HEQED
Health EQuity in EDucation

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Framework for health equity through education

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Content

Introduction

As the key aim of the HEQED project is to support higher education institutions in building competence in health equity, the descriptive framework at hand forms the basis for our work. This framework evolves on the backdrop of contemporary societal context in Europe 2022, and a continuous process of analysis and reflection on key concepts that will be outlined below.

With the onset of the HEQED project, we experienced that several global crises deeply impacted the daily lives, health, and wellbeing of people across Europe and elsewhere. At our very first team meeting in Bergen (Norway), February 2022, we all felt great relief as social distancing measures due to COVID-19 were being gradually removed. The COVID-19 pandemic up to that point had indeed demonstrated how (in)equity relates to health. Specifically, several factors have been found to increase health inequity during the pandemic, namely pre-existing conditions, place of residence (e.g., remote, overcrowding, homeless, institutionalisation), racialisation (e.g., ethno-racial and ethno-cultural diversity, immigration, or refugee status), occupation, gender identity/sex, religion/beliefs system, education/literacy level, socioeconomic status, social capital, and age, among other factors (Ismail, Tunis, Zhao & Quach, 2021). At the same day as our kick-off meeting started, Russia invaded Ukraine, and a Europe in war affected our thinking and work.

Our framing of HEQED evolved against this backdrop, as we met again in Zaragoza (Spain) in October 2022. During the events that took place in Zaragoza, the HEQED team and other key stakeholders, namely students, teachers and decision makers in higher education and the public, jointly reflected on the aspects previously discussed, as well as on other, new emerging issues including the current global climate crisis. Our joint effort contributed to further contextualizing and shaping our HEQED project, and thus also our framework for health equity through higher education. As a conclusion to the Zaragoza meeting, we agreed that we, as representing a major societal institution, namely the institution of higher education, are obliged to take a clear and visible stand towards justice, ethics and morality related in the context of higher education in pursuit of health equity, which is understood and conceptualized as a process and not an end in itself. Thus, HEQED emphasizes the following quote:" Equity is a solution for addressing imbalanced social systems. Justice can take equity one step further by fixing the systems in a way that leads to long-term, sustainable, equitable access for generations to come", which is retrieved from an online public health article titled "Equity vs. Equality. What's the Difference?" (Milken Institute School of Public Health, 2020). This future oriented approach underlines how ethical judgements and evaluations promote or hinder health equity in a global context.

The process

The process of designing and building a framework for health equity through education, as described above, was heavily grounded on current societal issues affecting people's health and wellbeing. We commenced by familiarizing ourselves with key concepts, including health (in)equity, health (in)equality, health (in)justice, (un)fair health and health(dis)parity, and exploring what they meant for the HEQED team members personally, as well as for our respective institutions. Establishing a fluid dialogue on these issues, through frequent meetings and sessions, within the group was important for finding common ground and reaching agreements. Diversity of opinions and perspectives on the subject matter was an important driver for deeper reflection on the concept of health equity in higher education.

Early in the process, we felt the need of linking our discussions and thoughts to an existing measure or evaluation system. We retrieved and analysed the evidence available around the topic of health equity in higher education in search of an existing framework. However, we soon realised that the degree and mode of integration of health equity into higher education healthcare programs was uneven, and that there was not a clear framework that we could use to guide the design and implementation of the project activities. Yet, we still felt that we needed a strong foundation on which to continue to develop our thinking.

The 17 Sustainable Development Goals (SDGs) are at the heart of the 2030 Agenda for Sustainable Development of the United Nations (UN), endorsed by all UN member states in 2015, and frames an urgent call for action to end poverty and other deprivations, improve health and education, spur economic growth and tackle climate change; in sum, to reduce inequity and build a sustainable society for all. Thus, we selected the UN SDGs as a tool or a framework to guide and systematise our work. We designed a Delphi questionnaire based on the 17 SDG, 169 targets and 248 global indicators to assess their degree of applicability and adequacy to measure health inequities in our context, and their degree of integrability in European health and social care professions programs. 9 participants from the HEQED group with experience as academics in 4 European universities and 1 NGO took part in this process. The result from this process was somewhat surprising, as not one SDG was perceived by the participants as being inadequate, irrelevant, or unapplicable to European higher education study programs (see full report on the results from this study), and a wide range of different indicators, pertaining to a variety of targets were identified as being useful to "measure" health (in)equity. This, to us, was a key point of inflection as we realized that 1) health equity was not circumscribed to healthcare, but it was a shared responsibility between healthcare professionals and the wider society; 2) that healthcare professionals were not, and could not, be responsible for promoting health equity, but that it was the whole of society that shared that responsibility; 3) that, as experts in healthcare, healthcare professionals should probably expand their role and exceed their traditional areas of practice to work, collaboratively, with other sectors; and 4) that achieving health equity is not an end in itself, but a complex process, in which healthcare professionals must become involved.

