Is 'health equity' bad for our health? A qualitative empirical ethics study of public health policy-makers' perspectives

Maxwell J. Smith¹ · Alison Thompson² · Ross E. G. Upshur³

Received: 3 February 2018 / Accepted: 23 August 2018 / Published online: 21 November 2018
© The Canadian Public Health Association 2018

Abstract

Objectives 'Social justice' and 'health equity' are core values in public health. Yet, despite their *normative* character, the numerous normative accounts of social justice and equity are rarely acknowledged, meaning that these values are often unaccompanied by an explanation of what they require in practice. The objective of this study was to bridge this normative scholarship with information about how these 'core values' are integrated and interpreted by Canadian public health policy-makers.

Methods Twenty qualitative interviews with public health policy-makers recruited from public health organizations in Canada, analyzed using an 'empirical ethics' methodology that combined empirical data with normative ethical analysis involving theories of justice.

Findings Participants viewed health equity and social justice as distinct, where the former was perceived as 'clearer'. Health equity was conceptualized as focusing attention to 'proximal' disparities in access to services and 'materialistic' determinants of health, whereas social justice was conceptualized as focusing on structural issues that lead to disadvantage. Health equity was characterized as 'neutral' and 'comfortable', whereas social justice was characterized as 'political' and 'uncomfortable'.

Conclusion These findings indicate that health equity dominates the discursive space wherein justice-based considerations are brought to bear on public health activities. As a result, 'uncomfortable' justice-based considerations of power imbalances and systematic disadvantage can be eschewed in practice in favour of attending to 'proximal' inequities. These findings reveal the problematic ways in which considerations of justice and equity are, and are not, being taken up in public health policy, which in turn may have negative implications for the public's health.

Résumé

Objectifs « La justice sociale » et « l'équité en santé » sont des valeurs fondamentales en santé publique. Pourtant, il est rare que l'on prenne acte des nombreux exposés sur la justice sociale et l'équité, malgré leur caractère normatif; ces valeurs ne s'accompagnent souvent d'aucune explication de ce qu'elles exigent en pratique. Le but de notre étude était de combler l'écart dans la littérature spécialisée avec de l'information sur l'intégration et l'interprétation de ces « valeurs fondamentales » par les responsables des politiques de santé publique du Canada.

Méthode Vingt entretiens en profondeur avec des responsables des politiques recrutés auprès d'organismes de santé publique du Canada ont été analysés selon une méthode « empirique éthique » combinant des données empiriques avec une analyse normative éthique incluant les théories de la justice.

Constatations Les participants considèrent l'équité en santé et la justice sociale comme des notions distinctes, la première étant perçue comme étant « plus claire ». L'équité en santé est conceptualisée comme mettant l'accent sur les disparités « proximales » dans l'accès aux services et les déterminants « matérialistes » de la santé, tandis que la justice sociale est conceptualisée comme mettant l'accent sur les problèmes structurels qui mènent à la défavorisation. L'équité en santé est

✉ Maxwell J. Smith
maxwell.smith@uwo.ca

Alison Thompson
a.thompson@utoronto.ca

Ross E. G. Upshur
ross.upshur@utoronto.ca

¹ School of Health Studies, Faculty of Health Sciences, Western University, Arthur and Sonia Labatt Health Sciences Building, Room 331, 1151 Richmond Street, London, ON N6A 5B9, Canada

² Leslie Dan Faculty of Pharmacy, University of Toronto, 144 College Street, Toronto, ON M5S 3M2, Canada

³ Dalla Lana School of Public Health, University of Toronto, 155 College Street, Toronto, ON M5G 1L4, Canada

décrite comme une expression « neutre » et « confortable », et la justice sociale, comme une expression « politisée » et « inconfortable ».

Conclusion Ces constatations montrent que l'équité en santé domine l'espace du discours où les considérations fondées sur la justice servent à guider les activités de santé publique. En conséquence, l'examen « inconfortable » des déséquilibres de pouvoir et des désavantages systémiques, fondés sur la justice, peut dans la pratique être évité en faveur d'un examen des inégalités « proximales ». Cela révèle des problèmes dans la prise en compte, ou non, de la justice et de l'équité dans les politiques de santé publique, ce qui en retour peut avoir des conséquences négatives pour la santé publique.

Keywords Health equity · Social justice · Health policy · Bioethics · Public health

Mots-clés Équité en santé · Justice sociale · Politique de santé · Bioéthique · Santé publique

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

– Dan E. Beauchamp (1976)

Introduction

‘Health equity’ and ‘social justice’ are routinely identified as core values in, and for, public health (Beauchamp 1976; Public Health Agency of Canada 2008; Commission on Social Determinants of Health 2008). Both values belong to the theoretical space of *justice*. That is, both social justice and health equity are meant to focus our attention to the normative demands of justice as they relate to the activities of public health policy, practice, and research: whether health benefits are distributed fairly, whether programs adequately respond to the needs of the most disadvantaged, and so forth. That social justice belongs to this theoretical space requires no further elaboration. For health equity, it suffices to note that health inequities are routinely interpreted as ‘*unjust* differences in health’ (Braveman et al. 2011; Wilson and Inequities 2011; Smith 2015), and so should be understood as relying upon some notion of justice in order to discern exactly which differences in health ought to be remediated *as a matter of justice*.

