



International Center for
EQUITY
in Health | Pelotas



WHAT IS HEALTH EQUITY?

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First things first

- What do we mean by health?
 - WHO definition: *Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (1948)*
 - Great definition, but difficult to measure
- What can we measure well?
 - Illnesses or conditions
 - Pneumonia, diarrhea, obesity, stunting...
 - Access to health services
 - When in need, managed to seek care?
 - Use of health systems
 - How many times saw a dentist last year?
 - Child was vaccinated?



Measuring health indicators

- Several challenges
 - Varying definitions
 - Vaccination for DTP (diphtheria, tetanus, pertussis)
 - How many doses to complete scheme? (usu. 3)
 - What age to measure? (usu. 12-23 months)
 - Source of information
 - Health system, health card, report from memory
 - DTP uses typically info from card and maternal report
 - Report subject to recall bias
 - How many times did YOU see a doctor last year???
 - In surveys, mothers have to answer when child stopped breastfeeding years after the fact

Measurement error!



Equity

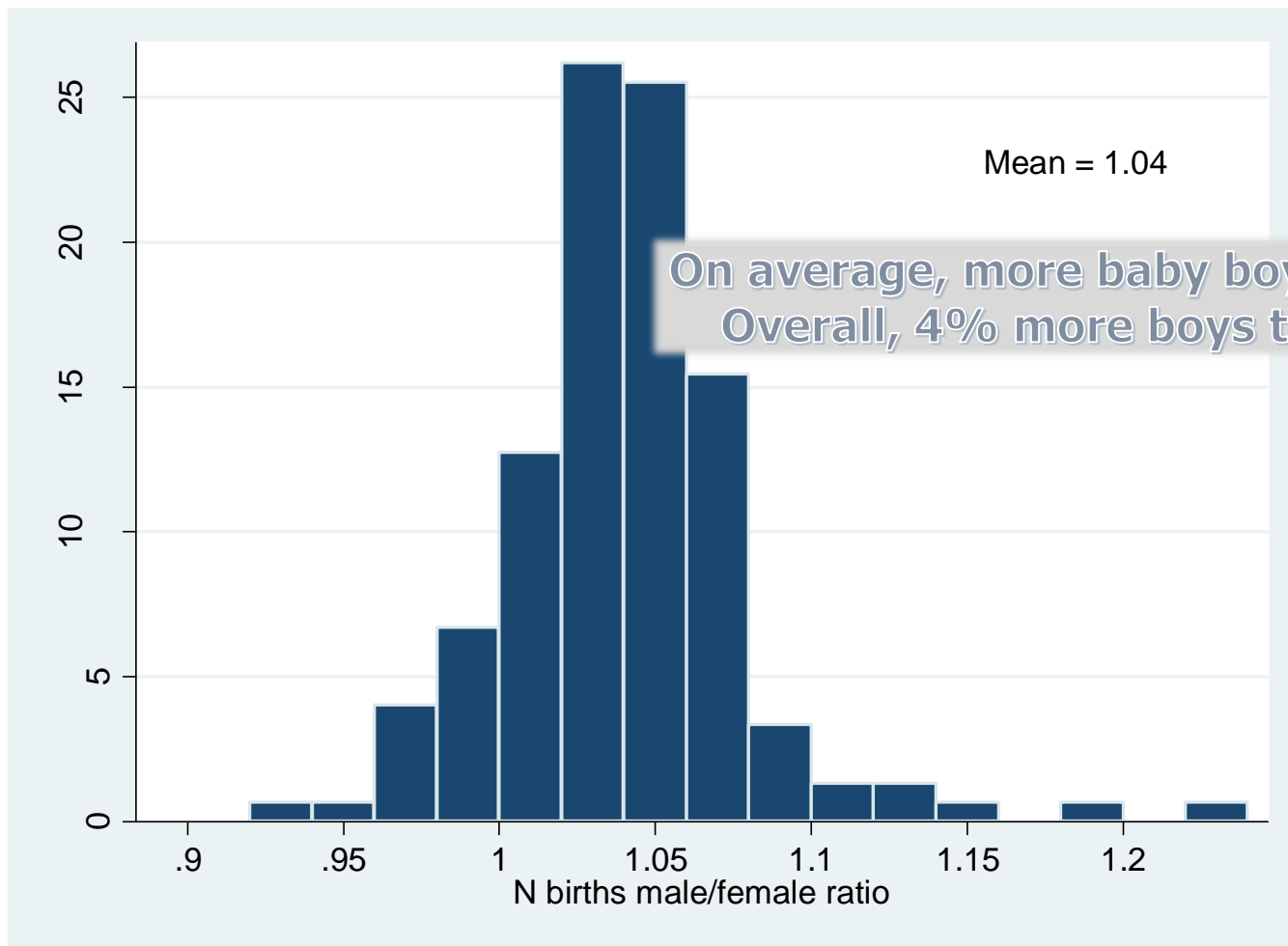
- Are we all equal?
 - Clearly not – we vary by age, sex, habits, profession
 - How to expect equality in health?

Three distinguishing features, when combined, turn mere variations or differences in health into a social inequity in health. They are systematic, socially produced (and therefore modifiable) and unfair.

