muscle mass. Patients' eGFR scores inform many clinical decisions, including referral to treatment or transplant, so "correcting" Black/African American patients' scores may lead to a delayed referral to nephrology care and kidney transplantation. This example of racial disparities in kidney disease outcomes demonstrates an avoidable difference in health outcomes caused by systematic, unfair bias.

A critical component of health equity is identifying and understanding the root causes of health outcomes differences due to a lack of fair and just opportunities versus individual preferences. For example, obesity follows an inverse social gradient and exemplifies a lack of fair and just opportunities. Obesity levels are disproportionately high in minoritized populations, low-income, and other socially marginalized U.S. population groups. Society tends to perceive obesity as the result of individual preferences in diet and exercise. While individuals have some personal responsibility for their health, research on social determinants of exercising and eating behaviors reveals the influence of powerful social and environmental factors (Kumanyika, 2019) as well as structural oppression and economic conditions (Lee & Pausé, 2016). The most consistent social determinants of obesity are socio-economic status (SES) and environments that promote obesity (i.e., high crime concentration, less healthy food access, and lack of walkability and recreational opportunities). Systemic oppression perpetuates a lack of fair and just opportunities resulting in inequity, particularly in lower SES neighborhoods and underrepresented racially and ethnically minoritized populations, increasing the likelihood of exposure to an obesogenic environment, exacerbating disparities in obesity.

Model Case

A model case is defined as the use of the concept in an example that includes all its defining attributes (Walker & Avant, 2019). The

Table 1
Defining Attribute Literature Synthesis

Attribute 1: Ethical Principles of Beneficence, Autonomy, and Justice as Defined by Belmont Report	Attribute 2: Absence of Unfair and Avoidable Differences	Attribute 3: Every Person has a Fair and Just Opportunity to Attain Full Health Potential
(Adelson et al., 2021; Benjamin, 2021; Boyd et al., 2022; Braveman, 2019; Cannon & Tuchinda, 2022; Davis, 2022; Field, 2021; Golden et al., 2021; Jackson et al., 2020; Jordan & McGinty, 2022; Liburd et al., 2020; McMillan Boyles et al., 2023; Melino et al., 2022; Nesbit et al., 2022; Peterson et al., 2021; Rich & Paschal, 2020)	(Alves-Bradford et al., 2020; Amdur & Yeung, 2021; Amri et al., 2022; Antequera et al., 2021; Beard & Sanderson, 2022; Braveman, 2022; Henson et al., 2019; Hirsch et al., 2023; Hudson, 2021; Kang & Barcelona, 2022; Kegler et al., 2019; Kelly, 2022; Lee et al., 2020; Moise et al., 2022; Peterson et al., 2021; Wallace et al., 2021)	(Agénor et al., 2021; Antequera et al., 2021; Beard & Sanderson, 2022; Braveman, 2022; Diaz et al., 2022; Gómez et al., 2021; Hahn et al., 2018; Jackson et al., 2020; Kelly, 2022; Khor et al., 2023; Lee et al., 2020; Lennon et al., 2022; Liburd et al., 2020; Moise et al., 2022; Naccarella & Guo, 2022; Peterson et al., 2021; Rich & Paschal, 2020; Salmond & Dorsen, 2022; Sieck et al., 2022; Wallace et al., 2019, 2021)

following model case fully demonstrates all the attributes of health equity and exemplifies the meaning of the concept. Ms. Lisa Smith is a 42-year-old woman living in inner-city Detroit, MI. She is a single mother of three children aged 25, 17, and 7 years. She juggles two jobs and does not have reliable transportation. She is very worried about her recent abnormal mammogram screening and was told that she needs to schedule follow-up tests as soon as possible. As a result of the National Healthcare to all policy, she knows that she is covered by health insurance regardless of her age, gender, race, work status, disability status, and income, just like everyone else. Later that day, she received a call from a nurse, who quickly arranged free transportation for her the next day to complete the follow-up tests in a medical center close to her home. The nurse listened to Ms. Smith's goals and concerns. During the conversation, the nurse also assured her that a patient navigator would work with her so she did not need to worry about figuring out the complex insurance issues and would also get free transportation for all her ongoing clinical visits. The patient navigator linked her to community resources when needed, including investigating participation in a clinical research trial. The nurse and the patient navigator upheld the ethical principles of respect for persons, beneficence, and justice when working with her to facilitate her autonomy, maximize the potential benefits while minimizing potential harms of the treatment, and justice with investigation into participation in research trials. In addition, Ms. Smith had a fair and just opportunity to achieve her full health potential with access to healthcare and treatment.

