Inequalities in Health

Future Threats to Equity

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In discussions about equity there is a tendency to focus on the inequalities in health status that appear to be the result of the material and immaterial consequences of a lower income, professional or social status in society. If we look at publications such as the Black Report in the UK or Ongelijke gezondheid in The Netherlands, we have to accept that despite our universal access to healthcare and the existence in many Western countries of social security measures that preclude 'real' poverty, considerable differences in health continue to exist between socioeconomic groups. This is corroborated for many other European countries in the research carried out by a concerted action led by Mackenbach. These inequalities in health have been referred to in many countries as inequities, meaning that society finds them unjust and expects them to be 'avoidable' or amenable to policy interventions. However, the research on the causal networks underlying the occurrence and the avoidability of inequalities in health remains sparse and intervention studies seem to focus on policy measures that can be evaluated, but which will most likely have a limited impact on the inequalities measured at the population level. Thus the research community leaves policymakers with very little evidence on which to build policy initiatives that are nevertheless requested by many governments. The third element, which needs to be addressed in this context, is the ominous inequality in access to healthcare. Since the debate on equity in health has rightly been initiated in the context of a broader, more intersectoral approach to health policy, very little attention has been paid, so far, to the issue of universal access to quality healthcare services. This is because in the second half of this century most Western (European) countries have created a healthcare system with universal access, financed either through taxation or through social insurance schemes. It is these financing systems that will be threatened in the years to come by the considerable demographic shift occasioned by the ageing of the post-war baby boom and the incentives for risk selection that have been introduced in many systems as part of the 'market' mechanisms. The benefits of these incentives have clearly been a greater efficiency at the patient or service level, but there is still the question of whether it will be a more efficient system also at a population level if equity considerations continue to require a system of universal access to all the healthcare technology that will become available in the coming years. The other side of the coin of risk solidarity is the delimitation of the collective responsibility, thus of a basic benefit package. It is important to realize that equity has been a fundamental underlying value that has led to the creation of the healthcare systems as we know them but which may have become so accepted that it is no longer carefully considered when looking at issues of rationing or health reforms.

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Inequalities in health have been widely documented. In fact they have been the prime subject of interest, the object of study, for epidemiologists, as differences in the occurrence of disease between populations give important insight into risk factors for specific diseases and hence in many cases for public health interventions. Unfortunately not all the underlying causes of inequality in health are preventable or amenable to interventions. Some of the health differences have to be attributed to characteristics of individuals or populations that cannot readily be changed, such as gender, race or age. For some, socioeconomic inequalities have long been part of that category, others have called for attention to specific policy for such social inequalities in health. Differences in health between social groups, defined by class, educational level, income or professional status have been recorded in every country that has carried out research (1–3) and have not visibly diminished despite social policies such as universal access to healthcare, greater access to educational opportunities, occupational health efforts or reductions in income inequality. Nevertheless, the interest in policies to reduce inequalities in health has grown tremendously in recent years (4–6).

Social inequalities have always had a special position in this field, for two reasons. First of all, the characteristics that define social inequalities between (sub) populations are at the very core of our social policies concerning distribution of wealth and power; take, for example, income distribution, education, profession or social class. The political ideologies on which these policies are based

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often have good arguments to support the view that an unequal distribution of these characteristics is either necessary or inevitable for society as a whole. However, none of these theories give any reason for why it is that inequalities in health should be aimed for. They do not contribute in any way to society and may in fact be detrimental if they hamper the individual's ability to contribute to society. Social inequalities in health are seen as an unfortunate side effect of choices in social policies in general that should be avoided, if at all possible. This makes it much easier to have a broad consensus on the fact that social inequalities in health in many instances can be viewed if not as inequities, that is to say unjust inequalities, but at least as undesirable inequalities. This explains to a certain extent the widespread support for policies to reduce inequalities in health (7, 8).

