Revisiting “Who Gets Care?”
Health Equity as an Arena for Nursing Action

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This article revisits and reaffirms Patricia Stevens’s earlier work on access to healthcare as an important arena for nursing action. Many of the conditions that affect access to healthcare, such as racism and oppression, also shape inequities in health outcomes. We propose a conceptualization of social justice that is consistent with addressing the conditions that influence health inequities. We also discuss the implications of a critical and feminist conception of social justice for nursing action, education, practice, research, and policy. Key words: access, health, inequities, outcomes, social justice, vulnerable or marginalized groups.

IN 1992, almost 20 years ago, Patricia Stevens challenged nurses and others to frame access to healthcare in its broadest sociopolitical context as a means of laying “theoretical groundwork for more effective investigatory and practical action to ensure equitable access.” This article was an important contribution in broadening nursing action to encompass the social, political, historical, and economic factors that shape access to healthcare. Building on Stevens’ call, our purpose is to further broaden the scope of nursing action to explicitly include both the conditions that shape access to health services and the structural conditions that influence health and produce health inequities. In an era of increasing disparities in wealth and growing health inequities, nurses need to shift their gaze from a predominant emphasis on individual recipients of care and a general acknowledgment of the factors that shape individual access to healthcare toward a broader set of social conditions, environmental factors, and structures that impact health outcomes particularly for those who are experiencing health inequities as a result of poverty, homelessness, violence, and other social factors.

Sherwin, a leading feminist scholar, argues that oppressive social conditions, such as racism, sexism, and classism, that shape access to healthcare are the same conditions that shape inequities in health with poverty being a major determinant of poor health. In this article, we will begin with a discussion of health inequities and the conditions that shape inequities. We propose that nurses need a conceptual understanding of social justice that is consistent with addressing the conditions that shape inequities in healthcare. We provide an overview of dominant conceptions of justice and propose an alternative conceptualization of social justice for nursing to address inequities that draws on Iris Marion Young’s work. Finally, we highlight nursing actions for addressing conditions that impact access to healthcare and those institutional factors that produce health inequities.

Equity refers to fairness or justice and can be understood as equity in access to
healthcare and equity in health outcomes. Inequities are unfair or unjust differences in access to services or health outcomes that result from structural arrangements that are potentially remedial. Whitehead and Dahlgren have suggested that inequities in health can be identified on the basis of distinguishing features. First, health inequities “concern systematic differences in health status between different socioeconomic groups.”(p2) Second, inequities are a product of social processes and are potentially remedial through attention to social processes. Third, inequities are the consequence of “unjust social arrangements” or social structures that perpetuate these differences.

ACCESS TO HEALTH SERVICES

To effect equity, nurses need to cast their gaze backwards or upstream to the conditions that perpetuate inequities. For example, people who are street involved (e.g., those affected by homelessness and/or drug use) often delay or do not access healthcare for a variety of complex and multifaceted reasons including concerns about stigma related to drug use and homelessness, criminalization of drug use, marginalizing discourses of blame and personal responsibility, poverty, and lack of system capacity. If we wish to effect equity of access, then attention is required to structural injustices that act as barriers to healthcare services such as addressing the stigma and discrimination experienced when accessing healthcare services by those disadvantaged by their social positioning in relation to class, gender, ethnicity, and so on.

McGibbon et al propose that

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.

The conditions that structure access to health services for groups identified as vulnerable or disadvantaged are critical to our understanding of health inequities and social justice. We concur with Drevdahl et al that inequities cannot be addressed through practicing with cultural competence at the individual level; rather, racism and other marginalizing discourses that reduce access to care need to be addressed.

