Resuscitating Equality: Bringing the Heartbeat Back to Healthcare

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Abstract: *Within the evolving healthcare sector, the focus on health equity has led to interventions that, despite good intentions, often fall short. Recognized by a broad spectrum of healthcare professionals, including numerous social workers, as marginally better than inaction—colloquially referred to as "better than nothing," these efforts risk overshadowing deeper structural and systemic issues. Consequently, they divert attention from the need for comprehensive solutions that genuinely address the roots of healthcare inequities. This manuscript delves into the nuanced interplay between health equity and equality through the methodology of critical analysis, drawing on the insights of critical social work and relevant theories of justice and power. While contemporary discussions increasingly restrict equality to uniform resource distribution, the core of social justice emphasizes equality's deeper significance: recognizing the inherent worth of every individual, regardless of their background. The primary objective of this article is to advocate for the "resuscitation" of equality in healthcare, aligning it alongside health equity to ensure a comprehensive approach for individuals and families. A reductionist view of equality may cloud essential structural health determinants and compromise truly equitable care. The ramifications for social work are clear: a fervent advocacy for both equality and equity is indispensable. By embracing equity and equality in their most nuanced dimensions, we ensure that individuals, irrespective of their unique circumstances, receive care that is both just and tailored, elevating the benchmark in healthcare delivery.*

Keywords: *Health equity, equality, structural determinants, social justice, utilitarianism*

Social work, fundamentally guided by a set of core values, aims to define and achieve what is ethically right, just, and beneficial for individuals, families and society (Adams et al., 2002; Allan et al., 2009; Mullaly, 2002). These foundational tenets offer a structured lens through which challenges are conceptualized and solutions derived (Campbell & Baikie, 2012; Weinberg, 2019). Yet, a troubling disjunction between these principles and their application in practice is palpable (Dominelli, 2017; Dore, 2019; Dupré, 2012; Houston, 2012). Compounding this inconsistency is a burgeoning focus on health equity, often at the sacrifice of foundational notions of equality. This shift has fostered a pervasive mindset within healthcare, encapsulated by the sentiment of preferring minimal action over total inaction—commonly rationalized as *better than nothing*. Such a stance, though superficially aimed at progress, inadvertently propagates apathy toward addressing the complex layers of structural injustices and systemic inequalities embedded within the healthcare system. This apathy towards deeper, transformative change not only undermines the pursuit of espoused equity but also implicates social work and other healthcare professions in the maintenance of the status quo, reinforcing existing disparities under the guise of incremental improvement (Downey & Thompson-Lastad, 2023).

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Adopting a Critical Social Work (CSW) lens, this article dissects the perils and challenges inherent in the better than nothing ideology, thereby seeking to harmonize social work's espoused values, principles, and practices. It foregrounds transformative interventions targeting oppressive, marginalizing, and exploitative structures and relations while outlining pathways toward such transformative shifts. The overarching ambition of this manuscript is to enrich healthcare social work discourse by cautioning against the perilous eclipsing of equality by an undue, sole focus on equity. By championing a balanced perspective, this article aims to reaffirm the quintessential importance of both equity and equality in the healthcare system, thereby resisting the facile allure of interventions that are merely better than nothing, and fall woefully short of grappling with the complex systemic underpinnings of prevailing issues.

Rooted in a Canadian context, this article commences with a rigorous examination of the complexities surrounding health inequities. Initially, it situates this critique within the broader paradigms of power and justice, elements quintessential to the discourse of social work. Subsequently, the article narrows its focus to interrogate these issues within the healthcare domain, emphasizing the sector's hierarchical structures and its original "spine" in the medical model. The article then widens its analytical lens to briefly consider the promises of health equity through socio-political theories, specifically utilitarianism, meritocracy, and neoliberalism. This expansion serves to unveil the often-overlooked ideological underpinnings that perpetuate health disparities. Lastly, the article delineates key implications for transforming healthcare practices, thereby advocating for more equitable systems.

In accordance with the ethical standards outlined by the Canadian Association of Social Workers (CASW, 2024) *Code of Ethics*, this manuscript ensures a conscientious selection of language throughout the article. Specifically, using the term "minoritized" (Sotto-Santiago, 2019) as opposed to other potentially stigmatizing or victim-blaming terms to highlight that the marginalization experienced by these groups is not a consequence of inherent characteristics but rather the result of systemic discrimination and inequity. This linguistic approach is intended to displace the onus of systemic inequality from the individual and situate it within broader socio-political contexts.

