EDITORIAL

Health equity: challenges in low income countries

The concept of health equity has been described as differences in health care that are unnecessary, unfair, and unjust and avoidable.[1,2,3] The term health equity and health inequality are not synonymous, though they are often used interchangeably.[4] Money[5], Braveman and Gruskin[6] have categorised equity as an ethical concept, grounded on the principles of distributive rather than procedural justice. Inequity and equity are concepts expressing a moral commitment to social justice.[7] In operational terms pursuing equity in health means eliminating health inequities that are systematically associated with underlying social disadvantages or marginalization.[1]

Health inequality on the other hand designates differences, variations and disparities in health achievements of individuals and groups. Health equality does not imply moral judgement. The crux of the distinction between equality and equity is that the identification of health inequities entails normative judgement premised upon one's theories of justice, society and reasoning underlying the genesis of health inequalities.[7]

Inequalities in health between population groups exist in all countries. These differences occur along several axes of social stratification including socioeconomic, political, ethnic, cultural and as discussed in this issue by Buyana, gender. The causes of inequalities in developed may be different from those in developing countries. In the developed Organization for Economic Cooperation for Development (OECD) countries access to personal health care services is universal, but inequalities in health status have been shown to be related to income and other socio-economic factors.[8,9] However in developing countries improved health among the urban population has been found to be due to access to improved health care knowledge and services rather than higher incomes.[10]

There is not a great deal of mystery as to why poor people in low income countries suffer from high rates of illness particularly infectious diseases and malnutrition: little food, unclean water, low level of sanitation and shelter, failure to deal with the environments that lead to high exposure to infectious agents and lack of appropriate medical care. Similarly there is a great deal of knowledge of the causes of non-communicable diseases that represent the major burden of disease for people at the lower end of the social gradient in middle income and high income countries. The World Health Organization global burden of disease study[11] identified underweight, overweight, smoking, alcohol, hypertension, and sexual behaviour as major causes of morbidity and mortality. These health inequities are the result of a complex system operating at global, national and local levels which shapes the way society at the national and local levels organises its affairs and embodies different forms of social position and social hierarchy.

Addressing social determinants of health will yield greater and sustainable returns to existing efforts to improving global health. There is need for empowerment of individuals, communities and countries[12] as shown in this issue in Orach et al. paper who discuss the empowerment needs of displaced persons living in internally displaced persons' camps in northern Uganda. Empowerment can be seen to operate at three interconnected levels/dimensions- materials, psychosocial and political. People need the basic material requisites for a decent living, they need to have control over their lives and they need a political voice and participation in decision making processes. Although individuals are at the heart of empowerment, achieving a fairer distribution of power requires collective social action – the empowerment of nations, institutions and communities.[12] In low income countries, persistent physical and chemical hazards are compounded by high rates of informal employment with negligible labour protection. Employment conditions provide a fertile ground for major improvement in of the physical and social environment[12]

Evidence from OECD countries shows that lower income groups use health services more than the better off.[13, 14] So in these countries underutilisation of health services is not a major factor in inequalities in health status between high and low income groups. Instead in Western Europe health inequity is viewed in terms of socio-economic determinants of differences in health status.

In contrast in low income countries, evidence suggests that the cause of inequalities may be a reflection of the failure of health care services to reach the poor[15] and, as Leon and Walt[16] point out, a matter of inequitable access to health services. This suggests the need, in developing countries, to focus health equity development programmes on improving fairness in the allocation of health care resources.

In most developing countries while the epidemiological transition is shifting the burden of disease from communicable to non communicable conditions, the process is still in an early stage in many developing countries particularly in South Asia, the Middle East, and Sub-Saharan Africa. In eastern and southern Africa, there is evidence that the HIV/AIDS epidemic may have delayed the onset of the epidemiological transition and in this issue Agaba discusses the cost to Uganda of providing HIV prevention and AIDS treatment services. According to WHO, reducing the communicable diseases burden is both more cost effective and globally more equalising than reducing non-communicable diseases. This contrasts with the very limited

evidence on the effectiveness of non health care interventions aimed at reducing the socio-economic causes of the inequalities in chronic diseases.

