Section 1

Introduction

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Why this book?

Gavin Mooney and Di McIntyre

Equity in health and equity in health care have been ill-served in recent years. While for many health care systems equity is stated to be an important goal, in several of these equity in policy terms has been paid little more than lip-service. While it is also the case that there has been an increasing research interest in the social determinants of health, the extent to which the recognition of the impact of these on health has led to action at a policy level has been limited. Poverty and inequality are now well recognized in the academic literature, especially in social epidemiology but in public health more generally, as contributing to population ill health. National and global policy makers, however, have been all too little concerned to address poverty and inequality and, inevitably, even less concerned to do so for reasons purely of improving health.

Health economists have contributed considerably to debates about the construct of equity in health care, be this seen in terms of health, access or use and whether horizontal or vertical equity. Beyond considerable success in the 1970s and 1980s in assisting methodologically to improving equity in health care through needs-based, RAWP-type resource allocation formulae (DHSS 1976), policy on equity in health care has been a field where health economists have made relatively little impact.

Considerations of 'need' were initially very useful in RAWP-type resource allocation formulae and indeed the scene of most policy success by economists on equity in health care. Quite why this was the area of success is not clear. Certainly in the UK, where such efforts began in the mid-1970s, the then Labour government was concerned that some of the equity ideals of the NHS had not been realized. It was further recognized that, crudely, fewer of the health problems but more of the health care facilities and, hence, resources were in the south of England, the latter largely because of the geographical inheritance of facilities by the National Health Service (NHS) when it was founded in 1947. There was also an appearance of objectivity in the formulaic approach to equity. The 'science' of numbers and the dependence on a mathematical formula seems to have been politically appealing.

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There are a number of reasons why the health economics of equity has struggled in recent years. In part it is because we have had an obsession with the measurable. Too great a concern with quantification has resulted in a gap emerging between health economists' conceptual thinking and their empirical work. As Sen (1992 p. 49) has argued in the context of equity: '"Waiting for toto" may not be a cunning strategy in a practical exercise.'

The unfortunate result of the concern with the measurable is that while most health care systems that do have a stated equity objective (and this in turn means most health care systems) define it in terms of access, what health economists have been measuring is use. This focus on use (which is measurable) has then distracted the subdiscipline from seeking to grapple, other than in principle, with access.

Sadly then, measuring has got in the way of defining equity. The prime candidates for the construct of equity in health care have been equal health; equal access for equal need; and equal use for equal need. There has been more or less agreement that the difference between the last two is that equal access means equal opportunity to use as opposed to actual use being equal. Most formulations of the 'for equal need' component have been in terms of seeking to ensure that access or use is the same for groups of people with equal health problems. More recently, prompted by the work of Culyer (1991), there have been efforts to consider need in terms of capacity to benefit. This notion highlights that for a need to exist, health care must be effective; ineffective care cannot be 'needed' as there is no capacity to benefit from such care. It also suggests that need should not simply be equated with ill health, as is too often the case; there is capacity to benefit from preventive interventions.

The distinction between horizontal and vertical equity is potentially important. Horizontal equity is about the equal treatment of equals; vertical equity about the unequal but equitable treatment of unequals. Equal access (and equal use) for equal need in itself is about horizontal equity. It is patently unfair that people with the same problems be treated differently. That is what has driven most polices on equity in health care at least on the delivery side. At the same time, treating people who are unequal equally is also unfair but more, as it were, complicatedly unfair!

For horizontal equity it is relatively easy to argue who is equal or the terms of such equality, e.g., people who have equally great health needs, essentially people who are equally sick. What is more problematic is that when we move to considerations of vertical equity, there is then a need to determine first how great any inequalities are, e.g., in health need, and then to decide how great any differences in policy response should be to these inequalities in need. Such judgments are clearly subjective and, as such, much more difficult to fit into some seemingly (even if falsely) objective, scientific, RAWP-style formula. Nevertheless, health economists should be tackling issues of vertical equity more directly than they currently do,

given the massive disparities in health and socio-economic status that exist in many countries and between countries.

As editors, we have been tempted to set out a definition of health equity in this introduction. We have however chosen not to. First, we subscribe to the view that however equity is defined it will not be the same in all countries, cultures or societies. There is unlikely to be a universally valid definition. Second, if pressed, while we might be tempted to argue for a definition that is along the lines of equal access for equal need, that opens up three cans of worms. What is access? What is need? And what about vertical equity, which risks being excluded by an 'equal access to equal need' type of definition? The book does discuss some potentially helpful ideas for defining equity but that is as far as we believe it is justified to go.