Simultaneously, to this process, we carried out a scoping review of the literature to answer the research questions: is there a framework or model for the integration of health equity in higher education health and social care programs? Scientific articles addressing this topic were selected if they described study program-wide interventions that focused on health equity as a whole. The process is still ongoing, but we are in position to discuss our findings. Throughout the search and selection process, it became clear that there have been plenty of attempts to integrate health equity, and related concepts, into health and social health programs. However, frequently, these interventions are restricted to a specific module or teaching activity, and they usually address one

single aspect of source of disparity, such as gender bias and race bias. We expect that the conclusions from this review will support the notion that there is a need to develop a program-wide framework to guide the process of integrating health equity into health and social care higher education programs.

Whilst the review was ongoing, we felt the need of finding a "true" meaning for the concepts we were using. Thus, we set off to carry out a concept analysis of health equity through Walker and Avant's eight-step method of concept analysis (Yazdani, Hosseini & Ahmady, 2016). However, we soon understood that this "more traditional" way of unpicking health equity and other related concepts was not what we needed. We needed to understand what we, as a group, understood by the various concepts and what they meant in our respective contexts. We therefore turned to a method of conceptualising via our rounds of discussions during the project period, in addition to collecting written text by the project members.

These processes, that still are and need to be ongoing, were important as they opened new and interesting ways to promote health equity through higher education. Addressing the very complex issue of health equity demands action and engagement from higher education institutions, which have the responsibility of training a healthcare workforce that is ready to respond to the current needs of society, and that will require a set of skills, knowledge, attitudes and, perhaps more importantly, values that are not fully integrated in today's study programs.

Value systems

Distribution of resources and ensuring sustainability at all levels are at the heart of health equity. The values we use to guide our actions and behaviour are central for understanding how health equity can be built. We therefore want to focus on some key value systems that we find useful when working towards health equity. We believe that if equity was easy, it had been reached long time ago and that one of the reasons why health equity is so hard to achieve relates to values. It is about making choices and initiate action based upon a set of values that in the long run benefit individuals, communities, and societies. Fully aware that a spectre of values connects to health equity, we wish to bring attention to certain value systems that we believe resonate to the timing and the context of the development of this framework for health equity in higher education, namely values related to human rights, ontological security, social justice, planetary well-being, and participation. The aim is not to give a comprehensive presentation, but to communicate our selection of values for the readers' further reflections and readings.

Human rights

Health equity is intrinsically linked to human rights. Human rights are universal and belong to all people. They are inherent and not given by an authority – we have them because we are human beings. They are inalienable and they cannot be taken away. They are indivisible, interdependent, and interconnected as they cannot be treated in isolation so that one has some rights and is denied others or that the rights depend on the situation.

The Universal Declaration of Human Rights (UDHR) was adopted December 10th, 1948, as an internationally protected and universal code that all nations could subscribe to. The human rights include civic, political, social, cultural, and economic rights and are inherent to all human beings, independent of nationality, ethnicity, sex, age, or other factors, clearly building on the intrinsic value of all human beings. The human rights are based on the key principles of equality, mutual respect, and dignity. Examples of human rights are right to health, food, shelter, political freedom, safety,

and education. The human rights are obligations to all governments to act is specific way to promote the human rights, and avoid actions that break the human rights, for example torture. Governments are obliged to react when the human rights of their population are breached, for example if children are being abused, if shelter is not available or if workers are hindered from being part of a union. The human rights have provided a framework for health policies, programmes, and practices, but for the future, we depend on a sustained political engagement to realise the human rights within health (Freeman, 2022; Gostin, Meier, Thomas, Magar & Ghebreyesus, 2018).