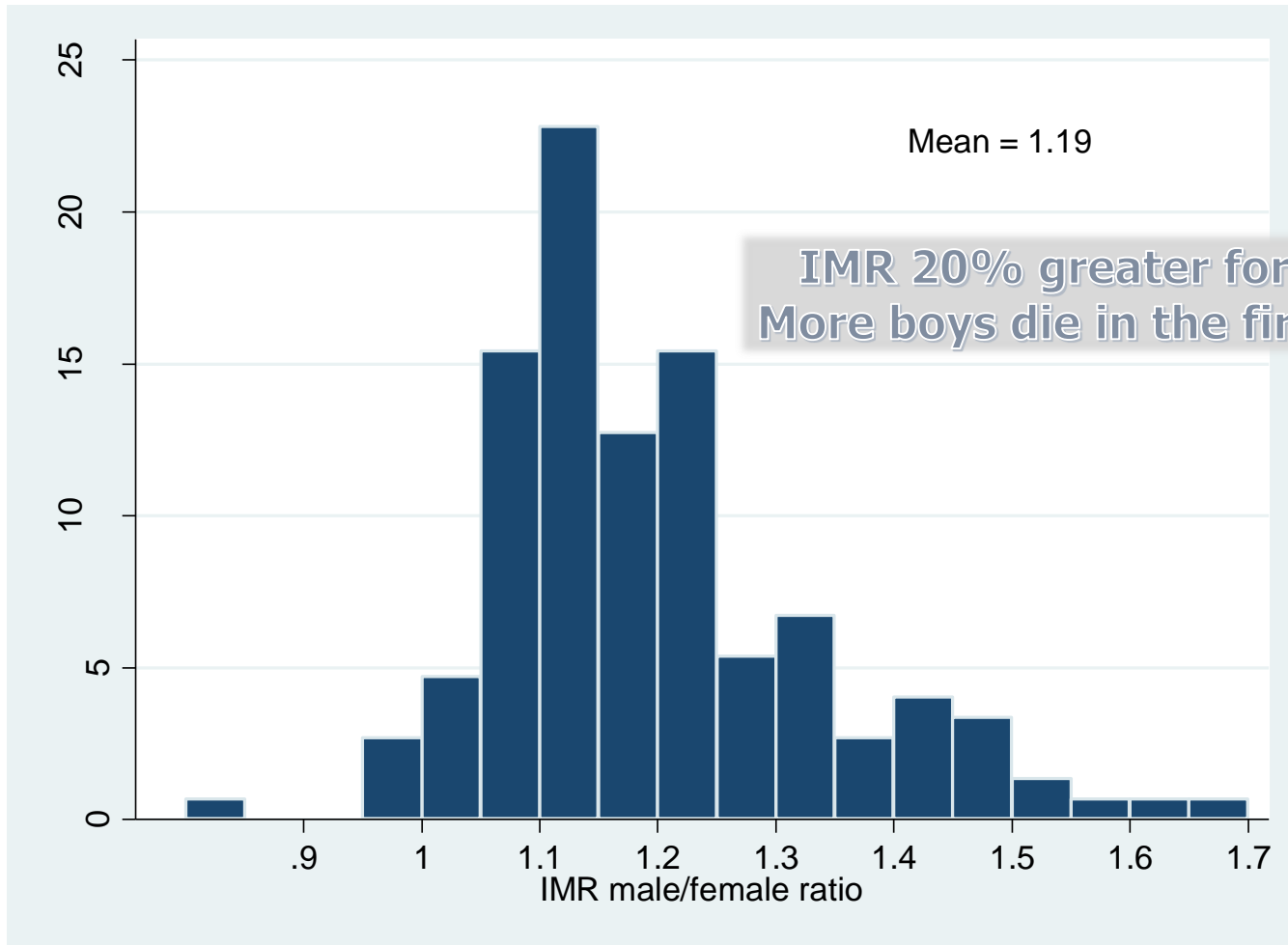
- According to Whitehead & Dahlgren (2006) the three features are:
 - Systematic patterns
 - Produced by social processes rather than biology
 - Widely recognized to be unfair



Male/female births in 149 surveys



Infant mortality rate – male/female ratio

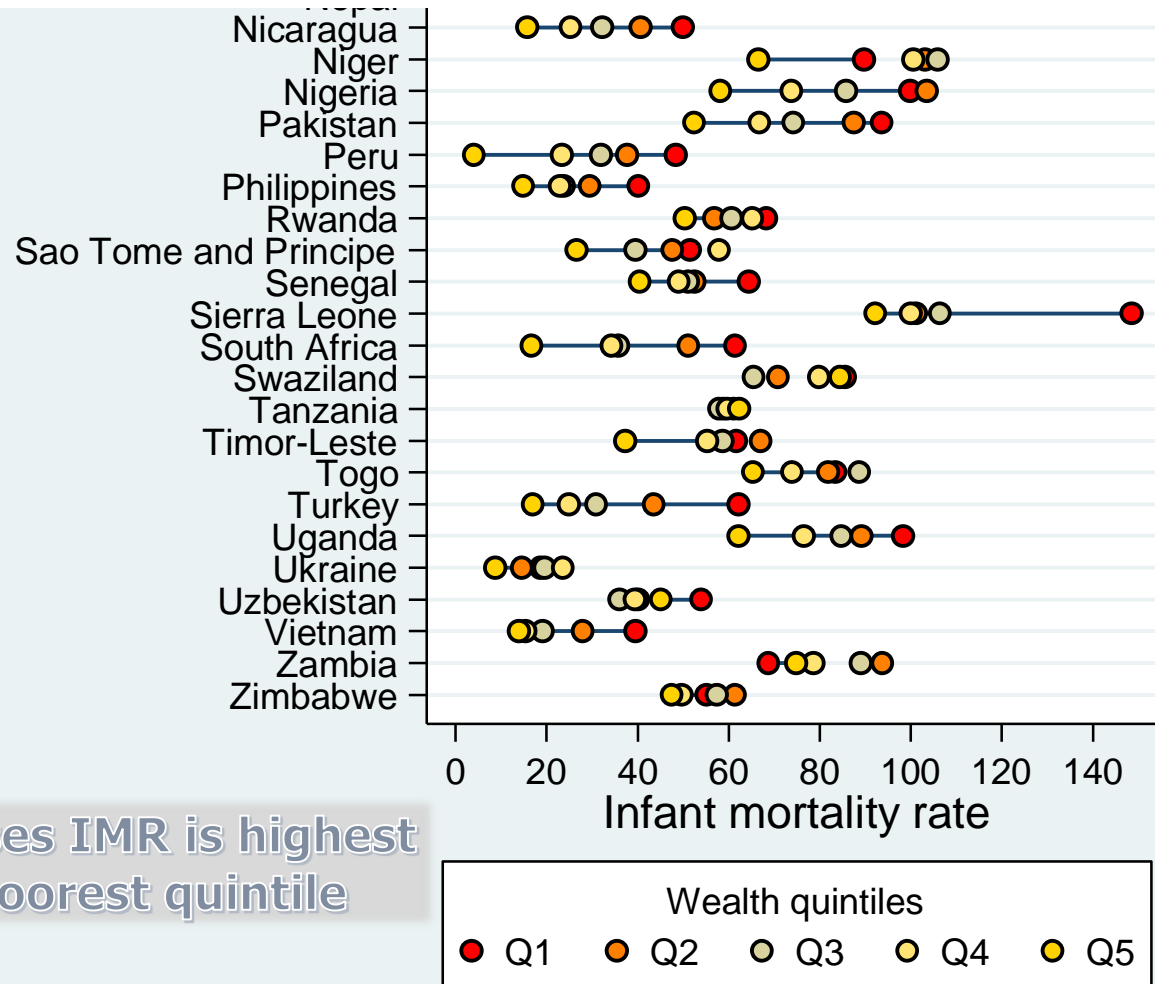


Overall, biological pattern

- But in some countries, maybe preferential care for
 - Boys
 - Or girls!
- But it is easier to see
 - Systematic
 - Socially produced
 - Unfair
- disparities across wealth quintiles!



Infant mortality rate



In most cases IMR is highest for the poorest quintile



In summary

- Inequalities
 - Observable (*measurable*) differences, disparities, gaps in health state, access/utilization of health services, coverage by health interventions
- Inequities
 - Inequalities that are systematic, and unfair, unjust and avoidable

Also see Kawachi et al. A glossary for health inequalities. J Epidemiol Community Health 2002;56:647–652.



