



Letter to the Editor

Re: Equity in health care: is it achievable?



Several notable works, dating back to at least 40 years, have been written on the issue of inequalities and inequities in health and health care. The 1980 Black Report highlighted inequalities in health between the rich and the poor.¹ This report was followed by The Health Divide in 1987 which echoed the Black Report in terms of socio-economic inequalities in health but also highlighted the role of lifestyle, poverty and the poor environment.¹ Wilkinson² wrote about the importance of narrowing the gap between the worse off and the better off in society to achieve a truly healthy society. Marmot championed the importance of addressing the social determinants of health.³ Universal health coverage whereby persons can equitably access quality health care without experiencing financial hardship is a laudable goal towards which World Health Organization member states have subscribed and are working towards.⁴

Nonetheless, certain sectors of society still appear to be faring worse. Have public health practitioners missed this target or are those in worse off health situations simply irresponsible, lacking the motivation to maintain healthy lifestyles?

The coronavirus disease 2019 (COVID-19) pandemic has not only challenged the capacity of health systems but has highlighted a failing in terms of healthcare delivery and is likely to perpetuate existing inequalities. The COVID-19 outbreaks originally reported from China in December 2019 suggested the virus disproportionately affected the elderly and caused severe disease in those with pre-existing medical conditions. More recent data from the United Kingdom and the United States of America highlight the ethnic disparity in persons affected, with black and minority ethnic groups apparently faring worse.^{5,6} This phenomenon could be attributed to the nature of jobs, overcrowded living conditions and pre-existing health conditions in this population subgroup. Certain ethnic groups are predisposed to chronic non-communicable diseases, with hypertension and diabetes mellitus prevalent among the black and Asian populations, respectively.^{7,8}

Many in this subgroup work in front line positions placing them in contact with large numbers of persons, thereby placing them at higher risk of contracting the virus. During the period of lockdown of essential services, in several countries, those most vulnerable to loss are daily-paid workers, who find themselves in a position without work and hence without the means to eat and properly live. Many are in rental accommodation and are unable to pay their rents. There are anecdotal reports that landlords have evicted such persons. Such a situation can only lead to mental anguish in addition to malnourishment, susceptibility to illness and further worsening of the health divide.

Some workers who manage to keep their employment during lockdown periods fit into an 'essential' category. They however need to put themselves at risk as they make their way to work often

using public transportation, which points to an element of injustice and unfairness. Some of these persons may have young children who require minding as schools have closed. Because older persons are required to self-isolate, grandparents cannot fulfil the child-minding role, and children are left in the care of relatives or friends and possibly at risk of intentional and unintentional injury, each with consequent effects. Such a situation hardly allows for an individual, who is trying to make ends meet to provide for his/her family, to focus on his health. This would be contrary to the findings of Maslow,⁹ whose hierarchy places physiological needs as primary. It is therefore somewhat unfair to label persons in this situation as irresponsible.

Governments should address the needs of the worse off in society so that when crises hit, they too can be resilient to withstand their effects. What is the actual solution? The over-representation of ethnic minorities with COVID-19 in hospitals is likely due to their prior poorer state of health, which is a by-product of both the healthcare system and individual factors. Sir Michael Marmot who championed the importance of addressing the social determinants of health revealed that in the past 10 years, inequalities in health has not been a priority and there has not been a national strategy in place.¹⁰

Notwithstanding, urgent work is needed to untangle why 40 years later, this divide persists and the reason for the apparent inertia on the part of governments. Measures are needed to address the key issues in a humane, sustainable way. Wilkinson and Marmot appear to have got it right—the key is in narrowing the gap, the need for social cohesiveness and social justice and addressing the social determinants of health. A socially cohesive society is a healthier society. There is a need to look at the 'cause of the causes', the causes of the structures that determine income, status and power in a society.¹¹

If health is truly viewed as a human right, a whole-of-society and government approach is required to realise this.¹² This was echoed at the 73rd World Health Assembly, whereby a draft resolution acknowledged the exacerbation of inequalities as a result of COVID-19 and calls on Member States to put in place a whole-of-society and government approach and to develop national action plans that will include attention to vulnerable groups.¹³

Everyone, regardless of status and without experiencing financial hardship, should be able to enjoy his/her highest attainable level of health.¹⁴

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