

# IS 'HEALTH EQUITY' BAD FOR OUR HEALTH?

A Qualitative Study of Public Health Policy-Makers' Perspectives

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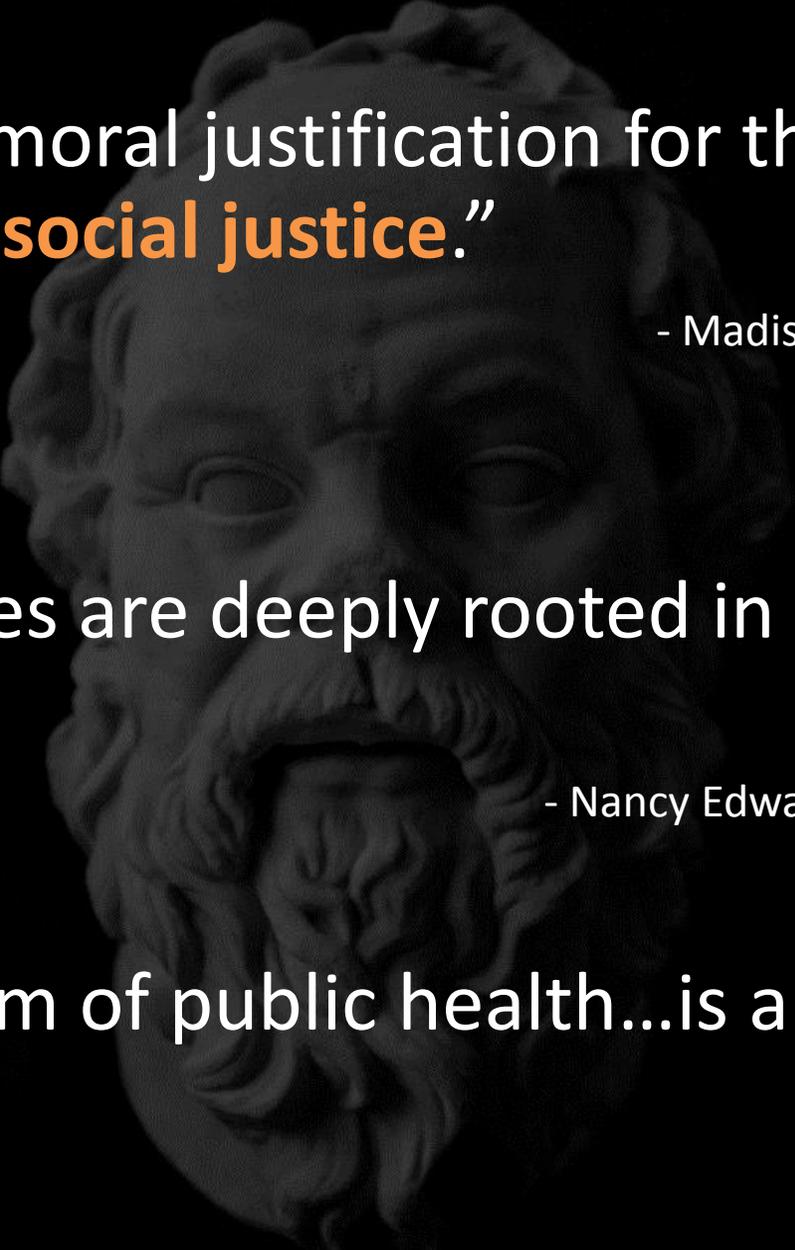


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# Disclosure statement

I have no affiliation (financial or otherwise) with a pharmaceutical, medical device, or communications organization.



“The foundational moral justification for the social institution of public health is **social justice**.”

- Madison Powers & Ruth Faden, 2006, p. 9

“**Social justice** values are deeply rooted in public health practice.”

- Nancy Edwards & Colleen Davison, 2008, p. 130

“...the historic dream of public health...is a dream of **social justice**.”

