



National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé



LET'S TALK
HEALTH EQUITY

PART OF THE LET'S TALK SERIES

WHAT IS HEALTH EQUITY?

The pursuit of health equity has become a worldwide public health objective.¹ Health equity means that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance.²

Health equity “involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill” (p. 5).² While striving to improve health outcomes for all population groups, the pursuit of health equity seeks to reduce the excess burden of ill health among socially and economically disadvantaged populations.²

WHAT IS HEALTH INEQUITY?

Health inequities are health differences between population groups—defined in social, economic, demographic or geographic terms—that are unfair and avoidable.³

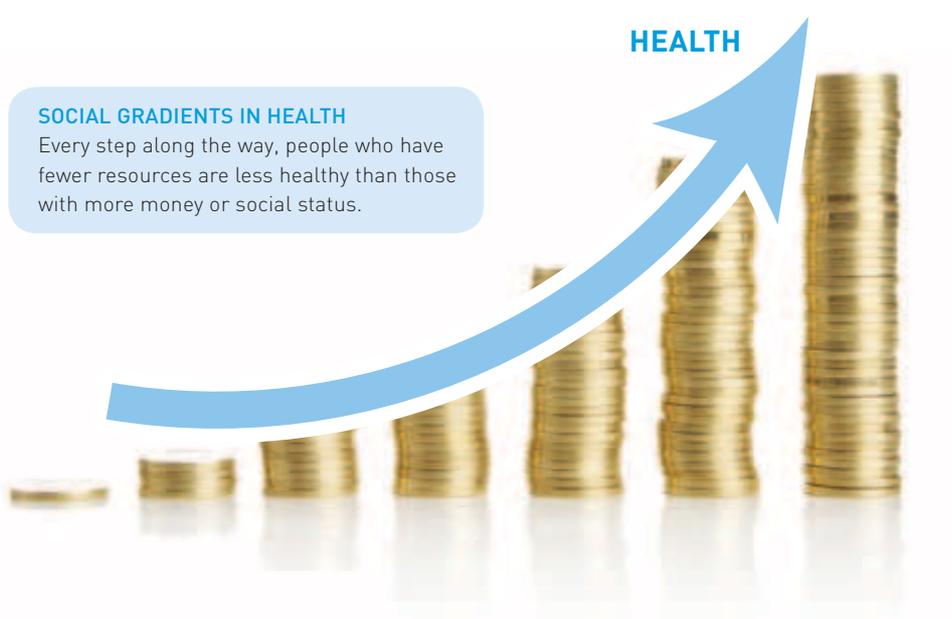
INEQUITY IS ABOUT DISADVANTAGE

The interrelated social and economic factors that influence the health of the population – the social determinants of health - are such that people burdened by lower education, poorer food quality, inadequate housing and/or other disadvantages live less healthy and shorter lives.^{1,4} These disadvantaged socioeconomic groups are rendered vulnerable by “underlying social structures and political, economic and legal institutions” (p. 96).⁵ The resulting variations in health outcomes are rooted in unequal social relations, such as gender inequity, racism, and social and economic exclusion.

SOCIAL GRADIENTS IN HEALTH

Every step along the way, people who have fewer resources are less healthy than those with more money or social status.

HEALTH



EXAMPLES OF HEALTH INEQUITIES IN CANADA

LIFE EXPECTANCY varies greatly at the health region level, from a low of 71 years to a high of 85 years. Health regions with lower life expectancies tend to have higher levels of long-term unemployment, larger Aboriginal populations, be rural or remote locations, have lower proportions of high school and university graduates, and smaller immigrant populations.¹⁰ Life expectancy also varies geographically within cities. In Montreal, an 11-year difference in lifespan has been found between the wealthiest and poorest neighbourhoods.¹¹

THREE FEATURES OF HEALTH INEQUITIES:²



Systematic

The systematic nature of health inequities is observed in a stepwise or linear pattern, meaning a relationship is present throughout society not simply between the most and least healthy.⁶ This means that health differences are not random, but are patterned across the population: those with higher social status tend to have better health than those with lower social status.



Avoidable

Health inequities are not the result of natural biological differences; they are the result of how societies distribute resources and opportunities. Health inequities are socially produced and are therefore avoidable through collective action by individuals, agencies, businesses, communities, and every level of government.^{2,7}



Unfair and unjust

Health inequity is a concept that expresses a moral or normative judgment referring to health differences that are unfair or stem from injustice.⁸

Underlying the concept of health equity is a commitment to social justice and basic human rights such as access to clean water, food, education and health care.⁹ Equity is an ethical principle that posits resources be allocated according to need, not based on underlying social advantage or disadvantage; that is, wealth, power and prestige.⁷

“Social injustice is killing people on a grand scale.”

Commission on Social Determinants of Health. Closing the gap in a generation: Health equity through action on the social determinants of health. Pg 34

RATES OF DISEASE AND DISEASE PREVENTION are associated with income. For instance, type-2 diabetes has been found to be four times higher among Canada’s lowest income group than its highest income group.¹² Children in Saskatoon’s six lowest income neighbourhoods experience about half the rate of immunization coverage compared to children in the most affluent neighbourhoods.¹³

DISTINGUISHING BETWEEN INEQUITY AND INEQUALITY

In the public health field a number of terms are used to describe health differences between population groups. The terms health inequalities and health disparities refer to measurable differences in health status.⁸ Inequality describes differences between individuals or population groups. Some differences are the result of genetic or biological factors; for example, older adults tend to be less healthy than younger people due to the natural aging process.² However, the majority of health inequalities between population groups reflect an unfair distribution of the underlying social and economic conditions required for good health.⁸ These health differences are frequently referred to as health inequities or socially constructed inequalities.^{11,16,17}

Hofrichter and Bhatia¹⁸ argue that “using the term health disparity instead of health inequity makes it appear as if injustice has nothing to do with it; it’s just a difference” (p. 19). They, and others, prefer to use ‘health inequity’ to refer to the sub-set of inequalities that are socially constructed.^{5,8,19} On the other hand, Whitehead and Dahlgren² state that in many countries, particularly European nations, the distinction between health inequality and health inequity is becoming obsolete, making the terms synonymous.

TAKING A HEALTH EQUITY APPROACH

Promoting health equity requires improving the living conditions that keep us healthy, and the social, economic, and health systems that support us when we get sick. Furthermore, tackling the inequitable distribution of power, money and resources is essential for improving health equity.¹

To take a health equity approach, practitioners, policy makers, researchers and organizations must transform how they work.¹⁸ Such an approach requires the public health workforce to align activities with social justice values. Instead of focusing on individual and behavioral interventions, public health practitioners who take a health equity approach seek to alter institutions, policies and practices that cause inequitable distribution of power and resources.¹⁸

LET’S TALK: HEALTH EQUITY

- 1) What examples of health inequities exist in your community?
- 2) What actions and policies at the local, provincial/territorial, and federal level might increase people’s opportunities to be healthy and reduce health inequities?
- 3) What are the root-causes of these inequities?
- 4) What are the opportunities in public health practice, research and decision making to effect change?

RACISM AND SOCIAL EXCLUSION are associated with negative health outcomes. Nunavut (where 85% of the population is of Inuit origin) experiences nearly three times the rate of infant mortality than Canada as a whole.¹⁴ A Toronto study found higher risk for psychological distress and deteriorating mental health status among selected racialized immigrants than among non-racialized immigrants.¹⁵

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