Accordingly, the language in the article is selected to not merely describe but also to prescribe, utilizing terms such as "addressing structural inequities" and "challenging systemic discrimination" to signal the necessity of societal change. The language aims to both amplify the agency of minoritized communities and make it evident that the accountability for change lies with the overarching societal structures. Moreover, intersectionality in the health and healthcare context is a critical framework for understanding and addressing health inequities that must be considered. The framework emphasizes the intricate ways in which multiple social identities—such as race, class, gender, sexuality, and ability—intersect at various levels of society to influence individual and population health outcomes. At its core, intersectionality examines how systems and structures of power, including laws, policies, and institutional practices, interconnect to create unique experiences of advantage or disadvantage (Collins & Bilge, 2016; Crenshaw, 1990).

Ultimately, and perhaps most importantly, this article serves as a critical engagement with pervasive challenges in social work. Extant scholarship has implicated the social work profession for its White Euro-centric origins and colonial roots (Khan & Absolon, 2021) and its role in perpetuating structural inequalities that result in exacerbated health disparities among structurally-made-vulnerable (SMV) groups, thereby raising ethical questions that cannot be ignored (Charles et al., 2017; Conner et al., 2009; Weinberg, 2019). For instance, social workers have been shown to reinforce dominant cultural norms, thereby contributing to the stigmatization and minoritization of SMV communities (Fennig & Denov, 2019). Also, the attitudes, beliefs, and biases endemic among social workers manifest in inequitable treatment of clients, resulting in reduced access to essential healthcare resources and compromised quality of services (Ben-Harush et al., 2016; Kubiak et al., 2011; Mahabir et al., 2021). The manuscript thus bridges the gap between ethical imperatives and empirical findings, offering actionable strategies to improve the social work profession's contribution to more just, equal, equitable and inclusive healthcare systems.

Health Equity

The concept of health equity, far from being a modern invention, has historical roots that date back to the early 19th century, with the last decade witnessing a pronounced re-emphasis. Ministries of Health (MOH) across Canada, as well as in other global jurisdictions, have increasingly advanced policies underscoring health equity (Health Quality Ontario, 2016; McFarling, 2021; Mooney, 2009; Yao et al., 2019). However, it should be noted that with the passage of time and amidst diverse policy contexts, the interpretation, communication, and operationalization of health equity have undergone nuanced shifts, occasionally leading to variations that deviate from their original conceptual underpinnings (Yao et al., 2019).

The forthcoming discussion will use an example from Ontario, Canada, where the health equity efforts were geared toward “maximizing positive impacts and reducing negative impacts” on the health of populations, stating health equity "allows people to reach their full health potential and receive high-quality care that is fair and appropriate to them and their needs" (Ministry of Health and Long-Term Care, 2009, p. 7). These initiatives also explicitly demarcated a difference between equity, which involved distributing resources based on individual needs, and equality, characterized by a uniform allocation of resources (Health Quality Ontario, 2016).

Substantial funding has been rechanneled that underscores the importance of health equity, as evidenced by the establishment of National Collaborating Centres for Public Health in Canada, Canadian Institutes of Health Research’s research initiatives aimed at understanding and acting on social determinants and provincial strategies for poverty reduction. These efforts represent a concerted national commitment to incorporating social determinants into healthcare practice and policy, embodying a shift towards a more equitable healthcare system (Edwards & Cohen, 2012; Low & Theriault, 2008). Images flooded social media feeds with captions stating, “It’s not about giving people shoes; it’s about giving them shoes that fit!” However, despite these shareable memes and funding

redistributions, the question of whether these policies have made a meaningful impact remains unanswered. Recent data indicate that health disparities are not only enduring but also increasing (Organization for Economic Cooperation and Development [OECD], 2023). For instance, socioeconomic status continues to be a significant factor in infant mortality rates, a fact that has been well-documented since the early 20th century (Hattersley, 2006; Tawney, 1964).

The overarching thesis of this article contends that Canadian healthcare policies have not evolved sufficiently to tackle the deep-rooted structures causing health inequities. The rigidity of Medicare, for instance, mirrors the 1968 model and has not kept pace with societal changes or the declining performance of Canada's health system (Tonelli et al., 2020). Systemic barriers and the societal power dynamics that are deeply embedded in structural barriers, social identities, and cultural norms, which vary across different demographic groups, are frequently overlooked. These inequalities are intertwined and intersectional (Collins & Bilge, 2016; Crenshaw, 1990) and arise from complex systems that dictate access to essential services. For example, work conducted by Amis et al. (2020) found the organizational reproduction of inequality in which organizational practices are directly implicated in the burgeoning of social and economic inequality. This may include underrepresentation in decision-making roles, which often leads to policies that exacerbate existing inequalities, and language and cultural norms may act as powerful tools to uphold the status quo with terms and labels used to minoritize specific communities.