This point is worth underscoring because the theoretical space of justice is vast and diverse; that there are countless competing accounts of justice contributed from moral and political philosophy (and elsewhere) suggests that both social justice and health equity likely preclude single (or simple) interpretations or applications. Yet, despite the ubiquity and stature of these declared values in organizational mission statements, ethical frameworks, and in public health scholarship, outside of the theoretical literature the specific justice-based considerations that ought to be brought to bear on public health activities are seldom expounded (Edwards and Davison 2008; Trotter 2008; Fafard 2012). Given the putative

centrality of these values to the way in which public health ought to be organized and practiced, it behooves us to understand the sorts of justice-based considerations and demands imbued by each value, whether each value instructs us to pursue distinct justice-related aims, and the degree to which each value actually informs the work of public health professionals.

While an emerging body of theoretical literature in the field of public health ethics has supplied important insights into how these values ought to be conceptualized in the public health context (Daniels 2007; Segall 2009; Powers and Faden 2006; Ruger 2010; Venkatapuram 2011), we believe that the task of specifying and clarifying the values that form the basis for policy decisions and actions in public health is both a theoretical and practical endeavour. As such, to complement an emerging body of theoretical scholarship in this area, this paper reports findings from a qualitative study that sought to understand Canadian public health policy-makers’ perspectives on the meaning and role of social justice in their practice. With the specific aim of illuminating the discursive space within which considerations of justice are engaged with and operationalized in the public health context, this paper reports findings from this study that concern participants’ perspectives on the relationship between social justice and health equity and the degree to which each value was perceived as interacting with their practice.

Methods

This study’s methodology falls within an emerging area of scholarship broadly referred to as ‘empirical ethics’ (Ives and Draper 2009), and in this case aimed to link empirical data generated from key informant interviews with the normative ethics debate surrounding the proper aims of social justice.

The manner in which this ‘linking’ occurred could best be described as ‘pragmatic’. Like Engel (2009), we take pragmatism to be the view that “epistemic reasons and

justifications—such as our reasons for taking a belief to be true or well confirmed—are either determined or can be overridden by practical or prudential reasons or justifications” (p. 185). As such, this study did not seek to discover some universal and unwavering ‘truth’ about what social justice is, nor was it seeking to validate normative theory or simply describe perspectives on social justice. What it ultimately aimed to do was generate empirical information about public health policy-makers’ perspectives on social justice, and, in light of this information, explore the practical or prudential reasons and justifications—derived from both theory and interviews—that might exist in supporting the further exploration of particular considerations of social justice in public health, or in advocating for the modification of how social justice is conceptualized and pursued in practice.

To accomplish this pragmatic aim, this study sought to establish a contextual understanding of the ways in which social justice is discussed in the practice of public health, including how the term is interpreted and used at ‘ground level’ (Ives and Draper 2009). This was imperative because ethical concepts like social justice and health equity are not simply superimposed onto a field like public health, and they typically do not logically entail specific policy directions or responses (Giacomini et al. 2009; Jennings 2015). Rather, when values like social justice are interpreted and discussed in the context of public health policy and practice, the meanings of these values are “transformed and contextualized or localized” (p. 9) (Jennings 2015). This study therefore aimed to situate theory and, ultimately, the ‘pursuit of social justice’, in practice¹; instead of normative theory underlying practice, this study sought to locate and understand theory within practice (Ives and Draper 2009).

Normative theory

This study’s theoretical background and interpretive apparatus for data analysis comprised multiple theories of justice that were themselves developed out of a particular concern with questions of social justice in public health. While Powers and Faden’s Twin Aim theory of social justice (Powers and Faden 2006) served as a focal point given the authors’ unique claim that it “offers a moral foundation for the theory and practice of public health” (p. 156) (Faden and Powers 2008), and that it “provides a fine, if not perfect, fit with the commitments and practice of public health” (p. 80) (Powers and Faden 2006),

the theories of Daniels (2007), Ruger (2010), Venkatapuram (2011), and Segall (2009), in addition to the broader theoretical landscape of social justice (i.e., theories developed without a particular focus on, or concern with, health, and public health), were also integral. While present space does not permit a discussion of these contributions and the salient differences between them, something brief will be said here to characterize the conceptual landscape of justice for those less familiar with the topic.

Justice consists of the apportionment of benefits and burdens, advantages, and disadvantages, to individuals in accordance with that to which they have a moral claim. As such, the pertinent task for justice is to say something about the sorts of moral claims that people have as a matter of justice, in addition to the manner in which competing claims ought to be evaluated and acted upon.²

Generally speaking, justice is often characterized as having distributive, procedural, and/or relational dimensions.³ Distributive justice applies criteria of justice to the distribution of certain goods. Substantial debate exists concerning the sorts of goods whose distribution ought to be of concern to us as a matter of justice (Cohen 1990). Traditionally, and particularly in the health context, these typically include access to services (e.g., immunization clinics), resources (e.g., health care resources; income), opportunities or capabilities to be healthy, and health outcomes themselves.⁴ Debate also exists regarding the criteria of justice used to prescribe the pattern or basis of distribution for any particular good, where typical candidate principles include equality, sufficiency, and priority (Ruger 2010). Multiple principles and currencies of justice mean that numerous permutations are reflected in competing accounts of justice; one may defend the view that justice demands the *equal* distribution of the *resources* viewed as being necessary to bring about health, that *access* to services be allocated with *priority* given to the least healthy, that policies and practices are organized to best ensure individuals reach a *sufficient* level of *health*, and so forth.