- Dan E. Beauchamp, 1976, p. 6

# Closing the gap in a generation

Health equity through action on the social determinants of health



# The Commission calls for closing the health gap in a generation

Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. We watch in wonder as life expectancy and good health continue to increase in parts of the world and in alarm as they fail to improve in others. A girl born today can expect to live for more than 80 years if she is born in some countries – but less than 45 years if she is born in others. Within countries there are dramatic differences in health that are closely linked with degrees of social disadvantage. Differences of this magnitude, within and between countries, simply should never happen.

These inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces.

Social and economic policies have a determining impact on whether a child can grow and develop to its full potential and live a flourishing life, or whether its life will be blighted. Increasingly the nature of the health problems rich and poor countries have to solve are converging. The development of a society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health.

In the spirit of social justice, the Commission on Social Determinants of Health was set up by the World Health Organization (WHO) in 2005 to marshal the evidence on what can be done to promote health equity, and to foster a global movement to achieve it.

As the Commission has done its work, several countries and agencies have become partners seeking to frame policies and programmes, across the whole of society, that influence the social determinants of health and improve health equity. These countries and partners are in the forefront of a global movement.

The Commission calls on the WHO and all governments to lead global action on the social determinants of health with the aim of achieving health equity. It is essential that governments, civil society, WHO, and other global organizations now come together in taking action to improve the lives of the world's citizens. Achieving health equity within a generation is achievable, it is the right thing to do, and now is the right time to do it.

# CORE COMPETENCIES FOR PUBLIC HEALTH IN CANADA

Release 1.0

## CORE COMPETENCY STATEMENTS

The core competency statements are not designed to stand alone, but rather to form a set of knowledge, skills and attitudes practiced within the larger context of the values of public health.

### ATTITUDES AND VALUES

All public health professionals share a core set of attitudes and values. These attitudes and values have not been listed as specific core competencies for public health because they are difficult to teach and even harder to assess. However, they form the context within which the competencies are practiced. This makes them equally important.

Important values in public health include a commitment to equity, social justice and sustainable development, recognition of the importance of the health of the community as well as the individual, and respect for diversity, self-determination, empowerment and community participation. These values are rooted in an understanding of the broad determinants of health and the historical principles, values and strategies of public health and health promotion.<sup>6</sup>

If the core competencies are considered as the notes to a musical score, the values and attitudes that practitioners bring to their work provide the tempo and emotional component of the music. One may be a technically brilliant musician but without the correct tempo, rhythm and emotion, the music will not have the desired impact.

### STATEMENTS IN SEVEN CATEGORIES

The 36 core competencies are organized under seven categories: public health sciences; assessment and analysis; policy and program planning; implementation and evaluation; partnerships, collaboration and advocacy; diversity and inclusiveness; communication; leadership.

Please see Appendix B for practice examples that illustrate each of the core competency statements.

