# Equity as a Goal for Health Care: an Operational Inquiry

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**Abstract**

Difference in health status, allocation of resources, provision of services and development of basic health infrastructure, both within and between countries raise questions of fairness. The means for assessing this differential, developing strategies to overcome them and documenting changes become crucial. This paper will explore the concepts of equity and justice from an operational perspective, present a number of scenarios in dealing with the health of populations and assess the impact of using equity as a goal for health care in those cases. The objective is to present an analysis of how the same goal in health care may result in different actions with variable result. An evaluation of the potential conflict between equity and utility is presented. Implications for further work on the means of assessing inequities, use of indicators and measuring the result of interventions is discussed (JPMA 50:419, 2000).

**Introduction**

The well described principles of biomedical ethics include beneficence (to do good), non-malfeasance (to do flO harm), respect for autonomy and justice[1]. Although Their universality can still be debated, their application has been found useful in Various national and regional settings[2,3]. Within the sphere of population health, especially the status and delivery of public health, the principle of justice can be regarded as a vital concept. Justice refers to the moral fairness of actions involving giving to each his/her due[1]. It is concerned with issues of distributive and social justice and provides an appropriate moral basis for raising questions and evaluating health care and delivery.

Health care systems around tile world are undergoing evaluation and reform with the intent of making them more effective and just for the people they serve[4,5]. Existing differences in health status, allocation of resources, provision of services and development of basis health infrastructure, both within and between countries, raise questions of fairness. The means for assessing this differential, developing strategies to overcome them and documenting changes become crucial. It is within this dynamic health care scene that a just care system can be considered an ideal one, that serves all people and takes special care of those who arc at particular risk.

This paper will explore the concepts of equity and justice from an operational perspective, present a number of scenarios in dealing with the health of populations and assess the impact of using equity as a goal for health care in those cases. The objective is to present an analysis of how the same goal in health care may result in different actions with variable results. This discussion will also set the stage for a further investigation into the means of assessing inequities in health, the use of indicators and measuring the result of interventions to reduce such disparities.

**Equity, Inequity and Utility**

Health is an integral human right which needs to be equally applied to all human beings irrespective of their individual characteristics. The acceptance of such a right is essential but not sufficient to achieve the objective of good health. The opportunity to become healthy must also be present and it is in determining the distribution of this opportunity that equity becomes important. Equity refers to fairness and justice, while recognizing the existence of differential need[6]. This need will differ between individuals and populations and therefore the response to that need will also have to be different[7].

Inequity in health states are a source of major concern for the global health community. Whether geographical, economic, gender-based or age related, they are caused by inequitable distribution of

resources and services or by policies and actions that favor one group over others. The magnitude of these inequities in health slates vary and though on principle they are all unacceptable, some are so great that they warrant immediate action[8]. It is concern for such inequities that is promoting (lie renewal of Health-For-All by the World Health Organization by 1998 with a central focus on ethics and equity[9].

Inequity in the opportunity to become healthy is also of great concern since it allows people to reach their potential level of good health. This opportunity is a complex mix of the recognition of rights, legal protection, socio-economic conditions and other factors that facilitate the production of health at the individual and community level. The complicated nature of this concept, though vital, makes it difficult to define generically, measure and control. In fact these factors often are the cause of inequity in health such as inequality in access[8]. This means that in the analysis of the causes of inequity in health states, the composite notion of opportunity must be evaluated and each of its components examined carefully.

Another concept of importance is that of utility, or the values of seeking the greatest good for the greatest number[6]. It involves the assessment of the costs and benefits of action and intends to maximize aggregate benefit. Cost effectiveness analysis and decisions based on it are thus utilitarian in approach. In the face of scarce resources, especially in the developing world, this becomes a very important concept and one that is often considered pragmatic. Recent methods for resource allocation within health have prescribed such an approach[4,10], but there are ethical concerns with their usage[11].

**Inequity in Health States**

In comparing health states of groups there are a number of standards that can be used. These include a comparison with other groups or with the "potential" of the group itself. The former is important for the notion of achieving equity in health states within countries and regions in order to ensure that no particular group is penalized. The latter concept recognizes the role of biological and other factors that cannot be controlled or changed thus revealing inequalities that are not issues of inequities[7].

These two standards, group comparison and inherent potential, are not mutually exclusive and cannot be an excuse for inaction. They represent different levels of equity analysis such that a search for inequity between groups leads to an investigation of factors that are impeding people in realizing their own health potential. Moreover, with the development of science and technology in the field of health, there is the issue of further increasing that potential level and therefore these standards are dynamics and could improve over time.

Groups of people represent unequal need for health care. This need requires a response that can create the conditions that will allow these groups to improve their health states. It must be recognized that often the very marginalized groups do not have the capacity to voice their needs. An estimation of the magnitude of that needs and its causes will be required to help in the development of possible interventions.