Procedural justice, on the other hand, consists of applying criteria of justice to processes rather than directly to actual distributions or outcomes (Daniels 2007). Hence, procedural justice may demand that public health decision-making accord with principles such as consistency, inclusiveness, and/or transparency.

¹ This pragmatic aim is consonant with, and is grounded in, our epistemological views, which tend toward critical realism. On this account, because knowledge is considered to be fallible and theory-laden (but not entirely theory-dependent), we believe that the data generated in this study cannot be detached from theory; what ‘counted’ as data at least to some extent was determined in light of the interpretive apparatus used in this study, which neatly aligns with our interest in linking the empirical data generated in this study with the normative debate surrounding the proper aims of social justice.

² One cannot do justice to the vast conceptual and theoretical landscape of justice in such little space, and so this brief characterization is necessarily an oversimplification.

³ As Jost and Kay (2010) note, it can be useful to distinguish between these dimensions of justice, but “little is gained by exaggerating or reifying such divisions” [p. 1143]. A theory of justice may address any or all of these aspects.

⁴ The act of specifying the currency of justice is itself a normative task, and as such, different accounts of justice invariably concern themselves with different goods according to the moral significance bestowed to such goods and the perceived capacities of social institutions to influence their distribution.

Relational justice requires a disposition to treat individuals in accordance with principles that express just relations. Only when principles of just relations are satisfied (e.g., when individuals are treated with equality of standing or status) can the distributions resulting from those relations (e.g., of health) be considered just. Respect, power, privilege, and responsibility have all been proposed as being central to relational justice, shifting the attention of distributive justice towards the critical investigation of social phenomena like domination, subordination, exploitation, oppression, and marginalization (Miller 2001; Jost and Kay 2010; Young 1990).

Finally, equity itself is often construed as a material principle of justice, which in the health context could be understood as concerning itself with the ratio of one's health needs to one's receipts (e.g., of health services); justice exists when this ratio is equal for all individuals. However, it is perhaps more typical in this context for equity to be understood in terms of *inequity*, which is commonly understood as referring to an 'unjust difference in health' (Braveman et al. 2011; Wilson and Inequities 2011; Smith 2015). As previously mentioned, this means that health equity ultimately relies upon some notion of justice in order to discern exactly which differences in health ought to be remediated *as a matter of justice*.

Data collection

Despite frequent calls to use qualitative methods in social justice research (Sabbagh and Golden 2007; Giacomini et al. 2014), there is a paucity of qualitative research exploring perspectives on social justice. This study employed a qualitative design, where data were generated through open-ended, semi-structured interviews. The interview guide was developed according to the aims and structure of what Brinkmann and Kvale characterize as a 'conceptual interview', which seeks to explore meanings and conceptual dimensions of central terms, and 'chart' participants' conceptions of phenomena, like social justice and health equity (Brinkmann and Kvale 2015). The interview guide incorporated questions that explicitly inquired about participants' perspectives on the meaning and role of social justice in the context of their practice, as well as questions that asked participants to speak freely in voicing their opinions, values, and judgements about the goals and scope of their domain of public health practice in order to explore participants' 'interpretive processes' (Patton 2001).

Interviews were conducted between March, 2014 and January, 2015. Recruitment of participants ceased when thematic saturation was reached within the data; that is, when new data no longer shed any further light on the issue under investigation (Sandelowski 1995).

Participants and setting

Because public health in Canada is the shared responsibility of governments at the municipal, provincial/territorial, and federal levels, this study did not set out to restrict the involvement of participants to any one of these levels. However, due to reasons of feasibility, participants were recruited from only one municipal level (public health units within the Greater Toronto Area) and from only one provincial level (public health departments or agencies at the provincial level in Ontario, which were also located in the Greater Toronto Area), in addition to recruiting participants from the federal level in Canada (who were located in Ottawa).

Key informants were recruited purposively based on their professional positions in order to permit in-depth inquiry into individual perspectives on the topic of interest and from the population of interest (Patton 2001). The key informants sought for recruitment were characterized as public health 'policy-makers'. 'Policy-maker' in this study refers not to a precisely defined, homogenous set of individuals who have this title, but rather to a population of interest to this study given their role in developing or implementing policy and practice change in public health organizations or agencies. Key informants therefore included policy advisors, policy-level decision-makers, and other individuals involved in drafting policy briefs or scientific guidance aimed at shaping policy.

A second aim of this study, the findings of which will be reported elsewhere, was interested in exploring and examining the extent to which the perspectives of public health policy-makers involved in different programmatic areas of public health were similar or different. As such, participants were recruited from two well-established programmatic areas, or 'contexts', of public health: chronic disease prevention and public health emergency preparedness and response. Government directories and websites were primarily used to identify potential participants (e.g., Government Electronic Directory Services (GEDS)). Once local contacts were identified, snowball sampling was used to identify additional potential participants involved in policy and practice change in the public health area of interest.