"Primum non nocer," first, do no harm (Shmerling, 2020), is attributed to the Hippocratic Oath and has surreptitiously infiltrated the fabric of healthcare (Potts, 2020). In fact, primum non nocer is not actually derived from the oath (Shmerling, 2020); nonetheless, it has become the axiom of healthcare which rests firmly on the medical model (Luxford, 2016). Do no harm fails to state explicitly but implicitly affirms power (Zaner, 1988). Potts (2020) describes it most clearly,

> it is naïve to believe that the misuse of medical power is not a temptation to people working in the medical profession. Even in the ancient world, writers on the ethics of medicine recognized the danger of power used to harm, rather than to help. (p. 916)

Not only do physicians have more knowledge, resources and skills than the person seeking care, but they also have backing from considerable legal, social, and institutional legitimation, thus creating dependency and ultimately having control (Illich, 1982; Jewson, 2009; Potts, 2020; Zaner, 1988). However, this is no longer limited to physicians. The effects of this widespread dominance mean that other professions, such as social work, are almost wholly complicit in perpetrating the violence, racism, ableism, and sanism that are embedded in the fabric of healthcare and healthcare systems (Beresford, 2016). Do no harm may avoid being directly implicated in negative discrimination (Solas, 2018b), but it does nothing to promote equality or equity, for that matter.

The ethos of social work is not just to avoid negative discrimination but to actively engage in promoting social justice, equitable resource distribution, and challenging oppressive systems (Sobočan et al., 2019). The CSW lens pushes further, recognizing that mere non-maleficence without a proactive stance on social inequalities does little to

address systemic issues. Historical patterns show that despite social work's commitment to ethical practice, actions informed only by ethics codes may not necessarily challenge existing social hierarchies. Thus, the passive posture of do no harm is seen as insufficient within social work, which aims to be transformative and to ally with service users for systemic change (Hugman et al., 2011).

The medical model, upon which healthcare is based, focuses on individual pathology or disease rather than considering the broader social, economic, and political factors that contribute to poor health outcomes—which the inclusion of equity aimed to do. However, the responses from the healthcare system remain unchanged, often blaming individuals for their poor decisions rather than addressing the root causes of the problem. This same system then places healthcare providers as healers and saviours (Shapiro, 2018) instead of addressing the sociopolitical context of oppression and promoting social change that will ultimately address the structural harms (Bettache & Chiu, 2019; Brodie, 2007).

The necessity to move beyond mere acknowledgment of these issues is evident. In the ensuing sections of this article, a critical analysis will be conducted, utilizing the theoretical frameworks of utilitarianism, meritocracy and, briefly, neoliberalism. This examination aims to interrogate and illuminate the values that undergird the prevailing models and frameworks of health equity in healthcare, particularly scrutinizing how power and justice are conceptualized and operationalized.

Utilitarianism

Most MOHs indicate a mandate to address injustice in their public service announcements, equity plans, and subsequent taskforces with no plan for or explicit discussion on power or justice. Implicitly, the assumed position is demonstrated through these types of utilitarian statements (Solas, 2018b) alluded to earlier, maximize positive impacts and reduce negative impacts (Ministry of Health and Long-Term Care, 2009). The main idea inherent in utilitarianism is that society is just when its major institutions are arranged so as to achieve the greatest net balance of satisfaction summed over all the individuals belonging to it (Blackorby et al., 2002; Brodie, 2007; Crash Course, 2016; Solas, 2008, 2018b).

The nuances are illusive, most unquestioningly assuming utilitarianism's beneficence. Solas (2008) advocates for a more critical approach, urging individuals to delve beyond surface-level appearances and examine the underlying architecture:

> the aim [of utilitarianism] is simply to maximize the allocation of the means of satisfaction, that is, rights and duties, opportunities and privileges, and various forms of wealth. However, when the principle of utility is satisfied there is no assurance that everyone benefits. In fact, the principle requires that some individuals *should* [emphasis added] accept lower prospects of life for the gratification of others. (p. 815)

By this definition of justice, deprivation is not only tolerated but sanctioned. The principle of utilitarianism demands that some, usually those who are already less favourably situated, forego greater life prospects for the sake of others. Many consider

utilitarianism as a means of facilitating the attainment of the ultimate advantage rather than perceiving it as an injustice (Blackorby et al., 2002; Hattersley, 2006; Solas, 2018b). These ideas are further buttressed with perceived economic restrictions. Thus, in a finite world, everything that anyone has is something that others cannot have.