This engagement can hopefully secure health care services to all, independent of nationality and ethnicity, it can hopefully provide our health care systems with the necessary competence to meet the complex needs of our societies. But also, we need a strong political engagement to develop our services and adjust our behaviour in a sustainable manner, that manages to balance needs and resource use. This is an enormous challenge today, and we fear that a higher level of inequity might be the result if there is not a political will or political power to make the necessary changes. The human rights give a valuable set of ground rules in such a development.

Ontological security

Ontological security is a stable mental state derived from a sense of continuity, order and trust concerning one's life and individual experiences. Ontological security refers to the need to experience oneself as a whole and a continuous person in time, as *being* rather than constantly *changing,* to realize a sense of agency. Individuals need to feel secure in who they are, as identities or selves rely on the ability to give meaning to their lives. Meaning is found in experiencing positive and stable emotions, and by avoiding chaos and anxiety. Ontological security also involves having a positive view of oneself, the world and of the future. It is about feeling safe in one's everyday routine and life on its social and physical entities and it should be considered as a basic right of people in a social reality of growing risks (Giddens, 1991; Jabareen, Eizenberg, & Zilberman, 2017; retrieved from Wikipedia 21.10.2022).

Social justice

The main idea behind the concept of health equity is that socio-economic circumstances can have considerable influence on an individual person's ability to be healthy and that these circumstances should be improved to allow people equal opportunities to develop healthy lives. Not doing so would be a form of injustice. This insight was brought forward in the seminal research of, among others, Michael Marmot (2015) which indicated that social conditions of individuals influence the direct causes of disease and health problems. These so-called social determinants of health were labelled "the causes of the causes" of sickness and disease and particularly pertain to conditions such as obesity, smoking- and nutrition-related diseases, and other lifestyle-related health problems. Central to these social determinants of health is that they are associated with the social context of individuals. Thus, the resulting diseases and adverse health conditions are in principle avoidable because social arrangements in these contexts can be created, changed, improved, or eliminated, making a strong case for de-individualizing the responsibility for being healthy in favour of a more collective responsibility in societies for improving health-enhancing conditions.

Against this backdrop Venkatapuram (2013) speaks of *health justice*, by introducing the concept of *Capability to be healthy* based on the so-called Capability Approach. The Capability Approach (see among others Nussbaum, 2011; Robeyns, 2017; Sen, 2001) is a normative-theoretic perspective on social justice, freedom, and wellbeing in which human wellbeing is viewed as the product of the interaction between the individual and his or her context. Furthermore, wellbeing is considered plural as it involves multiple values that constitute a valued and dignified life. Central to the

approach is the distinction between capabilities (realistic opportunities to lead a valued and dignified life) and functioning (the actual realization of certain of these opportunities); wellbeing involves converting means into realistic opportunities into preferred functioning, and this process is affected by various contextual variables. In other words: in order to realize a valued and dignified life, one should first and foremost have contextual options available for achieving such a life. In the same vein, Venkatapuram (2013) regards the *Capability to be healthy* as the result of on the one hand individual endowments and on the other hand contextual circumstances and opportunities: both individual factors and contextual factors determine the boundaries for a person's potential health. Furthermore, whereas someone may view the capability to be healthy or realized health in life as an *end in itself*, being healthy also operates as a tool to being able to pursue life projects that he or she finds valuable. Moreover, there is an important role attributed to human diversity and agency: persons are considered to have diverse backgrounds and preferences, and it is ultimately important that they are able to consciously weigh their choices and execute their chosen option. Thus, apart from being valuable in itself, health is an important condition for living the broader life one has reason to value.

In sum, social justice, social wellbeing, and health are intrinsically entangled. Health opportunities are heavily dependent on social circumstances and pursuing health equity comes down to a collective striving for equal opportunities of health for all humans.

