

# Defining Health Equity

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MOST PEOPLE, IF asked, would say that they are in favour of health equity. The term connotes fairness, and justice, which many Canadians would see as consistent with our values. And yet, when we push further to define the actions necessary to drive improved health equity, it is apparent that substantive differences regarding how health equity is defined persist. In this piece, we posit that agreement on some basic principles of a definition of health equity is the starting point from which the required changes in our healthcare system can be shaped and the conditions in which we might measure the impact of these changes can be created.

## **The Prevailing Lexicon and Dialogue around Health Equity**

There are prevailing definitions of equity in the literature. Deriving from Aristotelian notions of equity and justice described in the canonical *Nicomachean Ethics*, a delineation is often made between horizontal and vertical equity. Horizontal equity is, in its essence, treating like cases alike, and vertical equity is treating unlike cases differently. The crux of the contemporary debate on health equity often focuses on the relevant characteristics

that define sameness and differences.

Margaret Whitehead (1991) established the basic language of equity for health policy discussions, asserting that healthy inequity should be defined as “differences in health that are unnecessary, avoidable, unfair and unjust.” In doing so, Whitehead attempted to describe the characteristics of the sameness and differences at play, and to assert that inequities are more than just differences.

The International Society for Equity in Health provides a definition that elucidates the nature of these differences further, in “the absence of potentially remediable, systematic differences in one or more aspects of health across socially, economically, demographically, or geographically defined population groups or subgroups” (Macinko and Starfield 2002), picking up the concept of remediation introduced by Barbara Starfield (2001).

Paula Braveman expounded on these concepts by proposing a more technical definition aimed at clearer measurement and accountability (Braveman and Gruskin 2003). Braveman’s definition is more explicitly situated in a social justice and ethics framework, describing health equity as, “the absence of systematic disparities in health (or in the

major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage.” Braveman distinguishes her definition from those that predate her, asserting that avoidability should not be a part of health equity, as those differences that cannot easily be avoided should not be excluded as inequities.

### **In Practical Terms**

So how are these somewhat abstract definitions meant to help us in our thinking about the way that we allocate resources, design programs and make decisions? A few basic principles apply. Definitions in the literature help with the essential task of creating consistency in the approach to defining equity, but taking translation of these principles into a practical context is the next critical step.

### **Equity is about differences in factors that are controllable (broadly speaking)**

Critics of health equity as a relevant health-care construct argue that differences between individuals will always exist and that it is inexplicable which differences are inequities. Daniels explores a Rawlsian construct of equality of opportunity as the underlying principle in defining inequities; Whitehead argues that inevitability and avoidability are the defining features; Braveman’s anchor is whether an attribute is an underlying social disadvantage or places people in a social hierarchy.

In the simplest iteration, unnecessary and alterable differences are inequities. Those that are inevitable and uncontrollable are not. For example, on average, female babies have a lower birth weight than male babies. This is what Whitehead would describe as “natural, biological variation,” and they are not associated with different health outcomes. On average, babies born to low-income mothers also are of lower birth weight. This is typically the

result of poorer nutrition, inadequate prenatal care and other factors that are changeable and are not necessary.

Income, race, gender, sexual orientation, disability, language, immigration status and geography are among the most common factors for which there are correlated differences in healthcare access and outcomes. Differences in health among people in subdivisions of these groups are remediable and, as such, are inequities. The intersection between factors is often associated with the most marginalized individuals in society, and the greatest health inequities.

### **Equity does not mean we all get the same thing**

Different populations may require different solutions to achieve the same level of health status and same access to healthcare programs. This may include home visits, different hours of operation, services offered in different languages and integration of primary care preventive programs into other community programs. Patients have a right to the same access to and quality of care and services, but the care required may be different.

Examples can easily be selected from the spheres of primary and preventive care. Individuals in high- and low-economic quintiles may present to primary care with multiple risk factors for cardiovascular disease. A clinician may recommend more exercise and eating healthier to an individual in a high-income quintile; someone in a low-income quintile may require referrals to community services, including walking programs and cooking programs aimed at healthy eating within a limited budget (Canadian Medical Association 2013).

