Health-Care Access as a Social Determinant of Health
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as a Social Determinant of Health

ABSTRACT
The social determinants of health (SDH) are recognized as important indicators of health and well-being. Health-care services (primary, secondary, tertiary care) have not until recently been considered an SDH. Inequities in access to health care are changing this view. These inequities include barriers faced by certain population groups at point of care, such as the lack of cultural competence of health-care providers. The authors show how a social justice perspective can help nurses understand how to link inequities in access to poorer health outcomes, and they call on nurses to break the cycle of oppression that contributes to these inequities.

The social, economic and political circumstances of individuals, families, communities and countries are closely related to their health outcomes. Social determinants of health (SDH) refer to the social, economic, and political conditions that influence health and well-being. Using a social justice perspective, we make a case for affirming health-care access as an SDH. Equality and equity are discussed, with an emphasis on their relationship with oppression. Using everyday clinical examples, we outline the cycle of oppression that leads to social injustice. We conclude with a call to action for all nurses.

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The social determinants of health figure prominently in recent national and international health policy documents and initiatives (Canadian Nurses Association [CNA], 2005; Wilkinson & Marmot, 2003). Although most nurses are knowledgeable about the SDH, how these determinants are linked to social injustice through inequities in health-care access is not well understood.

The Public Health Agency of Canada (2007) and other stakeholders recognize health services as an SDH; however, there has been little sustained attention to inequities in access to health care and how they are linked to differences in morbidity and mortality for various populations (McGibbon, in press). Access refers not only to the availability of required services but also to how the services are delivered at point of care (e.g., cultural competence of health-care providers). These inequities play an important role in creating poorer health outcomes.

A discussion of inequities in health-care access from a social justice perspective directs our attention to the ways in which inequities are created and maintained. In the study of health inequity, social justice refers to the ethical virtue of collective responsibility for the fair and just distribution of the goods and services of society (Rawls, 1971). In this context, the measure of a society is how it treats its most vulnerable citizens. In Canada, poverty is the strongest determinant of health, and poverty rates

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**The social determinants of health**

- employment, unemployment and working conditions
- income and its equitable distribution
- food insecurity
- housing
- early childhood development
- education
- health care (primary, secondary, tertiary)
- social exclusion
- social safety nets
- identity (including gender, race, social class, dis(ability) and sexual orientation)

Adapted from *The Toronto Charter for a Healthy Canada, 2003; R. Wilkinson & M. Marmot, 2003.*

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In Canada, poverty is the strongest determinant of health, and poverty rates have not improved over the last two decades.
have not improved over the last two decades (Raphael, 2007). A social justice perspective prompts us to ask some difficult questions:

- Why do certain groups of people consistently live in poverty and have poorer health outcomes, even when biology and genetics are considered?
- Why is there a higher suicide rate among lesbian, gay, bisexual and transgendered adolescents (Kitts, 2005)?
- If we all have the right to health care, as outlined in the Canada Health Act, then why do inequities in access exist?

Equality, equity and access to care. Understanding the difference between equality and equity is central to this discussion. If we treat everyone equally, we don’t install wheelchair ramps, tailor health services for those who are homeless, or provide health interpreters for immigrant families. Equity in health care refers to the fair distribution of the goods, services and opportunities necessary for physical, psychological and spiritual health: “If overall equity is to be achieved, each individual’s needs must be met and every individual must have the opportunity to achieve full potential as a human being” (CNA, 2006). Accordingly, in the design and implementation of health care with equitable access, policy-makers and practitioners must make accommodations for the needs of individuals, families and communities. One of the reasons inequities in access to care exist is the cycle of oppression that operates throughout society.

Oppression and inequities in access to care. Figure 1 illustrates the cycle of oppression that can be seen in practice settings and in policy decision-making. For example, consider health-care access for social assistance recipients. Starting with biased information about social assistance recipients, practitioners may develop a stereotype, such as the commonly held belief that people receiving assistance are lazy. In fact, the reasons for unemployment among social assistance recipients are multiple and complex. These stereotyped views of clients mean that practitioners may be missing important contexts related to income, transportation and access to employment and child care when they are developing care plans or making referrals.

