



National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé



LET'S TALK LANGUAGE OF HEALTH EQUITY

PART OF THE LET'S TALK SERIES

The language we use reflects how we understand the world around us, our values and how we think about health equity for communities we are in service of.¹ This resource has been developed to explore foundational principles of inclusive language to support action for health equity. The intent of this resource is to encourage transparent discussion and intentionality about the choice of words we use to build health equity language. Language is fluid and shifts over time. The language used in this document, and the examples within, reflect the context and time in which it was written. The terms referred to throughout come from a combination of literature, practice-based evidence, and community sources.

WHY ARE WE TALKING ABOUT LANGUAGE FOR HEALTH EQUITY WORK?

“The words we choose to use when speaking and writing are powerful tools for communicating personal and organizational values and beliefs.”^{2(p14)}

Language matters — it can make people feel included or excluded, valued or dismissed, welcome or unsafe. The words we choose reflect our values, beliefs and implicit biases; the words we use also influence how these values, beliefs and biases change or remain the same over time.³ In this way, language both reflects and influences how we view people living with health inequities and the root causes of those inequities, and how we understand our role in public health.^{3,4} Health equity language shapes the questions we ask, whose needs we prioritize, the strategies we identify and how we interpret information and data.⁵

Stigmatizing and discriminatory language perpetuates and increases harm to people and communities who have been marginalized by systems of oppression.^{6,7} Words that reflect prejudice, oversimplify complex systems and relationships or minimize history can heighten bias, exclusion and fear. Language that does not reflect

the realities of people’s everyday lives undermines efforts to achieve health equity by reinforcing mistrust and fear of the health system.⁵

“Learning the language of health equity is crucial in removing walls of mistrust and building bridges of trust as a step towards achieving health equity.”^{7(p871)}

Language that promotes compassion, inclusivity and equity reflects the inherent worth of every person⁸ regardless of the circumstances they live in. Public health strategies and policies are more likely to impact health equity when they are based on language that is respectful and reflects community-identified priorities.⁹

The better we understand and are aware of the language we use, the better we will act to address injustice.

This document replaces the 2014 resource *Let’s Talk: Populations and the power of language*.

Health equity terms are not buzzwords. They are not just a tickbox to be checked in projects. Rather, they should be a promise to act, and this will only happen if there is a shared understanding of the terms and their meaning.

THE POWER OF LANGUAGE

“Nice words with no action hurt when they are uttered by those with power ... who refuse to take action.” - Mumilaaq Qaqqaq¹⁰

Power is baked into language. Intentionally reflecting on and shifting the language we use to describe equity is necessary to challenge dominant belief systems and power imbalances.

Words often reflect the dominant values, norms and world views¹¹ of existing power structures that determine privilege and oppression,⁵ which reinforces a “clear division between a ‘powerful us’ ... and disempowered ‘others.’”^{12(p13)} Using terms without reflecting on the power imbalance that they reinforce

allows us to avoid acting on those imbalances. (See Table 1 for terms that counter rather than reinforce a harmful power imbalance.)

For example, when we describe people and communities as users or recipients of our services (or “who we deliver services to”) rather than as a unique population with valued expertise, we lose sight of what is important to them and their ability to inform public health decisions and priorities.

TABLE 1: TERMS THAT COUNTER RATHER THAN REINFORCE POWER IMBALANCE

TERMS THAT FOSTER A REDISTRIBUTION OR REBALANCING OF POWER	TERMS THAT REINFORCE A HARMFUL POWER IMBALANCE
Invest in	Empower
People who navigate challenge with resiliency	Resilient
Partner Collaborator	Stakeholder
Community member Person	Patient Client Consumer (of health care or services)
In service of Working with community	Serve Provide service to

Other examples:

- **Empower** is often used in a positive sense, to describe how individuals or communities could feel if power is shared with them. However, this commonly used “nice term” actually reinforces power imbalance by implying that a privileged group holds power and that they decide who to permit or grant it to, and it does not leave space for challenging that imbalance.
- **Resilient** is often used as a positive attribute, describing the ability of a person or community to work through challenges. However, resiliency is not an inherent trait, and it is often a necessary response to an oppressive system in which individuals and communities *must* build resiliency in order to live. Using the term resilient as a positive attribute may shift the blame away from a system that has created an environment in which people must individually take action.
- **Stakeholder** is often used to identify key partners in an initiative. The word stakeholder is rooted in colonial practices and carries connotations of settlers who drove wooden

stakes into the ground as a claim to land before negotiations with Indigenous peoples whose land they were taking.¹³ It should be avoided especially when working with Indigenous communities, who have priority rights to equity not just an equal interest.¹⁴ Stakeholder also implies that every interest is equally represented (“at stake”) and puts organizations on the same level as community members who are marginalized by systems of oppression and experience poor health outcomes due to inequities. By equalizing interests, there is less room for community priorities.¹⁵

We cannot lose sight of what is important to people. As language is constantly shifting, working with communities to codevelop respectful and inclusive language is a must! Ongoing dialogue, formal consultations, pilot testing materials, engagement and evaluation are practical ways to do this. Be intentional in naming and challenging the power differential and ask: “How do we describe people who live with inequities, how do they describe themselves, and do these terms align?”