Ubiquitous feature

- Health inequalities show up everywhere
 - In rich and poor countries
 - In nearly all health problems
 - Across many different dimensions
 - Wealth, gender, occupation, ethnicity, age
 - Most often indicating excess morbidity among the most vulnerable
 - Or, if measuring health services and interventions, a gap instead of excess

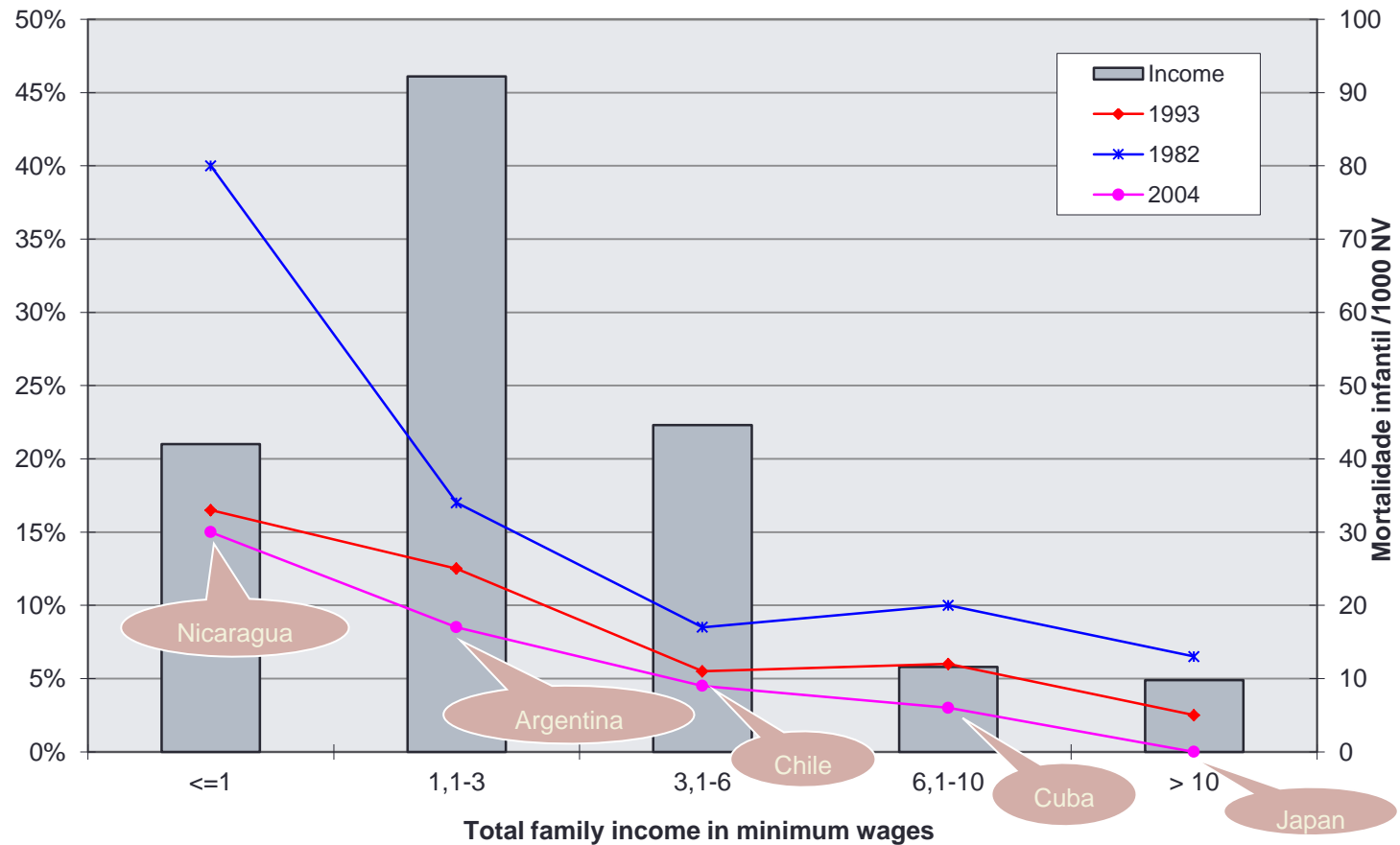


What do we measure?

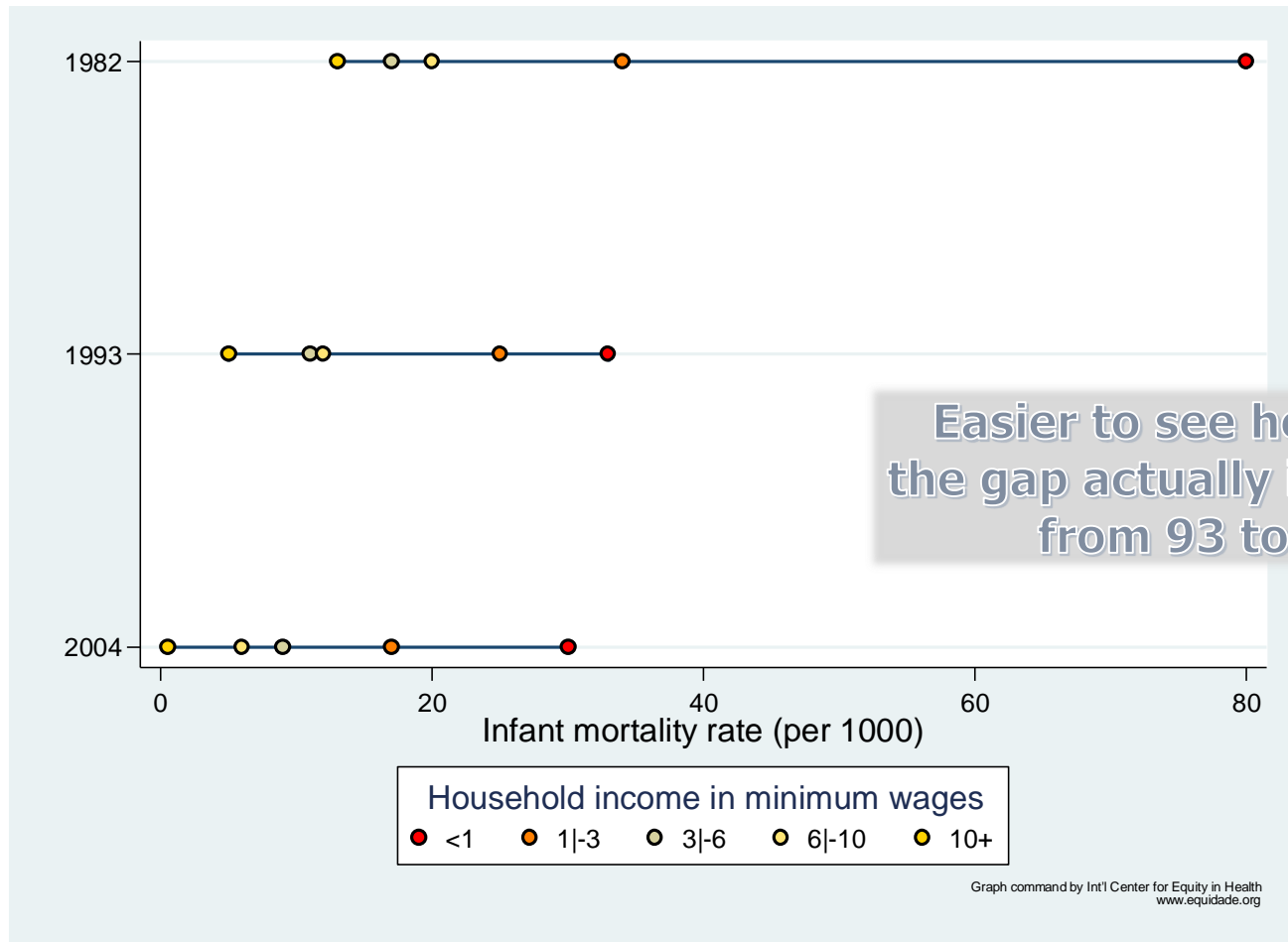
- Inequality is the measurable dimension of health inequity studies
 - Differences, gaps, variation
 - Of health status, exposure to risk factors, access to and utilization of health care services
 - Across several dimensions (or stratifiers)
 - Wealth, ethnicity, gender, education, age
- Inequity is “qualified” inequality
 - Based on principles
 - Social, cultural, political