Twenty interviews were conducted in total, with ten participants practicing in the area of chronic disease prevention (three at the federal level, three at the provincial level, and four at the municipal level) and ten participants from the area of public health emergency preparedness and response (three at the federal level, four at the provincial level, and three at the municipal level). The interviews ranged from 30 to 80 minutes in length, with an average and median interview length of 60 minutes. Each interview was conducted either in person or over the telephone by the first author. Interviews were audio recorded and were transcribed verbatim by a professional qualitative research transcriptionist, which were then verified by the first author by reading the transcript while listening to

the associated audio file. This study received formal ethics approval from the Office of Research Ethics at the University of Toronto and all participants provided written consent prior to participation.

Data analysis

The process by which data were analyzed aligns most closely with Braun and Clarke's method of 'thematic analysis', which is a method for identifying, analyzing, and reporting patterns or themes within data (Braun and Clarke 2006). Data analysis began by reading and re-reading each transcript to get a sense of the data corpus. Following this stage, initial codes were generated for each interview. The generation of codes was largely data-driven and was conducted with the aim of characterizing the words and ideas used in the data as descriptively as possible. Data management was facilitated by NVivo qualitative data management and analysis software.

Similar codes and similarly coded extracts were then collated in order to explore and identify potential themes within the data. Themes were actively identified if they captured something important or of interest in relation to this study's research questions and theoretical background (theories of social justice) (Braun and Clarke 2006). Themes were therefore constructed both inductively based on the descriptive codes, allowing analysis dimensions to 'emerge' from codes identified in the data, and deductively, based on the study's interpretive apparatus. The generation of themes was achieved, in part, by conducting a 'theoretical reading' of transcripts and codes (Brinkmann and Kvale 2015). This meant that this study's theoretical background 'sensitized' the analysis, suggesting 'directions in which to look' (which can be contrasted with the theoretical background being 'definitive', which 'defines what there is to see') (Brinkmann and Kvale 2015). At all phases of analysis, detailed notes were kept that identified which codes were added, removed, or collapsed, in order to establish an 'audit trail' (Lincoln and Guba 1985).

⁵ In the description of themes, data extracts are presented in order to illustrate the ways in which themes are supported by the data. Extracts were chosen according to their 'aptness' in illustrating the nature of the theme discussed. Each extract includes an identifier, which acts to contextualize the quote: the first three characters (e.g., 'P08') refer to the participants' numerical identifier (e.g., participant number eight), the second set of characters (either 'CDP' or 'PHEPR') indicate the programmatic area of public health practice coded for the participant (chronic disease prevention or public health emergency preparedness and response, respectively), and the third set of characters ('M', 'P', or 'F') indicate the level at which they worked (municipal, provincial, or federal, respectively). In some instances, data extracts are presented that include not just quotes from participants but also include the interviewer's interaction with participants. In these instances, participants' voices are prefaced by a 'P' at the beginning of quotes (to represent 'participant'), and the interviewer's voice is prefaced by an 'I' (to represent 'interviewer').

Findings

The two themes presented here speak to the ways in which study participants talked about social justice and health equity and shed light on the discursive role that different justice-based considerations played as situated within the participants' context of public health practice.⁵

The relative clarity and prominence of health equity

Participants raised the term 'equity' throughout interviews, even in direct response to questions about social justice, which suggests that they perceived there to be a relationship between the two. When probed about this, participants expressed that they felt the meaning of health equity is 'clearer' than social justice:

"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)

The general lack of clarity participants expressed regarding the meaning of social justice made more sense to us once participants made it evident that social justice is generally not perceived to be explicitly part of the discourse of their daily work in public health:

"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)

This had implications for how the subject matter was discussed in the remainder of each interview. For instance, when participants were asked to recall something in their public health work that they would consider to be 'unjust', or perhaps something that, to them, reflected an attempt to 'achieve' social justice, participants provided responses but often reverted to speaking about inequities and equity without addressing the fact that the question was about social justice. Overall, participants generally appeared to have a greater comfort in speaking in terms of equity and inequities rather than social justice and injustice. As will be illustrated in the next theme, though, while these findings support the idea that participants considered social justice and equity to have a close relationship, when prompted, they believed the two values evoked considerations of different kinds and used different words and ideas when discussing each concept.

