



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.<sup>1</sup> 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.<sup>2</sup>

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).<sup>2</sup> 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.<sup>2</sup>

## 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.<sup>3</sup>

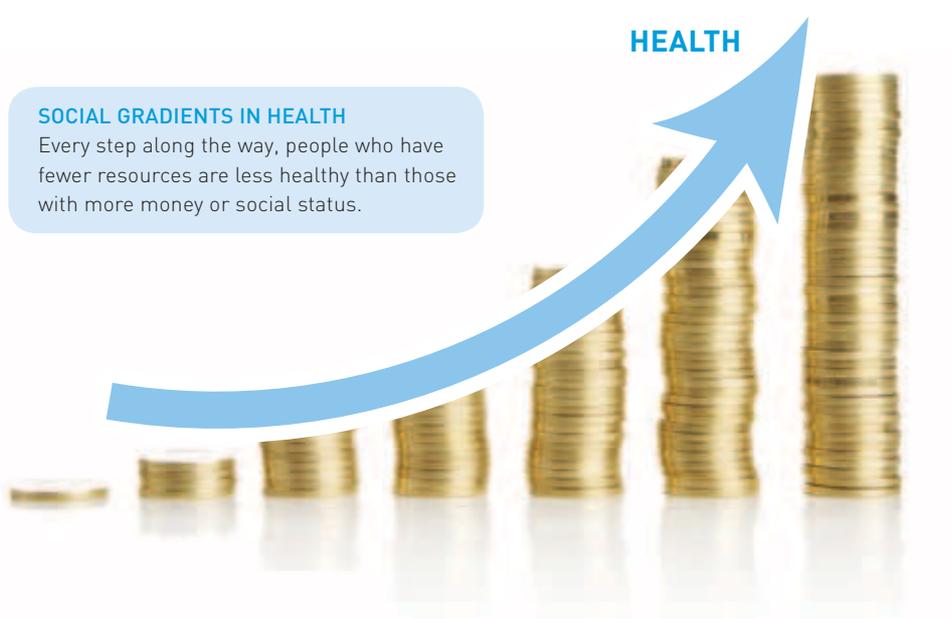
## INEQUITY IS ABOUT DISADVANTAGE

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.<sup>1,4</sup> These disadvantaged socioeconomic groups are rendered vulnerable by “underlying social structures and political, economic and legal institutions” (p. 96).<sup>5</sup> 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.<sup>10</sup> Life expectancy also varies geographically within cities. In Montreal, an 11-year difference in lifespan has been found between the wealthiest and poorest neighbourhoods.<sup>11</sup>

## THREE FEATURES OF HEALTH INEQUITIES:<sup>2</sup>



### *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.<sup>6</sup> 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.<sup>2,7</sup>



### *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.<sup>8</sup>

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.<sup>9</sup> 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.<sup>7</sup>

*“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.<sup>12</sup> Children in Saskatoon’s six lowest income neighbourhoods experience about half the rate of immunization coverage compared to children in the most affluent neighbourhoods.<sup>13</sup>

## 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.<sup>8</sup> 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.<sup>2</sup> However, the majority of health inequalities between population groups reflect an unfair distribution of the underlying social and economic conditions required for good health.<sup>8</sup> These health differences are frequently referred to as health inequities or socially constructed inequalities.<sup>11,16,17</sup>

Hofrichter and Bhatia<sup>18</sup> 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.<sup>5,8,19</sup> On the other hand, Whitehead and Dahlgren<sup>2</sup> 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.<sup>1</sup>

To take a health equity approach, practitioners, policy makers, researchers and organizations must transform how they work.<sup>18</sup> 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.<sup>18</sup>

### 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.<sup>14</sup> A Toronto study found higher risk for psychological distress and deteriorating mental health status among selected racialized immigrants than among non-racialized immigrants.<sup>15</sup>

