

Equity and INCLLEN

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Equity: An Overview 1

People agree that equity is of paramount importance in health and development. Beyond that, they are reluctant to explicitly conceptualize and commit to a realistic vision of equity in health. This is now the single most serious impediment to progress in addressing health inequities.

Societies must gain consensus on two pivotal issues:

- Equality of what (health, access, use, expenditures)?
- Equity among whom (income classes, gender, ethnic grouping, geography, religion)?

The policy dilemma, however, is in deciding how much inequality is inequitable? Responding realistically to this question reflects what a society judges is fair and what ill health it judges as avoidable.

Narrowly interpreted, "equality" would mean equal access to or use of services. However, a broader interpretation would include considerations of both horizontal equity, which requires that people with the same needs receive the same services, and vertical equity, which requires that people with greater needs receive greater services.

Amartya Sen argues for the goal of equal capabilities, where society ensures that each individual has the capability of converting an opportunity to its full potential benefit. This broadens the concept of need to include more than a medical indication; and broadens the concept of opportunity to include more than health care.

Equality is value-free, whereas equity is normative. Saying something is unequal is to describe a phenomenon; however, ascribing the differentials to a systematic effect of a variable is potentially to transform the description into a judgment. If the choice of variable is a social grouping considered to be unfair, and if the differential is thought to be significant and avoidable, then what is unequal is said to be inequitable.

Despite the limitations of proxy data in measuring inequity, they project a compelling picture of the widespread prevalence of inequities in health. A re-analysis by David Gwatkin *et al.* of the 1990 Global Burden of Disease data, showed that the poorest 20% of the population shoulder the greatest burden from communicable diseases (47.3% of deaths and 49.8% of disability-adjusted life years' (DALY) loss). On the other hand, the richest 20% bear only 4.2% of deaths and 2.6% of DALY loss caused by communicable disease. Other health indicators show differentials of 2- to 10-fold between rich and poor. Studies demonstrate health gradients across socio-economic groupings even within developed countries, where the major causes of deaths are non-communicable illnesses; and the poorest quintile may, in reality, be the nearly or working poor.

The effects of poverty on the health of individuals can easily be ascribed to its social consequences in feelings of risk, powerlessness, vulnerability, and low self-esteem, as well as to the absolute effect of material deprivation. Empirical evidence also shows that not only the incomes of individuals but also the distribution of their incomes within a society affects their health. Thus, in addition to the absolute impact of material deprivation, a socio-economic gradient has an independent effect on health. Some have advanced the loss of social capital (the cohesion and solidarity of a society) as a plausible mechanism to explain many deleterious health effects.

Thus new findings have generated enthusiasm for a social model of health that is based on the notions that:

- The welfare of the community is as important as the health of the individual; and
- At the individual level, the interpersonal aspects of health care are as important as the technical ones.

The social model of health recognizes the value of creating opportunities for community action, building social capital, and infusing health care with a genuine concern for the individual's personhood and autonomy.

This shift from a biomedical to a social model of health permits a broadening of the equity goal to include substantive equity, achieved through acceptable equalization of the individual's capability of benefiting from health actions with priority given to the disadvantaged. This broadening of the equity goal also permits inclusion of procedural equity, which is attained to the extent that the structure, process, or procedures to achieve substantive equity are fair.

INCLLEN is a truly global network with skilled individuals coming from different disciplines. A large part of it is based in developing countries where the discrepancies in ill-health are dramatic but it also has members in developed countries where gradients of ill health also exist. As a network, INCLLEN can go beyond answering the question of how to improve the health of the populations, and ask to whom the gains are accruing; and where there are inequities, to ask the question of why these persist and what else can be done.

The primary challenge is to ensure a constant awareness about inequities, the need to document the extent of existing inequities and a search for the cause of their persistence. What are the priority research areas for inequity in health? In other traditional priority research areas, how does one incorporate an equity "filter"?

Do the priorities change once you employ an equity filter? Think about how an equity filter can influence research design and hypotheses, sampling or delineation of inclusion and exclusion criteria. How will an equity filter guide analysis and recommendations?

INCLLEN has to start by visualizing what the equity filter will mean to it and how INCLLEN does its work. Specifically, INCLLEN can make meaningful contributions to:

1. The documentation of inequities in health - from surveys to clinical trials to systematic reviews, one can consistently ensure that data is collected and analyzed to allow examination of important covariates or explanatory variables for differences in outcomes or health status.
2. The elucidation of causes of inequities in health - INCLLEN's health social science perspective equips it well to examine issues like gender, ethnicity, and income gradients. One intriguing area of exploration is the effect of income gradients on health status of individuals in a population and if this can be proven to be mediated by deterioration of social capital. The first steps of conceptualization and measurement of an independent variable like social capital in a developing country is already a great challenge.
3. The exploration of the implications on the delivery of health care at the level of program and at the level of patients. The concept of inequities in health must be expanded to inequities in capabilities, with a resulting shift from a purely bio-medical viewpoint to a social model of health. There is a need to explore what this actually implies for doctors and other health care providers who "deliver" care, and for policy makers who make decisions affecting the health of populations.

INCLLEN working actively in this arena will be a great contribution to improving " health for all." And this time around, we mean for ALL - literally.

¹ An excerpt from: Tan-Torres Edejer T. Chapter 2: Health for some: health, poverty, and equity at the beginning of the 21st century. From Neufeld V and Johnson N (eds). Forging Links for Health Research: Perspectives from the Council on Health Research for Development. IDRC, Ottawa, 2001)

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