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**EQUITY AND THE SHAPE OF THE FUTURE
IN THE HEALTH FIELD
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First let me thank you for the honor you have conferred on me. The professorial rank is the highest to which any academic can aspire and conferment of these titles is guarded jealously by learned institutions. It is an even more single honor for me who is not at this time a practicing academic in the traditional sense of the word. Believe me that I will wear the honor with pride and hope by my future actions to enhance in some little way the reputation of this collection of scholars.

There may have been a time when it was accepted as normal to have differences in health status in the same way that it was a part of nature to have differences of various physical characteristics. But with the march of time, it has become clear that many of the differences in health status between persons, or between groups of persons, are in no way predetermined. There are differences that derive from the environment in which they live and differences in the extent to which there are means present to deal with the health issues that arise.

How does a moral concept such as equity enter into these considerations? It is those differences that we consider to be unfair and unjust that we call inequities.(1) What constitutes unfair differences in health? Is it unfair that one child in a family should have Down's syndrome and the others are normal? Is it unfair that one child should have sickle cell anemia while his siblings carry the trait and display none of the distressing symptoms of the disease? Is it fair that fewer urban women die giving birth than their sisters in rural areas? Is it possible to construct a gauge of fairness to be applied to the health conditions of individuals or populations? I construe differences as being unfair or unjust when they are avoidable and nonvolitional. They do not represent the free will of the person or group affected. In that sense, the two examples given above of differences in the children's individual health status do not represent inequity, but the differences between the urban and rural women probably do. It is perhaps necessary, to add the concept of responsibility in considering equity in the sense that there is some agent that can be held

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responsible for the difference. This last is of interest in the context of remedies to be applied to reduce inequities.

The problem of equity in all its dimensions is fast becoming one of the most widely debated issues in health literature, as it is being recognized that it is not good enough to improve the average state of health. Much of the discussion has been about measurement of equity, or rather of inequity, and there is debate about the differences between what is called vertical as opposed to horizontal equity.(2,3) I will not enter into a description of these measurement issues here, but instead I will invite you to listen to those who are the most affected by the conditions that cause the differences. It is poverty and the culture surrounding it that are the prime cause of the differences. We must listen to the voices of the poor, and when we have taken the time to listen to them and the marginalized, we will hear that health figures prominently among their concerns.(4) It is worth noting that it is not only the poor who value health above all else. In the millennium poll conducted for the United Nations that included several thousand respondents from all over the world, health appeared as the number one concern of all men and women.(5) Next in line was a happy family life, and much lower down came what could be interpreted as material wealth.

Health was more valued than wealth and the rationale of that distinction may be of interest in itself. John Stuart Mill is quoted as saying that “men do not desire to be rich, but to be richer than other men.”(6) This may be so because the external evidence of wealth is usually obvious. Much of the struggle between men that may be an expression of a fundamental and basic urge to be better and be seen to be better is played out in the display of the trappings of material wealth.(7)

But is not the same with health. There are no external manifestations in most cases to allow comparison with other men My observation is that persons individually or in groups wish for better health for its own sake and do not wish a priori to be healthier than other men. Women mourn for the loss of their children due to ill health because of the loss it causes them and usually make no comparison between the health conditions of their own and those who are better off financially. There is no doubt that the definition of inequity as opposed to inequality, implies a moral judgment about how society should function and distribute its resources, and some shrink from making moral judgments that are based on values that may not always be shared.

Much of the debate on inequality in circles other than those that deal with health has been on inequality of wealth. This concern has been muted somewhat as the attention has been focused on poverty rather than income inequality. As a recent essay in the Economist began “In polite policymaking circles, inequality is like the subject that dares not speak its name. In recent years, egalitarianism has lost much of whatever political appeal it ever had,”(8) It went on to point out that much of the focus, especially of the financial institutions, was on reduction of poverty and much less on reduction of inequality. This is of special relevance to Latin America where there has been some reduction of poverty in the decade of the nineties, but our region still shows evidence of increasing income inequality and has the dubious reputation of being the most inequitable

in the world. If in policy making circles there has been little interest in inequality in an area such as income, it is not surprising that there should also be muted interest in these circles on inequality in health, and perhaps even less in the inequality that we call inequity.

Then why should we be concerned about inequity in health? Perhaps the most important reason is that it is a matter of justice.(9) It was this call for there to be justice in the allocation of the prime determinants of health that, in my view was really behind the call for “Health for All” to which the nations of the world so readily subscribed. Second, we cannot divorce inequities in one domain of human development from the others. Equal consideration should be given to these essential capabilities or freedoms as Amartya Sen would say, of which health is one.(10) The bad life that afflicts the poor is multidimensional and encompasses deficiencies in material, bodily and social well being. Inequities in any of these are highly undesirable. Perhaps another reason is that as physicians we have the possibility to see clearly what can be achieved. We can see the level of deficiency because we have observed those who are in good health and know that it can be reached or restored. It is different with wealth or education where the upper bounds are not easily determined. It is usually those of us who are concerned about the differences in health that are unjust and unfair and represent distributive injustice who raise the flag of equity, and we do this also because we know that nations can never realize their full potential while there are gross inequities in health.

It has been known for a long time that health is socially constructed in the sense that it is determined by social factors. Gradients in health that relate to social status have been observed universally, and even within poor societies in which the level of health is low there may be gradients according to social hierarchy.(11) It is of fundamental importance to try to unravel the various mechanisms by which social conditions affect health. It is only after understanding this that we can make any attempt to put in place mechanisms to reduce health inequities The most compelling dissection of these that I have read comes from Diderichsen and Hallqvist. They posit four main mechanisms through which the social milieu affects health. They are social stratification, differential exposure, differential susceptibility, and differential consequences, and it is obvious that they are to some measure, interrelated.

