

EQUITY AND HEALTH

Mr. Minister, distinguished guests, let me thank you for the opportunity to participate in the inauguration of the Virtual Library here in Asuncion and at the same time address the issue of equity and health. This gives me the chance of dealing with three of the subjects that lie at the heart of the actions and activities of the Pan American Health Organization—health, information and equity. Health is our business—it defines what we do and the focus of all of our activities and interests. We were created to facilitate the work of the countries of the Americas in reducing the burden of disease.

From our very inception there was an emphasis on the collection of information by the member countries and sharing such information as to prevent the spread of disease. The Sanitary Code that sustains our Organization and was signed in Havana in 1924 states as one of its objectives:

The stimulation of the mutual interchange of information which may be of value in improving the public health, and combating the diseases of man.

Our founding fathers probably thought only of "sanitary information" or the information that has to deal with the sanitary conditions of the countries of the Americas. Our concept of information, its use and its value for health has changed significantly as I will show, and I will also make reference to the concept of information sharing that underlies the creation of the Virtual Library. I will also touch upon the relation of such information and its use to the determination of equity in health.

My area of responsibility is the Americas and from my first days as Director I addressed the usage of information and my concern for equity in health. I said that our Organization would traffic in information, meaning that information would be one resource in which we would involve ourselves heavily, ensuring that it was disseminated widely and used as an instrument to facilitate the making of diagnosis and the taking of decisions.

I also affirmed two principles that would guide our work—the search for equity and Pan-Americanism. I accept that there will be differences in human attributes and characteristics. There will be differences in the status of health that are determined by forces that are beyond human control. But when we see differences in health status or health outcomes that we deem to be unfair or socially unjust, then we deem them inequities. Equity implies fairness and almost by definition implies a state of affairs that is within the competence of humankind to achieve or deny. There are many human conditions that are distributed in an inequitable way, but I will concern myself only with health.

Throughout time, human beings have shown that health has a special value and the English derivation with which I am more familiar refers to the concept of being whole. This state of being complete or whole is unfortunately valued mainly when it is absent. The appreciation of the balance of our system that is implied by health is often not very high at the individual level and less so at the collective level, at least in modern times. It was not always so and the ancient Greeks and Romans revered the integrity or wholeness of the human person to the extent that they involved themselves in elaborate rituals to preserve that health. It is only very recently that in Western medicine we are recapturing that vision of wholeness that health implies. We are becoming increasingly concerned that all human beings should have the opportunity to enjoy the state of being whole or healthy and that the mind and body should not be considered separately.

We have difficulties in measuring the state of health, but perhaps that is the same difficulty we have in measuring other important human attributes. There is difficulty in establishing a scale for happiness or freedom. But in the absence of such indicators of the state of health, we use measures of illness or fatal events. The assumption is that if there is illness, then there cannot be the wholeness that is implied by health.

I shall use these indicators of illness or fatal conditions to describe some of the health conditions of the Americas and illustrate the difference in such conditions that cannot be justified in any good society and therefore I refer to them as inequities.

I always begin any description of the health in the Americas by affirming that there has been and continues to be significant improvement in all the standard indicators of population health. Life expectancy at birth is increasing and infant mortality rates are falling throughout the Americas. Death rates are declining and fertility rates also show a steady decline. As life expectancy increases, the percentage of elderly in the population rises. These phenomena are seen in all countries and Paraguay is no exception. Your infant mortality rate is falling and your life expectancy although lower than the average for the Americas is also increasing. The Region of the Americas can show marked improvements in many areas of disease control. We continue to be proud of having eliminated small pox and poliomyelitis and measles will soon be gone. Chagas disease is slowly but surely retreating and our colleagues in Veterinary Public Health note the success in the fight against foot-and-mouth disease, with improvement in the economic possibilities of those countries that have large herds of livestock.

There is certainly room for some satisfaction and credit must be given to the large numbers of health workers who struggle, often without recognition to put in place and maintain those programs that result in the health improvements I have mentioned. But we must avoid the satisfaction that leads to complacency. We are not totally satisfied, because in spite of the progress, there is still a lot to be done. We have not overcome tuberculosis as there are approximately one quarter million new cases every year. Thirty nine million persons live in malarious areas, children still die needlessly of respiratory infections and diarrheal diseases. Our blood supply is not universally safe and in many countries there is risk of transmission of HIV or hepatitis through transfusion. There are about 24 million persons in the Americas who suffer from depression that could be treated effectively with modern therapy and almost 400 persons die every day from tobacco related diseases.

Thus one source of dissatisfaction is with our slowness in applying the technologies that we know will reduce the burden of illness. But another source of dissatisfaction is with the inequities that occur—disparities that are socially unjust and should be unacceptable.