Health equity as a ‘safe’ alternative to social justice

Participants spent considerable time discussing the distinction between health equity and social justice, what each term meant to them, and the role each idea plays in their work. Participants used words like ‘proximal’, ‘neutral’, and ‘quantifiable’ to describe health equity:

“It [equity] feels more proximal. It feels more neutral. It feels more, uh, quantifiable, uh, quantifiable, okay? Whereas getting, moving from the discussion about health equity to unfair and unjust to talking about justice, 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, that some people don’t have the time or the inclination to do, okay? So that’s where I think the conversation needs to deepen on the difference between health equity and social justice.” (P07-CDP-P)

“For some reason equity to me seems almost [long pause] a little bit more, uh, objective or quantifiable, or more easily described, whereas social justice, to me, is, is a much broader, softer concept, um, but more all-encompassing.” (P14-PHEPR-F)

Participants contrasted the ‘comfortable’, ‘quantifiable’, ‘proximal’ nature of health equity with social justice, which was characterized as concerning ‘-isms’ (e.g., ‘racism’, ‘sexism’, ‘colonialism’) and ‘deeper’ ‘political’ and ‘structural’ issues. Participants indicated that discussing social justice would take their work in a very different direction than health equity:

“What’s the social justice impact of housing policy, of daycare policy? Let me tell you, that will, that will take the conversation in a, in a different direction, I believe, in a deeper, richer direction, than just, uh, and I don’t mean just, but, than simply talking about health equity or inequity.” (P17-CDP-M)

“They [a public health organization] noted that they have this big gap in their services around Aboriginal clients and they specifically did something about it. Is that improving health equity? Maybe, maybe, but it just goes right back to wondering, well, what exactly is health equity? Does that make any difference to social justice? I don’t think so. Because the structural things you haven’t changed at all.” (P10-CDP-P)

These distinguishing considerations of social justice were often characterized as a concern for the ‘why’:

P: “But I think a lot of it is...like, we can all agree to the principles. Most of us anyway. We do have an economist in our midst, which is an interesting, always an interesting perspective. But, I think where people get stuck is that there isn’t a very good understanding, at least within [the public health organization], it’s not top of mind as to *why* you have differences in outcomes according to income, or according to ethnicity, or things like that.”

I: “And that why matters?”

P: “And the why is key to the whole thing. In a deeper...in a deeper way.” (P13-CDP-P)

For participants, these distinct foci of health equity and social justice have practical implications. For instance, participants suggested that health equity focuses attention, and ultimately flavours the scope of ‘inequities’, towards ‘superficial’, ‘materialistic’ things rather than the ‘deeply embedded’ challenges that are more situated within the domain of social justice:

P: “[Sarcastically asking] Why do we have to focus on, you know, STI incidents in gay men, because they have got really high income? Okay? So this is, like, exactly the sort of the, the, the immediate reaction is, it’s [health equity] about income. It’s a materialistic interpretation of inequity rather than an understanding of sort of deeply embedded, um, sort of cultural or structural or other kinds of norms.”

I: “Do you think that, the deeply embedded in the ‘-isms’ like you talk about, is that more the domain of social justice?”

P: “Yes, yes, and that’s where, that’s why I think that it’s almost easier to talk about health equity.” (P07-CDP-P)

“A health equity impact assessment is, is more comfortable for people because it’s most likely going to focus on the materialistic kind of determinants and the, and the view of health equity, a materialistic view of health equity...They [‘most people’] totally think about health equity around disability access, basically, like ramps. It comes up more than you might expect...around the materialistic perspective of equity where it’s all about income and education, and it’s not about like racism and gendered stuff and, you know, more [Long pause] harder to get your head around that concept.” (P10-CDP-P)

This ‘superficial’ focus of health equity was reflected in participants’ discussions of the way in which health equity

considerations interact with or are implemented through public health activities: at the level of public health programming.

“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)

“Many people understand health equity in terms of equal access to services, that understanding is like, or they might say equitable access to services. So it’s *services, access...* That’s where the conversation moves to being about health equity to about social justice, okay? That’s the neat thing for me, when it gets to there. Whereas I think when we talk about health equity we’re often talking about, you know, a very shallow thinking about access to resources, access to health care.” (P07-CDP-P)

This focus on public health programming can be contrasted with where it is that participants considered the primary focus of social justice considerations to be, which was characterized as being in the realm of the ‘political’. In this context, participants discussed the associated constraints related to thinking about social justice:

“I see social justice certainly as the, the political piece of equity, and that’s perhaps just my interpretation, but I look at social justice more in terms of that piece and I look at equity much along the things of, so, what’s equitable in terms of programs and services, more of the softer side.” (P18-CDP-M)

“We don’t want to, if we wanted to turn our whole society upside down and hand all the power over [Laughter], I don’t think that’s going to happen, but that, in that, that’s where social justice starts to go, right? Which is where health equity is much more comfortable because it’s like, it’s like just about health, it’s like, I can keep my power but I want to reduce your diabetes, right? And, and I am okay with that.” (P10-CDP-P)

The foregoing extracts allude to the putatively divisive nature of social justice, which is contrasted with the ‘neutral’, ‘comfortable’ nature of health equity. Some participants suggested that health equity is an ‘easier’ way in which to discuss these justice-based considerations:

“Health equity for us is a lot easier to sell.” (P18-CDP-M)

Interestingly, one participant characterized the sorts of considerations imbued by health equity as ‘safe’, which renders them easier to discuss in practice, whereas other ‘social justice’ considerations are too divisive to be discussed:

“Talk about racism in here? Are you kidding? ... Institutional racism leads to people not going to the doctor. You know? And so, these things are very real, too, and to me that’s social justice, right? But, not in here.” (P13-CDP-P)

With all of that said, several participants acknowledged that, despite the importance of social justice considerations in public health, the considerations discussed above falling under the rubric of health equity may be ‘better than nothing’:

“If people don’t want, you know, like, uh, the collective consciousness...isn’t ready for social justice, then let’s just take health equity if that’s all we can get, right?” (P10-CDP-P)

“Ultimately you have to go there [engage with social justice considerations], but, I think that health equity becomes a transition point for getting into that, so it’s really around how do you take it further?” (P07-CDP-P)

Discussion

These findings say a number of important things about the tenor and scope of the discursive space wherein considerations of justice are raised in, and ostensibly brought to bear on, public health policy and practice.