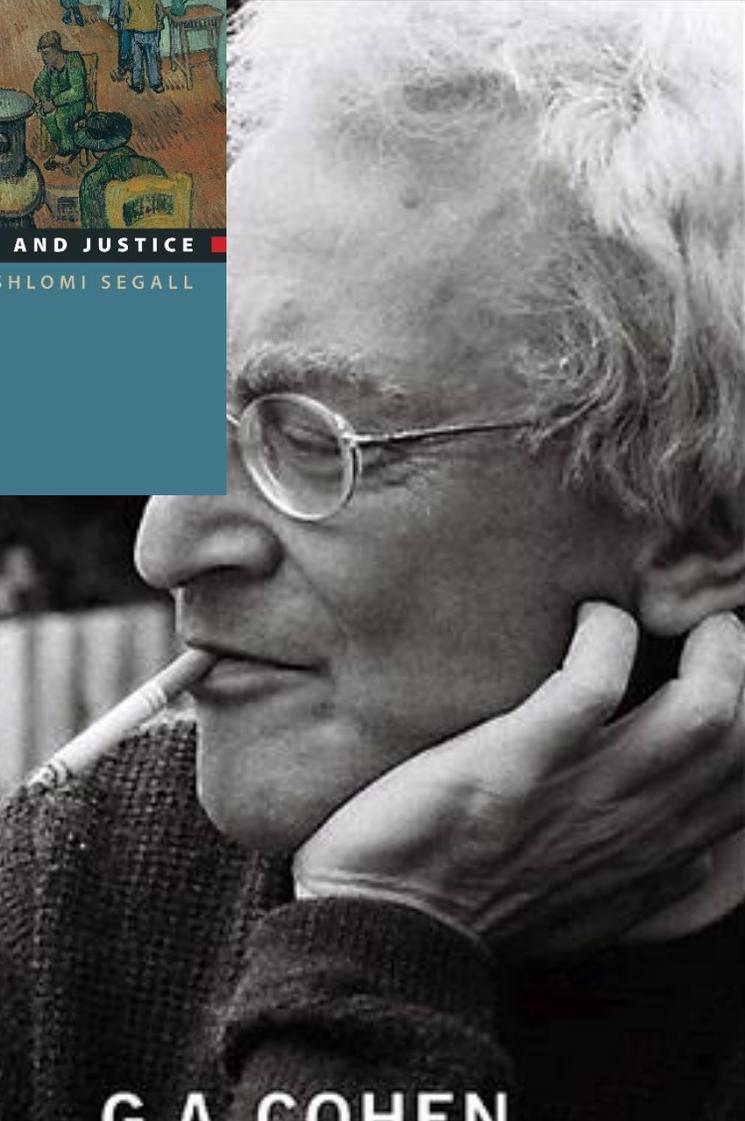
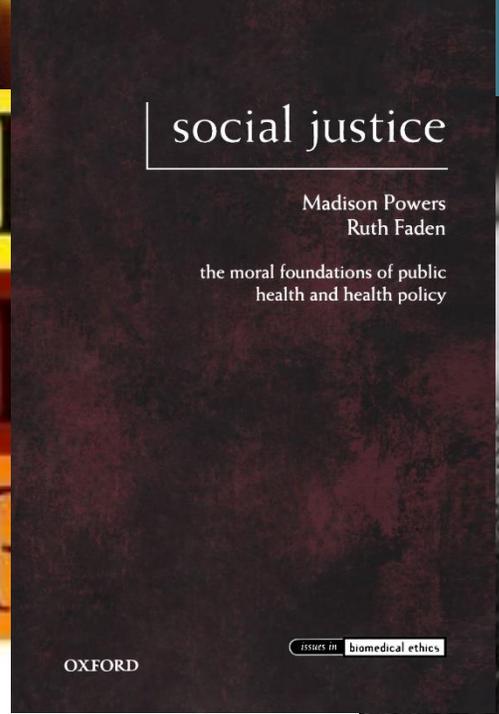
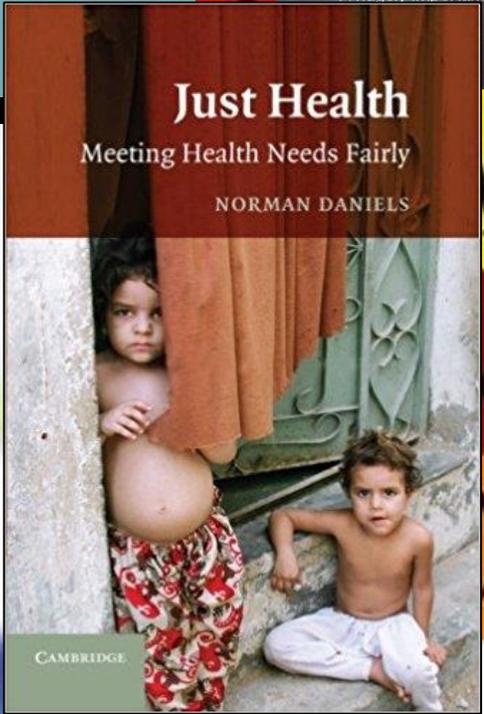