It remains the case that we are simply not seeing the breakthroughs in improved equity in the delivery of health care that were hoped for in the halcyon days of concerns for equity in health care in the immediate post second world war years. The prime example here is the British National Health Service introduced in 1947 and seen, accurately, by its founder Nye Bevan as being primarily about equity (Foot 1973).

Health economists have been active on the financing side in examining how different funding arrangements affect different income groups. In particular, they have analyzed tax-based systems, mandatory and voluntary insurance premiums and out-of-pocket payments to see how progressive or regressive each of these is. Important work has also been done by health economists at a comparative level internationally. The extent to which governments have picked up on this work in efforts to promote greater progressivity in financing has been limited. Sadly, this is especially so in the developing world.

There have been many advances in research in the social determinants of health, particularly relevant here being the work of social epidemiologists such as Wilkinson and Marmot (2003). They have provided good evidence that poverty and inequality can adversely affect health. Even they, however, have done too little to try to explain why poverty and inequality continue to exist to the extent that they do and indeed in some countries and across the globe, according to some indicators, are seen to have increased. Health economists have been largely absent from these endeavours. Of the little economic work here that has been undertaken, Navarro (2002), Coburn (2000) and Deaton (2003) have led the way; the first is not a regular member of the health economists' community, the second is a sociologist (but a contributor to this book) and the third is a mainstream economist.

Globally, attempts to reduce poverty and inequality and, in turn, improve health equity have not engaged the world community as one might have wanted. At a nation state level many governments have sought actively to control public

spending and relied more and more on the market to provide all sorts of services that were previously in the public domain and seen even as public and social institutions. Private sector involvement in the provision of health care has increased; the ethos of the market in health service thinking has increased yet more. The commodification of health care is much more prevalent today than it was 20 or even 10 years ago.

It is also the case that, politically, making the case for vertical equity, in essence a form of positive discrimination, is difficult. It involves more explicitly, and to a greater extent, a redistribution of resources from the well to the sick and almost certainly from the rich to the poor. Few governments in recent years, especially with the spread of neo-liberalism and its endorsement of small government, have been willing to use the tax system to bring about such redistribution. Private sector growth has exacerbated the problems.

Equity in health as opposed to in health care is much less debated and much less researched by health economists. It is not immediately clear just why. In general, it seems that so much of health economics has been in effect health *care* economics. This is odd, since within health care economics the emphasis has been very much on health. This is especially true with respect to economic evaluation, where cost utility analysis (CUA) with its concerns restricted to health has dominated and cost benefit analysis, which at least has the capacity to include wider dimensions of benefit, has very much taken a back seat. Yet that emphasis on health has not translated into much of a concern among health economists for the production of health at a broader social level, i.e., through the social determinants of health.

The dominance of CUA in economic evaluation may be a partial explanation for some of the neglect of the social determinants of health since, strictly, CUA is only applicable in the context of resource use that has health as the only output. Cost benefit analysis, which is what is needed for economic evaluation in the social determinants of health, is harder to apply, much more data intensive and methodologically more complex.

A yet simpler explanation may be that there has been less funding available for economic analyses to be conducted on the social determinants of health. Funding for health economics research has tended to follow funding for medical research, so that pharmaceuticals, clinical trials more generally and health services research, especially on funding issues, have been seen as the more fertile and in fact have been the more fundable areas of health economics research.

There is need for care here. It is not that the wider social, non–health care issues around health equity have been totally neglected by health economists. But the balance has been much more at the microscopic end of the scale than the macroscopic.

Switching to a yet wider or higher level, there has been little consideration by health economists of equity in health globally. The North-South divide in terms of

income is stark. It is as well in terms of health. How the policies of the World Bank, the International Monetary Fund (IMF) and the World Trade Organization (WTO) affect global equity in health have been little examined by health economists. Certainly WHO's Commission on Macroeconomics and Health had health economist representation but in general health economists have been missing from the global scene. For example we have been unable to find any health economics assessment of the likely impact of the Doha agreement (Hertel and Winters 2006) which, as it is firmly aimed at poverty reduction, if successful, will, in turn, have an effect on the distribution of ill health and hence equity in health globally.

More specifically, with the exception of the likes of Vicente Navarro (2002), there is little by way of a health economics critique or even assessment of neo-liberalism, the hegemony of neo-liberalism and their impact on health and its distribution. This almost certainly relates in turn to the lack of health economists' research on the social determinants of health. This is because neo-liberalism, together with the individualistic market thinking it breeds and the small government posturing it promotes, is not conducive to building the social capital and social cohesiveness treasured by advocates of the social determinants of health.

