



National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé



LET'S TALK
POPULATIONS
AND THE POWER
OF LANGUAGE

PART OF THE LET'S TALK SERIES

This resource has been developed to help practitioners, teams and organizations be intentional about their choice of language so that our words reflect and empower people and communities.

WHAT IS A POPULATION GROUP?

Public health distinguishes between **population groups**—often defined by social, economic, demographic or geographic characteristics—in its efforts to reduce the inequitable distribution of power and resources in society.¹

In public health we describe populations when we design and implement programs and interventions. We need descriptive terms to

- identify groups that are affected by the inequitable distribution of power and resources.
- describe and evaluate public health initiatives that seek to improve the health outcomes of specific groups of people.
- clarify program objectives, set eligibility criteria and allocate sufficient resources.

A *population health approach* focuses on improving the health of an entire population and improving equity between subpopulations.² The approach includes understanding that some population groups are healthier than others, not because of personal choice, but because of social, economic and environmental circumstances over the course of people's lives.³



THE LANGUAGE OF POPULATIONS IN PUBLIC HEALTH

Health inequities are shaped by social norms, including norms about language use. Language influences our attitudes. Words that reflect prejudice, that oversimplify complex relationships or that minimize history can heighten bias and exclusion. Words can also promote compassion, empowerment, inclusiveness and equity.⁴

Here are some of the terms that people in public health practice use to describe groups that are less healthy, at great risk of ill-health, and die earlier.

- | | | |
|----------------------------------|-------------------------------|--------------------------|
| » Priority | » Disadvantaged | » Disempowered |
| » Marginalized | » Under-served | » Underprivileged |
| » Vulnerable | » Who would benefit | » At-risk |
| » Hard/difficult to reach | most from intervention | » High-risk |
| » Targeted | » Disenfranchised | » Equity seeking |

Many of these terms have definitions and critiques in the public health and social science literature.^a

PRINCIPLES BEHIND OUR LANGUAGE

DIVERSITY EXISTS WITHIN POPULATION GROUPS.

Population groups are often defined by a single characteristic (e.g., low income), even though the people in those groups have varying advantages and needs. People often experience multiple and intersecting disadvantages.⁵ There is always more diversity within a population group than our language can capture.

ADVANTAGE AND DISADVANTAGE COEXIST. A focus on disadvantages requires a similar focus on advantages. Public health practitioners and researchers need to reflect on their own social, historical, and material position in the social structure.⁶ The better we understand the relationship between advantage and

disadvantage—including the power of social norms, historical injustices and structural discrimination—the better we are able to address injustice.⁷ This includes knowledge about the ways in which structural advantage is created and reinforced in our systems.

LANGUAGE INFLUENCES POWER DYNAMICS. Labeling populations can separate us from them, leading to victim blaming, stigmatization and a greater power imbalance between public health practitioners and community members.^{8,9} Sometimes we choose words that community members do not use to describe themselves, and, these words can induce stress and anxiety, even if they are used without malicious intent.⁴

a. For example see the Winnipeg Regional Health Authority's *Health Equity Glossary of Terms* available at www.wrha.mb.ca/about/healthequity/files/HealthEquityGlossary.pdf and the Alberta Health Services' *Towards an Understanding of Health Equity: Annotated Glossary* available at www.albertahealthservices.ca/poph/hi-poph-surv-shsa-tpgwg-annotated-glossary.pdf.

UNPACKING COMMON TERMS

HIGH-RISK POPULATIONS. The 1974 *Lalonde Report* proposed that public health interventions seek to reduce risk behaviours among high-risk populations. Lalonde recommended identifying high-risk groups based on risk behaviors (e.g., smoking, alcohol consumption) and biological markers (e.g., body mass index, blood pressure).¹⁰ People have criticized this risk behaviour approach because it does not alter social forces that influence health behaviours.⁸

PRIORITY POPULATIONS. The term priority population is used in a number of public health documents. *The Ontario Public Health Standards* uses priority populations to identify those at risk and for whom public health interventions may be reasonably considered to have a substantial impact at the population level.¹¹ The term implies that populations are identified through surveillance and epidemiological research. However, there is a risk that without specific inclusion of social justice values, the term can be interpreted too broadly, and be used to identify populations not experiencing disadvantages.

VULNERABLE POPULATIONS. Alberta Health Services defines vulnerable populations as “groups that have increased susceptibility to adverse health outcomes as a result of inequitable access to the resources needed to address risks to health” (p13).¹² The concept of vulnerability is based on the premise that “the same level of exposure may have different effects

on different socio-economic groups” (p6).¹³ This term is criticized because it underemphasizes the multi-dimensional processes that cause unequal distributions of material, cultural, social and political resources.^{8,14} Furthermore, characterization of susceptibility and vulnerability can be disempowering.

MARGINALIZED POPULATIONS. The term marginalized populations refers broadly to groups denied opportunities to meaningfully participate in society due to their lack of economic resources, knowledge about political rights, recognition and other forms of oppression.¹⁵ The broad nature of this term may pose a challenge when it is applied in public health programs and policies.

EQUITY-SEEKING GROUPS. The term equity-seeking groups can be used to describe groups taking an active role in altering processes and structures that influence health. Cohen et al. use this term to reference socially disadvantaged, excluded or marginalized population groups.¹⁶ The City of Toronto uses the term in its efforts to eliminate discrimination and to reference diverse communities.¹⁷ As with marginalized populations, the application of the term in public health practice requires a good understanding of community context because equity-seeking describes a wide range of individuals and communities.

KEY CONSIDERATIONS

Public health practitioners distinguish between population groups so that they can allocate resources and measure outcomes. However, labeling population groups may focus our attention more on individuals, such as “the homeless,” than on structures, such as unemployment, housing and societal factors such as racism that shape health inequities.



Being intentional and careful about our choice of language and engaging community members in conversations to choose appropriate language keeps power dynamics in view. You may be comfortable with more technical terminology or language shortcuts when you are working in house. This works only if respect is maintained.

Being alert to the language we use is one aspect of altering discriminatory beliefs and changing practice to address unequal power relationships. It helps us build bridges across sectors. Choosing our words carefully helps us create and deliver programs tailored to local context and need, and can help us maintain attention at upstream, system-oriented actions.

DISCUSSION QUESTIONS

- What words do you generally use to describe populations?
- What are the benefits, drawbacks and power dynamics of your language?
- What power dynamics are implied by the language of *poor people* and *people who live in poverty*?
- How does your language change when you are in different settings (e.g., health department, school, municipal office)? Is this appropriate?
- Can a change in language change power dynamics?
- What actions are you taking to modify the power dynamics that create ill-health?

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