While both health equity and social justice are situated within the theoretical space of justice, this study’s findings are particularly illuminating because they indicate that participants attributed particular (though not necessarily uniform) justice-based considerations and characteristics to each of these two values. Whereas participants described health equity with words like ‘proximal’, ‘objective’, ‘neutral’, ‘comfortable’, and ‘quantifiable’, social justice was described with words like ‘political’, ‘structural’, ‘subjective’, ‘qualitative’, ‘deeply embedded’, and ‘all-encompassing’. Social justice was also described as possessing a salient evaluative (i.e., normative) component. Health equity, on the other hand, was described as having a ‘neutral’ and ‘objective’ quality, and as focusing on or attending to the ‘proximal’—access to public health resources and services and the distribution of ‘materialistic determinants’ (i.e., things amenable to distribution) like income. As such, health equity appears to operate rather squarely within the distributive paradigm, whereas

social justice seems more likely to invoke considerations of relational justice.

The upshot of this is that these findings suggest that social justice and health equity are ‘used’ to point to *different* justice-related considerations, which emphasizes the importance of examining the role each value plays in practice. These findings indicate that participants were more comfortable speaking about health equity, that they perceived health equity as having a ‘clearer’ meaning, and that discussions of health equity were perceived to be more common than were discussions of social justice. For these reasons, we interpret these findings as suggesting that *health equity dominates the discursive space wherein considerations of justice are expressed among public health policy-makers*. As a result, these findings suggest that the justice-based considerations that are discussed and ostensibly brought to bear on public health activities may be those tending to be imbued by the concept of health equity.

The idea that health equity dominates this discursive space is further supported by examining participants’ perspectives on the relative ‘ease’ with which health equity and its particular considerations can be ‘used’ in comparison to social justice. Participants perceived health equity as ‘easier to sell’, ‘simplifying our lives’, and ‘safe’, whereas social justice was described as being ‘really difficult’ and subject to ‘political sensitivities’, eliciting ‘very strong reactions’ and requiring a personal confrontation of biases and privilege that many are likely to resist. In other words, these findings indicate not only that participants perceived discussions of health equity to be more common than social justice, but also that particular obstacles were perceived to exist that prevent or preclude discussions of social justice (and the considerations imbued by the value) from occurring. The prominence of health equity in the space wherein justice-based considerations are discussed may stem from the fact that the concept operates in such a way that allows one to raise and apply putatively ‘neutral’, ‘objective’, and ‘proximal’ justice-based considerations without wading into the divisive, normative, and uncomfortable territory of social justice. It facilitates the consideration of justice in relation to public health activities without asking ‘deeper’ questions about the social forces contributing to *why* health inequities exist, without confronting ‘deeply embedded structural or cultural norms’, and without ‘handing over power’. This may reflect a broader trend in public health which favours a reductionist thinking that tends to insufficiently engage with social parameters and theories (Krieger 2013).

Moreover, Participant 7’s reflection—that moving from health equity to social justice requires confronting and unpacking personal biases and areas of discomfort—signals the important role that social location plays in relation to the ‘ease’ with which certain questions or concerns of justice may be raised or addressed by policy-makers. These sentiments speak to the pervasive ways in which systems of inequality might manifest institutionally, which can render discussions of

social justice as ‘out of bounds’ or simply not ‘actionable’ given a lack of institutional mechanisms (or appetite) to pursue such concerns. As such, oppressive forces like racism should be viewed as manifesting institutionally in such a way that simultaneously disadvantages individuals in the provision of services (e.g., “Institutional racism leads to people not going to the doctor”) as well as by precluding policy-level discussion and intervention (e.g., “Talk about racism in here? Are you kidding?”). It also highlights the fact that those subjected to systematic disadvantage—those who may be far more comfortable confronting systems of inequality given their proximity to them—are less likely to occupy such positions in the first place. As such, the discursive space wherein considerations and concerns of justice can be raised in practice may in turn be circumscribed to that which is viewed as ‘safe’ by those who ultimately have the opportunity to occupy such positions. The upshot is that the ‘safe’ alternative that health equity offers may be decidedly ‘unsafe’ for those subjected to the greatest inequities. Failing to confront uncomfortable, structural injustices may therefore render work in ‘health equity’ complicit in perpetuating such inequities.