As one determinant of health, access to primary care services can affect the health of the population. As Sutherns and Bourgeault argue, access to healthcare is determined by the interaction of economic, political, and social forces, and beyond proximity to service is shaped by “(1) service availability (including numbers, locations, hours, and consistency, and variety of providers); (2) the resources to make use of available services (including economic and informational resources); and (3) the appropriateness of services provided (including gender, continuity of care, confidentiality, perceptions of quality, and cultural sensitivity).” Studies in Canada and the United States have found that community health centers are effective in enhancing access to primary care for those affected by inequities and can contribute to improving health outcomes. Development of public health and primary care partnerships to reach those who are homeless also have been shown to increase access to healthcare and improve health outcomes for groups identified as vulnerable to poor health outcomes. However, the root causes of poor health such as food security, housing, income, marginalizing discourses, and social inclusion may not be addressed by community health centers for complex reasons such as organizational mandates, financial constraints, contract agreements, and the pressure to meet immediate needs for medical care. Furthermore, despite a well-established public health services across Canada, few public health units focus on addressing the broader social determinants of health.

BEYOND ACCESS TO HEALTH SERVICES

It is access to the resources needed for health rather than simply access to primary care services that will have the greatest
impact on health equity.\textsuperscript{21,22} To date, equity of access in healthcare has received more attention than health equity as a function of the social determinants of health. The determinants of health are the economic and social conditions that influence health including housing, education, income, ethnicity, healthcare services, food security, early child development, employment, and social status.\textsuperscript{23} The determinants of health have been identified by epidemiologic studies comparing the distribution or burden of disease within subgroups of populations.\textsuperscript{24} Studying the burden of disease across subgroups (such as gender, ethnicity, race, religion, social class, age, occupation, or region) enables identification of groups who bear a disproportionate burden of disease.

Health can be understood as being an outcome of processes “that originate in the social structure, in which social position is embedded.”\textsuperscript{9(p107)} Graham describes social structures as the general conditions that are embedded in political, social, economic and historical forces that shape society. According to Graham, the social position of individuals is shaped by gender, ethnicity, and socioeconomic status and marks the point “where societal level resources enter and affect the individual.”\textsuperscript{9(p107)} The social and material environments of home, community, and workplace act as mediating factors in relation to social position and produce vulnerability to illness and injury. Thus, effecting equity requires that structural injustices and societal conditions that produce and ameliorate such injustices and contribute to vulnerability to illness and injury be addressed.

Effecting health equity would look to those broader conditions that produce health inequities such as poverty, inadequate housing, racializing structures, criminalization of drug use, social exclusion, and violence. Income inequality in terms of relative rather than absolute differences contributes to the development of health inequalities.\textsuperscript{25–28} For example, those who are at the highest risk for food insecurity and inadequate housing are those who live in relative poverty.\textsuperscript{29} It is these determinants of inequities that have the potential to affect health equity and decrease gaps in health outcomes between groups in society. In particular, it is the intersection of gender, race, and class in relation to the determinants of health that produce profound inequities. Thus, beyond examining how healthcare is provided we need to examine the ways that society is organized and the structural conditions that contribute to vulnerability, illness, and injury for groups in the population.

While population-based research has documented associations between particular conditions and social determinants, and in some cases, traced effects over time, this body of work does not help us to fully understand why women or why persons of color would face poorer health over the life course or what it is that children may be lacking that contributes to poor health in adulthood? Or more important to ask, why some persons in groups deemed at risk manage to avert poor health?\textsuperscript{30(p29)}

Inequities in access to material resources (including access to health services) interact with the person’s environment in ways that contribute to inequities in health outcomes. Gendered, racialized, and socioeconomic differences produce health inequities. Further examination of social processes (including discourses activated by healthcare providers) and institutional practices that replicate inequities over separations of time and space are required.\textsuperscript{31} We contend that both conditions that produce inequities in access and the conditions that produce inequities in health outcomes are important dimensions as an arena for nursing action.