Contrary Case

A contrary case is defined as not being the concept (Walker & Avant, 2019). Health disparities are a natural contrary case for health equity. In their concept analysis of health disparity, Downey and DiBenedetto (2021) defined health disparity as "preventable difference in health care opportunities and outcomes that disadvantaged populations experience due to a number of inequities in interpersonal and systemic contexts." (p. 225). The following case illustrates not upholding the ethical principles identified in the Belmont Report, illuminates unfair and avoidable differences, and limited opportunity for the attainment of full health potential. Mikayla Jones is a 13-year-old girl who lives in a crowded one-bedroom apartment with her mom, grandma, and three siblings near an industrial complex in an urban city. The industrial complex regularly contaminates the drinking water while concurrently polluting the air. There are no grocery stores with fresh produce within a five-mile radius. Mikayla has severe asthma. There are no health clinics or pharmacies nearby. Mikayla's family has financial difficulties and cannot regularly pay for her needed medications.

Health Equity Antecedents

Antecedents are events that must be in place before the concept can occur (Walker & Avant, 2019). The conditions linked to health equity can be grouped into six main antecedent categories of (see Figure 2 and Supplement 2) (a) Environmental (Carr et al., 2020; Gee & Ford, 2011; Givens et al., 2020; Golden, 2023; Khairat et al., 2019; Mui et al., 2022; National Academies of Sciences, Engineering, and Medicine (NASEM), 2021; Williams & Cooper, 2019; NASEM, 2017; World Health Organization, n.d.); (b) Financial and Economic (NASEM, 2017; Churchwell et al., 2020; Fink, 2009; Givens et al., 2020; Gómez et al., 2021; Jackson & Sadler, 2022; Khetpal et al., 2021; Lennon et al., 2022); (c) Law, Political, and Policy (Alves-Bradford et al., 2020; Brownson et al., 2021; Carr et al., 2020; Douglas et al., 2019; Givens et al., 2020; Golden, 2023; Hudson, 2021; Lennon et al., 2022; Schram et al., 2021); (d) Societal and Structural (NASEM, 2017; Carr et al., 2020; Churchwell et al., 2020; Fink, 2009; Gee & Ford, 2011; Givens et al., 2020; Healthy People 2030, n.d.; Jackson & Sadler, 2022; NASEM, 2020; Nesbitt, 2021; U.S. Department of Health and Human Services, 2022; World Health Organization, n.d.; Yearby et al., 2022); (e) Research (Churchwell et al., 2020; Gee & Ford, 2011); and (f) Digital Divide and Technology (Khairat et al., 2019; Ray et al., 2023; Rodriguez & Samal, 2023; Szymczak et al., 2023).

The Environment antecedent includes the critical elements involved in the geographical space in which people are born, live, play, work, and grow old (National Academies of Sciences, Engineering, and Medicine (NASEM), 2021; NASEM, 2017; U.S. Department of Health and Human Services, 2022; World Health Organization, n.d.). Descriptions of the environment include housing, food availability, parks and green space, city services, and water (Agénor et al., 2021; Ahn et al., 2021; NASEM, 2017; Downey & DiBenedetto, 2021; Healthy People 2030, n.d.; Pronk et al., 2021; Ray et al., 2023; Williams & Cooper, 2019). Within those physical aspects are unspoken conditions involving public safety, emergency and disaster preparedness (Golden et al., 2021; NASEM, 2021), livability, residential segregation, and employment opportunities, all of which have direct effects on health (Gee & Ford, 2011; NASEM, 2017). For example, climate change could drastically impact the entire environmental structure of neighborhoods (Cole et al., 2023; Golden et al., 2021; NASEM, 2021), nations, and global health (NASEM, 2017; World Health Organization. (n.d.)).