Infant mortality in Pelotas



Our current preferred presentation

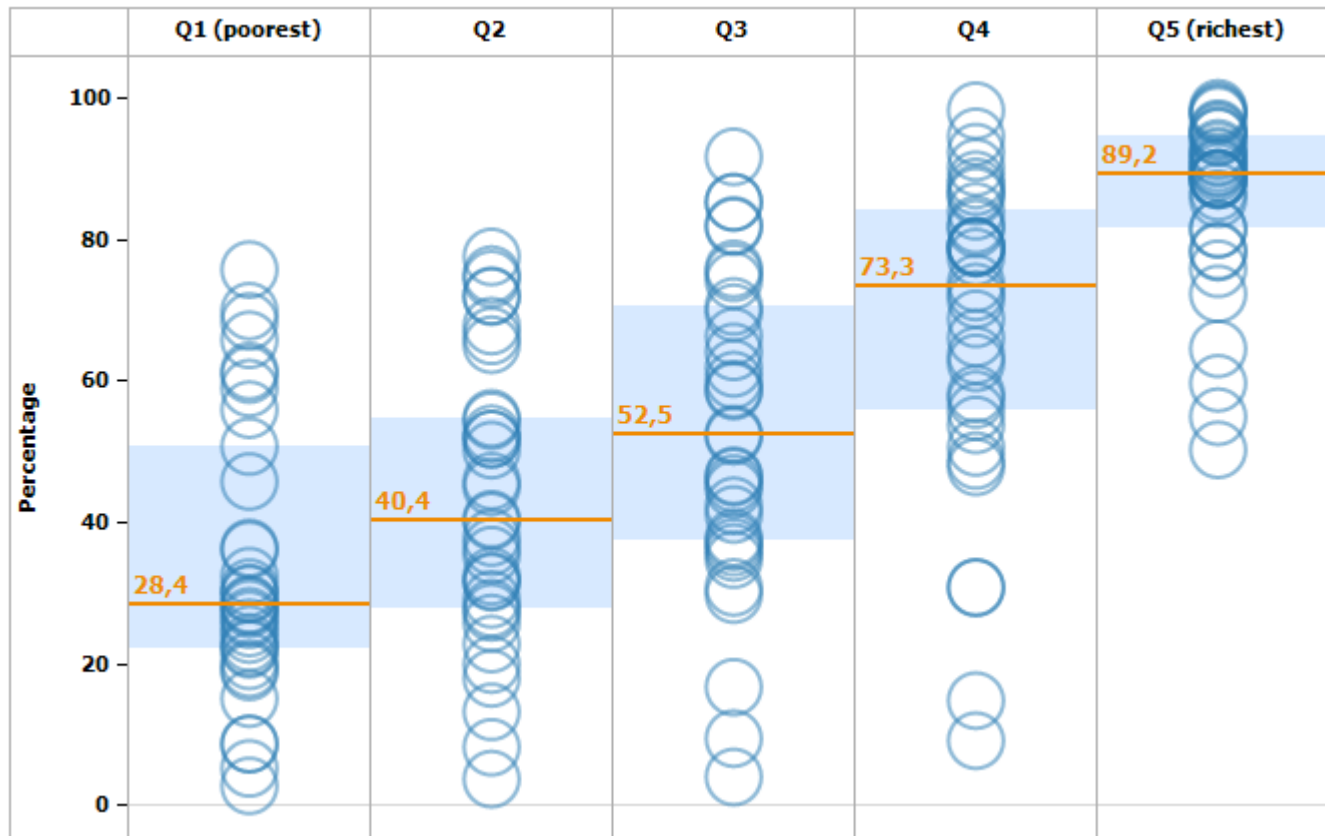


How do we interpret this situation?

- All groups have improved
- How did inequalities change?
 - Reduced?
 - Increased?
- 82 to 93 is an easier comparison
- But how about 93 to 04?
- **HOW DO WE MEASURE INEQUALITY?**
 - Let's hold the question for the moment!



