

EQUITY AND HEALTH: A CARIBBEAN PERSPECTIVE

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Any discussion of equity and health must take place within a context that focuses on creating an environment that enables human beings to enjoy long, healthy, and creative lives. Hence, the discussion of equity and health must revolve around human development, which denotes the process of widening people's choices and improving their level of well-being and capacity for self-empowerment. In its conceptual framework, UNDP has identified the following life conditions as critical to well-being:

- a long and healthy life,
- education,
- a decent standard of living,
- political freedom,
- guaranteed human rights, and
- self-respect.

When one considers these life conditions, they all seem so subjective that their interpretation varies from individual to individual, population to population, and community to community, based on one's culture, belief system, resources, etc. Notwithstanding this difficulty, one can make a quick identification of populations that exist in poverty. These populations are unable to contribute to their own individual growth and to the growth and development of their respective communities.

When discussing the topic of equity and health, many are immediately drawn to focus on poverty. In many instances, however, this focus is motivated by benevolence rather than development, and presents limitations in terms of social benefit. It permits solutions to be passive and more conscience-relieving than dynamic and demonstrative that the existence of poverty is a deterrent to the creation of global well-being and development. Poverty concentrates on deprivation of three essential elements: longevity; knowledge; and a decent standard of living.

- Deprivation of longevity relates to survival and vulnerability to death at an early age, specifically, life expectancy under 40 years.
- Deprivation of knowledge relates to being excluded from the world of reading and communication.
- Deprivation of a decent standard of living comprises three variables: percentage of people with access to health services, of people with access to safe water, and of malnourished children under the age of 5 years.

These deprivations define vulnerable populations who require specific investments so they can have the opportunity to survive and participate in the development process. Hence, in terms of our discussion for action on health and equity, these vulnerable populations must be identified, not because of a

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moral imperative but rather for a development imperative.

Having addressed the need to protect these vulnerable populations, let us turn our attention to the rest of the population in terms of equity and health in the developmental context. The barriers to an individual's or a population's quest for well-being are related to the determinants of health, including economic status, communication resources, the environment, the health/medical system, knowledge/access to information, and gender. In each of these areas, barriers to the attainment of well-being can be defined, identified, and studied epidemiologically. For example, Epi-data, which points to an increasing incidence and prevalence of asthma, can point to factors that require intervention and investment at different levels.

CURATIVE

As the balance of health determinants shifts, disease processes are manifested in relation to people's exposure to physical, chemical, or biological agents. Hence, the health system's curative component is central to the re-establishment of well-being, and the organization of the health system becomes a pivotal consideration. But the medical model construct cannot be considered sufficient. This paradigm of the health system, of which the curative component is a part, must reflect an active understanding of the role of the determinants in the manifestation of disease and attainment of well-being.

HEALTH FACILITIES/TECHNOLOGY

The relevance of health facilities and technology to health equity must be considered within the context of the global, national, and regional environments, and within these environments, in terms of the private and public sectors as well as the nongovernmental and community-based organizations.

Participatory planning with the involvement of all sectors can lead to equitable development and can support environments that promote health and well-being, resulting in priority programs reflective of epidemiological analyses and research.

TECHNOLOGY

An important aspect of the health care delivery system in relation to health equity is the availability of technology. The use of technology must be assessed based on its contribution to the well-being of the entire population. Because the availability of technology is dependent on very limited resources, its equitable contribution to health depends on analyzing who is in greater need. Access issues are relevant not only to the use of public resources to achieve health and well-being, but also to the use of private sector resources, a sector that is not always held to the same equity standard as the public sector. There should be no difference in terms of the basic permissible standards for the public sector, private sector, and nongovernmental organizations. For example, the availability of mammography for women, be it in the public or private sector, must meet standards for the equitable application of the technology.

Public resources must be used first to benefit the vulnerable groups of a society—not in a manner which will deter the generation of greater wealth, but with the intent of contributing to empowerment in a way that balances with other components of the society. This obviously cannot be done solely by the sector that is responsible for the contribution of health to development, but rather must be accomplished in dynamic partnership with other sectors.

The indices that will assist in the development of a formula for the maximization of resources and its greatest empowerment are:

- public expenditure ratio—percentage of national income that goes into public expenditure;

- social allocation ratio—percentage of public expenditure earmarked for social services;
- the social priority ratio—percentage of social expenditure devoted to human priority concerns;
- the human expenditure ratio—percentage of national income devoted to human priority concerns.

Clearly, depending on the philosophical forces in a society, the analysis of these ratios can be performed in different ways, such as focusing on the public and/or private sectors, thereby permitting different responses, all of which may be considered equitable. But the use of these ratios in any analytical approach would require further analysis as to whether the socially allocated resources are inappropriately aimed at curative health and therefore neglect to invest in broader determinants of well-being.

FINANCING

Discussions of financing structures for attaining health and well-being must include an understanding of global, regional, and national financing frameworks and the values that inform them.

Two components comprise the financing of well-being and health. The first is based on consumer choices and expenditures on activities related to determinants, e.g. binge dieting versus nutritious choices or water rates versus fashion. This component depends on a high level of literacy which, when combined with information, creates greater opportunity for consumers to choose healthy behaviors. The second component is related to how the curative component of the system is financed. If we recognize that resources are required to support a system that involves technology, and if quality assurance is to be maintained equitably, then technology must be accessed by all of society, and the system must have guidelines to ensure that standards do not vary according to individuals' ability to pay, e.g. access to mammography for early detection of breast cancer.

ACCESS

Access is not determined solely by physical access, but rather can be considered to have three components:

- (a) *physical access*—a facility is provided where services are offered.
- (b) *clinical access*—the provider is available and delivers a high standard of service in accordance with established norms. Clinical access also depends on the setting. For example, the operational norms and standards for an ICU vary with the mechanisms for financing in the private and public sector, or, outsourcing of staff in critical units can undermine or compromise continuity of care that is urgently needed. This does not mean that outsourcing is irrelevant, but rather that within the reform agenda, guidelines need to be developed to ensure that the financing agenda is in sync with the developmental objectives of equity and health.
- (c) *therapeutic access*—many patients, especially the elderly, are unable to purchase the pharmaceutical agents prescribed, and as a result, the full attainment of the health equity objective is inhibited.

In many circumstances for a significant percentage of the population (a) and (b) become operative and (c) is very difficult to meet whether in part or whole.

EFFICIENCY/EFFECTIVENESS AND EQUITY

Many who have addressed the topic of efficiency and effectiveness seem to conclude that it is difficult for efficiency/effectiveness and equity to complement each other. But achieving equity is dependent on the effective use of resources and technical efficiency, and any equity proposal should explain how the resources are to be distributed, and how effective and efficient that distribution has been in the past or

can be. In the context of development, the equitable use of resources must meet certain criteria, one of which is sustainability. The search for equity, then, must be approached through multiple steps for any given issue that affects human health. For example, immunization contributes to both individual and societal development. Likewise, when dealing with vulnerable populations, resources must target basic

determinants that affect individuals' health and that of the population at large. Hence, resource allocations should consider that society cannot develop if large sections live in poverty or vulnerable conditions. Also, resources must be invested within a structure that maintains human capital. In the end, the resources must be well targeted if efficiency and effectiveness are to contribute to equitable development.