These findings and interpretations significantly nuance the current understanding of the relationship between health equity and social justice that exists in the empirical literature. This literature reports that social justice is commonly perceived to be important, or in some way linked, to health equity (though this conceptual relationship has not been previously explored empirically). For instance, Rizzi reports that, for the frontline public health practitioners who participated in her Ontario-based study, the “theme of *fairness* was [a] dominant [frontline staff] descriptor of health equity, and [was] often made in reference to the concept of social justice” (p. 47) (Rizzi 2014). In addition, Knight states that, in her study, “[p]articipants described the role of the field in addressing health inequities as being grounded in the evidence base, as well as in the value of social justice, which they believed were mutually reinforcing. Recognizing that social justice underlies health equity requires strong engagement with the political process” (p. 192) (Knight 2014). Thus, on the basis of the existing empirical literature alone, one might simply infer that health equity and social justice are somehow mutually reinforcing in practice; that health equity is imbued with considerations of social justice, and so when health equity is invoked it ‘brings along’ social justice considerations and therefore helps to advance social justice aims.

Our data echo Knight’s finding in particular given that our participants similarly expressed that social justice concerns the political process and underlies health equity. However, our findings refine this understanding by indicating that the perceived link between social justice and health equity does not necessarily equate to the fact that social justice considerations will be systematically considered or addressed when health equity is invoked. To the contrary, our findings suggest that health equity may actually provide a way in which to discuss

justice-based considerations without engaging with the contentious subject matter of social justice, including the ‘political piece’ (or at the very least may provide a way to do so that takes these social justice considerations for granted). ‘Uncomfortable’ justice-based considerations of structural ‘-isms’, power imbalances, and systematic disadvantage can be eschewed (or simply taken for granted) in favour of attending to ‘proximal’ inequities. Engaging with divisive, political considerations is avoided by appealing to a concept that is putatively objective and neutral. The latter becomes ‘easier to talk about’, ‘easier to sell’, and ‘safe’, and for some may altogether obviate their perceived need (or appetite) to engage with the more challenging social justice considerations (e.g., “let’s just take health equity if that’s all we can get” (P10-CDP-P)).

While there is nothing inherently problematic with attending to questions of justice that attach to issues of access to resources and services, we will conclude by outlining two reasons why it ought to be viewed as concerning. First, it is concerning if this altogether supplants attention towards other considerations of justice, and especially those that concern upstream injustices that ultimately sustain or exacerbate issues of access to public health resources and services (i.e., to ‘structural’ determinants of health). Indeed, attending to issues of access alone fails to address other key aims widely considered to be important to justice, including the correction of “patterns of systemic injustice among different groups, seeking to improve rather than worsen systematic disadvantages in society” (p. 10) (Kenny et al. 2010). What we are left with, then, is a concept of equity that is detached from structural and societal considerations of social justice—considerations that are of central importance to nearly every account of social justice developed in the public health context (Daniels 2007; Powers and Faden 2006; Venkatapuram 2011).

Remediating ‘inequities’ in terms of access to public health services and resources is no doubt an important aim of justice. This aim recognizes that an injustice obtains when individuals or populations are deprived of particular benefits given their unequal access to those benefits. This is reflected in the first aim of Powers and Faden’s theory of justice, for instance, which seeks to combat *deprivation* in well-being (Powers and Faden 2006). Injustice is located in the adverse consequences for well-being that may obtain from inadequate access to important public health services and resources, and so addressing concerns of access works to remediate deprivations in well-being. However, this may do little, if anything, to combat the ‘enemy’ of the other aim of Powers and Faden’s theory, which is *disadvantage*. This second aim of justice concerns structural fairness, which locates injustice in the structural unfairness of social arrangements that distribute advantages and disadvantages. The aim requires that forms of disadvantage (e.g., discrimination on the basis of race or gender; prejudice; stigma; subordination), and not simply deprivation, be considered in the assessment of justice.

Operationalizing justice-based considerations solely through the remediation of ‘inequitable’ access to services and resources will fail to adequately address (or take into account) unfair social arrangements that may prevent individuals or populations from realistically improving their prospects for well-being and exiting a state of affairs where they are constantly at risk of decline. And, by not sufficiently engaging with social forces like racism, sexism, and colonialism, one will also fail to address intersectional forces that compound disadvantage. By failing to engage with the social mechanisms through which disadvantage, and conversely, advantage, are perpetuated and exacerbated—phenomena Powers and Faden refer to as ‘densely woven, systematic patterns of disadvantage’ (Powers and Faden 2006)—one will not only neglect a principal concern of justice, but will also likely fail to meaningfully redress inequities in deprivation that stem from disproportionate access to health services.

Second, by severing a connection between the sorts of justice-based considerations imbued by health equity and those imbued by social justice, it may be that the underlying normative assumptions and commitments of health equity can more readily be taken for granted. If addressing inequitable access to public health services is perceived as ‘neutral’ or ‘objective’—that is, if it is not in some way linked to the normative concern of injustice—then one may end up addressing those ‘inequities’ that are easiest to remediate, addressing those that may be far down on the list of inequities that *ought* to be remediated, or addressing those that may not actually be important to remediate *as a matter of justice*. In this form, health equity loses its critical capacity and establishes a path of least resistance to assessing and incorporating justice-based concerns and considerations in public health. While there is no doubt that ‘equity in health’ is critical and ought to be prioritized in public health, these study’s findings reveal the problematic ways in which considerations of justice and equity are, and are not, being taken up in public health, which may be bad for the public’s health.