In the utilitarian view, good is defined independently from right so that whatever is judged good for people is good, whether right or not (Solas, 2008). Selecting equity, irrespective of the MOH definitions provided, does not guarantee either "shoes" or "shoes that fit," but it has villainized equality and chides people from interrogating the system further. Social work embedded in the healthcare system is implicated in this approach—maximizing overall happiness. This has resulted in policies and practices that overlook the needs of minoritized and SMV populations. For example, policies that prioritize economic growth and fiscal responsibility over social welfare programs can lead to cuts in funding for social programs that are essential for minoritized populations. These cuts can result in reduced access to critical services, such as healthcare and housing, that are necessary for the well-being of SMV individuals.

Furthermore, the emphasis on measurable outcomes and evidence-based practices in social work can also contribute to minoritization, where the focus on measurable outcomes may prioritize interventions that are easier to measure and neglect interventions that are more complex and nuanced but may be more effective for individuals and communities. Finally, the emphasis on individual responsibility and self-sufficiency in social work can also uphold ideas of utilitarianism that may harm SMV individuals. This approach often fails to consider the structural barriers that prevent individuals from achieving self-sufficiency, such as systemic discrimination and lack of access to resources.

Meritocracy

It is said health equity allows people to reach their full health potential (Health Quality Ontario, 2016). Hattersley (2006) and Solas (2008, 2018a, 2018b) translate this message as the ability to rise. This is the premise of meritocracy, no more than a shell game, shifting inequalities to another place (Bettache & Chiu, 2019; Hattersley, 2006; Solas, 2008; Yu, 2006). Meritocracy's promise is the allowance to reach full potential. This conversely implies that persons in situations of poverty, homelessness, and addictions did not try hard enough with the opportunities provided to them. These individuals are the "losers" of the meritocratic system (Solas, 2018a).

A practical example is the model minority concept, a direct by-product of meritocracy. The model minority is one of the cultural consensuses that serve the White elite, hegemonic control (Bates, 1975; Bettache & Chiu, 2019). Yu (2006) describes the model minority as one which emphasizes certain individual character traits: hard work, frugality, strong family, and high regard for education, which are hailed as the path to individual success and personal salvation; referred to as the "winners" of the meritocratic system. Structural problems such as racism, sanism and oppression are otherwise inconsequential; what matters is your ability to rise once given the opportunity to do so—and if the model minority can do it, so can everyone else if they try hard enough (Solas, 2018a). Meritocracy

glorifies individualism and a competitive ethos and falsely represents it as a model of social justice (Hattersley, 2006; Solas, 2008, 2018b).

In their book, *This Is What Inequality Looks Like* (Teo, 2018), a Singaporean sociologist explores the lived experiences of low-income families in Singapore. The book challenges the Singaporean government's narrative that the country is a meritocracy and that those who work hard will succeed, arguing instead that poverty is often the result of systemic and structural inequality. Poverty in Singapore is often hidden and stigmatized, with many low-income families struggling to make ends meet despite working full-time jobs. The government's policies and discourse around poverty often blame individuals for their own circumstances rather than acknowledging the systemic and structural factors that contribute to inequality. Teo (2018) argues for a more nuanced understanding of poverty and inequality and for policies that address the root causes of these issues rather than just treating the symptoms.

Healthcare and social work policies and practices that uphold meritocracy can contribute to systemic injustice by perpetuating the myth that individuals are solely responsible for their own success or failure and ignoring the systemic barriers that prevent certain individuals and communities from achieving their full potential. For example, many social work programs prioritize individual responsibility, stating that individuals who may not return for healthcare visits are unmotivated, lost to follow-up or are non-compliant, and may blame even individuals for their poverty or lack of success instead of recognizing the ways in which larger social, economic, and political structures shape opportunities and outcomes (Dougherty, 1993; Whitley, 2018).

This approach in healthcare often results in a punitive and paternalistic approach and a focus on pathologizing individuals and families and treating symptoms instead of addressing root causes of poverty and inequality, leading to limited resources and support for systemic change. Additionally, meritocracy can lead to policies and practices that prioritize privileged groups over minoritized ones, perpetuating existing power imbalances and inequalities (Solas, 2018a).