The Financial and Economic antecedent is linked to many aspects of the environment. Wealth, socioeconomic status, and living conditions

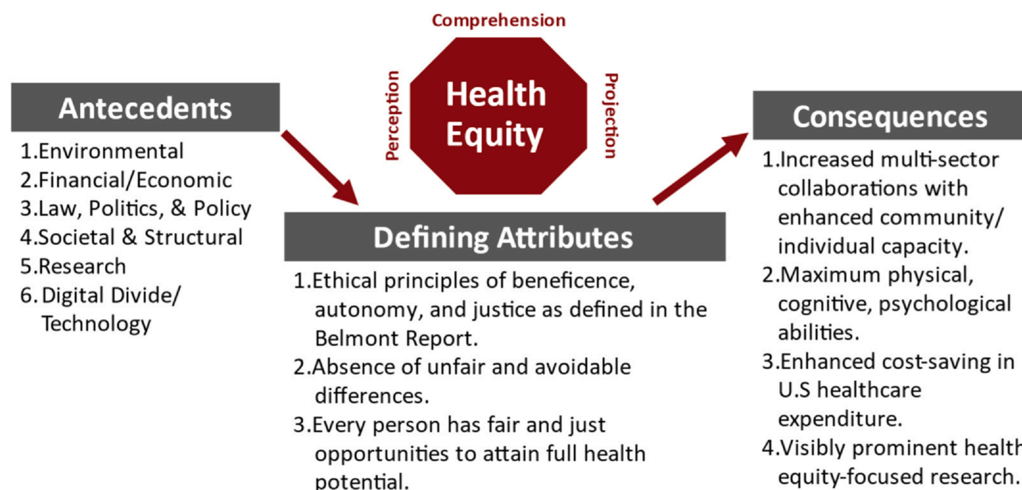

Figure 2. Health equity concept analysis diagram.

are directly correlated to health, as seen in the cost of healthcare, medications, and treatment (Braveman et al., 2018; CDC, 2021; CMS, n.d.; Healthy People 2030, n.d.; Jackson & Sadler, 2022). Recent discussions concerning financial wealth have described the need for people to have the ability to acquire and build wealth, as well as transfer this wealth across generations (Braveman et al., 2018; CDC, 2021; Gee & Ford, 2011). Central to these conversations are differences in wealth/resource redistribution and financial incentives, where comparisons between urban, suburban, and rural populations and their vulnerable communities can be striking (Bensken et al., 2022; CDC, 2022; Chomilo, 2023; Friel et al., 2021; Givens et al., 2020; Gómez et al., 2021; Liburd et al., 2020).

Law, Politics, and Policies inform the third antecedent. Structural racism operates through laws and policies that allocate resources in ways that disempower members of racially and ethnically minoritized populations and result in their inequitable access to power and resources (i.e., high-quality care). For instance, historical racial segregation was created by legislation and reinforced by the policies of economic institutions and housing agencies (i.e., redlining) (Agénor et al., 2021; Carr et al., 2020; Golden, 2023; Green et al., 2021). Racial profiling in the criminal justice system is another illustration of structural racism-related policies and practices that disproportionately affect marginalized racial/ethnic groups (Churchwell et al., 2020; Givens et al., 2020; Hudson, 2021; Jackson & Sadler, 2022; National Academies of Sciences, Engineering, and Medicine (NASEM), 2021; NASEM, 2017; U.S. Department of Health and Human Services, 2022). Policies and laws can also influence a person's immigration and legal status, which have broad implications for social services and health (Carr et al., 2020; Gee & Ford, 2011; Jackson & Sadler, 2022; Young et al., 2020). State laws have direct impacts on vital areas such as civil rights, marriage status, Medicaid expansion, child welfare/adoption, nutrition (Agénor et al., 2021), climate change (Cole et al., 2023), education, health insurance coverage (Agénor et al., 2021; Givens et al., 2020), and programs involving harassment, bullying, and hate crimes (Adelson et al., 2021; Kline et al., 2022). Lawmakers, public health officials, payers, providers, and other key stakeholders have issued a call for a more comprehensive approach to address this labyrinth of equity issues (Dawes, 2018; Douglas et al., 2019; NASEM, 2021; Rudner, 2021).