**CONCEPTIONS OF JUSTICE AND SOCIAL JUSTICE**

Health equity has been identified as a concern within public health worldwide and an idea that focuses on the question of a right to health (rather than a right to healthcare).\textsuperscript{32} Drawing on theories of justice can enhance our understanding of inequities, provide potential policy directions to reduce or ameliorate inequities, and make visible the influence of moral values on the choice of
actions. Conceptions of justice can be found within a variety of theoretical perspectives including libertarian, egalitarian, critical, and feminist perspectives. If, as suggested by Sherwin, we view ethics as a lens, it is possible to see different perspectives on justice reflected in policy and practice. Thus, understandings of justice and social justice in particular are central to addressing inequities in health and healthcare.

Libertarian conceptions

In North America, dominant conceptions of justice can be located within libertarian conceptions that place a high value on individual freedom or liberty. This is consistent with the current neoliberal political economic perspectives that focus on capitalism. Libertarian perspectives on justice underlie discussions of market justice. Healthcare is treated as a commodity and a matter for the market to resolve. An increasing focus on liberal individualism is readily evident in the rights-based challenges, which argue that individuals should be able to access healthcare services through increasing the availability of for-profit services for those who are able to pay. The growth of private for-profit healthcare reflects a shift toward libertarian market values and corresponding neoliberal values of personal responsibility for health. From a libertarian perspective, lack of clean water, sanitation, education, housing, and employment is unfortunate but not unfair; it is simply a manifestation of market forces. Rather than a matter of justice or unfairness, it is a matter of charity to provide aid. As Alkire and Chen point out, there are a number of problems with a solely humanitarian approach to addressing inequities. The focus is on the goodwill of the giver with accompanying dependence and power imbalances. Charity does not address the structural or root causes of inequities. Hence, there is no moral motivation to address unjust social conditions that contribute to inequities.

Egalitarian conceptions

John Rawl’s social contract theory has been extended by several authors such as Norman Daniels, in a move to provide a moral foundation for addressing health inequities. Daniels indicates that there is no social justice without equity in health and no equity in health without social justice. In their critique of bioethics, Daniels et al argue that bioethics has not looked upstream from the point of the delivery of medical services to the role of the healthcare system in improving the health of the population. Even more rare is for healthcare systems to look “further upstream to social arrangements that determine the health achievements of society.” Daniels argues that health inequities are intertwined with social position, social policies, and conditions in society and require more than a redistribution of healthcare resources. To address inequities, Daniels et al draw on a conception of Rawlsian justice to enhance democratic equality including political participation rights and equality of opportunity. These authors extend egalitarian notions of justice to equal access to a broader set of opportunities that affect health such as access to education, housing, early childhood development, public health, medical, and social services, which should be ensured to promote normal functioning. This can be understood as promoting a principle of fair equality of opportunity that, in Daniels’s view, is compatible with other perspectives on social justice. Enhancing equity would focus on ensuring equal opportunities for access to childcare, education, health, and social services to ensure fair and equitable distribution of societal goods as determined by particular definitions of health. Daniels proposed that it would be important to ensure that processes of decision making are fair and equitable according to criteria such as accountability for reasonableness.

Critical and feminist perspectives

Justice can be understood in many ways but the essence of most of these
understandings focus on the redistribution of healthcare resources rather than on the conditions that produce the distribution of resources and ill health. Here we draw on the work of Young to propose an understanding of social justice that is consistent with addressing the conditions that shape inequities in health. Young argues that it is a mistake to reduce justice to distribution per se, as the distributive paradigm “tends to ignore the social structures and institutional contexts that often help determine distributive patterns.” Young highlights the importance of addressing nondistributive issues such as decision-making structures and processes, division of labor, culture, and nonmaterial goods such as respect and power. She argues that the conditions that produce the distribution of resources and ill health are not accounted for and this has implications for rights, opportunity, power, and self-respect. She states, “A large class of issues of social justice, and those that concern claims that inequalities are unjust in particular, concern evaluation of institutional relations and processes of society.”

