Health Economics

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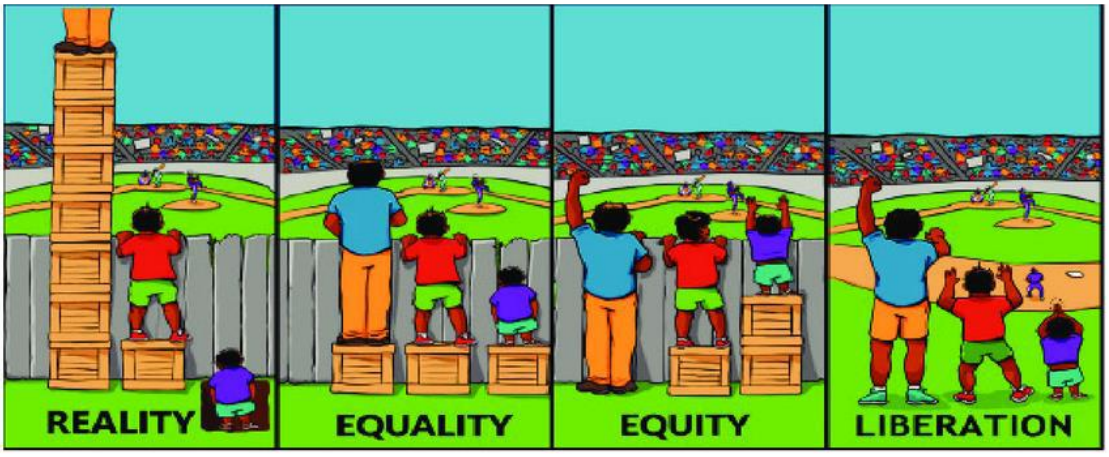
Week – 04

Lecture 16- Equity in Healthcare

Welcome, once again, our listeners, to this particular MOOC module on health economics. I am quite sure that you are getting certain directions to understand the entire module after reading the important three chapters, especially the background understanding, then demand for healthcare and supply of healthcare, and of course, other directions to this module would be on equity in healthcare. And it has linkages with other chapters, such as health systems, then it has linkages with health efficiency, it has linkage with evaluation, which we are discussing in different units as well. We will also present a tree map for it, as well as how all are linked. So, at this moment, I will be happy to address equity in healthcare.

We will discuss equity and its definitions. In the previous lecture, I told you that it was on the supply side perspective of healthcare and how the supply side is explained. Here, we are mentioning the types of equity as well. We have taken this picture from this site.



Source:https://www.internationalwomensday.com/Missions/18707/Equality-versus-Equity-What-s-the-difference-as-we-EmbraceEquity-for-IWD-2023-and-beyond

We also cited it here. It is not of our design, but one clarification is very clearly understood through the graph that: equality means the exact equal share. However, the marginalized one, even if an equal amount is provided, are not getting the benefit. That category has to

be further re-emphasized. Hence, unequal treatment is required, and hence, that will be called equity; disproportionate share is defining some level of outcome equality.

Again, outcome equality might not be possible if we have some horizontal equity versus vertical equity issues. We will clarify that. But in reality, what happens? There are two aspects, but the extreme best possible is the one where you just leave everything is free. The person at the end is called the liberation phase, where all are just watching the match or in the stadium without any fee as if the public policy is too active enough to guarantee the best outcome and freedom, etc. No questions of barriers are attached which is considered to be the new liberal policies.

However, it is very difficult to guarantee given the fact that there are lots of challenges and conflicts within the society. Hence, there should be some public policy capture. But in reality, through the public policy capture somewhere, the elite capture possibilities are emphasized. These elites are actually somehow occupying the space, and in reality, the elites are still climbing and getting the best benefit of the public goods. So, given this context, all the concepts are meant.

We will introduce you to the equity concept through different articles. We are actually not just clarifying the concept on our own; we are citing the articles. The first terminology is equity, which refers to the principles of fairness and justice in the distribution of healthcare resources and opportunities. It ensures that all individuals, regardless of their social and economic status, ethnicity, gender, and other factors, have equal access to healthcare services. Hence, they receive the same quality of care that we have just discussed in the diagram.

So, equity measurement is focusing on how fairly healthcare resources are delivered. So, fairer distribution is one of the mottos of the equity principle. In countries, government funding of healthcare or government-regulated funding in allocating resources is considered to be one of the fairest approaches to guaranteeing equity. However, allocating resources considering the differences in needs in different parts of the population is most which is usually made in government or public policy agenda. The most common approach based on population need factors such as age, gender, and morbidity are important.

