

WHEN I SAY

When I say ... health equity

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Health professions' education largely relies on the biomedical model of health, a Eurocentric and Westernised model focusing on pathology and disease risk.¹ Though valuable, this disease-based model does not dovetail with the World Health Organization's (WHO) holistic definition of health, 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'.²

The disease-based model of health does not acknowledge that opportunities for health reflect the environmental and social factors within communities and fails us for two reasons: (1) The unit of analysis within the biomedical model is at the individual level whereas the concepts of 'health inequity' and 'health disparity' exist at the population-level, and (2) the complex mechanisms that shape both concepts extend beyond medicine to include sociocultural and geopolitical factors. The WHO frames health as an attainable standard best understood through a biopsychosocial model of health that is equally ecological as it is rooted in human rights.³ Yet, a universally accepted definition of 'health equity' or standardised application across the health professions does not exist.

A health disparity is a population health metric empirically measured as new or existing rates of any given health outcome that disproportionately impacts socially disadvantaged populations. Health disparities are unfairly occurring due to social and structural factors such as stigma, disenfranchisement and historical marginalisation. Health disparities are not random or happenstance but patterned as 'health inequities', or macro social ills with no biological explanation. For instance, a patient diagnosed with a rare blood disease who dies prematurely due to unavailable treatment modalities should not be described as experiencing a health disparity. This example points out the disease status (and mortality) of an individual rather than a poor health outcome

affecting a socially disadvantaged population. Additionally, the rare blood disease in this example is a naturally occurring health difference that can be attributed to genetics as opposed to a health inequity.

Even though health inequities explain *why* health disparities exist, what counts as a health disparity is not uniformly understood or measured. In the United States, the health disparity concept overwhelmingly refers to unfair racialized health differences, while in France and the United Kingdom, for example, the term 'health inequality' is used to describe unfair population health differences.³ These outcomes are not described as racial, but geographical and socio-economic, further indicating how imperfect current metrics are in operationalising unfair health differences that are likely an interplay of race, class and place given its multidimensional and intersectional nature. Health disparity and health inequality literature are limited by the ongoing practice of attempting to neatly fit complex phenomena into categorical data.

Often, the terms 'health equity' and 'health disparity' are erroneously conflated. A comprehensive definition of health equity has been offered as, '...everyone has a fair and just opportunity to be as healthy as possible'.⁴ We agree that health disparities indicate *what is* by reflecting measurable epidemiological data, while health equity reflects *what should and could be*.⁵ The existence of health disparities indicate how far we are from achieving health equity. To achieve health equity, there must be a focus on improving the health of populations who fare the worst, which are the populations who experience health disparities. For instance, access to safe and quality food, education, housing and transportation are examples of social determinants of health that favourably affect the health of some populations while adversely impacting others due to structural inequities such as segregation and poverty. The double pandemic of racism and COVID-19 illustrated how codependent our lives are when communities are not well or do not feel safe. The social determinants of health affect the quality and length of all of our lives. As such, the call for health equity benefits everyone and is not a zero-sum game.

Thanks to the Center for Faculty Excellence Educational Research Grant, The George Washington University School of Medicine and Health Sciences for seed funding of our IRB-approved health equity study.

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Framing health equity and health disparity discussions in a historical and sociocultural context is essential, while humanising patient populations. In this way, the values that cut across social identities, including the need to feel safe and respected, provide for oneself and one's family and preserve community identity, is recognised. To deepen one's understanding of structural inequities, we must identify the root causes of poor health outcomes. After all, health disparities exist among populations who experience historical oppression and exclusion. We need to look beyond local phenomena towards global threats to health equity such as climate change, migration, political instability and corruption for why health gaps remain. Attempts to address social disadvantage must include examinations of privilege, power imbalances, implicit bias and racism stemming from the reality that we will never achieve health equity without racial equity.

With these critical understandings, defending calls for equity are appropriate when there is a maldistribution of power, wealth and resources. It is crucial that the health professions rely on our connect- edness as a global community to utilise a biopsychosocial model of health that applies a health equity lens to all research, clinical care, education and community engagement. Additionally, the onus for teaching and applying health equity concepts should not fall squarely on members from underrepresented groups. Silos that exist and continue to feed health disparities need to be re-examined and dismantled as we educate the health professions community to lead this change. Corraling around a uniform definition and measurement of health inequity and health disparity is paramount for the health professions workforce to advance health equity, including its social and structural determinants.

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How to cite this article: Ward MC, Ganjoo R. When I say ... health equity. *Med Educ.* 2023;57(2):121-122. doi:10.1111/medu.14962