Planetary well-being

Planetary Health is an emerging paradigm of public health built on the anthropocene assumption. This states that humans entered in a new geological epoch where six out of nine planetary boundaries, the safe space of functioning for the life in the biosphere, have been broken by the human activity in the last 70 years. We gained global life expectancy average degrading the ecosystems that sustain human and animal health. Therefore, there is no health nor mental health without environmentally sustainable and resilient health practices. Under the planetary health approach, health and nature are so intertwined systems that we need a new epistemology to embrace such a complexity. Planetary health is a unifying narrative for orienting transdisciplinary research, promoting health in all policies, and integrating programs able to tackle the social, commercial, and environmental determinants of health. Acknowledging that the "pensée unique" of the advanced globalization has been the rationale for promoting the ecosystems exploitation and justifying health inequities, the Planetary health approach opens the door to indigenous knowledge and diversity to enrich a debate that requires a way of thinking more connected with the nature. It is in this transition, where the Planetary health vision is under construction, that health workforce and education are called to rethink the very concept of wellbeing.

When human beings rebuild their self-consciousness and identity in close connection with the environment, considering that quality of life and the highest attainable standard of health depend on this network of local and global determinants, the borders with the otherness become more fluid. That is why, for instance, some persons feel a deep empathy with the suffering Earth as a living being up to experience themselves a high degree of distress. Planetary wellbeing is not anymore, a subjective status or experience, but a feature of a natural system, eventually mirrored in the human 'dasein'. Literature reports a shift from individual conceptualization of wellbeing to the wellbeing state of natural processes.

Framing wellbeing as the harmonious or synergic functioning of complex systems where needs and rights of human, animal, and ecosystems are all respected, means introducing a different idea of limit that will need a collective renegotiation, ending in new social norms. The need of human beings of transforming the nature for their basic needs (from food to shelter) cannot put at risks non-

human beings and entities, in the present nor in the future. On the contrary, each human action should aim co-benefit across generations. Those actions, that could not be labelled anymore as 'pro-nature' initiatives, have a positive impact per se on mental health and wellbeing as reported by social sciences.

Satisfying human basic needs is a cultural and social construction. The doughnut economy approach or the de-growth social movements are examples of reframing those constructs about basic needs. Planetary health is about how to reorganize the society in order to satisfy all layers of the Maslow's pyramid of needs without harming the ecosystems from which our wellbeing depends on.

"Planetary wellbeing acknowledges the value of both human and nonhuman well-being for their own sake (intrinsic value): the moral right for both humans and non-humans to exist, to have their needs satisfied, and to realise their typical characteristics and capacities. The needs of organisms—both human and nonhuman—are interconnected so that the satisfaction of the needs of various entities creates both synergies and conflicts. Hence, the concept transcends the level of individual organisms and focuses on the integrity of Earth system and ecosystem processes underlying the wellbeing of all forms of life." (Kortetmaki et al., 2021, p.3).

Participation

Participation on societal arenas is tightly linked to values of human rights, democracy, social justice, and social inclusion. Participation relates to various forms and degrees of participation, which contain a normative dimension when societies aim to encourage and facilitate citizens to take part on various arenas (e.g., school, work, leisure, civil society, community, cultural, political). It is presented as a value, because it is perceived as good for individuals, communities, and the society at large that citizens involve themselves through their participation (e.g., voting, activism, going to school, using the library etc). Participation in society is also seen as a solution to challenges related to the state and to our welfare (Ågotnes & Larsen, 2022).

We believe that by emphasizing the value of participation on societal arenas, and by staying critical towards the existing imbalances related to citizens' various premises of taking part and having opportunities to use and contribute to the development of social and health services and other goods of a society, this project will constantly bring awareness to processes of social inclusion, exclusion, and marginalization.

These processes relate to the issue of privilege and of oppression: Privilege is a benefit that one has, and others not. It is not earned. People has privilege, because of who they happen to be. Oppression is the other side of the privilege coin – it is a disadvantage that others do not suffer, that one did not earn or deserve. It is a disadvantage, because of who they happen to be. Unchecked privilege leads to irrational sense of entitlement and a lack of understanding of a different position.

A holistic, health promotion approach towards health (and) equity

Based upon the selection of value systems above, this section describes the key concepts that we operationalize later as applied concepts in the context of higher education.

