

EDITORIAL

Inequity in Health: Let's not Live with it

Variations in population health between nations and among various social and economic groups within a nation beyond a certain limit is unjust. Such variations hinder the population from attaining its maximum health and life potential and have far-reaching implications in terms of human development, health and social consequences. There is a growing realization among policy-makers and implementers of development programmes that the extent of variation in health among social groups and nations should be minimized as much as possible not only for the benefit of the most disadvantaged but for all. This realization itself is a step forward towards the reduction of unnecessary disparity. However, the challenge remains as to how to tackle this undesired phenomenon.

Social inequity in health vs health inequity

The first step towards dealing with unacceptable disparity is to define what is unacceptable. Due to the inherent nature of human variation, no two individuals or group of individuals can possibly be equal. Then how is the line drawn between an acceptable and an unacceptable level of inequality? Should the yardstick be dependent on the level of development of the society in which the individuals live? Or should there be universal criteria for defining inequity in health? If so what could be those criteria? While ideal answers for the above are hard to get, people still use various techniques to map the situation (1,2).

Inequality, in its simplest form, can be viewed as a sum of 'unavoidable inequality' and 'potentially-avoidable inequality' (3). A part of the 'potentially avoidable' inequality can be unacceptable and unfair, and can also be termed as inequity. Efforts to reduce inequity should then be directed towards 'potentially avoidable' and unfair inequalities. Now the challenge is

to decide whether the health status of individuals alone be used in classifying individuals in inequitable conditions, meaning that anybody in poor health is in an inequitable condition irrespective of their socioeconomic or other discriminatory conditions, or whether the health status of individuals be examined by their socioeconomic or other discriminatory social factors to see whether the variation among various socioeconomic groups is equitable. Arguments in favour of studying socioeconomic inequality in health has been made by many (4,5), and correspondingly, examination of the health status of individuals by social or similar other grouping is the popular strategy.

Conceptualization

What follows next is the conceptualization of the link between societal and individual factors and the health status of individuals. This implies an understanding of society on the one hand and human biology and clinical issues on the other. Diderichsen and Hallqvist proposed one such framework elucidating the pathways from the social context to health outcomes identifying the policy intervention points (6,7). Such a line of conceptualization is helpful in understanding the determinants of health inequity with a clear identification of proximate determinants operating at the societal and health fronts, which can be pinned down for policy formulation to reduce health inequity.

Remedial actions

After the identification of action points to remedy inequity comes the formulation and implementation of actions. Although quite often health is a biomedical outcome, its determinants may well lie outside the scope of the biomedical paradigm. Social inequity in health has its roots in societal factors, and almost certainly, the reduction of social inequities in health would require affirmative action in the social and health sectors. In addition, a preventive or curative response to a health problem can only be effective in reducing social inequity in health if the disadvantaged in the society make equal (if not more) use of the opportunity when they need it. If the available services are primarily used by those with least need and more effectively than those with greatest need, then such services, in fact, increase health inequity.

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Unfortunately, this appears to be the case in many developing countries, a phenomenon which was termed some years ago as the 'inverse care law' (8).

The other issue not often discussed in the context of health interventions is the relative effectiveness of curative versus preventive measures in reducing health inequities. It is understandable that when a poor person becomes sick, s/he not only needs resources for curative services but also incurs an opportunity cost in lost wages. Thus, with unequal access to health services, the impact of illness is certain to be unequal for the poor and the better-off in any society. Evidences have started to accumulate that immunization programme reduces inequity in childhood mortality (9), and increasing equity in prevention programmes has greater potential than curative programmes for improving population health (10).

Resource allocation and targeting

Frequently, the health problems experienced mostly by the poor do not attract much attention from relevant agencies, and as a result, adequate resources for alleviating them are not allocated. This may be true both locally and internationally. If decisions about resource allocation are solely governed by the magnitude of the population needing a particular service, it is likely that the poor or otherwise disadvantaged will be ignored resulting in increased inequity in the society. As market forces influence the private sector, it is, thus, up to the public sector to pay special attention to the cause of the poor. The other important issue is whether to develop and implement programmes targeting the poor or to implement universal coverage programmes with equal emphasis on everyone in society—rich and poor. Some argue that as with the introduction of any new technology in society, the rich take advantage first, and eventually, others in society embrace and receive them afterwards (11). This can make progress slower and, in fact, widen the rich-poor gap to start with. It has been found that programmes targeted at the poor can indeed improve the condition of the poor in a short period of time (12-14).

Community mobilization

In the context of equity, at least three stakeholders are involved: the supply-side actors, professionals, and the people whose improvement all strive for. Clearly, there is a crucial role for people. Often one wonders how much of it (equity) can be offered. Should pro-equity actions include sensitization of the beneficiaries or other

stakeholders? If so, to what extent? It is clear that a balance between the two needs to be reached.

The supply-side aspect of community mobilization needs the sensitization of the stakeholders. This requires an evidence-base for advocacy, and eventually, designing an organizational response at the local, national and international level. The Global Health Equity Initiative (GHEI), later incorporated in the Global Health Equity Gauge Alliance (GEGA), is one such international activity, which has been very effective in generating interest on the topic globally with special attention to the developing world. Recently, INDEPTH (International Network for the Continuous Demographic Evaluation of Populations and Their Health in Developing Countries) has also started to focus on equity issues in generating quality data at its sites in many developing countries (15). The present issue of JHPN is also a modest attempt to compile evidences on the situation of health equity around the world, especially the developing world, such that relevant quarters become aware of the situation and take remedial actions.

Monitoring and evaluation

Success of all programmes should be assessed with an equity lens such that corrective measures can be taken at the appropriate time. The tendency of evaluating programmes with only pre- and post-intervention outcome indicators ignoring the implementation process may also not be the best thing to do. It is not of much help knowing after the completion of the project that it did not work for it also means an opportunity has been missed. Intervention programmes should rather be monitored in a manner that facilitates early warnings for the programme to be modified, if necessary. This demands the development of practical and user-friendly monitoring tools to monitor equity gains. The activities of GEGA and INDEPTH and data generated by Demographic and Health Surveys have a big potential to contribute to evaluating and monitoring the equity impact of various programmes.

Conclusion

Inequity in any sphere of life, especially in health, should be addressed with utmost importance. A clear understanding of the determinants of inequity, guided by a clear conceptual framework, is a pre-requisite for defining pro-equity actions. It is only through development of responsive communities of various stakeholders together with pro-equity policy, adequate

resource allocation and proper monitoring and evaluation that the dream of an equitable society can be materialized.

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