The allocations are made based on the proportionate to the measures of their need, and this approach has been done in terms of the weight of the funding towards those with worse health conditions. Hence, after that, some problems were raised that we are going to clarify. It is not clear that the appropriate level of funding should be proportionate to a particular measure of need. Or that is rather creating further divides in the society, we will clarify. This demonstrates how challenging it can be to implement the objective to generate vertical equity and horizontal equity. Hence, we will clarify what is called vertical equity and horizontal equity.

The vertical is the one where we will give unequal treatment to the unequals. So, in our society, we know that it is fractured in different forms by their religion, ethnicity, and culture, and hence, since they are unequal, they should be unequally treated. Especially so far as the standard of living is concerned, there are unequals, and hence unequal treatments should have been given. That is precisely called vertical equity. Coming to horizontal equity, it is called just equal treatment to the equals.

Those who are equal have to give on the basis of religion; same religion should be given the same status. Even within the same religion, there are also divide but it is not captured in the horizontal equity principle. So, hence it is not clear that the appropriate level of funding should be proportionate to a particular level of need or not. What should be the right one in principle? This is easier, but putting it into practice is not so easy. So, in our next lecture, we will emphasize the practical aspects as well.

So, in the perinatal mortality rates, in an example, this refers to the period of pregnancy and post-pregnancy-related mortality. As per the World Health Organization's definition, Perinatal mortality is the death of a baby between 28 weeks of gestation towards or before the first seven days of life. In that case, we are just clarifying between the rural context and the urban context. In the rural, you will see it is quite the rates used to be very worse whereas little better, less rates of these perinatal deaths are lesser than rural in urban areas. The cost of lowering the rate is higher in rural areas because of the other reasons, like service users are usually most costly to reach, whereas in urban areas, this is less costly.

The focus here through this example will emphasize in terms of reducing the difference between these two. So, out of a budget, we might do less to lower the number of deaths in rural area, and in urban area, we might do more to lower the number of deaths. So, basically, the target might be since in urban area it is 100 whereas in rural area it is 80 given the expenditure. But this has a dilemma in terms of policymakers or for the policymakers. This prevents more deaths by spending on the urban areas, though, but at the same time, the disparity again becomes wider.

So, urban area used to be attractive with higher spending, and so that though in terms of that deaths, these kind of deaths are prevented, but gaps again between these two increased. Everyone likes to see both fewer deaths and less inequality, but there are many questions making this very difficult choice between a more efficient intervention that is for death and a more equitable one. Is the additional fairness worth 20 deaths, and how the expenditure to be allocated is the major concern?

Another example is taken from England's case based on their experience in urban area. This is owing to differences in referral rates. The poorest part of the district in England used to have the highest rates of treatable coronary heart disease and getting less treatment because of their locational disadvantages than the most prosperous parts of England. This

leads to the least capacity of the benefit, and we are getting more. Prosperous parts have the least capacity to get the benefit, but they are getting more. Those likely to benefit got very less. Hence, there are possible differences again.

In this case, the allocation of resources is indeed inefficient. More improvement could be achieved with the existing budget by different allocations, and greater efficiency would also lead to greater equity. Hence, efficient allocation results in better equity. Being ill or at risk is a necessary condition for being able to benefit from the treatment, often those who can benefit most with low income or above average morbidity, etc. In some cases, it is more expensive to treat poorer people because they may also need longer time in hospital and the higher cost of running prevention programs for poorer people.

Those choosing to attend the screening program tend to be those who are richer and have less disease, and so on. There are different examples we have cited and different contexts. I am not emphasizing much. The above two examples shed light on several aspects of equity, which are said to be based on their stratification of their standard of living. There is no simple definition of equity.

Hence, it is also important to consider equity in the health sector since it is complex, and only then can we be able to clarify their overall equity. So, again, another factor in addition to this problem is poverty, which again affects ill health and constrains access to health care. So, action to improve equity in access to health services can help, but it tackles symptoms more than the causes. The problem of health equity is largely a problem of more than general economic and social inequalities, and the solutions lie outside the health sector because it is not just only the health sector that matters. Other aspects, in addition to the health sector, were connected and should also be dealt with. Such as poverty associated with poor health and countries with great social inequalities, as I already mentioned, are also attached more conditional factors.

The rapid changes in Central and Eastern Europe from the 1990s onwards were associated with rapid increase in income, inequity, and worsening of health. So, countries with state funding or social insurance funding would aim to provide nearly equal access to important services. I think if you remember, some of the countries have mandatory public health provisioning in health care, they have nearly equal access. Whereas when both parties are functioning private and public, the equity concern is more. Normally, the state should offer care on the basis of need and not income or ability to pay.