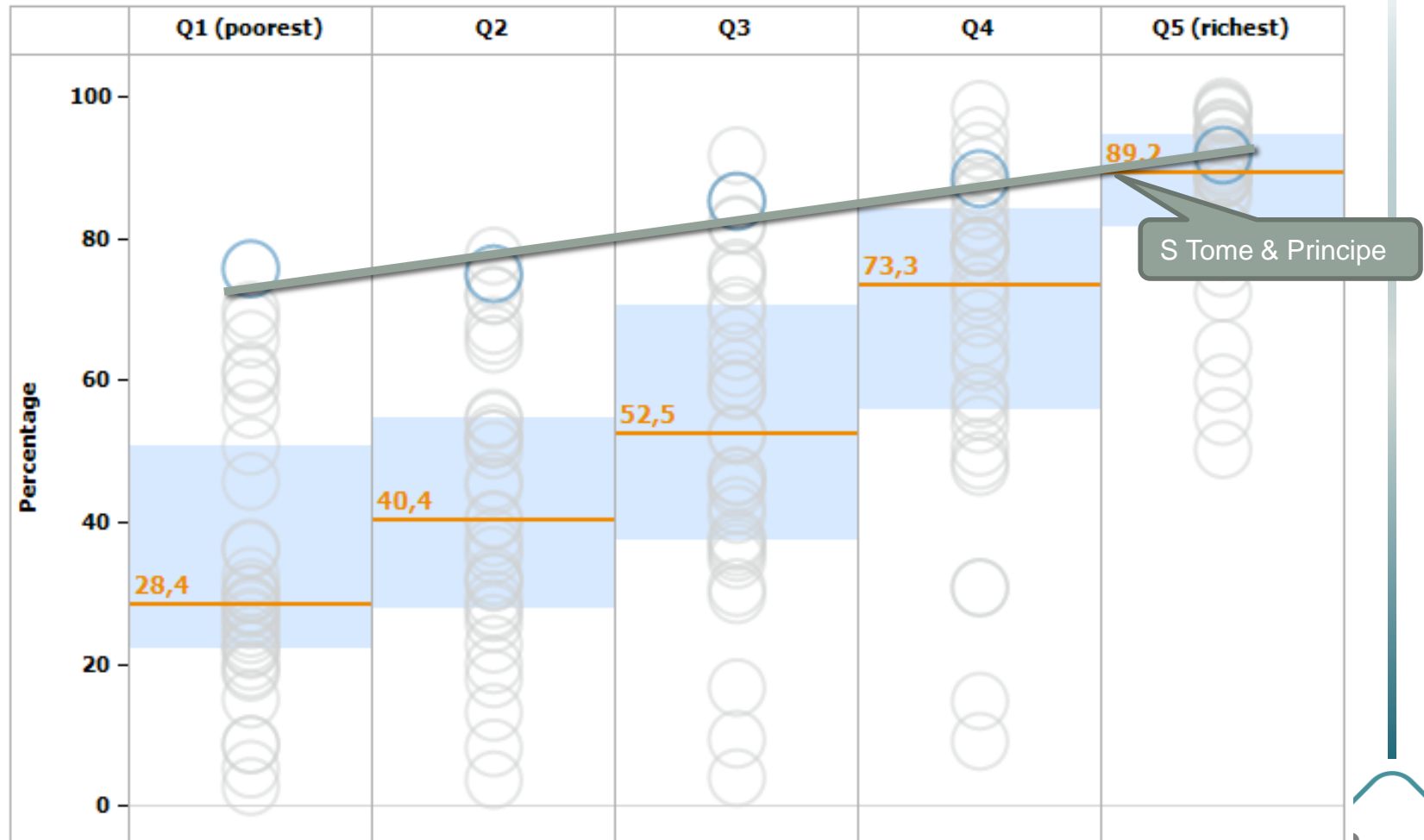
Skilled birth attendant in Africa



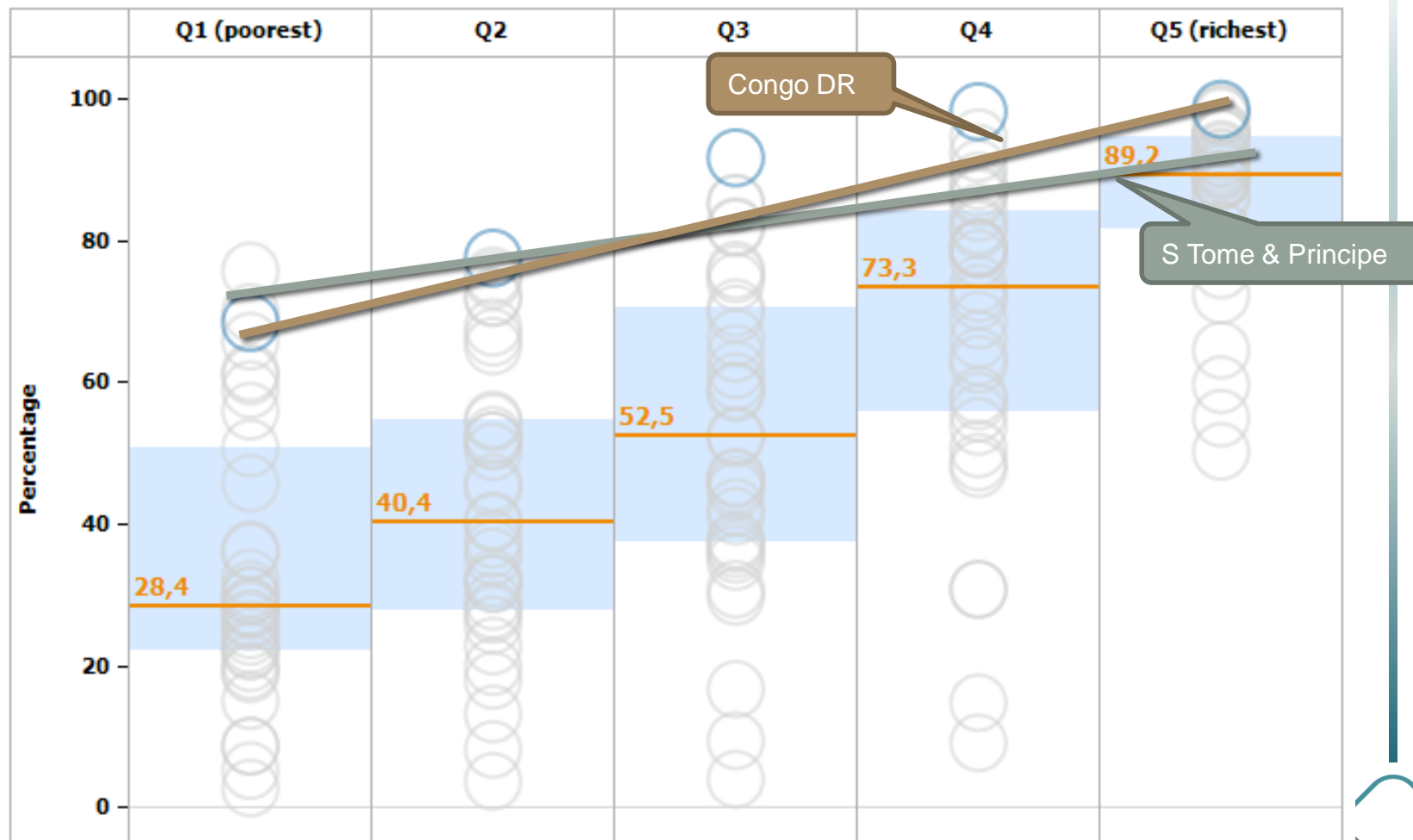
Visualizations from WHO Equity Monitor
http://www.who.int/gho/health_equity/en/index.html