Societal and Structures involved in modern life are the fourth antecedent and are particularly complex (CMS, n.d.; Gee & Ford, 2011; Givens et al., 2020; Jackson & Sadler, 2022; NASEM, 2020, 2021; U.S. Department of Health and Human Services, 2022; Williams & Cooper, 2019). Healthcare for all involves access to basic needs and community services (Adelson et al., 2021; CDC, 2021; Givens et al., 2020; Williams & Cooper, 2019; World Health Organization, n.d.) such as pharmacy/medications, biomedical and medical treatments (Friel et al., 2021), and enrollment in Medicare and Medicaid, particularly for those who are homebound (Center for Disease Control and Prevention (CDC), 2021; Yearby et al., 2022; NASEM, 2022; Centers for Medicare & Medicaid Services (CMS). (n.d.)). The restricted percentage of providers per community is compounded by the quality of their education and awareness of health inequities (Alves-Bradford et al., 2020; Kelly, 2022; National Academies of Sciences, Engineering, and Medicine (NASEM), 2021; Perry & Moll, 2021). Racial and ethnic groups' inequitable access to treatment and vaccines during the pandemic amplified long-lasting health inequities and led to disproportionate COVID-19-related mortality and hospitalization (Givens et al., 2020; Mude et al., 2021; Yearby et al., 2022). Demographic and cultural aspects of language, religion, gender, disability, and age directly influence a wide spectrum of social issues such as connections/networks, employment, workforce diversity, health literacy, resource opportunities, and distribution of power (Alves-Bradford et al., 2020; Diallo et al., 2022; Fink, 2009; Gómez et al., 2021; Jackson & Sadler, 2022; National Academies of Sciences, Engineering, and Medicine (NASEM), 2020; Peterson et al., 2021; Williams & Cooper, 2019; NASEM, 2017; Centers for Medicare & Medicaid Services (CMS). (n.d.); Healthy People 2030, n.d). Cultural, work-related, and social networks are deemed particularly important for those with limited resources and person-to-person contact (Alves-Bradford et al., 2020; Melino et al., 2022; Peterson et al., 2021). These complex multifaceted issues are associated with the capacity of individuals and the community.

The fifth antecedent of Research includes the exclusion of minoritized and marginalized participants in research (Alegria et al., 2021) and the rise of health equity tourism, the practice whereby investigators with no prior training in or dedication to health equity conduct equity-focused research (Lett et al., 2022). There is a lack of inclusion, diversity, equity, and justice considerations when recruiting participants in traditionally restricted clinical trials and limited patient engagement in research design. Much of the disengagement and participatory reluctance can be traced to populations with historical memories of past unethical and often tragic research efforts (Folayan et al., 2022; Hudson, 2021). When trial participants are homogenous (i.e., primarily White), findings may be skewed and not generalizable to population groups with a higher burden of health disparities. Thomas et al. (2011) argued that the lack of inclusion and diversity has contributed to the knowledge gap in guiding interventions targeting minoritized populations. Reconsideration of approaches to governmental systems, translation-to-practice, analytical methods, and multilevel intergenerational interventions call for coordinated efforts between advocacy groups, policymakers, judiciary, and researchers exploring expanded areas of research (e.g., equitable population-focused studies, restorative justice-based research, and differential effects of COVID-19 related health outcomes) (Alcaraz & Yanez, 2022; Alegria et al., 2021; Antequera et al., 2021; Carr et al., 2020; Douglas et al., 2019; Gee & Ford, 2011; Milburn et al., 2019; Moise et al., 2022; Peterson et al., 2021; Sieck et al., 2022; Welch et al., 2022). Health equity tourism poses a potential risk of exacerbating knowledge gaps and research outcomes that fail to address meaningful implications for advancing equity outcomes.

The final antecedent is the Digital Divide and Technology. Quality health information, educational opportunities, and knowledge acquisition are informed by this digital divide and those who have access to computers, connectivity, and the internet (Braveman et al., 2017; Churchwell et al., 2020; Dodd-Butera et al., 2019; Jackson & Sadler, 2022; Khairat et al., 2019; Ray et al., 2023; Szymczak et al., 2023). Although these technologies are now considered ubiquitous, rural areas may lack basic hardware/software platforms, high-tech equipment, Wi-Fi, computer literacy, and a private space for telehealth and video calls, all needed for individuals to engage in their own wellness through personal electronic healthcare records and systems (National Academies of Sciences, Engineering, and Medicine (NASEM), 2021; Rodriguez & Samal, 2023; Sieck et al., 2022; Szymczak et al., 2023). Investing in hi-tech healthcare in these underserved communities will require not only the proper equipment/applications but also a supportive telemedicine team with expertise in decision support and a digital environment assessing convenience, cost, trustworthiness, timeliness, and benefits (Rodriguez & Samal, 2023; Szymczak et al., 2023). Artificial intelligence is a new 21st-century paradigm that must also be managed to avoid yet another form of health equity exploitation and bias (Rodriguez & Samal, 2023).