Health here adheres to the World Health Organization (WHO) definition that; "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", retrieved from the WHO online section of health and well-being. Moreover, a human rights' approach to health implies that all human beings have the right to attainment of the highest achievable level of health and wellbeing. The Universal Declaration of Human Rights (1948) states that all people have the right to the standard of living adequate for their health and wellbeing including food, clothing, housing, and medical care, and necessary social services. Furthermore, we wish to emphasise that people's perceptions of what good or bad health and well-being mean may differ widely across individuals or groups in a society. In diverse societies there may for instance exist quite diverse perceptions of how to interpret and deal with health-related issues like symptoms, illness, diagnosis, recovery, and treatment.

Equity here refers to the perspective of WHO that states that equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental our human rights. Health equity is achieved when everyone can attain their full potential for health and well-being**."**

In other words, health equity is achieved when all of us have fair opportunities to achieve our fullest health potential without barriers that are unnecessary, unfair, unjust, avoidable, and remediable. The key words for me in the WHO definition of equity are unfair, avoidable, and remediable. This means that there is a lot what we can do to eliminate these unfair, avoidable, unjust, unnecessary barriers and find other equitable solutions.

Health equity here refers to an active process of action, activism, judgments, and reflection, which is performative and an ongoing process. Health Equity is a fundamental component of social justice that indicates the absence of avoidable, unfair, or remediable differences among groups of people due to their social, economic, demographic, or geographic circumstances (PAHO, 2022). Health equity is a complex societal phenomenon, as it involves several interconnected factors and problem issues. For example, barriers related to information, communication, and language to accessing health care may impact how people develop illnesses and treatment. One may for example misunderstand health care advice or be confused with what kind of treatment one could choose. Perhaps one has a desire not to access healthcare at all. This leads to the significance of finding *trust* in societal institutions. When people do not understand or believe in the knowledge communicated from larger societal institutions (e.g., from the health care institution or higher educational institution), trust may represent a great barrier to believe in or wanting to reach care or information about health.

Operationalisation of Health equity in higher education

The framework for health equity is a dynamic process that always will be changing. The framework for health equity through education is about values, reflexivity and being capable of acting. These are cornerstones when we have designed a learning environment and learning material for promoting health equity through education. There are probably dozens of good ways to support learning of health equity, our learning strategy and learning materials is one suggestion and is described in short here. What we see as most important is to find ways to build values, develop reflexivity and to act.

Building values

Can we accept the extreme differences in health care service and health expectations that exists within the world? We have shortly described six key value systems that we see as central and helpful: human rights, planetary health, social justice, ontological security, inclusion and belonging. We believe that having these in mind are supportive for our "ethical compass".

Develop reflexivity

For us to act, we need to be aware that our views, definitions, beliefs, words, actions, and inactions impact health equity. We need to start by reflecting on who we are and how that shapes our views and experiences of health, human rights, and health equity. Critical reflection is necessary, we do not know what we do not know. It starts with each one of us. That is where we see intentionality kicking in–reflect–act–reflect. Reflecting who is in and who is out, and why they are, are important starting points. We know that sex, age, race, religion, disability, ethnicity, social status, income, and several other social and environmental factors are important causes of health inequities. Therefore, we must remove barriers, and be intentionally reflexive to ensure that we do not create or perpetuate barriers unintentionally. It can happen that we unintentionally create or perpetuate barriers because we take many things for granted without questioning them and without recognizing that there are other forces working for and against us in the background (Nixon, 2019).

Acting

We believe that we cannot expect our learners to act in a highly equitable manner if they have not experienced their educational programs to be equitable. This means that we as educators must build an educational structure and we must adapt our actions, study plans and pedagogy to be more equitable. We need to do this for all our various contexts, for the various and diverse learning groups and within the various and diverse organisations and groups of colleagues. It might for example mean that some students get more supervision than others, it might mean that the exam structure can be different between the students, it might mean that there are several gold standards within the same program. As a therapist needs to take into consideration the situation of the patient, a teacher and supervisor, an educational system needs to take into consideration its students. And we need to act on it. The concept of "co-creation"/ "co-production"/ in research and applied services raise as important. By involving citizens to participate in defining and developing services that may speak to us and to our health needs, and as such contribute to develop grounds for health equity in a society.