The second reason why social inequalities in health stand out has to do with the historical development in most Western countries of the idea of universal access to healthcare. With the arrival of effective medical technologies, most of our countries have devised a system of healthcare financing (be it through taxation or social insurance schemes) that guarantees equal access to services, regardless of ability to pay. Many Western countries made the necessary reforms for such a universal healthcare system just after World War II. The social optimism of that post-war period was instrumental in gaining the political support for such an ambitious policy measure and we are all justly proud of that period in our health policy history. However, in our perhaps somewhat naive optimism, we assumed that universal/equal access to health services would also mean equality in health outcome and perhaps even health status. It is in this light that 'a right to healthcare' seems to have been transformed by some into 'a right to health'. By providing universal access to healthcare, many countries assumed they had created the conditions for equal health. The persistence of social inequalities in health in the second half of this century in all countries where this has been studied has greatly shocked many of the health policymakers.

The more recent attention on social inequalities in health as a target for health policy has much to do with the WHO Health for All campaign (9), which had made a reduction in inequalities in healthcare its target number 1. Much of the attention of policymakers, at both a national and an international level, has rightly been focused on the determinants of health that lie outside the direct responsibility of the healthcare system. Unequal distribution of important determinants of health such as safe housing, good working conditions, safe environment, healthy food, access to sport facilities and an unequal distribution of lifestyles that are detrimental to health such as smoking has drawn attention to preventive and intersectoral policies—and rightly so. Social inequalities in health are much more likely to be caused by those wider determinants than by equal access or equal effectiveness of healthcare. In the future, intersectoral policies on these determinants of health will continue to be powerful policy instruments.

However, with the renewed focus of policymakers on the wider determinants of health, issues concerning healthcare policy as a potential contributor to the population's health are sometimes neglected. In policymaking circles considerable attention has been given to health reforms and the introduction of elements of the economic thinking of that period, be they health planning, control of the supply side or (internal) markets. Little attention has been given in recent years to the contribution to equity of universal access to effective healthcare and the potential threat to inequalities in health of endangering that universal access. In this paper I draw attention to this other aspect of inequalities in health, that is the guarantee for universal access to healthcare services, in the changing circumstances of the next millennium.

FUTURE THREATS TO UNIVERSAL ACCESS

In the coming years most of the Western countries will experience a rapid ageing of their populations with the concurrent result of a rapid rise in the need for and the costs of healthcare. This is because the post-war baby boom has now reached the age group in which increased disease and disabilities occur. As our experience with the technology increases, many of our new technologies tend to increase the age limits of the target population, further reinforcing the upward push of ageing on healthcare costs.

None of this would be such a problem if the post-war baby boom had not been followed by the post-pill sexual revolution. The introduction of oral contraceptives and the very rapid spread of their use has resulted in a rapid reduction in the size of birth cohorts from 1970 onwards. These small birth cohorts will have to bear the costs of the healthcare needs of the large, older, baby boom cohorts. This demographic imbalance greatly endangers the solidarity between generations, especially within a social insurance system. It becomes a very attractive proposition when one is young and at low risk of illness simply to opt out of the general system, where such a high price has to be paid for the needs of high-risk, elderly patients. In opting out of the system, however, the financial viability of universal access will be threatened. Since lower socioeconomic groups have a higher health risk, and are less able to pay for health insurance in a commercial market, the threat to universal access under a social insurance system is directly related to one avoidable determinant of further growth of future inequalities in health.

More than ever before, governments have to consider carefully on what they are willing to impose financial solidarity, and that it is more than the mere argument of cost containment; the reason for priority-setting. It is not necessarily an exercise in reducing the current package of benefits, but in critically appraising it from the viewpoint of collective responsibility. In this appraisal both the issue of asking only for a contribution for services that will effectively contribute towards the goals of healthcare and the issue of the priority of certain services over others need to be addressed. Only by rationally delimiting the package for which we are willing as a society to guarantee universal access and thus the financial contributions can we maintain access to essential healthcare for all.