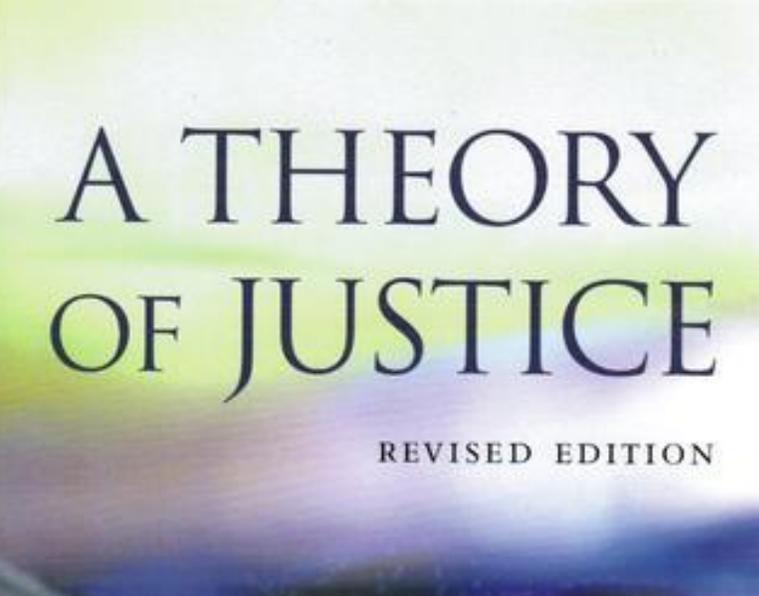
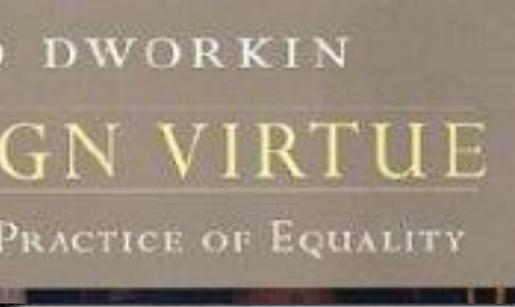
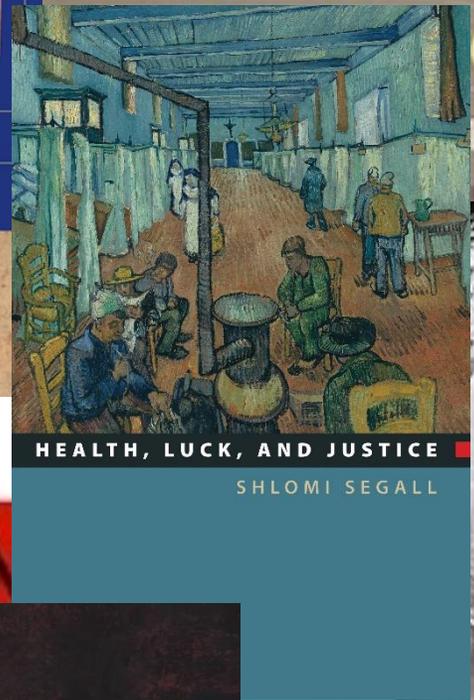
