Equity care in health : why have health economists had so few successes – and what can we do about it?

Gavin Mooney, Professor of Health Economics, Curtin University, Perth Australia; Visiting Professor Aarhus University, Denmark and the University of Cape Town South Africa

AIES Conference, Florence, October 2007

Paper intended to provoke

- **Why haven’t we health economists done better on equity?**
- **How might we do better in future?**

List of tasks we have set ourselves

- defining equity
- measuring equity
- devising funding formulae
- comparing equity in different countries
- examining the barriers to use by only money fees, distance and time costs.

Bob Evans: ‘moved the target to hit the bullet’

- **Ignored wider social and cultural equity issues**
- **Ignored our divided but ever-so-rich neo liberal world**

Outline of paper

- How to define equity and access
- Who should do that
- Equity as a cultural construct
- Health equity on the neo liberal globalising stage
- Equity from a political economy stance
- Alternative to neo liberalism, welfarism and extra welfarism
- Short epilogue on regional resource allocation in Italy.

What construct of equity and access?

- Opportunity to use health services
-
- Freedom to use health services (Thiede et al) including ‘the notion of empowerment to make well informed decisions’.

Whose values are to count?

- To date most definitions from health policy makers or health economists
- Need to see equity and access seen through the eyes of the citizens.

Citizens' jury in Perth, Australia

- ***Equal access for equal need, where equality of access means that two or more groups face barriers of the same height and where the judgment of the heights is made by each group for their own group; where need is defined as capacity to benefit; and where nominally equal benefits may be weighted according to social preferences such that the benefits to more disadvantaged groups may have a higher weight attached to them than those to the better off.***

Equity and culture

- **Recognition in health literature that *health* is cultural construct**

- **Limited acknowledgment that equity is**
-
- **Almost no recognition in *health economics* literature**

Example from Australian Aboriginal health

- **Health is not just the physical wellbeing of the individual but the emotional social and cultural wellbeing of the whole community. This is a whole of life view and it also includes the cyclical concept of life-death-life.**

Impact of culture on health

- Different cultures can have different impacts on health
- Need to watch; Corin: ‘unsupported ethnocentric illusion’
- Eckersley: the negative impact of modern western life of ‘cultural fraud’
- ‘the promotion of images and ideals of ‘the good life’ that serve the economy but do not meet psychological needs or reflect social realities.’

The impact of clashes of culture

- **Between individualistic cultures and communitarian cultures**
- **Frimpong-Mansoh: ‘The world in which we live now is a complex blend of both individualism and communitarianism.’**
-
- **Oversimplification?**

Culture and health care

- **Mackintosh and Koivusalo:**

- **‘the organization and functioning of health systems are grounded in and constrained by the culture, resources and values of a country, yet operate in a field of medical care and normative policies which is open to international exchange and learning’.**

Neglect of local cultures

Ethical issue

-

2000 World Health Report, WHO used

- ***their*** **criteria**
- ***their*** **weights**
- **then applied them to *all* countries**
- **no account of local preferences**

This is WHO elitism on a world stage.

Neo liberalism’s problems for health equity

- Poverty and inequality lead to loss of self esteem
- Impact furthered by lack of caring
- Fed by neo liberalism's undermining of solidarity

Navarro

- **shows that redistributional policies for income, employment and services are the keys to improved health status for populations, especially for those most disadvantaged**

Neo liberalism

- movement of doctors from developing to developed
- Mackintosh UK 2004: 4.3% of doctors trained in sub-Saharan Africa and 11.5% in South Asia
- Ghana has lost to migration around 45% of all its doctors ever trained, and around a quarter of its nurses
- 1968-81 Brazilian economy’s economic miracle
-
- Russia

Individualism and disengagement bad for health

- **UNESCO: in ‘our increasingly diverse societies … policies for the inclusion and participation of all citizens are guarantees of social cohesion’.**

Hegemony of neo liberalism

UNESCO on cultural diversity:

- **‘Globalization, in its powerful extension of market principles, by highlighting the culture of economically powerful nations, has created new forms of inequality, thereby fostering cultural conflict rather than cultural pluralism.’**

How to proceed

- **Equity and access and culture**
- **Accept health care system as a social and cultural institution**
- **Access and equity elements of this social institution.**

Different evaluative perspective

- **Anderson's alternative: 'focuses on the *irreducibly* numerous, intersecting ways people's social positions – of wider scope than the individual, but narrower than all of humanity (as of gender, race, ethnicity, class, and so forth) – affect their points of view.'**

Mooney proposal: communitarian claims

- **John Broome: a claim to a good involves a duty that a candidate for that good should in fact have it.**

- **Communitarian claims ‘recognise first that the duty is owed by the community of which the candidate is a member and secondly that the carrying out of this duty is not just instrumental but is good in itself’ (Mooney).**

Procedure

- 1. Community's preferences to decide the principles underlying access and equity
- 2. Different cultural groups - different barriers and different abilities to mount the barriers

The key

- **Diversity of cultures can only be maintained if there is diversity of economic systems.**
- **Neo liberal globalisation is destroying diversity, both culturally and economically.**
- **The best defence of diversity of culture is diversity of economic systems allied to strong social institutions to promote a solidaristic society.**

Epilogue: some thoughts on Italian health equity

- **1999 reforms proposed first steps towards defining a core benefit package that all regions should guarantee**
-
- **Further regions unable to raise sufficient resources [to provide the core benefit package] to receive additional funding from the National Solidarity Fund …. *based on criteria* recommended by government …**

Key issues

- which criteria?
- how are these to be determined?
- answer: communitarian claims

Resource allocation regionally in Italy

- In any region, what is the scope for 'doing good'?
- Can the regional populations (citizens) determine what ‘good’ they want?
- Might they want to weight the good to some group(s) higher than others?
- Should the allocation formula be used to 'compensate' those regions which are less well off with respect to MESH infrastructure?
- Are there differential costs of service provision?

Conclusion

- **Hope some of the ideas in my paper will at least get you thinking in a different way about the health economics of equity.**