In terms of social stratification, the nature of the social environment may itself confer health risks There are societies or parts of societies in which the cultural norms are themselves harmful, as is the case with the deprived neighborhoods in which there is a culture of violence. There are societies in which the level of male dominance puts females at risk not only for violence, but for other health problems. But the most egregious aspect of social stratification is the distribution of power, prestige, and privilege that ensures that persons with those attributes have access to the means necessary to protect their health. It is not only economic means, but resources such as information that are unevenly distributed in society, and may condition the assumption or rejection of health damaging behavior. The extent to which health differentials that derive from social stratification represent inequity depends very much on the social discriminator. Given the mutability and other characteristics of economic power, health

differences that are so determined must be deemed to be unfair and thus represent inequity. The question may very well be asked if there is indeed any determinant in the social context that when functioning as a discriminant, does not lead to inequity if inequitably distributed.

Differential exposure implies that different social groups are exposed to different risks. There is good evidence that lower social classes are exposed to a set of environmental risks that do not affect higher social classes. These risks are often mediated through the media of occupation and housing. For example, the lead poisoning in children that is associated with exposure to lead paints is found almost exclusively in the lower social classes who live in old substandard housing. It is not only a single exposure that contributes to the health condition, but there may be a cumulative effect derived from the fact that mobility through the classes is usually a very slow process.

Differential vulnerability implies that, because of social class, different groups may be more easily affected by some risk even though that risk is equally distributed across all social classes. Vulnerability may be biological as well as social. The biological may stem from the fact that the social environment is associated with factors such as poor nutrition for example, that make persons more susceptible to disease. The malnutrition may occur in utero, programming the unborn child to a higher risk of developing a range of chronic diseases. Social vulnerability may arise from deficiency in areas such as education or lack of the spiritual resources that Robert Fogel emphasizes as being necessary for optimum human development.⁽¹³⁾ This concept of vulnerability can be related to that of resilience. It is obvious that all groups do not react identically, and while being differentially vulnerable, differential resilience may condition the appearance of one or other pathology. Indeed resilience may mitigate the vulnerability of the group.

There are differential social and economic consequences of ill health and these are seen most clearly in the effect of a major illness on the poor. Because the poor have, by definition, fewer resources, a major illness may entail consuming not only reserves but those resources needed for eking out a living.

This framework has been put forward as being helpful in determining the possible policy options for reducing health inequity. The usual reflection is that correction of these mechanisms cannot come from individual action, and the levers for change exist outside the health sector to a large extent. I am becoming more convinced that there is no or little possibility that the social stratification can be addressed solely and uniquely by individual action. There has to be considerable input by the state. In those situations or countries in which there has been reduction of the health differentials, there has always been a strong state presence. This of course, does not absolve groups such as academics to involve themselves in presenting the data and evidence to inform state action. When I refer to the state I must also include the nongovernment state actors that are playing an increasingly powerful role in shaping society.

There is a large literature on the changed or changing role of the state in Latin America, showing how it has been reduced in size, but hopefully concentrating on those

functions that it alone can discharge. Education is a classic example of one of the factors contributing to social vulnerability, the distribution of which can be best done by state action. The state health system has a major role especially in reducing the differential social consequences of ill health. The ideal mechanism for accomplishing this is by some system of protection through insurance that allows for sharing of risks throughout a large population.

But one of the characteristics of all the systems in Latin America is the steady drift toward a more pluralistic and marketized mode of delivering the goods and services required in the health sector as compared with the predominantly dualistic system that that existed about 100 years ago. This rise of pluralism in the health field goes hand in hand with pluralism in other areas as the state has been shorn of several of the functions that it formerly performed. However, I would predict that we will see a return to more state control of the delivery of the goods and services needed in health: or at least the state assuming the responsibility to see that they are provided. This will be a consequence of a renewed concern of the state for security which, after all, is one of the prime reasons for there being a state, but this increased influence or control will be felt in areas beyond those related to the security based on “hard power,” and include security based also on what a Canadian Minister of Foreign Affairs called “soft power.”

If we wish to construct a future for health in which there is more equity, there are certain prerequisites. First, there must be a clear understanding of the difference I have tried to establish between inequality and inequity, and the acceptance that there is a moral basis to the description of health differentials as representing inequity. It is equally important to stress the need for good health data. I have emphasized repeatedly, perhaps to the point of tedium, that before one can determine inequity one has first to establish a difference. The Pan American Health Organization has dedicated a considerable amount of effort in strengthening our technical cooperation with our Member States for the improvement of their health information systems. We need to have better data on mortality and morbidity and on the extent to which our health systems perform the functions that are intrinsic to them. We need to have our data so disaggregated that we can determine where the health differences lie in terms of such variables as sex, geography, and social status before we can advocate for policies to reduce the differences. We are pleased with the advances so far, and our publication of the core data and the publication by the countries themselves of their own basic indicators represent real progress.

Another prerequisite for achieving more equity is that there be more powerful advocates for the proposition. This advocacy must come from within as well as without the health sector. We in health must be both advocates as well as proselytizing for the cause. The inequity of gender discrimination will only be addressed by society at large. But I do believe that we can achieve more equity in health and that is one of the fundamental principles or values that has guided our Organization. And finally there will have to be focused state intervention to ensure that more of the determinants are distributed equitably and thus contribute to more equitable health outcomes.

I thank you again for the honor you have bestowed on me and hope I have convinced some of you of the importance of some of the issues involved and what we have to do to contemplate and perhaps achieve a future in which there is more equity in health.

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