

# Towards an Understanding of Health Equity: Glossary Methods

AHS Tri-Project Glossary  
Working Group

Population and Public Health

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## Acknowledgements

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## Introduction

The idea of developing a glossary was identified by two Units within Population & Public Health, Alberta Health Services (AHS) who agreed that a common understanding and standard use of terms was essential for collaborative work within the area of health disparities, health inequalities and/or health inequities.

The intended audiences for the glossary include the following groups:

- i. AHS Population & Public Health;
- ii. AHS Integrated Steering Committee on Promoting Health Equity; and

- iii. AHS Leadership.

The purpose of the glossary is to

- i. Provide a relevant collection of defined terms related to health disparities, health inequalities and health inequities that are meaningful and practical for AHS; and
- ii. Build knowledge capacity with respect to these concepts within AHS Population and Public Health.

## Overview

An AHS ad-hoc working group coordinated the development of the glossary and was comprised of one representative from *Reducing Disparities, Health Promotion, Disease and Injury Prevention (HPDIP)*; *Healthy Public Policy, HPDIP*; and *Public Health Innovation and Decision Support, Surveillance and Health Status Assessment (SHSA)*. The three teams' respective work intersects along the lines of research, policy and practice.

A systematic process was implemented to search the peer-reviewed and grey literature to identify terms and subsequent definitions. The working group applied a *population health lens*<sup>1</sup> in the selection of terms and definitions throughout glossary development. Working group decisions were based on consensus, and a review process was employed that engaged

Managers, Directors and representatives from the respective areas noted above.



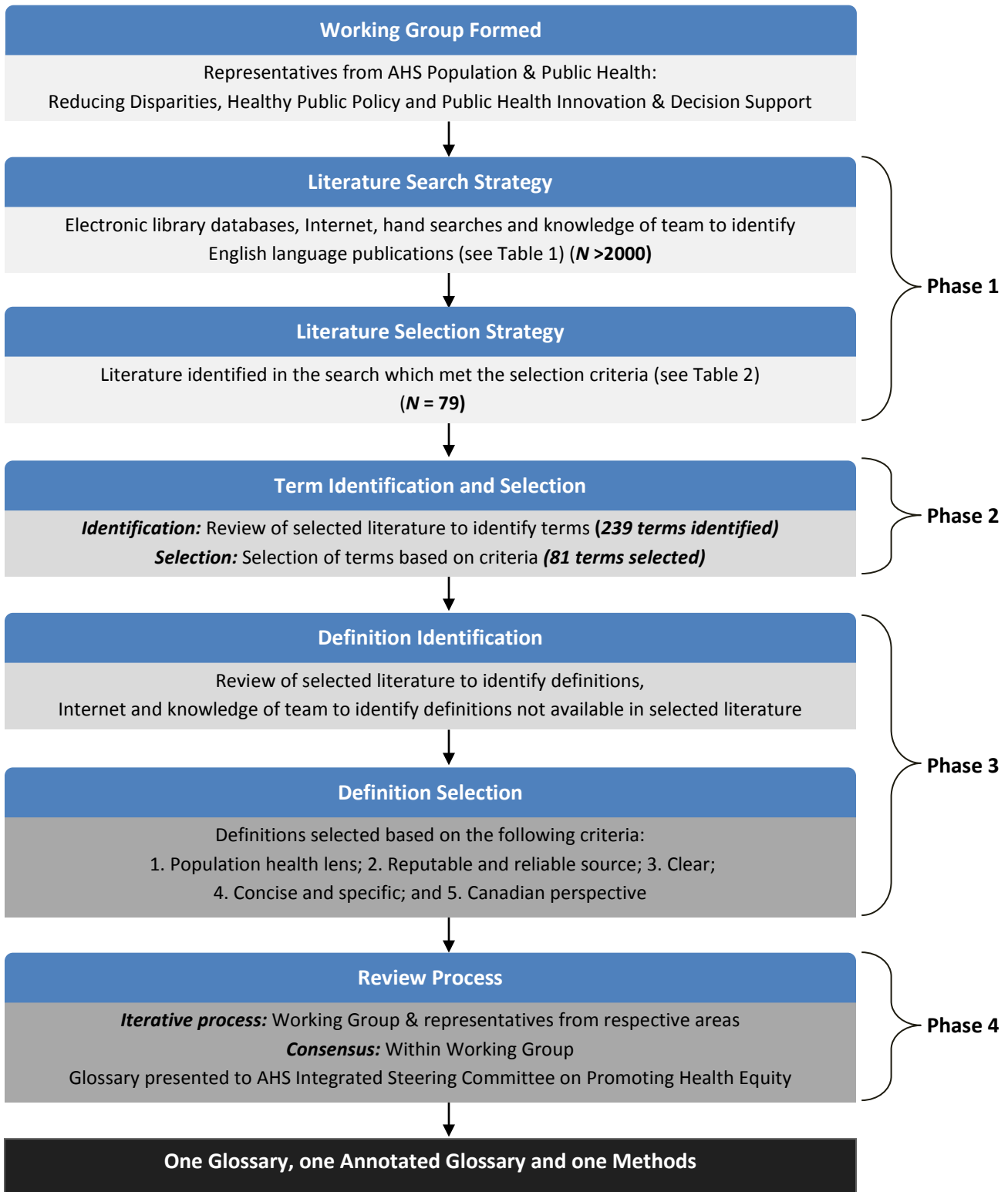
The glossary was developed in four phases. The overall process is presented in [Figure 1](#):