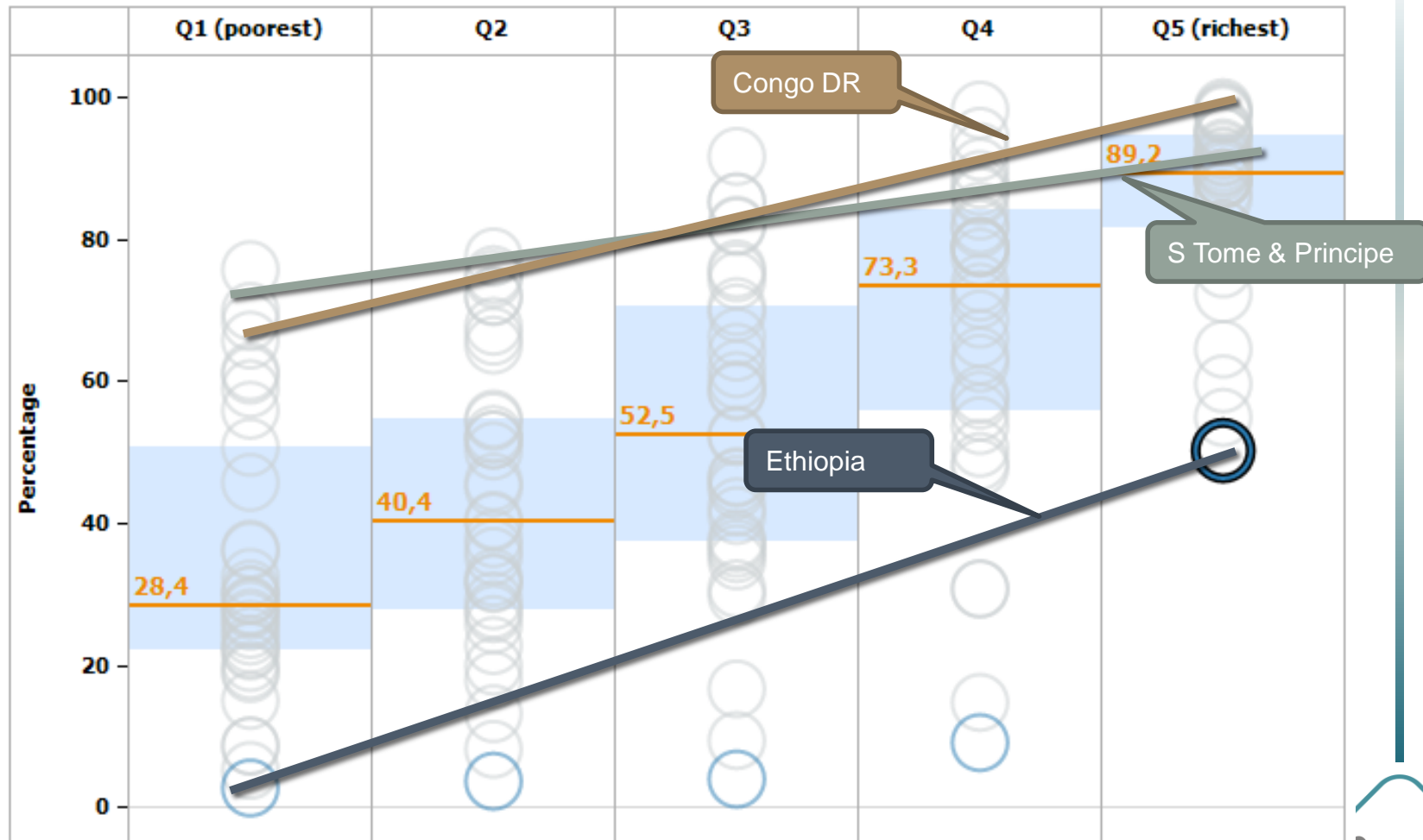
Let's start with the best for the poorest



And add the best for the richest



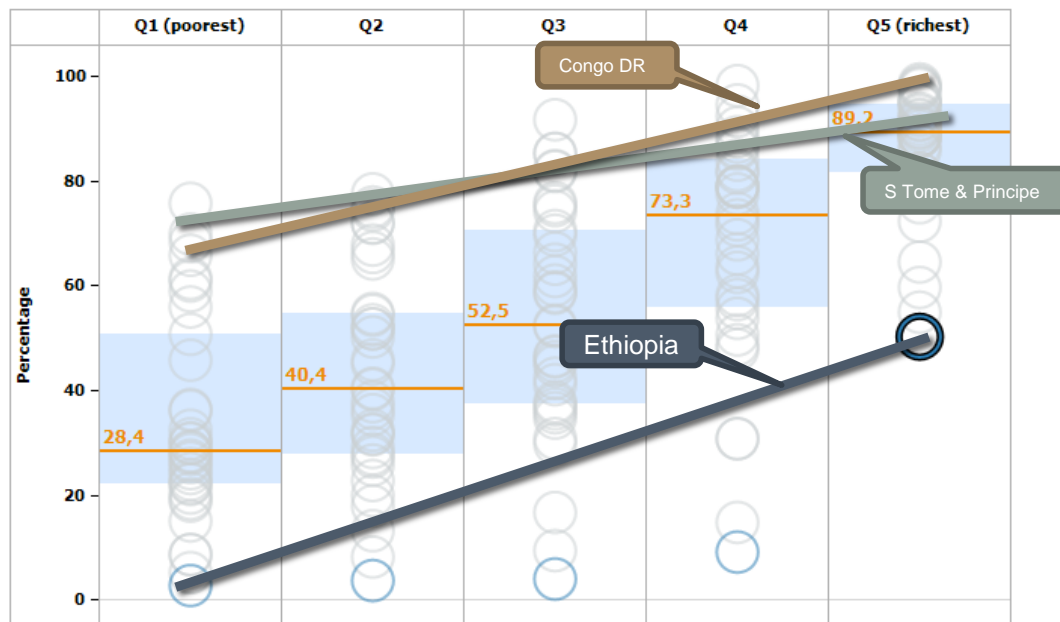
And finally the worst for the richest



And finally the worst for the richest

The slope of the line shows the distance between richest and poorest

Important to look at inequalities, but also at the level of coverage!



A few questions related to health equity

- Do we want all pregnant women to have access to a skilled professional to deliver? Or just those who can afford it?
- Brazil has a national health system that is universal, but we still have inequalities.
 - Is cost the only barrier to equitable health?
- Is health a commodity or a right?