So, reality, which I already said, is often different because of some captures in the country. The users used to have some bargaining power with the providers based on their power, and the provider used to be sometimes rude to the people who are at the bottom sections of society, and sometimes they are not getting the access they deserve. So, the design may be equal access, but the reality is that those with more money power get better access. Hence,

as I told you, elite political capture has more reasons to explain the inequalities or inequity in the Indian context. Even equity principles are taken off in different programs, but eventually ended up with inequities.

In India, access depends not just on one classification of differences but on holistic differences such as income, employment, age, disease, caste, class, etc. And other things I think I have already mentioned, I am not specifying much on this. So, a common principle is due to others as you would have them due to you. So, you contribute, and in return, you will get a better one. Greater equity will be achieved only at the expense of worsening the overall level of health.

Equity, like most desirable ends, has a cost as well. Different philosophical perspectives on equity, some of which we also discussed in other weeks on Rawls's theory of social justice and in particular in week number 8. And Sen's theory on equality in capabilities, you can refer to that here as well. Another one is also called utilitarianism, and others suggested by Smith and Norman 2011. We will discuss some of these details in week number 8, as I mentioned.

This Rawls theory is considered to be an elegant formulation that does not require people to care about each other. It even works better when people are highly selfish. So, some of the things we will clarify further without delving into the philosophical debate. The following three steps would clarify the concept of equity. First, there should be some distinction between equality and equity. We started explaining through that chart from the very first page.

Something is unequal, but it does not mean that it is considered inequitable or unfair. For example, people born with diseases or disability will tend to use more health services than people without illness, giving rise to unequal utilization that is not necessarily inequitable. Amongst people who are born with diseases and disability, richer people use more health services than poorer people. Inequality as inequitable because inequality is mentioned as inequitable. Not just looking to see how unequal something is across population groups, such as across rich or poor people or across different geographical regions, but rather interested in determining the fairness of any observed inequality, those should be emphasized.

So, first, what we mentioned is clarifying equality versus equity. The second one is in terms of sense terminology, what is the thing that health policymakers seek to distribute equitably. What is that is more important? Is it access to healthcare, or is it the actual use of healthcare, or is it actual health outcomes? So, the actual use of just the provision is not enough. The actual use and the specific outcome are to be also guaranteed so far as equity is concerned. So, these are common equity goals in health policy.

It is not just not unusual to find more than one of these equity goals espoused by national healthcare policies as mentioned. Providing equal access to healthcare will not give rise to equal utilization of healthcare or equal distribution of health, that is, unless everyone has the same initial health status and the same capacity to benefit. So, the starting point of healthcare and this position is important if you are actually treating them as equal through the equal distribution. But largely, Indian society, in my understanding, it is actually since undistributed then the base is different; hence, unequal distribution is important. Similarly, other things like equal utilization of healthcare will not necessarily yield an equal distribution of health.

So you can just follow some of the works we have cited. A large number of literature in health economics that is concerned with measuring access to healthcare, the lack of clarity in how access is defined and how it should best be measured should be altered. The third one, besides the first two, which I have just discussed, the second one is the sense of emphasis on the thing that we are emphasizing. The third one is related to vertical versus horizontal equity. Unequal to the unequals, as we already mentioned in the case of vertical, and in the horizontal, there is just the reverse equality to the equals.

So, equality in the treatment of people, that is, people in different regions and different socio-economic groups, males, and females with equal needs, should be treated equally. For example, if healthcare resources are distributed across a country, all people will have the same level of access to healthcare. Whereas in the case of vertical unequal treatment to the unequal where people have unequal needs for healthcare, the treatment will be appropriately unequal. So, no need to give further examples.

I think it is mentioned you can follow it. Whether the focus should be on the first one, that is, horizontal or vertical, the analyst requires some means of measuring and controlling for the healthcare need, and that is to be discussed based on the appropriate data. The need could be defined in terms of the scale of suffering and health problems or in terms of the capacity of the benefit. So, anyway, we have given you the basic backdrop of the difference between equality and equity. So, in the next class, we will be happy to address you further details on it, measuring aspects of tools or suggestions for equity and equality. So, we will be emphasizing some theories of equity and redistribution, then the traditional model and their problems and their theory of distribution or other theories of distribution and their problems will be emphasized.

With this it is time to close. I think we will be happy to get better things in the next class. Thank you.