## REFERENCES

1. Commission on Social Determinants of Health. Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization; 2008 [cited 2012 Sept 21]. Available from: [www.searo.who.int/LinkFiles/SDH\\_SDH\\_FinalReport.pdf](http://www.searo.who.int/LinkFiles/SDH_SDH_FinalReport.pdf).
2. Whitehead M, Dahlgren G. Concepts and principles for tackling social inequities in health: Levelling up part 1. Geneva: World Health Organization; 2006 [cited 2012 Sept 21]. Available from: [www.euro.who.int/\\_\\_data/assets/pdf\\_file/0010/74737/E89383.pdf](http://www.euro.who.int/__data/assets/pdf_file/0010/74737/E89383.pdf)
3. World Health Organization. "Equity Team" definition. Health and Human Rights and Equity Working Group Draft Glossary Unpublished 2005. 2005. Unpublished Work.
4. Public Health Agency of Canada. Reducing health inequalities: A challenge for our times. Ottawa, ON: Author; 2011 [cited 2012 Sept 21]. Available from: [http://publications.gc.ca/collections/collection\\_2012/aspc-phac/HP35-22-2011-eng.pdf](http://publications.gc.ca/collections/collection_2012/aspc-phac/HP35-22-2011-eng.pdf).
5. Krieger N. A glossary for social epidemiology. *J Epidemiol Community Health*. 2001;55(10):693-700.
6. Marmot M. The Status syndrome: How social standing affects our health and longevity. New York: Henry Holt and Company. 2004.
7. Braveman P, Gruskin S. Defining equity in health. *J Epidemiol Community Health*. 2003;57(4), 254-258.
8. Kawachi I, Subramanian SV, Almeida-Filho N. A glossary for health inequalities. *BMJ; J Epidemiol Community Health*. 2002;56:647-652
9. Public Health Agency of Canada. Core competencies for public health in Canada: Release 1.0. Ottawa, ON: Author. 2007 [cited 2012 Sept 21]. Available from: [www.phac-aspc.gc.ca/ccph-cesp/pdfs/cc-manual-eng090407.pdf](http://www.phac-aspc.gc.ca/ccph-cesp/pdfs/cc-manual-eng090407.pdf).
10. Greenberg L, Normandin C. Disparities in life expectancy at birth. Health at a glance. Ottawa: Statistics Canada Catalogue no 82-624-X. 2011 [cited 2012 Sept 21] Available from: [www.statcan.gc.ca/pub/82-624-x/2011001/article/11427-eng.pdf](http://www.statcan.gc.ca/pub/82-624-x/2011001/article/11427-eng.pdf).
11. Le Blanc MF, Raynault MF, Lessard R. Report of the director of public health. Social inequalities in health in Montréal. Progress to date. Montréal, Quebec: Direction de santé publique de Montréal. 2011 [cited 2012 Sept 21]. Available from: [http://publications.santemontreal.qc.ca/uploads/tx\\_asssmpublications/978-2-89673-119-0.pdf](http://publications.santemontreal.qc.ca/uploads/tx_asssmpublications/978-2-89673-119-0.pdf).
12. Dinca-Panaiteescu S, Dinca-Panaiteescu M, Bryant T, Daiski I, Pilkington B, Raphael D. Diabetes prevalence and income: Results of the Canadian Community Health Survey. *Health Policy*, 2011;99(2),116-123.
13. Lemstra M, Neudorf C, Opondo J, Toye J, Kunst A, Tournier C. Disparity in childhood immunizations: Limited associated with Aboriginal cultural status. *Paediatr child health*, 2007;12(10):847-852.
14. Statistics Canada. Infant mortality rates, by province and territory. Ottawa: Statistics Canada CANSIM, table 102-0504. 2012 [cited 2012 Sept 21]. Available from: [www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health21a-eng.htm](http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health21a-eng.htm).
15. Toronto Public Health, Access Alliance Multicultural Health, Community Services. The Global City: Newcomer Health in Toronto. 2011 [cited 2012 Sept 21]. Available from: [www.toronto.ca/health/map/newcomer.htm](http://www.toronto.ca/health/map/newcomer.htm).
16. Muntaner C, Lynch J. Social inequalities and their effect on health and well-being. *Int J Health Serv*, 1999;29(1):59-81.
17. Marmot MG. Understanding social inequities in health. *Perspect Biol Med*, 2003;46(3 Suppl):S9-23.
18. Hofrichter R, Bhatia R, editors. Tackling health inequities through public health practice: Theory to action. 2nd ed. A project of the National Association of County and City Health Officials. Oxford University Press: New York, New York; 2010.
19. Braveman, P. Health disparities and health equity: concepts and measurement. *Annu Rev Public Health*. 2006; 26:167-94.



National Collaborating Centre  
for Determinants of Health  
Centre de collaboration nationale  
des déterminants de la santé

### NATIONAL COLLABORATING CENTRE FOR DETERMINANTS OF HEALTH

St. Francis Xavier University  
Antigonish, NS B2G 2W5  
tel: (902) 867-5406  
fax: (902) 867-6130  
[nccd@stfx.ca](mailto:nccd@stfx.ca) [www.nccd.ca](http://www.nccd.ca)

Written by Hannah Moffatt and Sume Ndumbe-Eyoh, with guidance from Karen Fish and Connie Clement. Dr. Nathalie Boivin, University of Moncton, and Marty Mako, Niagara Region Public Health, provided external peer review.

The National Collaborating Centre for Determinants of Health is hosted by St. Francis Xavier University.

Please cite information contained in the document as follows: National Collaborating Centre for Determinants of Health. [2013]. *Let's talk: Health equity*. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.

ISBN: 978-1-926823-32-4

Production of this document has been made possible through a financial contribution from the Public Health Agency of Canada through funding for the National Collaborating Centre for Determinants of Health.

The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada.

This document is available in its entirety in electronic format (PDF) on the National Collaborating Centre for Determinants of Health website at: [www.nccd.ca](http://www.nccd.ca)

La version française est également disponible au : [www.cnads.ca](http://www.cnads.ca) sous le titre *L'équité en santé : Parlons-en*.