1. Literature search strategies
2. Term identification and selection
3. Definition identification and selection
4. Review process

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<sup>1</sup> The Population Health Template: Key elements and actions that define a population health approach, Health Canada, Population and Public Health Branch, Strategic policy Directorate, July 2001, draft.

Figure 1: Project overview



## Literature search strategies (Phase 1)

A literature search was conducted from May to July 2010 to identify relevant, English language publications that defined and/or discussed health disparities, health inequalities and/or health inequities. A focus on frameworks, blueprints, guidelines, approaches, strategic planning and policy documents relevant to the subject area was implemented under the assumption that these materials would constitute a body of information that would address similar issues and employ comparable vocabulary associated with the subject area.

The following data sources were included in the search process (duplicate articles identified through different databases or search strategies were excluded):

### *Electronic library databases*

A number of bibliographic databases were searched using search terms and document type in the title, abstract and text categories (Table 1). Limits were further implemented based on document type to focus the search results.

**Table 1. Literature search strategies: Electronic library databases and Internet**

Databases/ Internet	Search Terms	Document type
<ul style="list-style-type: none"> <li>▪ MEDLINE</li> <li>▪ EMBASE</li> <li>▪ PsycINFO</li> <li>▪ CINAHL</li> <li>▪ Cochrane Database of Systematic Reviews</li> <li>▪ Business Source Complete</li> <li>▪ HealthSTAR</li> <li>▪ Proquest Dissertations and Thesis</li> <li>▪ Web of Science</li> <li>▪ CSA Illumina including:               <ul style="list-style-type: none"> <li>○ Social Services Abstracts</li> <li>○ FRANCIS</li> <li>○ Sociological Abstracts</li> <li>○ SocIndex</li> <li>○ PAIS International</li> </ul> </li> <li>▪ Google Scholar</li> <li>▪ Searches were augmented by searching the World Health Organization (WHO), Public Health Agency of Canada (PHAC) and American Public Health Association (APHA) websites</li> </ul>	<ul style="list-style-type: none"> <li>▪ Equity or inequity or equities or inequities</li> <li>▪ Disparity or disparities</li> <li>▪ Equality or equalities or inequality or inequalities</li> <li>▪ Socioeconomic or socio-economic or socioeconomic factors</li> <li>▪ Aboriginal</li> <li>▪ Gender</li> <li>▪ Geographic location</li> </ul>	<ul style="list-style-type: none"> <li>▪ Framework or frameworks</li> <li>▪ Strategic plans or strategies</li> <li>▪ Position paper(s)</li> <li>▪ Blue print(s)</li> <li>▪ Guidelines</li> <li>▪ Health care utilization</li> <li>▪ Public health</li> <li>▪ Health policy</li> <li>▪ Approach</li> </ul>

**Internet**

There were two approaches to the Internet search. The first approach was to search the websites of the following organizations: World Health Organization (WHO), Public Health Agency of Canada (PHAC) and the American Public Health Association (APHA). The second approach involved using the search engine, Google Scholar, with the search terms and document type used as key words ([Table 1](#)).