Pedagogy and learning strategies

As health equity has a base in health justice, we used the capability approach (CA) as a basic theoretical foundation for looking at health equity. Here the key is creating opportunities. From the CA perspective, we follow the line of thought of Rutger Claassen, who added agency as an important

capability to create functioning in relation to health equity. In this sense pedagogy is related to personal agency, participatory agency, and navigational agency. As learning is, like health equity an ongoing process, we will start with an opening for critical consciousness (conceicão) concerning health inequities and equities (Freire, 2022). This means developing skills and knowledge to recognize opportunities and possibilities. Next to conceicão, it is needed to develop skills and knowledge to create autonomy and freedom, this will bring opportunities in action, or in CA words bring capabilities in function.

The pedagogical approach in HEQED is anchored in the described view of health equity as expressed in the HEQED project and follows the Bologna process and competency-based learning as defined in the European Qualification Framework (EQF). With competence we on a general level understand that a person has the ability to act and solve problems in concrete and specific situations. It is assumed competence is developed through experience. In the ECTS users' guide 2015 competence defines as:

"The European Qualifications Framework (EQF) defines competence as the ability to use knowledge, skills and personal, social and/or methodological abilities, in work or study situations and in professional and personal development. In the context of the EQF, competence is described in terms of responsibility and autonomy. In addition to that a competence contains knowledge and skills it also comprises the attitude the person has in the matter. Knowledge comprises what is known and understood. This normally builds on theory and insight in research in the field. Skills relate to ability and actions one can perform. The attitude is in part a personal and social ability but may relate to methodological reasoning in any given discipline. In working life this can give the person motivation, endurance, and ability to handle setbacks and change.

We value active and student-centered learning based on the ambition to create meaningful learning for the student. Student-centered learning, as the term suggests, is a method of learning or teaching that puts the learner, not the teacher at the center. The European Student Union (Attard, 2010) describes student-centered learning as follows: "Student-Centered Learning represents both a mindset and a culture within a given higher education institution and is a learning approach which is broadly related to, and supported by, constructivist theories of learning. It is characterized by innovative methods of teaching which aim to promote learning in communication with teachers and other learners and which take students seriously as active participants in their own learning, fostering transferable skills such as problem-solving, critical thinking and reflective thinking."

A student-centered approach put focus on the learning, competency and career development of the student. The student makes the decisions on his or her studies and takes responsibility for the choices made during studies. A learning-oriented approach provides the student with a self-directed, active learning experience and an inclusive and supportive study environment. We perceive the student as an active, responsible individual and this is something we want to support in each student.

In HEQED we also recognize that knowledge is constructed by the activities of the learner and thus "Constructive alignment". This is a design for learning that can be used to engage students in self-directed learning activities that optimize their chances of achieving learning outcomes. Alignment occurs when learning activities support students to develop knowledge, skills and understandings intended, which can be measured and evaluated by themselves or others (Biggs & Tang, 2015).

With the goal building values, develop reflexivity and promote action, we have designed an open digital learning environment that is easy to further develop and to adapt to various contexts and

learning groups. The learning environment is based upon active and participatory learning. Central are stories that the learner can engage with. The stories can be presented as a picture, as text, movie etc. The learner is then asked to analyse and reflect around this story from the described value points. The final task is to make an action plan or suggestion for how to manage to meet the goal of health equity in the specific case. For the reader, it is probably very clear that there are no simple answers to these situations and that looking from various value systems, the learner with probably experience conflicting interests. This is an important part of the learning. If promoting equity was easy, it would already be in place.

Conclusion

This framework for health equity through education is built in 2022, in the context of a world and Europe with major challenges. The framework is built in a process of multiple methods and subtasks involving multiple discussions, stakeholder mapping, a consensus process, concept analysis and a dive into the literature. We strongly believe that educational institutions have a responsibility and possibility of promoting health equity, and that this can be done by working together across sectors and professions. We clearly see that health equity is not built by working within the health sector alone. A large spectre of values is connected to health equity, and in this framework, we bring attention to value system that we find important in our contexts and in our time. These are *human rights, ontological security, social justice, planetary well-being,* and *participation*. To operationalise health equity within education, we point to four key action points: 1) building values, 2) developing reflexivity, 3) acting and 4) pedagogy and learning strategies. An important conclusion from our work is that a framework for health equity is a dynamic process, it is not a fixed document. A framework for building health equity will always be changing, and it should always be changing. A framework needs to be used and developed within its complex contexts, with its key values and the abilities to reflect and act as a solid ground.

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