Stereotypes can lead us to think in a particular way that demonstrates prejudice. If we believe that people receiving assistance are lazy, we may think they don’t really want to work. Then, when we act in a particular way, based on our prejudice, we are participating in discrimination. When we treat people on social assistance disrespectfully during a nursing assessment, we are actively discriminating. In this way, we are contributing to lack of full access to competent and compassionate health care. When our discriminatory actions are supported by systemic power within the health-care system — for example, when substandard intake assessments aren’t challenged — oppression is the result. The cycle of oppression perpetuates policy-making that supports social injustice. It is important to note that biased information, stereotyping, prejudice, discrimination and oppression often happen without the perpetrators noticing or acknowledging the problem. The resulting social injustice is evidenced in poorer health outcomes for a growing number of Canadians.

Social injustice is bad for your health. People living in poverty, women, seniors, people of colour and LGBT people tend to have generally poorer health outcomes. For example, women around the world, and across all age groups, have higher rates of depression.
than men (World Health Organization [WHO], 2000). Researchers have linked women’s depression with poverty, inequality and discrimination (Belle & Doucet, 2003), as well as with family violence and violence due to war and civil unrest (WHO, 2000). Aboriginal peoples living on reserve have reported rates of heart disease 16 per cent higher than the overall Canadian rate, and aboriginal women and men have life expectancies 4.8 and 8 years shorter, respectively, than overall Canadian rates (Indian and Northern Affairs Canada, 2003).

Studies have shown that certain groups of people do not have adequate access to health services because of discrimination based on their social class, race, ethnicity or sexual orientation (Fish, 2007; Karlsen & Nazroo, 2002). Discrimination at point of care has been documented as a significant barrier in terms of black women’s access to health services in Canada (Enang, 2002). In the U.S., black women are less likely to be diagnosed with cervical cancer before third stage and are less likely to have appropriate follow-up (Akers, Neumann, & Smith, 2007). Similarly, African-American lung cancer patients are less likely to receive chemotherapy (Earle et al., 2000). Canada’s aboriginal people and African-Canadians report consistent barriers in accessing to care, including racism among service providers (McGibbon & Basset, 2008).

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<thead>
<tr>
<th>Reflecting on social justice, the social determinants of health and inequities in access</th>
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<tbody>
<tr>
<td><strong>Practice</strong></td>
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<tr>
<td>• Does my practice area offer education sessions on social justice, the SDH and inequities in access (e.g., the relationship between postnatal outcomes and unemployment or between seniors’ health and the cost of home heating)?</td>
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<tr>
<td>• Do I routinely associate client “non-compliance” with the possibility that the client has no money for transportation or prescribed treatments?</td>
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<tr>
<td>• Is lack of action on my part a form of discrimination?</td>
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<tr>
<td><strong>Education</strong></td>
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<tr>
<td>• Do I incorporate social justice, the SDH, and inequities in access in my teaching of the specialty areas (e.g., the relationships between cardiac outcomes, race, gender)?</td>
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<tr>
<td>• Does my institution offer faculty training on social justice and health?</td>
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<tr>
<td>• Is lack of action on my part a form of discrimination?</td>
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<td><strong>Research</strong></td>
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<td>• Am I encouraged to ask research questions that address the issues of marginalized peoples?</td>
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<td>• What steps do I take to ensure diverse participants and perspectives are included in my sample?</td>
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<td>• Do I use appropriate research methods (e.g., participatory engagement) to study inequities in health care?</td>
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<td><strong>Management and Policy</strong></td>
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<td>• Does my workplace implement policies that explicitly address social justice, the SDH and inequities in access? Are these policies reviewed regularly?</td>
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<td>• What happens when I apply the CNA social justice gauge (2006) to the policy documents of my workplace? Of my political party?</td>
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<td>• How does my political party perform on social justice issues such as child poverty and homelessness?</td>
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TAKING ACTION

Inequities in access are sustained through systemic, policy-based oppression. Nurses are well positioned to build on the profession’s solid historical roots of advocacy and political action to break the cycle of oppression. Social justice is a key aspect of CNA’s core values and is considered to be a valid and achievable policy goal (2006). Our challenge to all nurses is to act on the clear connections between social injustice and health-care access as a social determinant of health.

It is imperative that the nursing profession begins to routinely incorporate social justice thinking in practice, education, research, and management and policy. Advocating for the design and delivery of more equitable access to health care is crucial. As the largest group of health professionals in Canada, nurses have the power to promote and lobby for equity in the health-care system.

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REFERENCES