HOW TO SET PRIORITIES

In a recent report of the Scientific Council for Government Policy, 'Public healthcare' this issue was raised (10). The Scientific Council for Government Policy is an independent advisory body of the Dutch government that can publish reports with policy recommendation on long-term and broad policy issues, without the consent of the cabinet, but with a legal requirement of cabinet to react to the report. In the past 25 years it has often been able to start policy debates on issues that were not yet considered politically 'ripe'. In this particular report, published a year ago, a system for priority-setting is proposed, not primarily reduce the current benefit package or to cut the healthcare budget, but to ensure that under the expected financial pressure in the future, citizens are treated fairly and equal need receives equal care.

The underlying premise is that society should opt to have a clear delimitation of collective responsibility, which is determined primarily by the consequences of leaving certain services to the individual's responsibility, namely that in the case of need, society must then be willing to accept that access to care can and will be denied to those who are unwilling or unable to pay for it. The second conclusion of the report was that in order to maintain universal access to good quality care for the services considered to be a collective responsibility, it is best to have one general funding system (a compulsory social insurance system or a tax-based system). Only then can incentives for efficiency and for risk solidarity be combined effectively. That aspect of this report will not be elaborated on in this paper, in which we concentrate on the delimiting of collective responsibility, the priority-setting exercise.

Setting the objectives

The Scientific Council proposes a system of priority-setting that involves three critical steps, in which especially the last has implications for equity. In the first step the dual objective of health policy is described. Usually, and more so in the light of the renewed attention for health in the WHO campaign, the objective of health policy is defined as the maintenance, promotion or restoration of the population's health. This has resulted in cost-effectiveness analysis, in technology assessment (with health benefits including quality of life as the outcome of interventions), in considerable attention being given to policy interventions outside the healthcare system that can create the circumstances in which health is likely to be promoted, and in potential health gains as the ultimate achievement of policymakers. In this focus on health much of the traditional purpose of healthcare, that is caring for those who are ill and nursing the sick, seems to have disappeared. Despite the advances in healthcare, there are still large numbers of patients for whom no cure is available, patients who need palliative care, the terminally ill or chronic psychiatric patients. The services that provide this type of care can and should not be judged by their potential contribution to health for these patients, but by their ability to alleviate suffering. If one can agree on this dual objective of health policy, health gain and nursing the sick, one can see that preventive services, including intersectoral policies will mostly contribute to the former, and care services to the latter objective, while curative services will have elements of both. It does, however, also limit the objective of health policy to services that contribute to that dual objective, with the exclusion of other services such as, for example, social or welfare services, which might care for individuals or improve their quality of life without necessarily affecting their health. One might even take it a step further and argue that, given the necessity to set priorities, it is wise to abandon the unrealistic WHO definition of health, and to revert to a more modest definition of health as the absence of physical and mental illness. Thus in that first step of priority-setting, healthcare services (including prevention in the broad sense) should either improve the health of individuals or provide (nursing) care for individuals who can no longer take care of themselves because of ill health. By clearly defining the objective, the outcome measure by which effectiveness is to be assessed has been provided. We should only include in our basic benefit package those services that effectively contribute to our goals.

A hierachy of collective responsibility

The second step involves the acknowledgement that, within the general collection of services that effectively contribute towards our goals, there might be additional arguments for collective over individual responsibility. In the area of prevention, this might mean the necessity for collective action in clean air control, because an individual cannot achieve this, or the difference in the state's responsibility in the case of the prevention of infectious diseases, which might make vaccination programmes more of a collective responsibility than screening programmes for non-communicable diseases. Similarly, there has long been a tradition in curative services, referred to as the rule of rescue, of life-saving interventions being performed before the ability to pay has been ascertained. In some countries this has even been documented in law, whereby illegal immigrants will be given access to care in life-threatening situations, whereas in other cases access to healthcare will be denied. Finally, with the institutional care provided for chronic or handicapped patients, we tend to give priority to those patients who are mentally incapacitated and thus unable to secure help themselves. In the first two categories they are characteristic of the interventions that provide arguments for collective responsibility. In the last group it is the characteristic of the individual cared for, as in these cases the limits are not so much determined by the type of service provided as by the patient groups entitled to the services.