### **Equity does not mean an equal distribution of resources**

The “equality vs equity” distinction is most

salient in discussions of distribution of resources. A simple equality principle would dictate that \$X will be spent on healthcare for each person in our society. In reality, this is not a principle in action anywhere. Healthcare dollars are disproportionately spent on seniors, children and those with acute clinical needs. In an equity context, the discussion extends to whether systemically disadvantaged individuals and/or groups ought to be allocated additional resources to achieve the same access to healthcare.

Drawing an example from outside of healthcare, every school in Canada has been furnished with a ramp to allow individuals requiring wheelchairs to have access to public education. In so doing, additional resources have been allocated to certain individuals to allow them access to education. Assuming that we deem healthcare to be a public good in the way that education is, the same argument can be extended. Increased dollars are required to enable some individuals to have access to healthcare. For example, a person living in Canada with low English or French proficiency will have a higher cost per healthcare interaction if medical interpretation services are offered to help that person communicate with their clinicians.

**Equity is about fairness, justice and values (but we do not need to talk about it that way)**

Some describe equity as an ethical construct or a basic human rights principle. Discussions about health equity are inherently about what we value. Implicitly, the reason we care about some differences being alterable and avoidable is because we see those differences as unfair. There are many interventions that have been implemented to address gaps in equity, and yet there is a lack of comfort in discussing the rationale for these programs being grounded in fairness.

Increasingly, there are programs in place to provide transport to individuals who lack the means or the ability to reach their medical appointments. Increasingly, diabetes prevention programs are being tailored to the dietary patterns of the populations being served. Increasingly, healthcare mobile services are being brought to communities who might not otherwise be able to access them. All of these programmatic and resource allocation decisions are rooted in a desire for greater equity, and moreover fairness – that individuals and communities be afforded the same access to health services that can benefit them.

In a Canadian context, we can avoid explicit reference to justice and fairness by simply seeing health equity as a means of realizing the principles of the Canada Health Act, which among the central tenets is that residents should have access to healthcare without financial or other barriers as obstructions. This basic tenet is a neatly packaged reference to health equity (although not comprehensive), and one that can be referenced in Canadian dialogue without unearthing debates about social justice and human rights.

**Equity of...what? Access, quality and outcome**

Perhaps the most debated aspect of defining health equity is what exactly we are seeking equity of. Agreement is often reached that there should be equitable access to healthcare, or equitable distribution of healthcare resources. More contested are the concepts of equity of outcome, quality of care and, chiefly, health status (Whitehead 2002). Some have argued that equity of outcome is pivotal to health equity, and social reform to engender greater equity in social determinants of health is required to achieve more equitable health outcomes (Daniels 2002).

We would argue that for the healthcare system, we are striving for equity of access

to and quality and outcome of care. We are distinguishing health outcome from health status, insofar as an outcome is the result of a given intervention or interaction, and a health status is a more holistic concept. While equity of health status is a critical and laudable goal for society, it may be too broad for the traditional healthcare system itself to wrestle with alone. Efforts to affect wage disparity and availability of affordable housing, as examples, are critical to reducing inequities, but the healthcare system cannot be the sole or primary influencer in these domains.

### **Why This All Matters: Implications for Measuring and Improving Health Equity**

How we define equity is important. Despite the litany of definitions available in the academic literature, we do not have a way of defining equity in Canada that allows us to treat the issues seriously and effect change.

Definitions help us measure how equitable our healthcare system is, set goals for improvement and assess progress against those goals. As healthcare providers, planners and administrators, we have become conditioned to focus efforts on the indicators, measures and targets required of us through accountability and public reporting. There is a need to clarify our definitions of equity sufficiently to bring measurement and achievement of equity aims into the forefront of healthcare discussions, debates and accountabilities.

Clear definitions and parameters of health equity shape the actions and interventions we select to ameliorate health inequities. They help each organization understand its role in achieving health equity, and the types of activities that can be spread and replicated from one organization to the next to the end of achieving equity.

Subsequent columns will flesh out some of the language, measures and dimensions

of health equity that will facilitate effective approaches to improving health equity and the “mainstreaming” of equity into all health policy decisions. They will address the relationship between equity and sustainability, technology as an enabler of equity, the impact of a changing population on planning, efforts to measure health equity and how we might embed equity principles into how we measure patient experience. At a minimum, future columns will increase attention to how equity can become a core element of how we define the success of our healthcare system.

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