Young argues that differences rather than distribution ought to be the starting point for any theory of justice. Such differences exist along lines of gender, ethnicity, class, and social positioning that act as constraints on individual freedom and well-being and impact on the development of inequities. The intersection of gender, ethnicity, and class, in particular social contexts, contributes to the development of inequities and injustices. In addition to intersectionality, a key feature of a critical perspective is that groups affected by differential conditions rather than individuals are a focus of concern and meaningful participation of groups affected by inequities is central to action. Beginning with differences in health and healthcare access between groups draws attention to social, political, historical, and economic conditions related to social positioning that underpin both inequities in access to healthcare and inequities in health outcomes. Participation of those affected is not only important, but it is also central to discussions of social justice and the conditions shaping meaningful and equitable participation are of paramount concern.

**RECOMMENDATIONS FOR PRACTICAL ACTION**

In this final section, we reflect on what such understandings of social justice in the arena of health inequities mean for nurses and discuss nursing action to address health inequities. We include concrete actions that challenge and shift institutional practices that produce inequities by making health inequities visible (and therefore actionable) within healthcare institutions. We identify practical and political actions for practicing nurses, and nursing leaders, educators, and researchers.

**Shifting institutional practices**

Nurses are located within institutional structures and under the influence of societal discourses that shape their work practices. From their various positioning within institutions, nurses can either promote or resist institutional practices that influence health inequities. We propose that feminist practices of critical self-reflection and deepening political consciousness are the first steps toward practical action by nurses to address health inequities. Nurses can and should see people and their health as embedded in social locations and the material conditions of people’s lives. Biomedical thinking creates artificial separations between medical concerns and social issues, but as we have argued, it is important to identify the social conditions that influence health if we are to address health inequities. Recognition that the person’s social location may affect their ability to follow medical advice profoundly impacts the nature and scope of effective nursing interventions.

For example, a pregnant woman experiencing symptoms of preterm labor is sent home from the hospital with instructions to decrease her activity (or possibly with
prescribed bed rest). If nurses working in the hospital or triage setting do not ask about the woman’s family situation and personal resources, there is no way to identify that she is on her own most of the time because her partner travels for his employment and has no other family members available to help her care for her 2-year-old. Nurses individually and collectively could challenge the institutional practice of not assessing the resources available to the person for looking after health at home prior to hospital discharge. The lack of predischarge nursing assessment highlights how institutional work processes can perpetuate health inequities.

Another example would be someone who does not have housing being labeled as “non-compliant” for not routinely administering his or her insulin injections. Further exploration might discover that this person has no place to store insulin and no resources to purchase supplies. Nurses and other care providers need to critically reflect on the assumptions they make about people and consider how their own actions might contribute to marginalizing discourses and practices that contribute to inequities. Canam suggested that nurses need to value and articulate their knowledge about the person and his or her situation/health resources. Difficulty in articulating this contextual knowledge may also be understood as the result of systematic charting practices that do not allow what nurses know to enter into institutional work processes.

Many nurses have important information about the social conditions affecting health on an individual patient/person level. However, many times this information is charted informally (on a white board or worksheet) or not at all. Unless this information is charted somewhere, it remains invisible (and therefore inactionable) by the healthcare institution. Nurses frequently complain that they do too much charting. And yet, much of that charting is done on behalf of physicians, other healthcare providers, and the managers of healthcare institutions. The important things that nurses know about a person’s life situation and the resources available to them may deliberately have been omitted by an institution more concerned with processing patients quickly, dealing with a select list of “medical conditions,” speedy hospital discharge, and enlisting patients and family members (usually women) to assume responsibility for healthcare in an effort to save institutional health expenditures. Current management discourses focus on short-term efficiencies and “service improvements” rather than addressing the structural conditions that underpin health inequities.