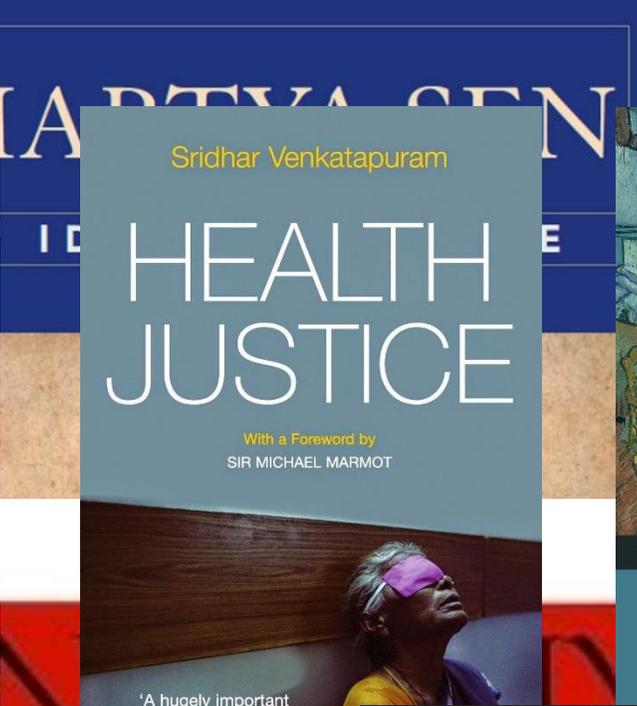
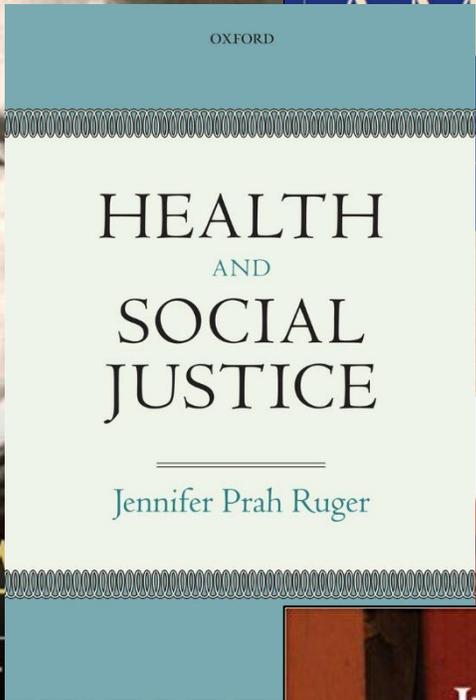
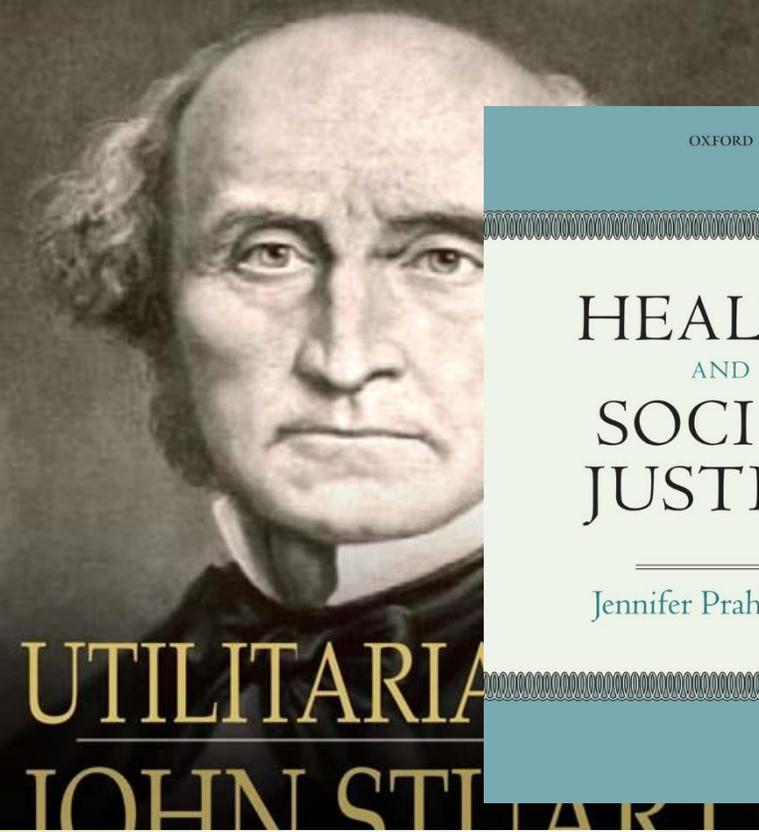