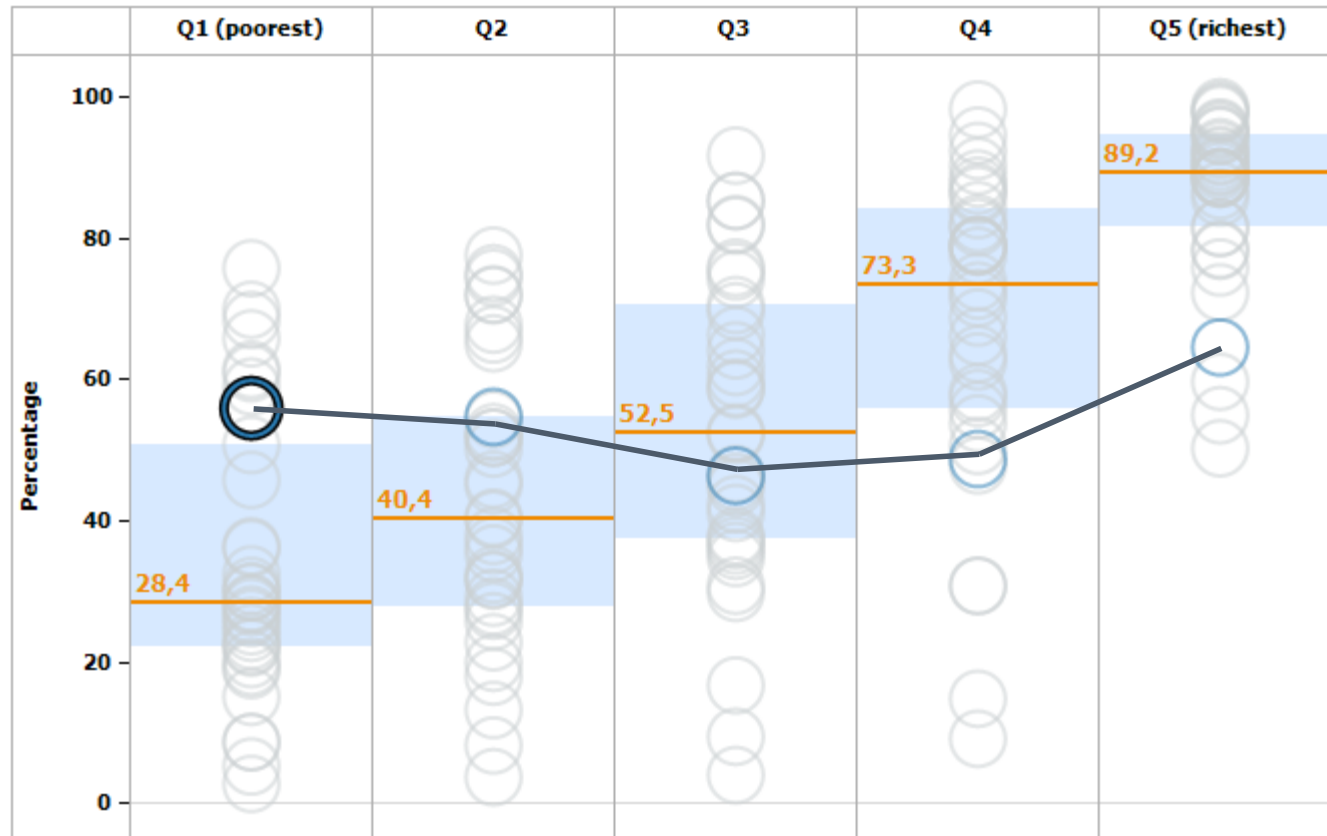


Difficult questions!

- Lots of different patterns of coverage and inequality
- National averages can hide large inequalities
- But only looking at inequalities can be misleading
- Different panoramas mean different solutions
- Let's have a look at different patterns of inequality for SBA