Compliance with ethical standards

This study received formal ethics approval from the Office of Research Ethics at the University of Toronto and all participants provided written consent prior to participation.

Publisher’s Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

References

- Beauchamp, D. E. (1976). Public health as social justice. *Inquiry*, 13(1), 3–14.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qual Res Psychol*, 3(2), 77–101.

- Braveman, P., et al. (2011). Health disparities and health equity: The issue is justice. *Am J Public Health*, 101(Suppl 1), S149–S155.
- Brinkmann, S. and S. Kvale. *InterViews: Learning the Craft of Qualitative Research Interviewing*. Third ed. 2015, Thousand Oaks, California: Sage Publications, Inc.
- Cohen, G. A. (1990). Equality of what? On welfare, goods and capabilities. In M. Nussbaum & A. Sen (Eds.), *The Quality of Life*. Oxford: Oxford University Press.
- Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the commission on social determinants of health*. Geneva: World Health Organization.
- Daniels, N. (2007). *Just Health: Meeting Health Needs Fairly*. New York: Cambridge University Press.
- Edwards, N. E., & Davison, C. M. (2008). Social justice and core competencies for public health: Improving the fit. *Canadian Journal of Public Health*, 99(2), 130–132.
- Engel, P. Pragmatic encroachment and epistemic value. In A. Haddock, A. Millar, and D. Pritchard, Editors, *Epistemic Value*. Oxford University Press: Oxford. 2009.
- Faden, R., & Powers, M. (2008). Health inequities and social justice: The moral foundations of public health. *Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz*, 51(2), 151–157.
- Fafard, P. (2012). Public health understandings of policy and power: Lessons from INSITE. *Journal of Urban Health*, 89(6), 905–914.
- Giacomini, M., Kenny, N., & DeJean, D. (2009). Ethics frameworks in Canadian health policies: Foundation, scaffolding, or window dressing? *Health Policy*, 89(1), 58–71.
- Giacomini, M., Hurley, J., & DeJean, D. (2014). Fair reckoning: A qualitative investigation of responses to an economic health resource allocation survey. *Health Expect*, 17(2), 174–185.
- Ives, J., & Draper, H. (2009). Appropriate methodologies for empirical bioethics: It's all relative. *Bioethics*, 23(4), 249–258.
- Jennings, B. (2015). Relational liberty revisited: Membership, solidarity and a public health ethics of place. *Public Health Ethics*, 8(1), 7–17.
- Jost, J.T. and A.C. Kay. Social Justice: History, theory, and research. In S. Fiske, D. Gilbert, and G. Lindzey, Editors, *Handbook of Social Psychology*. John Wiley & Sons, Inc.: Hoboken, New Jersey. 2010.
- Kenny, N. P., Sherwin, S. B., & Baylis, F. E. (2010). Re-visioning public health ethics: A relational perspective. *Canadian Journal of Public Health*, 101(1), 9–11.
- Knight, E. (2014). Shifting public health practice to advance health equity: Recommendations from experts and community leaders. *Journal of Public Health Management and Practice*, 20(2), 188–196.
- Krieger, N. (2013). *Epidemiology and the People's Health: Theory and Context*. New York: Oxford University Press.
- Lincoln, Y.S. and E.G. Guba. *Naturalistic Inquiry* 1985, Newbury Park, California: Sage Publications, Inc.
- Miller, D. (2001). *Principles of Social Justice*. Cambridge, MA: Harvard University Press.
- Patton, M.Q. *Qualitative Research and Evaluation Methods*. Third ed. 2001, Thousand Oaks, California: Sage Publications, Inc.
- Powers, M., & Faden, R. (2006). *Social Justice: The Moral Foundations of Public Health and Health Policy*. New York: Oxford University Press.
- Public Health Agency of Canada. *Core Competencies for Public Health in Canada*. 2008.
- Rizzi, K.E. *Perceptions about equity in Public Health: A comparison between frontline staff and informing policy in Ontario*. 2014, University of Western Ontario. p. 107.
- Ruger, J. P. (2010). *Health and Social Justice*. New York: Oxford University Press.
- Sabbagh, C., & Golden, D. (2007). Reflecting upon etic and emic perspectives on distributive justice. *Soc Justice Res*, 20(3), 372–387.
- Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, 18(2), 179–183.
- Segall, S. *Health, Luck, and Justice*. 2009, Princeton: Princeton University Press.
- Smith, M. J. (2015). Health equity in public health: Clarifying our commitment. *Public Health Ethics*, 8(2), 173–184.
- Trotter, G. (2008). The illusion of legitimacy: Two assumptions that corrupt health policy deliberation. *The Journal of Medicine and Philosophy*, 33(5), 445–460.
- Venkatapuram, S. *Health Justice: An Argument from the Capabilities Approach*. 2011, Cambridge, UK: Polity Press.
- Wilson, J (2011). Health inequities. In A. Dawson (Ed.), *Public Health Ethics: Key Concepts and Issues in Policy and Practice*. New York: Cambridge University Press.
- Young, I. M. (1990). *Justice and the Politics of Difference*. Princeton, NJ: Princeton University Press.