In Uganda, although communicable diseases are the main causes of disease burden, the incidence of non-communicable diseases such as heart diseases, diabetes and cancer is growing.[17] The country thus faces a double burden of diseases. The country's health indices are poor with high maternal mortality ratio of 435 deaths per 100,000 live births, infant and under 5 mortality rates are 75 and 137 per 1,000 live births respectively.[17] Studies by the MoH/WHO in 2005 showed higher crude and under 5 mortality rates amongst the displaced population in northern Uganda of 1.52 and 3.18 per 10,000 population per day respectively compared to the national average.[18] The Uganda National Health Service Survey of 2002/03 revealed that : 39% of Ugandans were classified as poor, and the northern region had the highest incidence of poverty 63% compared to other regions. [19] Similarly, the Uganda Human Development report of 1998 showed that while human poverty index (HPI) for Uganda was 39.3, the northern region had the poorest HPI indicator of 45.7 compared with eastern, western and central regions.[20] Thus the causes of health inequity in Uganda are associated with socio-economic, conflicts and displacement, and poor health services delivery.

Although inequities in health result from the social conditions that lead to illness, the high burden of illness particularly amongst socially disadvantaged populations creates a pressing need to make health systems responsive to population needs. International, national and locals systems of disease control and health services provision are both determinants of health inequities and powerful mechanisms for empowerment. Central within this system is the role of primary health care.[12]

The health care system is itself a social determinant of health, influenced by and influencing the effects of several other social determinants including gender, education, occupation, income, ethnicity and place of residence are closely linked to access, experience of and benefits from health care. Leaders in health care have an important stewardship role across all branches of society to ensure that policies and actions in other sectors improve health equity.[21]

In some instances, however, health systems perpetuate injustices and social stratification. In low income and middle income countries, public money for health care tends to go for services that wealthy people use more than poor people[22] as for example in Uganda, where health care financing is highly inequitable, as discussed in this issue by Zikusooka et al.[23] Reforms that tend to charge at the point of use are a disincentive to use of health care. Out-of-pocket expenses for health care deter poorer people from using services leading to untreated morbidity.[24] Such expenditure can lead to further impoverishment or bankruptcy. The larger the proportion of health care that is paid out of pocket, the larger the proportion of households that are faced with catastrophic health expenditures.[21] In this context, previous attempts in Uganda to introduce prepayment schemes in the Community Health Insurance have proved to be unsustainable and failed to deliver on the promise of equity, as discussed by Kyomugisha. The Uganda government is therefore currently investigating and proposing to introduce a broader prepayment scheme for health care, in the form of Social Health Insurance. Zikushooka and Kyomuhangi look at some of the issues surrounding the introduction of Social Insurance in Uganda and its impact on private health insurance schemes, and make recommendations to ensure that social health insurance brings health equity to the country.

The right to health and attainment of the highest standards of health care obliges government to create conditions to ensure equitable access to health services. This obligation on the state extends to refugees and internally displaced persons as discussed by Orach et al. The challenge to health inequity calls for deliberate and concerted efforts on the part of governments and development partners to put in place strategies for effective interventions.

Current efforts to revitalise primary health care worldwide should go hand in hand with attention to social determinants of health. Just as a social determinants approach to improving health equity must involve health care so must programmes to control priority public health conditions include attention to social determinants of health. Such actions must include multiple sectors in addition to the health care sector.

The capacity of the health system to provide effective services should be strengthened through the availability of adequate skilled manpower, essential equipment, drugs and supplies in health facilities, to meet the needs of the population they serve. Both central and local health systems and governments ought to ensure allocation of adequate financial resources and ensure availability of adequate number of human resources for health and procure adequate logistical and material supplies towards effective implementation of quality health care services. These aspects of health care delivery are discussed further in this special issue of African Health Sciences, by all the authors.

Coherent actions across government sectors including finance, education, housing, employment transport and health at all levels are essential in improving health equity.[21] Involving civic society and the voluntary private sectors is vital for health equity and can help to ensure fair decision making.[21] Health and health equity should become vital corporate issues for the whole government, placing responsibility for action at the highest level and ensuring its coherent consideration across all policies. Although action across government ministries is required, ministries of health have central roles in stewardship and information. This function requires strong leadership from government Ministries of Health and World Health Organization.

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