Consequences of Health Equity

Walker and Avant (2019) define consequences as incidents or events that happen as a result of the occurrence of a concept. As health equity has not yet been reached, the consequences discussed here are theoretical in nature. There are four categories of consequences for health equity (see Figure 2 and Supplement 2). First, at

the societal level, a consequence of health equity includes increased multi-sector collaborations and cross-sector networks and enhanced organizational, community, and individual capacity that enable healthy lives (Adelson et al., 2021; Cole et al., 2023; Gertel-Rosenberg et al., 2022; John et al., 2021; Srivastav et al., 2020; Thimm-Kaiser et al., 2023). The second consequence of health equity, at the individual level, is health outcomes in which everyone achieves their highest health potential with reduced morbidities, mortalities, disease burden, decreased disease incidence and prevalence, and a better quality of life. Specifically, a person's physical, cognitive, and psychological abilities are maximized (Peterson et al., 2021; Srivastav et al., 2020). The third consequence is the cost-saving in U.S. healthcare expenditure, including the use of current and evolving technology (Carr et al., 2020; Epstein, 2022; Kang & Barcelona, 2022; Sieck et al., 2022; Szymczak et al., 2023). The last consequence is health equity-focused research, which has become visibly prominent with (a) expanding and improving race and ethnicity data collection (Cash-Gibson et al., 2020; Kang & Barcelona, 2022; Wasserman et al., 2019), (b) increasing clinical trial participation, and racially and ethnically minoritized participant engagement in collaborative research to adequately reflect their current state and disease burden (Brownson et al., 2021; Cash-Gibson et al., 2020; Diallo et al., 2022; Lennon et al., 2022; Milburn et al., 2019), and (c) advancing medical and scientific knowledge available for all to reduce health disparities (Churchwell et al., 2020; Gee & Ford, 2011; Jackson & Sadler, 2022).

Empirical Referents

Empirical referents function as a metric to ascertain if the concept is present or not (Walker & Avant, 2019). Despite being part of the Walker and Avant's method, empirical referents are not always identified within a concept analysis. In the context of health equity, organizations have long grappled with the metrics of health equity and disparities (Zimmerman, 2019). Thus, this concept analysis does not define empirical referents for health equity.

Discussion

Health equity is a critical outcome that hinges on a multitude of societal and structural changes. It is distinct from health disparities, which serve as the metric used to measure progress toward achieving health equity (Braveman, 2014). This concept analysis offers an in-depth understanding of health equity, a term that often varies in interpretation. To propel policy and research in this domain, a unified definition is vital. Using the exhaustive literature review, the authors propose a definition of health equity as the "*fair and just opportunity for all people to achieve their full health potential without variation from personal characteristics, historical oppression, and societal influences.*"

Six key antecedents to health equity were identified: environmental factors, financial and economic conditions, legal and political contexts, societal and structural conditions, research, and digital divide and technology. The COVID-19 pandemic laid bare the disproportionate inequities of health for many people living in vulnerable communities who were denied protective measures like working from home and equal access to the breakthrough therapies available to combat this often-deadly virus. Addressing these antecedents is essential for achieving health equity as they are linked to the potential consequences of achieving health equity, which are significant and multi-layered. At the structural level, these include striving to achieve the highest level of health and improved health outcomes for all. Health equity can lead to societal influences, community and individual capacities, economic factors such as cost-saving, and advancements in research. These consequences can profoundly impact an individual's health and quality of life.

There is concern that "health equity tourism" will undermine not just research efforts but also broader diversity, equity, and inclusion efforts by healthcare systems, professional institutions, regulatory agencies, and the justice system (Lett et al., 2022; Nweke et al., 2022). This term explains the practice of investigators lacking health equity expertise and/or community engagement "…parachuting into the field in response to timely and often temporary increases in public interest and resources" (Lett et al., 2022, p. 17). "Tourists" exit these exploited communities with data that disregard the people behind the numbers and spread misinformation "pollution" that reinforces racial/ethnic stereotypes and perpetuates this destructive cycle (Lett et al., 2022; Nweke et al., 2022). A poem by Petteway (2022) describes this phenomenon from the viewpoint of wounded community members who seek to "claim our own biopsies" (p. 673). Researchers must engage communities to build trust and come to truly know their members as partners and co-investigators who are deeply invested in their neighborhoods and people (Petteway, 2022).