These additional reasons for collective responsibility are unlikely to lead to the exclusion of large groups of services in most of our Western countries, but they often will give an indication for priorities in countries with radically lower financial resources for health, such as the developing countries. Similar arguments were recently identified in the Swedish priority-setting exercise.

Limits to cost-effectiveness

This leads to the final step in the priority-setting exercise, that of the limits to the cost–benefit ratio, in the original sense of the word. After all, there comes a point where additional benefits, be they in terms of health gains or in terms of improvement in the quality of the care given to the sick, no longer warrant the costs paid to secure them. This happens for each individual but it also happens for society as a whole when a benefit package for universal access has to be defined. There are two issues here that concern equity.

The first is the proposal to use one common outcome measure for each of the two objectives against which the effectiveness of interventions and services will have to be measured. This means that the measure by which health gain is expressed must be able to show improvement in health along generic lines, including both the length and the quality of life and express societal preferences rather than individual preferences in the evaluation of these health gains. The measure best suited for this purpose so far appears to be the Disability Adjusted Life Years (the DALY) as introduced by the World Bank and WHO in the 1993 World Development Report (11, 12). The measure is still relatively new and needs more work done on it, but it does have the standardization of both measurement and valuation of health outcomes that is a necessary condition for an equitable approach to equal needs and potential benefits over disease categories and over patient groups. One can argue that in the field of cost effectiveness and health outcome, much more has been achieved in terms of equitable measures of benefit than in the case of services aimed at caring for sick patients rather than achieving health gains. How do we compare the benefits achieved by extra investment in the care of psychogeriatric nursing-home patients or the mentally handicapped? Do we use normative measures of quality such as the number of baths given each week or the hours of personal care given? Or do we compare the satisfaction of individual patients with the care provided? And how do these two relate? In this field much more work still needs to be done to ensure a transparent and equitable method of comparing costs and benefits over services and patient groups.

The second aspect is that of the unit by which cost effectiveness should be measured. If an intervention achieves health benefits for a common disease, the potential contribution of universal access to such an intervention for the population's health is large. That is why much attention is given to major diseases in health policy. For preventive interventions, whereby many healthy individuals are being exposed to an intervention without ever knowing who has benefited individually, the population health benefit is the only unit by which to judge and compare the cost effectiveness of the intervention. This is not the case, however, for curative services. Here health gains for the individual need to be the unit of comparison, so that interventions with the same cost-effectiveness ratio for a common and a rare disease are treated equally. After all, the individual citizen has a right to expect equal consideration of access to care, given his ability to benefit from a certain cost, regardless of the question of whether it concerns a common disease or whether he is the only one suffering from a specific disease. Governments have a responsibility to treat individual citizens equally and avoid arbitrary decisions based on other considerations, such as, for instance, a very vocal patient group or the market potential of drug companies.

CONCLUSION

These last two conditions are essential if society wants to limit universal access to health services in an equitable way, equitable over patient categories. It is, however, the system of compulsory social insurance or a tax-based national health service that needs to ensure that the resulting services for which society has guaranteed universal access are of equal quality for all.

Equity of health benefits in terms of social groups in society depends more on our ability to maintain a common healthcare system for all than on the priority-setting exercise itself. Unless we are willing to extend our goals from universal access to universal ability to benefit from health services, we may in the future lose one important instrument for preventing and sometimes redressing existing social inequalities in health. Policymakers concerned with equity in health would do well not to limit themselves to the determinants of health outside the healthcare system but also to consider the threat to universal access to good quality care.

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