Neoliberalism

Neoliberal thought has further entrenched this individualistic perspective, dislocating social assistance commitments and exacerbating social inequalities (Bettache & Chiu, 2019). What prevails in the neoliberal medical model is the view of distress as a disease and holds individuals and families responsible for fixing their own problems (Peters, 2019). And here, the pattern begins to become clearer. In every case, whether health equity, determinants of health, utilitarianism, or meritocracy, the onus is placed on the individual to deal with the adversity. Harvey (2007) in their book, *A Brief History of Neoliberalism*, describes it poignantly:

> for those left or cast outside the market system – a vast reservoir of apparently disposable people bereft of social protections and supportive social structures – there is little to be expected from neoliberalization except poverty, hunger, disease, and despair. Their only hope is somehow to scramble aboard the market system

> either as petty commodity producers, as informal vendors (of things or labor power), as petty predators to beg, steal, or violently secure some crumbs from the rich man's table, or as participants in the vast illegal trade or trafficking in drugs, guns, women or anything else illegal for which there is a demand. (p. 185)

This analysis necessitates a critical rethinking of the prevailing framework that, while recognizing individual needs, compels individuals to internalize and adapt to systemic shortcomings as personal failures. In instances where individuals overcome these vast challenges, it is the neoliberal paradigm that lauds them as exemplars rather than acknowledging them as exceptions to a deeply flawed system. Neoliberalism should not be seen as separate from those who profit from it: the Euro-White elite that, in a post-colonialist world, will always have a head start, open road and increased speed limit (Bettache & Chiu, 2019; Brodie, 2007; Solas, 2008, 2018a).

For social work, upholding social justice is a complex, somewhat nebulous, and multifaceted task that involves grappling with various philosophical, ethical, and ideological perspectives (Mullaly, 2007). If we are not careful, and if we are not critical and diligent, the foundations on which our profession stands are liable to shift. Social work must prioritize systemic change, challenge power imbalances, and advocate for policies and practices that promote equality—in its fulsome definition, equity and justice for all individuals and communities.

This article concedes that healthcare has shown a progressive shift from a purely biomedical to a more holistic understanding of health. This evolution embraces a broader understanding of health determinants, as illustrated by the Lalonde (1974) report. This seminal document expanded the conceptualization of health determinants to encompass not only the biological but also environmental factors, thereby enhancing the comprehensiveness of health strategies and interventions (Glouberman & Millar, 2003). However, this shift came alongside the abnegation of responsibility, accountability or ownership of those structures, placing the inequality and injustice as personal rather than political (Bettache & Chiu, 2019; Brodie, 2007; Hattersley, 2006; Solas, 2008, 2018a).

At the core of social justice resides the principle of equality, which functions as an essential pillar in the formulation of a society characterized by fairness and justice. Equality transcends the rudimentary idea of merely distributing resources or opportunities evenly among individuals. It represents a profound philosophical belief: irrespective of their background or circumstances, every individual possesses inherent value and worth (Solas, 2018a, 2018b; Tawney, 1964). Consequently, each person merits respect, recognition, and equal treatment in every facet of life.

It is imperative to elucidate that championing equality does not equate to enforcing a homogenous or uniform standard upon all. Equality does not mandate that everyone receives identical resources or achieves similar outcomes. Instead, it is about acknowledging the unique needs, aspirations, and hopes of each individual and ensuring that they are afforded equitable structures and systems for actualization. One example is Health in All Policies (HiAP), which strategically evaluates the health and societal impacts of decisions made across all governmental sectors, aiming to enhance synergies for health and social outcomes. It is pivotal because it addresses the wide range of factors affecting

health outcomes—such as structural determinants of health—which often fall outside the healthcare sector's purview.

HiAP emphasizes improving public well-being by requiring all governmental departments to consider the upstream influences on health and social conditions in their policymaking. This process encompasses analyzing both the direct effects of policies, like those altering taxation to support affordable housing, and the indirect implications of non-health-related policies, such as zoning laws that might encourage urban sprawl, thereby increasing pollution and fossil fuel use. At its core, HiAP focuses on tackling the root causes of health disparities, including inadequate infrastructure, scarcity of clean water and sanitation services, limited social protections, and barriers to accessing essential services and healthcare (Tonelli et al., 2020). Other examples include universal basic services, universal health care, universal education, housing first initiatives, and universal childcare.