We recognize that nurses working in hospital settings may be constrained by institutional structures and work processes. Often, nurses do rationing work, limiting access to needed health services when we activate medical record forms constructed around “eligibility criteria.” If nurses thought about charting what they know as a form of resistance to inequitable practices, then information about the conditions of the person’s life could enter into institutional work processes. For example, when it is known that someone is admitted with no fixed address, what actions are undertaken and charted in relation to discharge planning to ensure that the person has a place to recover and the available resources to follow the “medical treatment plan”? One way to advocate for resources is to acknowledge that these factors influence health and charting creates an account of them. Nurses have long been taught to address health needs, so finding ways to draw attention to inequities in the conditions that affect health is an important part of nurses’ work. Medical record forms are powerful organizers of nursing work and warrant our careful scrutiny for the effects they have on individual people and on vulnerable groups. Community health nurses also have knowledge about the material realities of people’s lives because the resources available for health may be more visible in the home. However, they too may need ways to insert their concerns into institutional work processes in a way that makes them actionable by the program or institution. As Canam...
has suggested, community health nurses may be struggling with finding the language they need to express what they know about people living in the community. When “core deliverables” rather than the needs of people and communities structure which nursing activities count, we need to be aware of the risk of increasing health inequities. Monitoring the long-term impact of health promotion/prevention programs at the population level also needs to include subgroup analysis for those groups most at risk for health inequities.

When nurses take up social justice as addressing the conditions that result in health inequities, groups of nurses could join together to discuss their observations and concerns. Medical record reviews could then be used to substantiate their observations and the options available to nurses to address these concerns. For example, a group of nurses could identify that they have discharged people postoperatively “to the street” and critically analyze the health implications and ethical dimensions of such situations. If these nurses have recorded this observation, a medical record review can help identify the magnitude of the “problem” in the local setting. Perhaps the “incident reporting” structures already in place could be activated to help raise awareness of the unacceptability of this action. Managers could support nurses who need a process to make these concerns visible to the healthcare institution.

Nurses could also work together toward garnering resources to address health inequities. At this point, nursing action becomes a form of social and political action that includes working with those most affected. Nurses, particularly public health nurses, have historically done this kind of health advocacy work for the poor and most marginalized groups in our society. Today, nurse practitioners may be also well positioned to carry on this important nursing tradition. Embracing social justice as a way to address inequities in health returns us to our roots as leaders in improving the social conditions of people’s lives with the goal of health for all people.

Young suggested that groups affected by differential conditions rather than individuals are a primary focus of concern. Nurses, by knowing people in the contexts of their lives, have knowledge of the effects of societal discourses and institutional practices on the lives of particular individuals and families (a form of situated knowing). However, framing health inequities from a critical social justice perspective requires political and community action. Nurse leaders could role model how to work with others across sectors to address the conditions that affect health (such as housing and poverty) and result in poor health outcomes.

Health inequities can be identified by comparing health outcomes of subgroups of the population. Some of the most disadvantaged are those who experience multiple and intersecting inequities. For example, when nurses thoughtfully consider the problems experienced by female lone parents who are poor (economically disadvantaged) and are also members of visible minorities (experience racial inequities), they understand that it is vital to work across sectors (such as health, employment, child welfare, housing, and education) to address these health inequities. This knowledge of intersecting oppressions can be used to expand our action beyond primary care and public health toward collaboration between sectors.

Nurses who are healthcare leaders and planners can help mobilize community resources across sectors to address health inequities that disproportionately affect certain groups. Nurses who are knowledgeable about policy and political processes can help mobilize groups of nurses to address access to the resources needed for health and advocate for needed reforms in health policy and/or institutional practices. Meaningful participation of the people affected by health inequities is central to any action.

Health policy

Health policy (and health policy research) is part of a broader structural context for
addressing access to healthcare and the social conditions that produce health. In the development of health policy, the issue is not necessarily to achieve consensus of moral values but rather to engage in dialogue and recognize that the goal is to find convergence of different theoretical perspectives in relation to identified questions of justice and health policy. For example, there is considerable agreement among those holding diverse conceptions of justice that providing universal healthcare coverage is morally justified. Nurses participating at the health policy level need to identify whether the policy addresses the social conditions that affect health outcomes. When assessing the impact of policy, we need to consider whether the policy is sensitive to gender, race/ethnicity, geographic location, and social class. In other words, we need to ensure that healthy public policy addresses the ways in which inequities in access to healthcare interacts with access to social resources and with institutionalized oppression to produce inequities in health outcomes.