#### ONE... PUBLIC HEALTH SCIENCES

This category includes key knowledge and critical thinking skills related to the public health sciences: behavioural and social sciences, biostatistics, epidemiology, environmental public health, demography, workplace health, and the prevention of chronic diseases, infectious diseases, psychosocial problems and injuries. Competency in this category requires the ability to apply knowledge in practice.

*A public health practitioner is able to ...*

1.1 Demonstrate knowledge about the following concepts: the health status of populations, inequities in health, the determinants of health and illness, strategies for health promotion, disease and injury prevention and health protection, as well as the factors that influence the delivery and use of health services.



Sridhar Venkatapuram

# HEALTH JUSTICE

With a Foreword by  
SIR MICHAEL MARMOT

'A hugely important  
contribution'  
AMARTYA SEN



'Do not mistake Sridhar Venkatapuram's *Health Justice* for an arcane treatise of interest to a small number of political philosophers. It is, rather, a bold consideration of human entitlement to "the capability to be healthy". The book, which illuminates a "blind spot" in modern political philosophy, is also a call to action: as Venkatapuram notes, theories of justice serve as goal and guide, highlighting health disparities and laying the moral groundwork for social change. *Health Justice* will be required reading for philosophers and those interested in health disparities but I hope, too, that it will be read widely by all who formulate social policies and by those, including physicians, who implement them.'

Dr Paul Farmer, Harvard Medical School and Partners In Health

'A very impressive achievement. Sridhar Venkatapuram is uniquely placed to bring together literature in political philosophy and social epidemiology to generate a persuasive capability approach to health justice. This book is a major contribution to debates in the definition of health, the capability approach to justice, and global health ethics.'

Jonathan Wolff, Director of the Centre for Philosophy, Justice and Health, University College London

'*Health Justice* is a crucial and impressive work. In contrast to earlier theorists, it argues convincingly for a theory of social justice that recognizes people's moral right to the capability to be healthy. Venkatapuram combines a wealth of insights from sources such as philosophy of health and welfare, political science and economics. Thereby he makes a fascinating original contribution to the theory of health and welfare.'

Lennart Nordenfelt,  
Linköping University

Social factors have a powerful influence on human health and longevity. Yet the social dimensions of health are often obscured in public discussions, due to overwhelming focus in health policy on medical care, individual-level risk-factor research, and changing individual behaviours. Likewise, in philosophical approaches to health and social justice, debates have focused on rationing problems in healthcare and on personal responsibility. However, a range of events over the past two decades such as the global experience of HIV/AIDS, the international women's health movement and the flourishing of social epidemiological research have drawn attention to the robust relationship between health and broad social arrangements.

In *Health Justice*, Sridhar Venkatapuram takes up the problem of identifying claims individuals have in regard to their health in modern societies and the globalized world. Recognizing the social bases of health and longevity, Venkatapuram extends the 'capabilities approach' of Amartya Sen and Martha Nussbaum into the domain of health and health sciences.

In so doing, he formulates an inter-disciplinary argument that draws on the natural and social sciences as well as debates around social and global justice to argue for every human being's moral entitlement to a capability to be healthy.

*Health Justice* aims to provide a concrete ethical grounding for the human right to health, while advancing the field of health policy and placing health at the centre of social justice theory.

Sridhar Venkatapuram is a Wellcome Trust Fellow at the London School of Hygiene and Tropical Medicine and an Affiliated Lecturer at Cambridge University. He has recently been elected a fellow of the RSA and the UK Parliament Office of Science and Technology.



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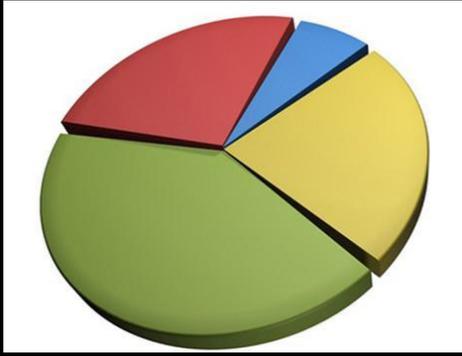
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The passion of the CSDH about social justice was perhaps not matched by the depths of our analysis of what we meant by it. We were influenced by Amartya Sen's ideas on capabilities and human flourishing. But, as chair of the CSDH, I felt the need for a better articulation of the philosophical underpinnings: why are avoidable inequalities in health unjust?