The significance of grasping and integrating this principle into policies, practices, and academic discussions is paramount. Neglecting or misinterpreting equality results in a fundamental misunderstanding of the essence of social justice and, consequently, hinders the journey toward a genuinely equitable society. When equality is absent, certain individuals and groups are denied access to opportunities and resources, leading to unfair advantages for some and disadvantages for others. This creates, perpetuates and sustains interrelated systems of oppression (Solas, 2008, 2018a; Tawney, 1964; Teo, 2018). From these crosshairs, an individual could not possibly reach the promise of full potential. This promise requires more than an equal start; instead, an individual must have both an equal start and an open road (Solas, 2008, 2018b).

According to the International Federation of Social Workers' (2018) *Global Social Work Statement of Ethical Principles*, "Social workers work to bring to the attention of their employers, policymakers, politicians, and the public situations in which policies and resources are inadequate or in which policies and practices are oppressive, unfair, or harmful" (Ethical Principle 3.4). It is incumbent upon social workers to actively champion and advocate for the realization of true equality in both policy and practice, fulfilling their duty to foster a more just society.

Implications for Social Work: Health System Transformation

The healthcare system can play an integral role in the optimization of individual and family health. However, doing so requires radical self-reflexivity and moral courage (Blackstock, 2020) by social workers, researchers and policy actors to ensure that those who shape the production of information that influences health system decisions are aware of their power, values, and position. Awareness, however, is not enough; it must translate into the kinds of questions that are asked, the policies that are made, how research is conducted, and what and whose knowledges are used and implemented. Justice-informed practice, research and policy transcends the mere description of health inequities and focuses on the goal of social justice as a mechanism for social change and transformation (Cho et al., 2013; Crenshaw, 1990; Hankivsky et al., 2017; Collins & Bilge, 2016).

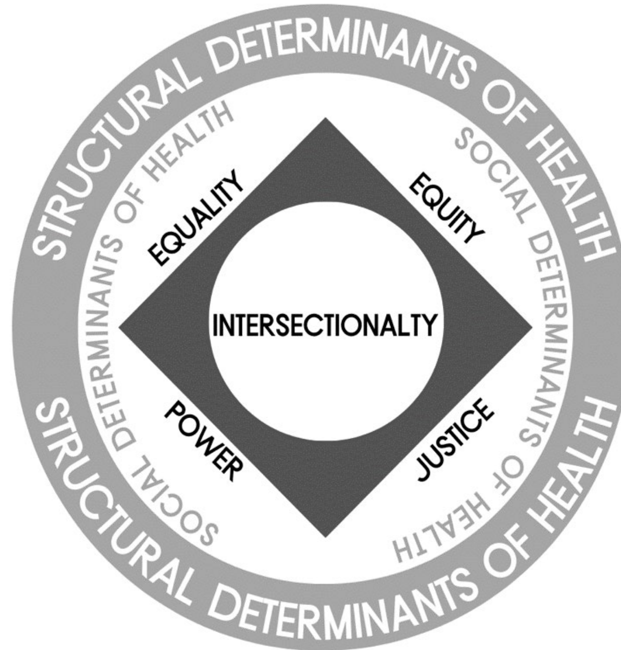
First, to truly transform the distribution of health and illness requires direct intervention in the fundamental social, economic, and political processes, relations, and systems of power that produce health inequities. These actions include, but are not limited to, the evolution of conceptual models of health to account for complex intersections of health and disease determinants that take power into consideration. Figure 1 provides a visual representation to elucidate these intricate relationships, positioning them within an expansive framework of power, justice, and structural determinants of health. Intersectionality, as depicted in the figure, roots itself in the understanding that identities, informed by categories like ethnicity, gender, and socio-economic status, do not operate in isolation. Rather, they intersect in systemic ways, collectively influencing individuals' experiences. Such intersections can either amplify or curtail their access to health resources and, consequently, their overall health outcomes.

Adjacent to this foundational concept of intersectionality is the closely intertwined ideals of equality and equity. The refined understanding of equality finds its articulation here, emphasizing the discernment of individual nuances but asserting that irrespective of one's background or external factors, each individual possesses an equal intrinsic value. Such a belief necessitates the unequivocal recognition, respect, dignity and worth of every individual across various spheres of life. Crucially, this comprehension of equality does not promulgate the notion of uniformity. Equity underscores the need for tailored interventions that account for individual circumstances, all with the aim of achieving equitable outcomes.