A NOTE ABOUT LANGUAGE AND TRANSLATION

Culture lies in language. The meaning, interpretation and application of terms vary by culture, context and understanding. Language is about the words themselves and what they mean to the people being described, including, but not exclusive to, the language they are spoken in.

Words used in one language to describe health equity concepts do not always translate directly to other languages and maintain the original intended meaning. Health equity words that exist in one language often have no equivalent or related term in another language.

It is critical to avoid assumptions that an English health equity word or concept is automatically transferable to the context of groups and communities who live with inequities. Work with partners and communities to understand and adopt the terminology that works for them.

BUILDING A LANGUAGE THAT DRIVES ACTION FOR HEALTH EQUITY

“Shifts in language can facilitate shifts in attitudes, assumptions and behaviours, and help reframe complex issues ... so not to focus on individual responsibility and instead recognize how circumstances and conditions shape health outcomes.” ^{8(p1)}

People hold multiple and intersecting identities that shape experiences of advantage, disadvantage, privilege and oppression. The language we use must reflect the complexity of everyday life, moving beyond the focus on a single dimension of health to the multifaceted root causes of injustice.¹⁶ When we collaborate with and listen to communities at all points in our work, our health equity language will better reflect this reality.

Building a shared language for health equity is a continuous learning process that must come from a place of humility and respect.

Open and ongoing dialogue allows practitioners, teams, organizations and communities to codevelop health equity language. The following sections intend to support discussion on health equity language in public health that is unique to each workplace, environment, community and identity.



PERSON-FIRST LANGUAGE

“Equity-focused, person-first language seeks to center the lived experience of people and communities without reinforcing labels, objectification, stigmatization and marginalization.”^{5(p7)}

Person-first language (see Table 2) prioritizes the person instead of the condition and is less likely to perpetuate stigma.¹⁷ Language that is equity-focused and person-first centres the lived expertise of individuals without relying on stigmatizing labels⁵ and maintains the focus on humanity.¹⁸

However, condition-specific terms like *homeless*, *criminal*, *drug addict* and *poor* are painful to hear and lead to victim-blaming. Other terms such as *hard to reach* or *non-compliant* imply that people refuse services or do not want to participate, when the reality is that what is offered may not be accessible, safe, respectful or affordable.⁹

Stigmatizing labels convey that one group is inherently inferior and imply responsibility of the individual rather than the systems that have been imposed on them.¹⁸ Stigmatizing language separates “us” from “them,” transmitting bias and judgement¹⁹ and contributing to people feeling

excluded, unwelcome and unsafe in public health environments. This type of language further damages the relationship and fosters mistrust between public health and communities.

Vague terms such as *vulnerable*, *marginalized*, *disadvantaged* and *priority population* are often used to refer to groups living with inequities. Any population can be deemed a priority depending on what the goals of a particular strategy are, which may not necessarily be rooted in social justice. Ambiguity created by vague language can unintentionally shift attention away from addressing the roots of health inequities.

Ask community members what terms and phrases they prefer to use to describe themselves, their environments and their identities. Avoid assumptions about how a person wants to describe themselves. How we speak about people living with inequities is ultimately up to them.

SYSTEM-FOCUSED LANGUAGE

System-focused language (see Table 2) shifts the narrative from a traditional biomedical and behavioral emphasis towards the broader structural and social determinants that cause downstream impacts on health.⁵ Using system-focused language maintains attention on how inequitable systems and circumstances shape health, instead of on individual behaviour and blame.⁸ When we use language that names systems and structures, it aligns with the scope of public health and allows us to identify a clearer path to action.

Conversely, individual-focused language hides the structural and social nature of health outcomes,⁹ limiting discussion about what is required at a policy and systems level to change it.²⁰ If the terms we use focus on individual traits and behaviour, there is misalignment with the essence of what public health is, and the path to action on health equity is less clear.

ASSET-BASED LANGUAGE

Asset-based language (see Table 2) focuses on the skills, knowledge and contributions of individuals and communities.²¹ Public health action that uses an asset-based approach supports the perspective of contribution, growth, sharing power with communities and respect for diversity in culture, abilities and other socioeconomic factors.²²

In contrast, deficit-based language focuses on identifying gaps and addressing deficiencies.^{21,22} Approaches that are built from deficit-based language prioritize fixing problems and use a “power over” approach that reinforces oppression where an advantaged few hold power over people who live in marginalizing conditions.



EQUITY-SEEKING VERSUS EQUITY-DESERVING?