Social policy that addresses the determinants of health and the determinants of inequities are critical to addressing health inequities. European health researchers have identified some of the constraints and barriers to “Health for All” programs that could be addressed when developing health policy. Participation of groups of people affected by inequities is essential to the policy process and requires attention to issues of power and decision making. Health policy needs to reflect what is known about the multiple structural factors that create and perpetuate health inequities. Systematic overviews of the webs of policies that affect certain groups deemed as vulnerable would provide valuable feedback on what is needed for policy development and course correction.

**Nursing education**

Nurse educators also need an awareness of how institutional practices can maintain health inequities. We need to reflect on how neoliberal assumptions about “personal responsibility for health” enter into and influence our work of educating the next generation of nurses. Taking up social justice in the way we have proposed leads to nursing experiences that are community based and collaborative across sectors especially early in the curriculum. Joining forces with other groups working in the community to address health inequities can result in powerful learning opportunities. For example, we have involved our schools of nursing students in community projects designed to address homelessness and substance use as part of their course requirements. Nursing students then have the opportunity to gain first-hand knowledge of the strengths and capacities of individuals, groups, and communities. They have also had the opportunity to observe nurses in leadership roles within communities acting to address structural conditions in society.

Further research about the opportunities and barriers to nursing education for students from ethnic minorities, low-income groups, and/or rural communities is also needed. Particular attention needs to be paid to multiple and intersecting inequities and to the structural and institutional barriers that perpetuate these inequities.

**Research**

A social justice approach grounded in knowledge about the conditions that affect health requires a variety of research approaches including population-level studies that make visible the effects of health inequities. Institutional ethnography, a methodology developed by Dorothy Smith, a feminist sociologist, has been helpful for identifying the effects of institutional practices on particular people’s lives. Mapping institutional structures and work processes allows the possibility for targeted change that addresses structural inequities. Texts create “virtual realities” and are also a site of action where much of the work or governing or ruling is accomplished. Understanding how things get written into texts helps us
understand how they are created as action-able (or not). Judith Lynam\textsuperscript{30} proposed a theoretical perspective that pays attention to “both micro- and macrolevel processes” and their influence on health inequities. Her perspective draws on the work of Dorothy Smith (above) and Pierre Bourdieu\textsuperscript{50} and may provide direction for further nursing research that attends to the conditions that produce health outcomes or disparities.

Participatory action research or community-based research approaches, which involve the people most affected, are also highly congruent with this understanding of social justice. We need to ensure that research is undertaken that documents successes and evaluates over time the outcomes of our health (broadly understood) interventions. We need to know how effective our intersectoral collaboration has been over time in addressing intersecting inequities. Given the complexities of our healthcare system and the social conditions that need to be addressed, we need to ensure that we allow sufficient time for the effects of these social justice strategies to be reflected in healthcare outcomes.

**Conclusion**

A critical and feminist perspective of social justice leads nurses to work towards addressing the conditions that *produce* health inequities. Inequities in access to healthcare interact with inequities in access to social resources (such as housing, education, and social assistance) and with institutionalized oppression to produce inequities in health outcomes. A critical perspective of social justice is central to understanding the goal of equity and provides insight into the processes that can affect health equity. Rather than focusing on the distribution of resources, we need to draw on conceptions of justice that seek to redress injustices in the underlying social conditions and structures relative to social positioning that influence inequities. We need ways to make visible the institutional practices that result in health inequities and work across sectors to create new ways of making health within reach of all people. We need to build upon Patricia Stevens’ conceptualization of healthcare access as an arena for nursing action and embrace a conception of health equity as part of a broader arena for nursing action.

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