Mississauga Halton **LHIN**

Building Health Equity Capacity in the Mississauga Halton LHIN

Health Equity Glossary

SYSTEM PLANNING COMMITTEE ON HEALTH EQUITY

Ontario
Local Health Integration Network

Preamble

The aim of this glossary is to provide a clear and useful set of terms and definitions and common understanding to some of the terminologies related to health equity, diversity. This glossary is going to be used by health services providers and community based agencies.

This Annotated Glossary is a “living document.” This implies that an evolution of understanding will occur as the organization and its components learn and develop. The intention is for this document to be revised and updated on a regular basis to better reflect changes in use of the terms contained within it and overall societal change.

We recognize that language is constantly evolving as such we would like to encourage you to explore other sources to further enhance your understanding of these terms and add to the list as these meanings change.

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Accessibility – The ability, opportunity and means to approach, consult, and utilize an organization's services and organizational structure (Hamilton Centre for Civic Inclusion, n.d.).

Equity in Health – can be—and has widely been—defined as the absence of socially unjust or unfair health disparities; however social justice and fairness can be interpreted differently by different people in different settings.
For the purposes of operationalization and based on measurable criteria, equity in health can also be defined 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—that is, different positions in a social hierarchy. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health; health is essential to wellbeing and to overcoming other effects of social disadvantage(Braveman & Gruski, 2003).

Exclusion–The feeling or experience of being disempowered degraded or disenfranchised through intentional or systemic discrimination (Regional Diversity Roundtable, n.d.).

Gender – is a social construct that ascribes an individual with roles, responsibilities, norms, aptitudes, behaviours and expectations. In reality, gender roles are affected by a variety of other identity factors including, age, class, race, ethnicity, religion and ideology. Gender Based Analysis is about looking at the differences between and among different groups of women and men, and helping to mitigate or eliminate differential negative impacts (Status of Women Canada, 2012).

Gender Identity – which does not always correspond to biological sex, is a person's self-image or belief about being male or female (Regional Diversity Roundtable, n.d.).

Health Equity –The concept that all people are able to reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, sexual orientation, age, social class, socioeconomic status or other socially determined circumstance (adapted from Whitehead and Dalgren, 2006).

Health Inequality – differences in the health status of individuals and groups. The reasons for these differences range from biology and genetics to broad social and economic factors (Public Health Agency of Canada, 2011).

Health Inequity – health differences between population groups defined in social, economic, demographic or geographic terms that are:

1. *Systemic* – meaning that differences are not random, but are patterned across the population where those with higher social status tend to have better health than those with lower social status.
2. *Avoidable* – meaning that health differences are not the result of natural biological differences but are the result of how societies distribute resources and opportunities. Because they are socially-produced, they are avoidable through collective action by individuals, agencies, businesses, communities, and every level of government.
3. *Unfair and unjust* – meaning that a moral or normative judgment where one determines a health difference to be unfair, or stemming from an injustice is required (National Collaborating Centre for Determinants of Health, 2013).

Inclusion – Having a sense of belonging, feeling respected and supported, valued for who you are and having opportunities to participate. Power imbalances could be a barrier to the feeling of inclusion. For example, people within a dominant group could make decisions, as they possess the power to do so; for those outside this dominant group there is often a lack of support needed and feelings of inequality develop (Miller & Katz, 2002; Donaldson, 2005; Halton Region and Sudbury District Health Unit, 2011).

Intersectionality – Gender, age, race, sexual orientation, socio-economic status and disability often intersect and people who fall into any of these categories should not be considered a homogenous group. Only focusing on poor economic status, for example, may distort our understanding of how inequity works, who suffers from it, and how it can be addressed. For this reason, any effective solution to health inequities must be informed by an understanding of intersectionality (Central East LHIN, n.d.)

Marginalization – the process of establishing and maintaining a social hierarchy of people in which the dominant group is considered the norm or the "centre" (e.g., white, heterosexual Canadians), while non-dominant individuals or groups (often referred to as *diversity*) who exist outside that normative centre are necessarily anomalous or "marginal." Those who exist at the social, political, and economic edges of society do not have the same access to life opportunities that members of the dominant group have.[1] Put another way, marginalization refers to "the experience of certain groups, which do not have full and equal access to and cannot participate in the social, economic, cultural and political institutions of society."[2] Research demonstrates a direct link between marginalization and health inequities (Central East LHIN, n.d.).

Marginalized populations – Groups of people that experience marginalization. Marginalized populations include but are not limited to ethno-racial or ethno-cultural
groups, immigrants and refugees, people of low socio-economic status, women, sexual and gender minorities, people with disabilities, youth, seniors, people living in certain geographic areas, Aboriginal peoples, and those experiencing addictions and mental health issues (Central East LHIN, n.d.).

Racialized-To differentiate or categorize according to race or to impose a racial –character or context (Regional Diversity Roundtable, n.d.).

Social determinants of health – Conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources. The unequal distribution of the social determinants of health is mostly responsible for health inequities (WHO, 2008).

[1] Bishop, A. (2002). *Becoming an ally: Breaking the cycle of oppression in people.* London: Zed Books
[2] City of Toronto Task Force on Community Access and Equity. (1999). *Final report.* Retrieved from http://www.toronto.ca/inquiry/inquiry_site/cd/gg/add_pdf/77/Governance/Electronic_Documents/City_of_Toronto_Material/Task_Force_on_Community_Access_and_Equity.pdf

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