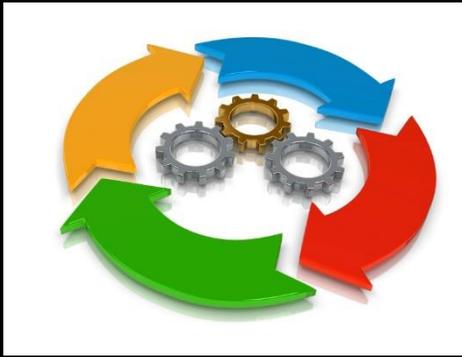
## Principles of justice

## 'Currency' of justice

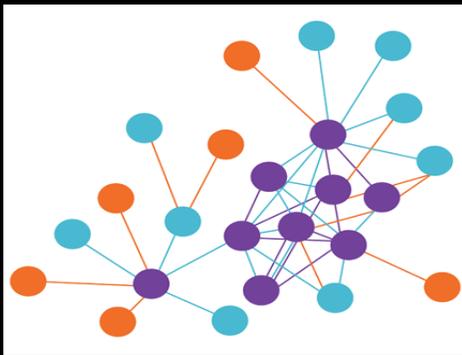




- **Distributive** considerations



- **Procedural** considerations



- **Relational** considerations

# Health equity

## Health Equity in Public Health: Clarifying our Commitment

Maxwell J. Smith\*, Dalla Lana School of Public Health and Joint Centre for Bioethics, University of Toronto

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Health equity is increasingly identified as a principal goal to be achieved through public health policies and activities. However, what is to be measured in the assessment of health equity and how inequities in health ought to be redressed are among the pressing questions that must be answered if health equity is to serve as a meaningful and consistent ethical guide for measurement and intervention in public health. In this article I argue that the concept of health equity, in the form it is predominantly found in public health, suffers from normative indeterminacy and is therefore unlikely to provide actionable normative guidance to public health policy-makers, practitioners and researchers. I argue that the concept of health equity, as it is commonly defined in public health, ultimately rests upon assumptions of a more fundamental, yet tacit, conception of justice to do its normative work. In this vein, I expand upon a critique of Margaret Whitehead's (1992) oft-cited definition of health equity made by James Wilson (2011) to raise additional reasons not explored by Wilson, or others, as to why Whitehead's definition remains inadequate in providing normative guidance to policy-makers, practitioners and researchers in public health.

Health equity is increasingly identified as a principal goal to be achieved through public health policies and activities (Public Health Agency of Canada, 2008; Centers for Disease Control and Prevention, 2013; American Public Health Association, 2014; Canadian Public Health Association, 2014a; World Health Organization, 2014a). In addition to public health's aim to improve population health, a commitment to health equity requires attention to the distribution of health benefits and burdens amongst population groups. However, what is to be measured in the assessment of health equity and how inequities in health ought to be redressed are among the pressing questions that must be answered if health equity is to serve as a meaningful and consistent guide for measurement and intervention in public health.

In order to identify and measure health inequities we must first know exactly what the concept of 'health inequity' entails. This involves both a descriptive and normative task; the descriptive task requires us to name the criteria that must be met in order for something to be considered a health inequity (e.g., 'differences in health status between two or more populations') and the normative task requires us to justify the relevance of those criteria (i.e., why should differences in health status

between those populations be worthy of our moral attention?). Similarly, while in public health we perhaps most often seek to identify and redress health *inequities* (a remediable aim), we might also seek to promote health *equity* (a positive aim). As such, we ought to understand not only what constitutes health inequities but also the ideal that we are to achieve with health equity.<sup>1</sup> Finally, we ought to know how it is we are to move from health inequity toward health equity. This requires information about how inequities *can* be redressed (a descriptive task), and more importantly, how inequities *ought* to be redressed (a normative task). That is, we should seek to redress inequities in a way that is consonant with the very ethical motivation that initially led us to consider the inequities to be morally significant; for if the means of redressing a health inequity is itself considered inequitable, it ought to be avoided for the same reasons supplied for redressing the initial inequity.<sup>2</sup>

Given these numerous considerations it is not surprising that health equity is a multivalent concept that has the potential for divergent interpretations, each having significant implications for the public's health. For instance, different population groups (e.g., citizens vs. noncitizens), different metrics (e.g., health status vs.