We can think of differences in individual health that should not occur and represent inequity. This focus on individual health as a right is very firmly enshrined in the constitutions

of many of our countries and several of the grand declarations on human rights include the right to health. I prefer however to cite those that do not speak of the right to health per se, but rather to the right to those measures, the presence of which gives the individual the opportunity to enjoy health. The human rights approach would see health as an essential good and therefore, there should be no place for the conditions that deny individuals that good.

However, I will refer more to the health of populations or groups and rather emphasize the distributional aspect of health or its determinants. There are differences in health outcomes that we take to be unfair or unjust, and we can see this by looking at specific groups and comparing one with another depending on the indicator used, or one can establish the degree of unfairness by examining the distribution of some health outcome as well as examining the distribution of one or other determinant of health.

It is critical to establish in discussions about equity in health that such inequalities or differences that are inequitable must be avoidable. Unavoidable differences cannot be inequitable. In addition to being avoidable, they must be beyond the control of the individual or group that is under consideration. The persons by their own volition cannot avoid those situations or conditions that lead to inequitable distribution of health outcomes. The fact that the individuals or groups cannot avoid the conditions implies that there must be action or inaction by society or groups in society that makes the affected populations subject to the inequitable conditions. This naturally leads us to the various measures that society, more often represented by the state can and should take to ensure equitable distribution of the determinants of health outcomes and reduce the avoidable differences or inequalities. We will not enter any further here into whether the state in its role of avoiding avoidable differences should act on the utilitarian principle of seeking the greatest good for the greatest number or seeking the greatest good for those with greatest need as required by the egalitarian approach. This is akin to the age old debate between the maximization of happiness or the minimization of unhappiness.

Let me return to our concern for the unequal or inequitable distribution of the determinants of health that lead to differences in health outcomes that are unfair and unjust. The major determinants of health fall into the following categories: biological, environmental, social

which includes such aspects as income, place of residence or work, gender, age, housing and education. In addition health services as well as individual behavior determine health outcomes.

Differences in health due to biology in general do not fall into the category of being avoidable although with our nascent ability to change the course of biological events we may soon see biologically induced health outcomes subject to external manipulation. In any case, these differences are likely to be more individual and less population based. I will purposely not deal with the physical environmental changes or individual behavior and for the purposes of this presentation concentrate on some specific social determinants and health services.

The distribution of income is a major determinant of health outcomes. Whereas traditional approaches to the relation of wealth to health dealt with absolute differences between groups divided according to income, there is much interest now in the distribution of income in a society and its effect on various outcomes. It has been known for centuries that the poor are less healthy and die younger and there are numerous eloquent statements on the role of poverty in disease. The one I quote often is taken from the World Health Report of 1995 that says:

The world's most ruthless killer and the greatest cause of suffering on earth is listed in the latest edition of WHO's International Classification of Diseases, and A to Z of all ailments known to medical science, under the code Z5Q.5. It stands for extreme poverty.

And it goes on:

Poverty weilds its destructive influence at every stage of human life from the moment of conception to the grave. It conspires with the most deadly and painful diseases to bring a wretched existence to all who suffer from it.

But there are now convincing data from many places in the world that there is a clear relation between income distribution and health. In those countries in which the income distribution favors the rich few there is higher infant mortality rates, and lower life expectancy. As a consequence of the maldistribution of income there may be the kind of social incongruence or

intergroup dissatisfaction that manifests itself in physical terms. This is of particular relevance to the countries of Latin America and the Caribbean, which have the unfortunate reputation of having the worst distribution of income in the world.

If we use the argument that the differences in health outcomes related to mal distribution of income are inequitable then by definition they must be avoidable and society should have some mechanism of correction. In theory this is true. Maldistribution of income is not preordained and immutable, but is the creature of a certain form of societal organization. In practice, the current dominant form of social organization stimulates or favors maldistribution of income. The inexorable drive towards more economic globalization fuelled by the information revolution leads to a widening of the gap between the rich and the poor. In spite of the demonstration that inequality of income need not be the consequence of the economic growth, I see no persistent tendency in the Americas towards adopting any fiscal policies that tend towards better income distribution. The dominant ethos is to give rein to those processes the outcome of which is maldistribution of income with the consequences for such things as ill health and then provide social safety nets for those who are the most marginalized.

The term gender refers to the social constructs that determine the relationship between the sexes and as a concept has entered recently more and more into any discussion on how any aspect of human functioning is organized. There are obviously health outcomes and needs that derive from the biological differences between men and women. However, it is becoming clearer that they are differences that relate to the social construct that gender implies. Gender based health inequity would therefore imply those differences between men and women that are unjust and avoidable and spring not from their biology but from the way society views and treats them.