Encasing these central tenets are the overarching constructs of power, justice, and structural health determinants. Power emphasizes the societal dynamics that delineate access to resources and the capacities for decision-making. Justice embodies the moral commitment to fairness in the distribution of resources and opportunities, all the while aspiring for optimal health outcomes for all. Structural determinants of health refer to societal conditions, encompassing socio-economic factors, governing policies, and prevailing norms.

This intricate configuration illuminates the fact that societal structures underpin the foundation, subsequently influencing the internal dynamics of power and justice. These dynamics, in turn, shape the intricate dance of equality, equity, and intersectionality. For social workers, academicians, policymakers, and other healthcare disciplines, this holistic perspective underscores the imperative for a deeper, integrative comprehension of health. It posits that genuine health equity can only be attained when these multifaceted components converge harmoniously.

Figure 1. *The Complementary Dynamics of Equality and Equity in Health*



Hankivsky et al. (2017) provide concrete examples of this conceptual model with a focus on research, suggesting if these dynamics were more systematically understood and prioritized in research, the conceptualization of health problems, diseases, and illnesses would be more accurately addressed at their root cause. In turn, treatment opportunities, effective interventions, and necessary policy changes will be more clearly delineated and pursued.

Another example, "medical deprofessionalization," a term taken from Illich (1982), empowers individuals and communities to care for themselves and each other. This calls for a shift away from the focus on medical technologies and towards a more holistic approach to health that emphasizes prevention and community-based care. It also advocates for greater patient autonomy, control over medical decisions, and the dismantling of the medical-industrial complex (Amundson, 2005; Cresswell & Spandler, 2016; Haegele & Hodge, 2016; Relman, 1980).

This is not to suggest a rejection of the medical profession, but rather the integration of medical and healthcare advancements alongside traditional healing practices at the individual level that does not leave out the structural inequities that contribute to poor health outcomes for minoritized communities. A focus on individual empowerment is necessary but not sufficient to address these broader issues.

To promote greater equality in healthcare, it is important to address these underlying structural and systemic issues. This can include expanding access to other health disciplines, such as physical therapy, psychotherapy and occupational therapy, for

example, while continuing to address the root causes of health disparities. Additionally, policies that prioritize equality, notably in the realm of universal healthcare, comprehensive drug coverage, and robust anti-discrimination laws, are foundational in affirming the inherent worth and dignity of every individual. For instance, the implementation of universal healthcare systems ensures that every citizen, irrespective of their socio-economic status, has equitable access to essential healthcare services. This approach to healthcare is predicated on the principle that health is a fundamental human right, recognizing the equal value of every person's life and health.

Similarly, comprehensive drug coverage programs aim to eliminate financial barriers to necessary medications, ensuring that all individuals, especially those from minoritized communities, can manage and maintain their health without the burden of prohibitive costs (Boozary & Laupacis, 2020). Together, these policies embody a commitment to equality not merely as sameness in treatment but as an affirmation of the equal worth of every individual. They operationalize the concept of equality by starting from a foundational belief in the universal worth and dignity of all persons, thereby facilitating access to resources and opportunities needed to achieve optimal health outcomes and societal participation.

Moving From Clinical Practice to Critical Practice

The field of social work faces recurrent identity crises, often drifting away from its foundational ethos—respecting individual dignity, advocating for social justice, committing to truth and reconciliation, and valuing human connections, to mimic other healthcare professions (Gitterman, 2014; Hugman, 2009; Longhofer & Floersch, 2012). Contributing to this issue are long-standing debates concerning the medical model of care. Vic Finkelstein, a pioneer of anti-oppressive approaches, contended that social workers were as entrenched as medical doctors (Roulstone, 2013). Oliver et al. (2012) extend this further to say that the medical field, by virtue of its authority, has engendered a cadre of pseudo-professions aimed at restoring normality—among which social work is included (Oliver, 2009, 2016). Moreover, disability activism has criticized social work for perpetuating, rather than challenging, ableism and capitalist ideologies (Eiler & D'Angelo, 2020).

Several factors contribute to this trend, chief among them are external pressures such as austerity measures and the biomedical orientation of the healthcare system (Alderson, 2021; Andrews et al., 2021; Cresswell & Spandler, 2016; Danermark, 2019; Eiler & D'Angelo, 2020). These constraints lead to prioritizing cost-effective biomedical interventions over comprehensive social approaches, thereby reinforcing existing social work practices to the detriment of clients' economic and psychological well-being (Fante-Coleman & Jackson-Best, 2020; Islam et al., 2017; Iyer et al., 2015; McGorry et al., 2007).