**Hand Searches**

Reference lists of included publications were

hand searched for additional, relevant literature.

**Knowledge of team**

The working group and representatives from each of the collaborating areas were able to expand upon the search strategy by providing articles known to them based on their professional expertise. These articles were accepted for review to ensure all sources were included and explored.

**Literature selection strategy (Phase 1)**

The same selection strategy was implemented for all the literature identified, regardless of the search strategy used. To support the process of selecting literature, objective inclusion and exclusion criteria were developed ([Table 2](#)). At least two working group members

independently reviewed the literature identified to determine if it met the selection criteria. All literature selected by either one of the reviewers was reviewed to identify terms and definitions.

**Table 2. Literature selection criteria**

Criteria	Included	Excluded
Purpose of literature	Literature which includes a theoretical, philosophical or commentary discussion. These included discussion papers, frameworks, blueprints, guidelines, approaches, strategic planning and policy documents	Studies where the main aim was to present a quantitative assessment of the impact of health inequalities on a population (e.g., age standardized incidence by socio-economic measures)
Content	Literature which incorporated terminology or discussion of health disparities, health inequalities and/or health inequities	Clinical, biomedical, community-based participatory research, response commentary (e.g., an individual responding to a specific article - similar to an editorial), case studies or intervention studies
Population Health Lens	Literature that was framed from a population health perspective	Literature focused on individual level interventions
Language	English	Non-English
Time period	2000 to 2010	Prior to 2000 <sup>1</sup>

<sup>1</sup>One paper that was included was identified through a hand search of a reference list and had been published in 1998: *Independent inquiry into inequalities in health report*, by D. Acheson.

## Term identification and selection (Phase 2)

### *Term identification*

Working group members independently reviewed the selected literature to identify terms. A spreadsheet was developed to keep track of who reviewed each article and which terms were identified.

### *Term selection*

To determine if the term should be included in the glossary, the working group collectively reviewed each term using the following criteria:

- 1) ***Specific Health Disparities, Health Inequalities and/or Health Inequities Terminology/Concepts*** - The term was fundamental to describing, understanding and explaining the factors that generate health disparities, health inequalities and/or health inequities and was necessary in demonstrating its relationship with foundational concepts. Discussion of health disparities, health inequalities and/or health inequities would be limited or impossible without its use (e.g., social exclusion, vulnerable populations).
- 2) ***Generic Terminology*** – If a term was predominantly used in health promotion, public health, surveillance, medical or

epidemiology literature, the term was not included as it would be better described elsewhere (e.g., public health glossaries) and were not relevant or necessary to the current topic. Examples of excluded terms were *attributable risk*, *chronic disease* and *risk factor*.

- 3) ***Root Terms*** – For similar terms, the root term was selected and its variations defined within that specific term. For example, for the terms *socio-economic status*, *low socio-economic status* and *high socio-economic status*, the root term is *socio-economic status* and the other two terms were included under *socio-economic status*.

Additionally, a small number of relevant terms specific to the Canadian context were included. This was deemed necessary as most of the literature was international and would not adequately capture these terms. For example, the terms *Aboriginal* and *First Nations* were selected as terms through the identification process when reviewing the literature, whereas *Métis* and *Inuit* were not identified in the literature review. To ensure consistency and equality of terms, *Métis* and *Inuit* were included as terms for the glossary.

## Definition identification and selection (Phase 3)

### *Definition identification*

For each term, up to four definitions were obtained from the literature by working group members. Once a definition was identified any subsequent definitions were either

- 1) Assessed to be the same as the initial definition;
- 2) Identified as an alternative definition. Alternative definitions were determined to be sufficiently different such that they could

separately describe the term with different meaning; and

- 3) Assessed as augmenting the initial definition and were added to further refine the definition.

When a definition was not identified for a specific term from the literature chosen, three Internet searches were performed:

- 1) An online search of the following organizational websites was completed: WHO, PHAC, APHA and AHS;
- 2) The search engine Google was utilized with key words being the term itself and *definition or glossary*; and
- 3) An Internet search of online dictionaries was performed.