It is evident that the burden of illness borne by women is higher because of their reproductive functions, but it is becoming clearer that women experience greater morbidity than men. There is a higher prevalence of acute and chronic conditions among women. The inequity is not found so much in these kinds of diseases; it is found in more subtle and pernicious way as for example in the ill health that results from domestic violence. The violence against women is

a manifestation of the power relationships in society that are based on gender. The other clear manifestation of gender based health inequity relates to the treatment of women in the health services. For similar morbid events women receive less optimal treatment than men. I have always held that the health services in our region were not "female-friendly."

Is gender based health inequity reducible or avoidable? The answer must be yes and it will depend in large measure on the slow and painful process of having society learn to appreciate and value the differences between the roles that the two sexes play. Part of the solution will also lie in bringing to light these differences that were thought to be biological and therefore unavoidable, but are really gender based and avoidable.

I will mention only one other aspect in this category and that is age. As our life expectancy increases, the percentage of the elderly in our society will increase and we will become more conscious of age related or rather intergenerational inequities. There is the tendency for the young and healthy to view the elderly and their health problems as a burden, as there is no doubt that the morbidity is higher among this segment of the population, leading to a disproportionately greater use of the health services. This occurs at the time they are economically less active and considered to be less productive in the conventional sense. In addition the morbidity and adverse health outcomes may relate to the maldistribution of such social goods as housing. However, to deny this section of the population access to the services that their morbidity warrants is regarded as avoidable and inequitable.

By far the largest body of literature on health equity relates to the provision of health services and the financing of health care, although there is question as to the role of the conventional health services in ensuring or protecting population health. Most of the efforts at reform of the health services seen in our countries have equity as a prime goal.

In my view the two most important aspects are equity in terms of access to care and equity in terms of the allocation of care resources. Equity in terms of access implies that there is no avoidable barrier to any persons obtaining services. There is considerable discussion as to whether the accessibility is essentially a characteristic of the services themselves or of the

population for whom the services are provided. The difficulty I always encounter in making the separation is that simply providing access is not enough, because the transactional costs of accessing these services vary tremendously both because of the services themselves and the ability of the individuals to pay that cost. I have always been more philosophically inclined towards the allocation of health care according to need. The grave problem is that need is poorly defined and in the richer societies demands that cause inordinate financial strain on the services are readily translated into needs which are often very difficult to resist because of the political implications.

A major concern in Latin America is the provision of care for the large numbers of the unemployed in the informal sector. This group that is predominantly poor and female have no access to coverage by the social security systems, and often the public services offer them very little. This lack of coverage is avoidable and socially undesirable and currently there are several approaches being tried, including the testing of micro-insurance schemes rooted in the communities themselves. The ultimate objective is to have such schemes link together to share risk and diminish costs. However, I have doubt that these can be viable without some state input that guarantees at least their initial stability.

One of the basic problems is that in many countries the expenditure on health is low and public expenditure is itself low compared to what is spent in the private sector. The latest data we have for Paraguay, for example, shows that health accounts for 5.1% of GDP, but because GDP is so low, this amounts to about \$86 per person, and two thirds of this is in the private sector. The social insurance accounts for 40% of the public expenditure, but only covers about 20% of the population. This scenario is not uncommon and shows the difficulty the state has in providing all persons with access to services.

The search for equity in health must be guided in large measure by reliable data that are transformed into information. There must be information about the nature and distribution of the health problems, such that countries, especially those with scarce resources, can apply them most effectively. But it is not only information about the health outcomes and their distribution that must concern us. This time there is a major effort to access the information available in the

world as a whole and use it for the solution of our particular local health problems. This is what the virtual library offers—a future in which there is an unlimited access to the storehouses of scientific knowledge in our Region and the world. It also supposes that the information provided everywhere is available everywhere, and there is maximum interconnectedness. Information confers power and one of the fears of many as the digital age rolled down upon us was that there would be a divide with an unequal possibility of access to critical information. The Virtual Library makes it possible for us to assuage those fears.

Mr. Chairman, I as Director and the Pan American Health Organization are committed to be loud advocates for there to be more equity in health in our Region. We do this not only because the moral aspect of it is one that is proper for us, but also because we believe that it is good for the societies in which we live. Differences between and among persons that are avoidable are a cause for the kind of jealousies that lead to social instability. It is not the differences in health outcomes that will be obvious, but many of the determinants lend themselves to comparisons that are unhealthy for our societies. All countries, rich and poor can put in place the systems to determine where and why the avoidable inequalities lie and all countries can dedicate much of their available resources to reducing those inequalities, which we think represent inequity.