Health equity is a concept separate from health disparity. Health equity is an outcome evasive in its definitions, as it depends upon numerous societal and structural changes. Central to the definition is a focus on the person at the center of this conundrum, with that focus radiating outward to the multitude of historical, societal, legal, political, economic, environmental, and technological factors impacting a person's ability to achieve optimal health. The melding of these elements reflects the Belmont Report and solidifies the definition of health equity: "*the fair and just opportunity for all people to achieve their full health potential without variation from personal characteristics, historical oppression, and societal influences*."

Limitations

Despite the comprehensive nature, this concept analysis has limitations. It is based on the available literature within the last 5 years. While aiming to be inclusive, the proposed definition of health equity may not capture all the nuances of this concept as understood in different cultural, social, or geographical contexts. Additionally, the intersectionality of varying identities and the subsequent potential for compounding barriers to health equity were not explored within this paper. Furthermore, the analysis primarily focuses on the definition of health equity within the context of the U.S. health system, which may limit its applicability to other health systems globally.

Despite these limitations, this analysis provides a foundation for further exploration and understanding of health equity. It contributes to the education and training of healthcare professionals, informing the development of curricula and training programs. A clear conceptualization of health equity can guide nursing practice and healthcare policy toward more equitable care and help identify the impact racism has on health and inform the interventions to address it.

Conclusion

In conclusion, this concept analysis provides a comprehensive understanding of health equity, a term that is critical to the advancement of health care policy, practice, and health care education. The definition of health equity, as the "*fair and just opportunity for all people to achieve their full health potential without variation from personal characteristics, historical oppression, and societal influences*," underscores the importance of addressing the multifaceted antecedents of health equity. The analysis highlights the need to address environmental, financial, economic, legal, political, societal, structural, research, and technology factors to achieve health equity. The potential consequences of obtaining health equity are substantial.

Despite the identified limitations, this concept analysis lays a foundation for future research, policy development, and practice aimed at promoting health equity. This concept analysis is intended to deepen the understanding of health equity among healthcare professionals. It is not meant to encourage "health equity tourism," a term coined to describe researchers who abruptly shift their focus to health equity without the requisite expertise, potentially perpetuating inequities and diluting the field (Lett et al., 2022). A clear conceptualization of health equity can guide nursing practice and healthcare policy toward more equitable care, help identify the ways structural racism and implicit bias affect health, and inform interventions to address it. Understanding health equity is a crucial step toward actualizing health equity.

CRediT Statement

Chrystal L. Lewis: Methodology, Validation, Formal analysis, Investigation, Resources, Data Curation, Writing – Original draft; Review and Editing, Visualization. *Alice Yan*: Validation, Formal analysis, Resources, Data curation, Writing – Original draft; Review and editing. *Michelle Y. Williams*: Conceptualization, Resources, Validation, Writing – Review and Editing. *Lynnette V. Apen*: Validation, Formal analysis, Investigation, Resources, Data curation, Writing – Original draft; Review and editing; Supervision, Project administration. *Cecelia L. Crawford*: Validation, Formal analysis, Investigation, Resources, Data Curation, Writing – Original draft; Review and Editing, Visualization. *Lisa Morse*: Data Curation, Writing – Original draft. *Anna M. Valdez*: Design, Resources, Reviewing and Editing. *G. Rumay Alexander*: Conceptualization, Writing – Review and Editing. *Ernest Grant*: Validation, Writing – Review and Editing. *Claire Valderama-Wallace*: Validation, Review and Editing. *Dale Beatty*: Validation, Resources, Writing – Review and Editing.

Funding

The authors did not receive any funding for this work.

Declaration of Competing Interest

The authors do not have any conflict of interests to disclose.

Acknowledgments

The authors would like to acknowledge the conceptualization contributions of Maria O'Rourke, PhD, RN, FAAN, particularly around the development of the first health equity defining attribute of ethical principles. They would like to acknowledge the support of Hong-nei Connie Wong for her assistance in building their literature search strategy. They want to acknowledge Ashley Son, MPH for project administration and Hillary Duncan, MSN, RN, PHN, Jonathan Dinh, and Pamela Princess Josue for their assistance with article screening. Finally, the authors would like to acknowledge the expertise of Drs. Sheldon Fields, Peggy Chinn, and Lucinda Canty and their generosity in providing feedback on this work.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.outlook.2023.102032.

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