- Health inequities = **unjust** differences in health
- Health equity relies upon, and requires clarity with respect to, **social justice**

“While widely advocated, an explicit theory of justice **is rarely identified.**”

- Aline Gubrium et al., 2014, p. 121-122

“The vast majority of these articles **simply presumed that everyone working in public health already knows what justice is.**”

- Griffin Trotter, 2008, p. 457

# Methods

- ‘Empirical ethics’: generate empirical data and link with normative ethics debate regarding the proper aims of health justice
- Qualitative, semi-structured, conceptual interviews
- Purposive sampling
- Key informants (‘policy-makers’) from municipal (Toronto), provincial (Ontario), and federal (Canada) public health organizations
- Thematic analysis (Braun & Clarke, 2006)

# Methods

20 Interviews



10 - chronic disease prevention



10 - public health emergency  
preparedness and response

# Equity = clearer, more common

“I’d say equity, you know, the answer to your question is that **equity is clear to me. Social justice, I think the definitions are fuzzy.**”

- P03-PHEPR-P

“We talk about equity but we don’t, we, **we don’t talk about social justice.**”

- P04-PHEPR-P

“**I don’t hear the term social justice**, um, that specific term, what I am hearing more and more is that talking about, um, health inequalities and health inequities.”

- P16-CDP-M

# 'Health equity' vs. 'social justice'

“It’s almost more **easy** to talk about health equity. It feels more **proximal**. It feels more **neutral**. It feels more **quantifiable**. Whereas moving from the discussion about health equity to unfair and unjust, to talking about social justice, requires that personal confrontation and unpacking about, ‘what are my biases?’ ‘What am I not comfortable with?’ ‘How do I feel about certain things?’...This requires overcoming **racism, gender bias, entrenched values and attitudes**...yeah, there’s a lot there.”

# 'Discursive space' for justice-based considerations in public health

Health equity	Social justice
<ul style="list-style-type: none"><li>• 'Proximal'</li><li>• 'Superficial'/'shallow'</li><li>• 'Materialistic determinants'</li><li>• 'Access to services'</li><li>• Distributive in character</li></ul>	<ul style="list-style-type: none"><li>• 'Political'</li><li>• 'Deeply embedded'</li><li>• 'Structural determinants'</li><li>• '-isms' (e.g., racism, colonialism, sexism)</li><li>• Relational in character</li></ul>
<ul style="list-style-type: none"><li>• 'Neutral'</li><li>• 'Comfortable'</li><li>• 'Objective'</li></ul>	<ul style="list-style-type: none"><li>• 'Contested'</li><li>• 'Uncomfortable'</li><li>• 'Subjective'</li></ul>
<ul style="list-style-type: none"><li>• 'Clearer'</li><li>• 'Beaten to death'</li></ul>	<ul style="list-style-type: none"><li>• 'Unclear'</li><li>• 'Nobody talks about social justice'</li></ul>

# Implications

“I think public health can point out challenges related to social justice, but I am not sure it can actually solve them. Whereas **public health is in a position to deal with equity in terms of access.**”

- P03-PHEPR-P

“If people [aren't] ready for social justice, then **let's just take health equity if that's all we can get, right?** It's good, good enough, right? At least it's better than nothing, um, and, you know, maybe once everybody is perfectly comfortable with health equity, of which, you know, a fair number of people are not, uh, then, then we can move on.”

- P10-CDP-P

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