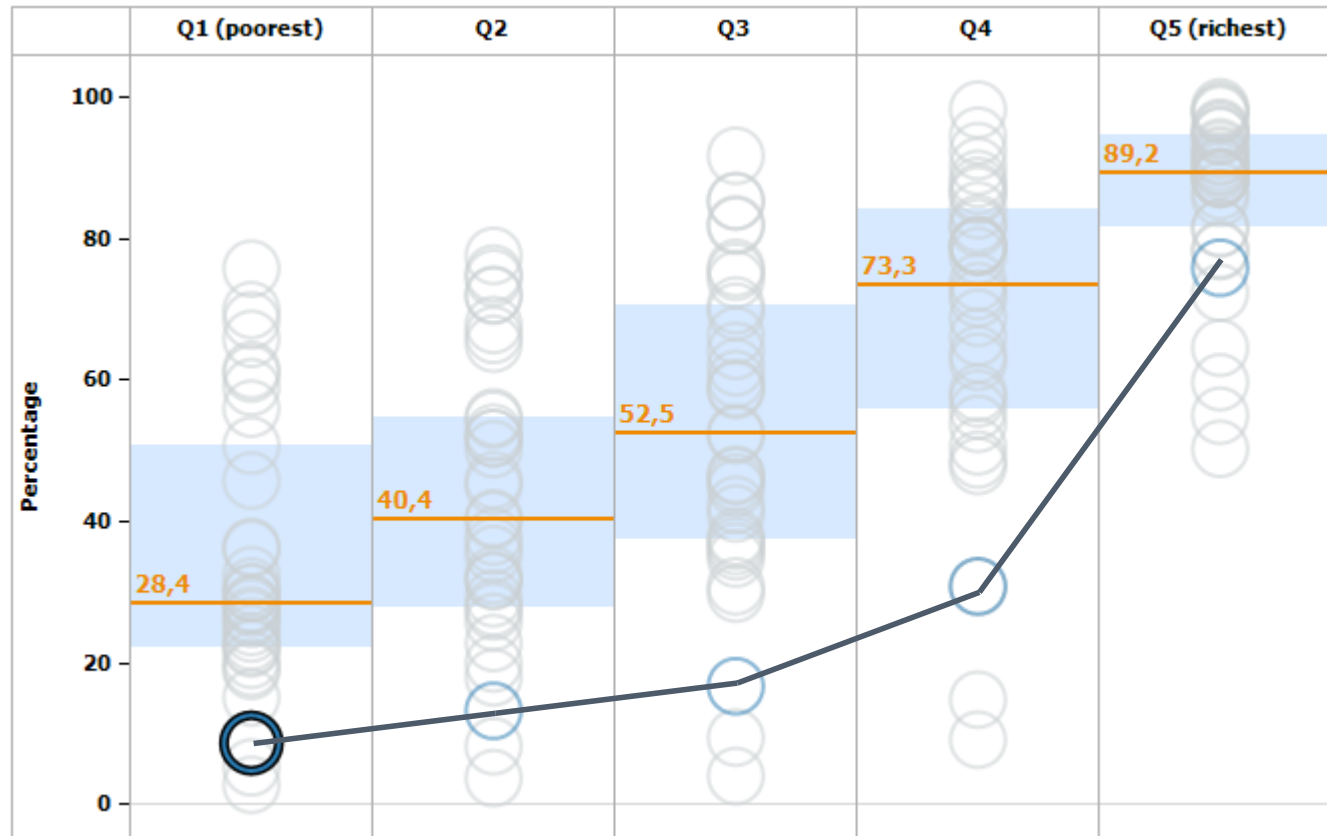
Burkina Faso



A rare case of relatively low inequality with intermediate coverage



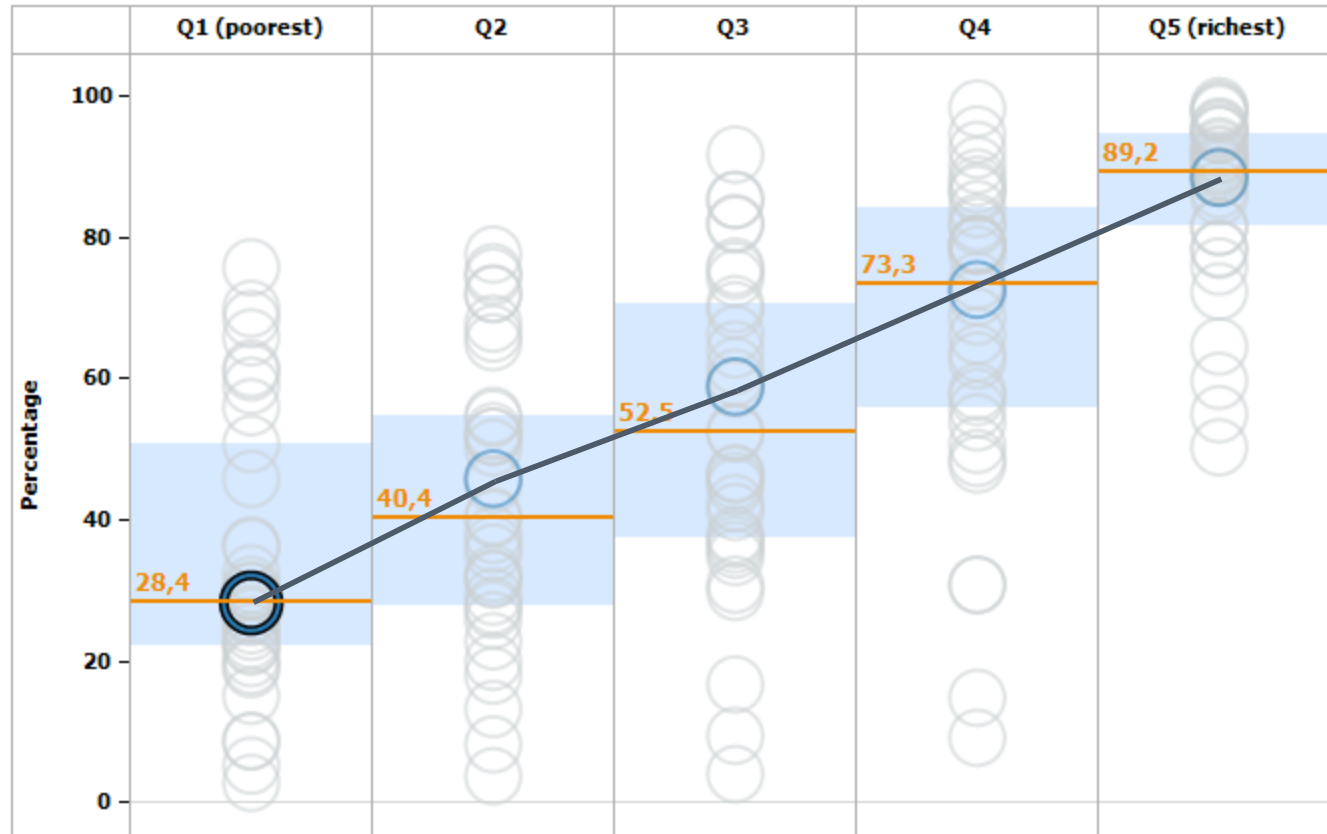
Mali



Typical case of “top inequality” – the richest in a much better situation than the rest.



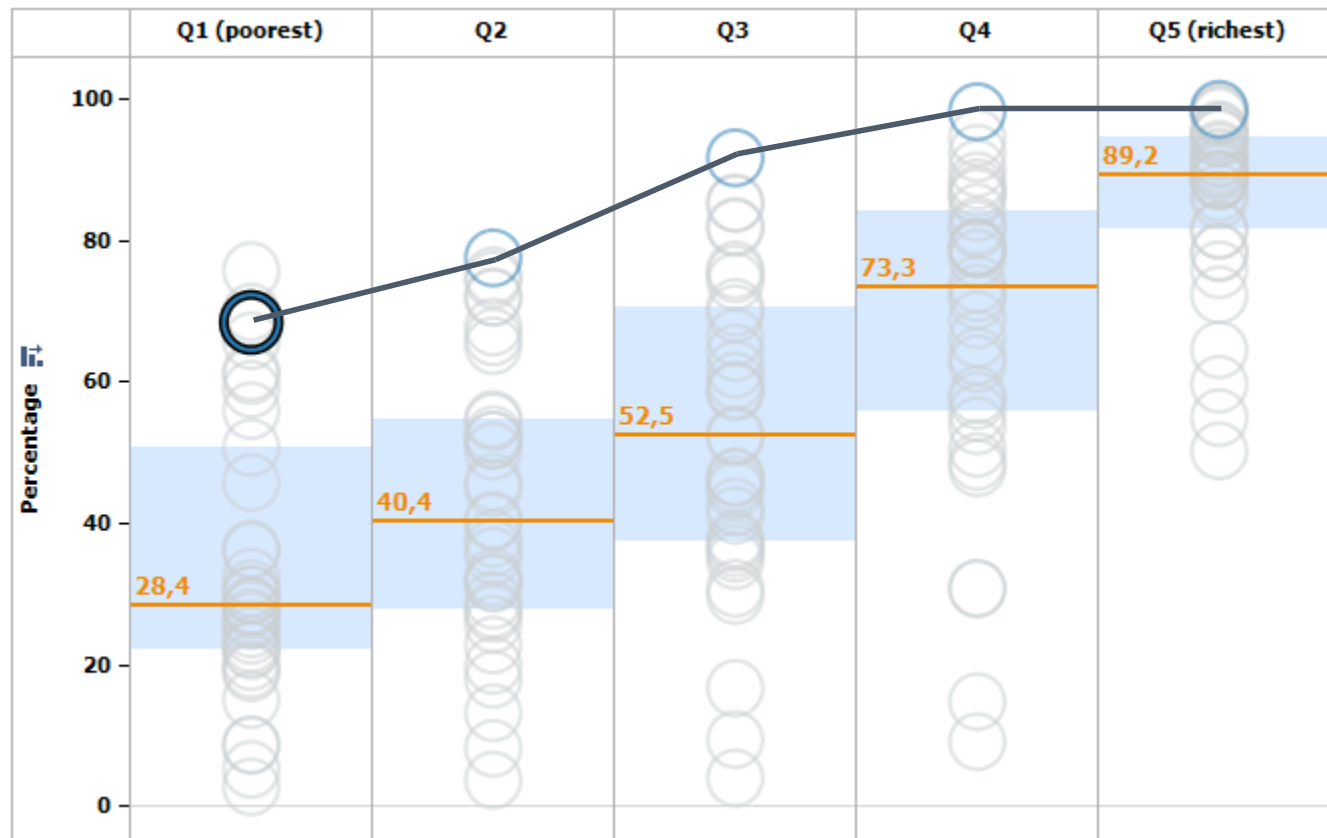
The Gambia



Typical case of “linear inequality” – roughly linear pattern with similar differences between groups.



Congo



(not so) Typical case of “bottom inequality” – where the poorest are much worse than the rest.



What implications for policy?

- Low inequality or top inequality
 - Generally mean that coverage need be increase for most of the population
- Linear inequality
 - Is usually similar – meaning that universal efforts to improve health coverage of interventions is warranted
- Bottom inequality
 - Usually marks a later stage in scaling up an intervention (lacking an equity lens) and may entail a focused effort to increase coverage among those left behind



Summing up

- Health inequalities are very common
- Appear in health status and in care-related aspects
- Need to be systematic, unfair, avoidable to be considered *inequity*
- What we can actually measure is inequality
- There are several patterns of inequalities
- That have different implications for policy