It is not just that health economics has largely failed to make an impact on equity; health and economic policies have largely failed to make an impact on equity in general at a macroscopic level. More recently, there has been less concern with social justice not just in health but in western societies more generally with, for example, public expenditure as a proportion of national income in general falling and taxation in many countries losing some of its progressive edge.

On equity there have, however, been some successes in a range of areas in the world such as Cuba, the state of Kerala in India, Sri Lanka and Costa Rica. It can be argued, too, that Scandinavia has long been a region where equity in both income and health has been a major part of public policy – and with some considerable success. We need more health economics analyses to tell policy makers what they can learn from these countries and regions.

The contributions to this volume critically consider some of the health and health system equity challenges facing us. After this introductory chapter, David and Elaine Coburn lead off in a theme on equity in general, providing an overview of health inequity issues from a global perspective. This is followed by a chapter from Amiya Bagchi, which takes both an historical and global look at equity in health and health care in the context of social, economic and cultural issues. Then Gavin Mooney reflects on the importance of focusing on community and culture, particularly indigenous culture, in pursuing both health and health system equity. The section ends with a chapter by Alan Maynard, who compares and contrasts libertarian and egalitarian approaches and what they mean for health systems, particularly drawing on the experience of the British National Health Service.

Chapters 6 and 7 examine the conceptualization and application of health service access. Michael Thiede, Patricia Akweongo and Di McIntyre explore the different dimensions of access and illustrate how each dimension can be evaluated using data from Ghana. Lucy Gilson explores in some detail, through the lens of trust, one specific dimension of access, namely cultural access (or acceptability). This is the dimension of access that too often receives least attention yet it is critical to address if we are to promote health system equity.

The next section focuses more directly on equity and health systems. Maureen Mackintosh examines the delivery side and picks up on the particularly important element of health care delivery of the availability of human resources and the need for their redistribution at a global level. Di McIntyre focuses more on the financing side and considers the role of alternative health care financing approaches in addressing health system inequities, particularly in the context of the substantial private health sectors that exist in many African countries. By pursuing financing mechanisms that strongly promote health system cross-subsidies in this public-private mix context, income redistribution can be promoted simultaneously.

Chapters 10 and 11 discuss equity at an individual country level, examining Brazil and Thailand. Silvia Marta Porto, Claudia Travassos, Maria Alicia Domínguez Ugá and Isabela Soares Santos analyze how equity in Brazilian health care has improved, explaining why but also how it can be improved yet more. Viroj Tangcharoensathien, Supon Limwattananon and Phusit Prakongsai consider both the delivery and financing sides of health systems through reviewing progress towards equity in Thailand. These two chapters also serve as a useful end point for the country, regional and global perspective chapters by providing insights into how to monitor progress towards equity.

All of the authors offer positive suggestions as to how health equity might see a more positive future. There is hope.

The final chapter, by Di McIntyre and Gavin Mooney, provides not so much a conclusion to the book but rather a reflection on where we might be going on equity in health and health care, and the contributions that are needed from health economists to further this.

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Section 2

Equity in general

2

Health and health inequalities in a neo-liberal global world

David Coburn and Elaine S. Coburn

Summary

Health inequalities are central to current health policy internationally and in many nations. As health improvements have slowed, the extent and depth of health inequalities in the developed world have become too obvious to ignore. At the same time the profound differences in health between the developed and underdeveloped world, between obesity for some and starvation for others, has created a moral crisis. Yet, the often proclaimed solution to human problems, neo-liberal free trade producing economic growth and improved human wellbeing, i.e., market fundamentalism, has proven a failure. The dogmatic application of neo-liberal doctrines perversely increases those social inequalities that are among the basic causes of health inequities. The issue then becomes one of creating conditions that would permit more variegated approaches to improving human well-being and reducing inequalities. Ironically, the dynamics of globalization, broadly defined as a view of human beings sharing the same planet and the same fate, has produced opposition to the untrammelled dominance of multinational corporations and the states they influence or control. If we know something about who and what the enemy is, we do not as yet know solutions other than doing something differently and more humanely. There are examples of countries and areas that do better than others at translating economic growth into improvements in human welfare. We can learn from them. Yet the onus remains on us to do whatever is within our capabilities to develop a more just and equal world.

Introduction

The rich live longer, healthier lives than do the poor. In US metropolitan areas, the health differences between high and low socio-economic status areas equal '[t]he combined loss of life from lung cancer, diabetes, motor vehicle crashes, HIV infections, suicide and homicide' (Lynch *et al.* 1998). In the USA, people in the

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