Equity-seeking refers to people who experience significant barriers due to discrimination, disadvantage and other socioeconomic factors.²³ While this term is technically correct, it positions an individual as having to ask for equity²⁴ — putting them in a vulnerable position by implying they are responsible to “seek” what they need^{24–26} from those with the power to give, deny or ignore.²⁶

Equity-deserving is increasingly being used in its place. This term situates communities as deserving of equity instead of having to ask for it,²⁴ placing responsibility on those with power and systemic influence (dominant group) to shift the conditions,²⁴ recognizing equity as a right.²⁶ However, it is seen by some to denote that not everyone deserves equity.²⁷

Equity-denied is a term that encompasses both, describing people who face barriers to access and opportunities due to systemic discrimination.²⁷

This is an ongoing conversation in public health. Which of these terms is chosen will depend on context and community preference.

ANOTHER TERM WE OFTEN USE: LIVED EXPERIENCE

Lived experience is often used to refer to groups who are at the centre of health equity efforts. However, this term is a label that blends a wide range of intersecting influences on health, each of which impacts the other, and downplays the unique experience of each individual.

On its own, the term lived experience is not specific to inequities. Everyone has the lived experience of something — of being White and wealthy, for example. Using the term lived experience without specifying *what* an individual or community has the lived experience of dilutes the focus on health equity. However, even if the term is more specifically explained — for example, referring to someone as having the “lived experience of living on low income” — it reduces the experience to that specific circumstance and ignores the multiple intersecting issues affecting a person’s health and well-being. Also, the word “experience” does not accurately reflect the significance of the knowledge that is gained by living with inequities or the value of this expertise as legitimate and valid evidence.

If we want to support meaningful engagement of people with inequities in public health work, we need to be clear about who we need to engage with and the value of their experiences as a valid source of evidence and knowledge.

Lived/grounded expertise of inequities more accurately reflects the validity of experience as evidence that comes only from living in the context of structural and social inequities. Use caution when referring to someone with the “lived expertise of ...” (e.g., low income), and make sure it is set in the context of multiple intersecting circumstances.¹⁶

TABLE 2: PERSON-FIRST, SYSTEM-FOCUSED AND ASSET-BASED TERMS VERSUS TERMS IMPLYING STIGMA, BLAME AND DEFICIT

TERMS THAT ARE PERSON-FIRST, SYSTEM-FOCUSED AND ASSET-BASED	TERMS THAT REINFORCE STIGMA, BLAME INDIVIDUALS AND ARE DEFICIT-BASED
People who live in marginalizing conditions created by ... Communities who are marginalized by ... Marginalization created by systems of oppression	Marginalized E.g., marginalized groups
People who live in vulnerable conditions created by ... Communities who are made vulnerable by ... Vulnerability created by systems of oppression	Vulnerable E.g., vulnerable groups
People who are experiencing poverty People who don't have homes/are underhoused People who don't have jobs/good working conditions People who are discriminated against by ...	Poor, homeless, unemployed, etc. E.g., the poor, the homeless, the unemployed
Communities who are under-resourced or underinvested Communities who society has not invested in	Underserved
Groups who are economically/socially excluded by systems who can profit Communities who are exploited/oppressed by others in power	Disadvantaged, underprivileged, priority population, target population
Not yet engaged Systemically excluded	Hard to reach
Groups who are experiencing disproportionate negative effects/prevalence/rates of ...⁹	High-burden, high-risk
Unable to adhere to ...⁹	Non-compliant
People who have yet to ...⁹ People with limited access or ability to ...⁹	People who do not ... (use or access a service, for example) — this might sound like it is person-first, but it still shifts blame onto the individual because there is a focus on choice
People who possess unique strengths and abilities	Low/limited proficiency
People who require ongoing support	Frequent flyer, repeat user
People who are working toward unique goals	Achievement gap

KEY CONSIDERATIONS

“By learning best practices for inclusive language, healthcare professionals can eliminate bias, promote impartiality, reduce stigmas, and above all else, be helpful to all people.”²⁸

Language and terms have the potential to perpetuate or reduce health inequities. The outcomes of efforts to achieve health equity will be diluted if there is no common understanding of the terms being used or if these terms do not reflect community priorities. It is critical that public health:

1. Creates open and ongoing dialogue on health equity terminology and language that shift and flow with changing context.
2. Uses person-first, system-focused and asset-based language in all health equity work to break down power structures and achieve shared goals.
3. Practices humility and respect in health equity work by learning from community and developing a shared language.

DISCUSSION QUESTIONS

- What various social positions and identities do you hold? What forms of privilege and/or disadvantage do you experience related to these positions and identities? How do they influence the words you use to describe people and communities when talking or writing about health equity?
- What beliefs do you hold about the people and community groups you work with? Do these beliefs foster person-first, system-focused and asset-based language? How are these beliefs influencing the words you use and actions you take when doing health equity work?
- What values do you personally hold? What values does your organization hold? How are these values reflected in or influenced by the health equity language you currently use?
- Consider your organization’s work plans, strategic plan and other documents. What terms are used to describe structural and social determinants of health and health equity? What terms are used to describe the communities your organization works with? How are those terms consistent or inconsistent with how communities and people would describe themselves?
- Whose voices are reflected in the health equity language and terms you use? Whose voices are excluded?
- How will you reach out to communities for discussion on health equity language? What are important considerations for doing this?
- How does your language change when you are in different settings (e.g., health department, school, municipal office)? Why?

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