#### **Definition selection**

After following the above process to identify definitions for each term, team members reviewed all definitions and recommended one, or sometimes two definitions (i.e., the alternate). In some instances, a definition was developed using a combination of sources. The following five appraisal criteria were used:

1. **Population Health Lens<sup>2</sup>**: the definition should reflect the following principles. The definition must
  - a. Focus on/address/infer/speak to the health of populations or

subgroups, rather than the health of individuals;

- b. Accommodate and/or align with the concept of inequities (as unfair and unjust socially- produced differences in health between populations or groups);
- c. Be amenable to measurement (practical rather than philosophical or utopian);
- d. Convey an understanding of, and differentiate between, the various determinants of health; and
- e. Embody/convey an “upstream” understanding of how health inequities are generated.

2. **Reputable and reliable source**: the definition comes from a highly-regarded and trustworthy source<sup>3</sup>;
3. **Clear**: the definition outlines the argument in accessible language that is understandable by the audience with minimal specialist knowledge necessary;
4. **Concise and specific**: the definition is brief (i.e., one to three sentences) and to the point; and
5. **Canadian perspective**: the definition is relevant to the Canadian context and is frequently cited within Canadian literature.

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<sup>2</sup> The Population Health Template: Key elements and actions that define a population health approach, Health Canada, Population and Public Health Branch, Strategic policy Directorate, July 2001, draft.

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<sup>3</sup> The following University of Sydney website provides a list of common types of reputable source material and provides strategies for evaluating sources for use in academic writing (retrieved February 16, 2011): [http://writesite.elearn.usyd.edu.au/m2/m2u2/m2u2s2/m2u2s2\\_1.htm](http://writesite.elearn.usyd.edu.au/m2/m2u2/m2u2s2/m2u2s2_1.htm)

## Review Process (Phase 4)

The Tri-Project Glossary Working Group used an iterative review process that involved the working group, respective Managers and Directors and representatives from each of the respective areas. Consensus within the working

group for all definitions was achieved. The glossary was presented to the AHS Integrated Steering Committee on Promoting Health Equity for approval.

## Addendum

The methods outlined in this document apply to the *Towards an Understanding of Health Equity: Annotated Glossary* and the *Towards an*

*Understanding of Health Equity: Glossary* finalized on June 20, 2011.

## Appendix 1

### Guiding Principles

#### *Principles associated with a population health lens*

The phrase *population health lens* represents the paradigm or perspective used to capture the subject matter addressed in the Glossary and reflects two broad elements drawn from The Population Health Template.<sup>4</sup>

While the Population Health Template identifies eight key elements or principles that comprise a population health approach only the following two are unique to the *definition* of a population health approach or lens, although all eight elements are necessary for *implementing* a population health approach. The two most relevant elements therefore are

- 1. A focus on the health of populations**
- 2. An ability to address the determinants of health and their interactions**

In addition to a focus on the health of populations, population health assesses health status and health inequities over the lifespan at the population level. There are 3 key principles embedded in the first element relevant to a population health lens: a focus on populations, a measurement component and a focus on health inequities.

#### Principle #1

*The definition must focus on/address/infer/speak to the health of populations or subgroups, rather than the health of individuals.*

#### Principle #2

*The definition accommodates and / or aligns with the concept of inequities (as unfair and unjust socially produced differences in health between populations or groups).*

#### Principle #3

*The definition must preferably be amenable to measurement (practical rather than philosophical or utopian).*

<sup>4</sup> The Population Health Template: Key elements and actions that define a population health approach, Health Canada, Population and Public Health Branch, Strategic policy Directorate, July 2001, draft.

The second unique element of a population health approach is that it addresses the determinants of health and their interactions. According to the Population Health Template, this element *frames* the health issue in terms of *how it came about* –what factors or determinants contributed to its emergence or worsening and how far *upstream* are these factors located. This qualification is essential in order for the definition to be consistent with a focus on health inequities which in turn requires differentiating between the categories of health determinants that generate inequities in health outcomes and for internal consistency across the definitions.

**Principle #4**

*The definition conveys an understanding of, and differentiates between the various categories of health determinants.*

**Principle #5**

*The definition embodies / conveys an 'upstream' understanding of how health inequities are generated.*