To address these issues, Dietz (2000) suggests transitioning from clinical practice to critical practice, which necessitates a political engagement aimed at helping clients contextualize their experiences within broader social and political frameworks. Critical practice involves dismantling pathologizing discourses, identifying systems of inequality, and fostering transformative relationships (Allan et al., 2009; Ballan, 2008; Elliott et al.,

2005; Sanders, 2021). This approach shifts the practitioner's role from that of an expert to a co-collaborator (Harvey & Kitson, 2016; Kitson et al., 2013; Kitson, 2009). Whether in community health social work or in a hospital setting, in critical practice, the focus should be on collaboration—as equal partners and acknowledging clients as an integral part of the interactive system that impacts their well-being (Eiler & D'Angelo, 2020; May & Raske, 2005; Oliver, 2009).

A dedication to critical practice broadens the epistemological landscape, inviting a wider range of understandings and interventions for client distress. This aligns with social work's core commitment to human well-being and emancipatory change (CASW, 2022; Dietz, 2000; Dominelli, 2017; Mullaly, 2002, 2010). Hence, for effective and emancipatory practice, social workers must scrutinize both the knowledge they acquire and its application in practice, recognizing that knowledge wields power. The currently rising inequality is not a natural or inevitable phenomenon but rather a result of political choices and economic policies (Atkinson, 2018).

Social Workers Resuscitating the Heartbeat of Healthcare

At the core of justice are the structural and institutional arrangements that shape people's life chances over time. Injustice resides in the social order, not in people (Hattersley, 2006). It is precisely that disorder in the social order that is responsible for turning the natural diversity of human beings into oppressive hierarchies (Solas, 2018b). Inequality, espoused by the MOHs is not simply or primarily the result of unequal distributions of resources. This unjust distribution stems from unjust social structures, processes and practices. While concern about the end-product of distributional patterns is important, it offers no more justice than utilitarianism provides if the basic allocation structures responsible for producing and maintaining unequal shares of the social product go unchallenged.

True egalitarians neither expect nor want to create a society of identical mediocrities (Hattersley, 2006; Solas, 2008, 2018b). The objection is not to natural endowments or unique personhood differences, but to the artificial differences conceived by people in privileged positions that propagate the opinion that the view of equality is utopic and unfeasible due to the diversity of people it aims to assist. If each individual is to achieve their full potential, economic as well as institutional barriers to progress must be eliminated.

Equality must be resuscitated in healthcare. We must resist the cancelling of equality by mistaking it for uniformity. It is not about shoes or shoes that fit, but why are people in a just society without shoes at all? Equality must be accorded to every individual, and it must do so not because some innate or universal characteristic of individuals, but precisely because of the significant and tangible inequalities that exist between individuals. Nothing more and nothing less.

Conclusion

In the realm of healthcare, marked by disparities that favour a select few, the call for systemic transformation is urgent. The existing inequities underscore the need for healthcare authorities to fundamentally reassess and reconstruct frameworks to guarantee access for all. This means addressing the structural and systemic barriers that prevent individuals from accessing opportunities and resources and promoting policies and practices that ensure everyone has an equal chance to succeed.

This article returns full circle to the statement, "It's better than nothing." Perhaps the origin of this statement is actually from the people who have learned to expect nothing from us in the healthcare system. This realization prompts a critical reorientation towards equality, affirming every individual's inherent right to health and well-being which includes healthcare treatment and opportunities. This paradigm shift, advocating for equality as the cornerstone of healthcare policy and practice, challenges existing norms and lays the groundwork for a new healthcare ethos that rejects complacency in favour of comprehensive and holistic solutions.

At the heart of this academic discourse is the critical need for social workers to deeply understand the philosophical foundations that underpin current healthcare practices. Utilitarianism, meritocracy, and neoliberalism often masquerade as benevolent, ostensibly promoting progress, while in reality, they solidify existing injustices. Without critically engaging these concepts, social workers might inadvertently support the very injustices they seek to dismantle. The absence of a nuanced comprehension of these ideologies deprives social workers of vital tools for critical analysis, advocacy, and the pursuit of structural change. By acquiescing to minimalist interventions and an overarching sense of apathy, the status quo is inadvertently maintained, and the existing barriers are fortified, thereby obstructing meaningful progress and the realization of our professional and ethical commitments. Without equality, justice cannot be achieved, and society will continue to be marked by unfairness, inequality, and injustice. A return to equality is called for. All people must be treated as equals. Let that be the place we start with nothing sufficiently less than that.

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