**Operationalizing Equity**

Let us assume there is a perfect indicator for quantifying health slates and it is used to measure the health status of a population of a country. This indicates that there are three groups within this population at different levels of health status from poor to best. In other words, we have evidence of an inequitable situation and on further analysis we find that the health status correlates with the economic level of these groups. This is not an uncommon situation in the developing world where the richest have the best and the poor the worst health status measured by any number of indicators[4]. This situation yields itself to a number of questions. Is this picture acceptable for a country? From the perspective of bioethics and especially under the concept of justice, it is unfair and unjust and is not acceptable. Thus, there is a moral basis for action to reduce this inequity. It is in the magnitude and distribution of this action or response to inequity that care must be taken as it will create the measures and opportunity for these groups to achieve better health.

One response can be an equal distribution of resources to each group. This action can be taken under

time consideration that all groups have an equal right to available resources and does not take into consideration their unequal needs. It overlooks the fact that the poorer sections have a lower health status and consequently a greater need for morn resources. Under the assumption that this input yields equal health benefits, all the groups will benefit by the same amount and improve their health status. However, the magnitude of the inequity between them will persist. There may be an attempt to rationalize this situation by arguments stating that the poor will have a better health status after receiving these resources and so at this higher level such inequity may be tolerable since all the groups have benefited. This opens to debate whether health status differentials can be ignored at certain levels of health.

Another premise for action could be raising of health status of all groups to a pre-determined, national leve. This would require the unequal distribution of resources according to the need of these groups. The need being, greatest in the poor group would merit more resourccs as compared to the rich group. The result woul4 be the achievement of the same health status by the groups. In this situation once would no longer be able to find inequity in health states within the hypothesized country. Such a response accepts the equality in rights to resources but gives greater consideration to need and reduction of differences. Al groups still benefit but by differing amounts. This could mean that the next level of search for inequity could begin and international comparisons may result in raising the national norm to create regional and eventually global equity in health.

Such representations are necessarily simplistic and do not account for the nature and type of interventions required, the ariation in benefits produced in each group and the role of a host of other health and social factors that complicate the situation. A number of other scenarios can be depicted including improvement in health status of all groups to above a national minimum while retaining inequity, distribution of resources according to purely utilitarian principles and the effect of transforming resources from one group to the other However such illustrations serve a useful purpose in demonstrating the different results of interventions taken on similar moral grounds.

**Equity-Utility Conflict**

Assessing these scenarios from a utilitarian perspective, one could argue that the net aggregate benefit over all the groups should determine the type of action taken. The action that results in the highest' overall health status of the population would be given consideration on this ground This would not necessarily involve consideration of the distribution of benefits and may even have the potential of further increasing the existing inequity between the groups if the allocation gave more to the already better groups.

it has been stated that there may be a conflict between equity and utility when it comes to the distribution of health resources[12] The allocation of resources as propagated by equity concerns can not be utilitarian, as they may need a large increase in effort to serve marginalized groups with small benefit. The argument is based on two important assumptions. First, that it is not cost effective to reach the remote, very poor or marginalized groups. And second, that it is desirable to reach them under concerns for equity.

The first assumption is dependent on the measurement and allocation of both costs and benefits. Let us assume that in order to improve coverage for a health program an attempt is being made to reach the last 10% of the population in a remote geographical settings. The cost of building roads, establishing basic services and ensuring access will be great. However, a large part of these casts need not be allocated to the health sector. The building of roads, provision of water and sewage and infrastnicture are not just a health concern but rather an overall development, social and economic concern that affect all other sectors, it is therefore inappropriate to label such costs under health. On the other hand the benefits obtained from those health interventions will be immense. The measurement of such benefits need to be done to capture the gain made by the population and it is important to have an indicator that can assess the change in health slate rather than the absolute level. Under these conditions, with less of the cost allocated to health and a greater measured benefit, there will be many cases where the utility-

equity conflict will either disappear or become reduced.
The second assumption related to the desirability of increasing coverage is mostly true. However, using the geographical example, there may be situations where this may not be the case. For example with immunization interventions and the creation of herd immunity, it is not desirable or required to reach the last 10-20% of the population since all groups are protected with a lower coverage.
Although the discussion above is limited to a few examples the idea presented is the allocation of resources as determined by equity need not necessarily be different from those determined by more utilitarian purposes. It varies by the nature and type of health interventions, allocation of costs, measurement of benefits and needs to be done on a case by case basis. It also goes to show that either way the explicit nature of the reasons for taking action would vastly improve health related decision making especially in the developing world.

**Operational Concerns**

The assumptions used in the above analysis are important limitations in the search for a system of surveillance for equity[13]. Indicators to assess inequity in health states have been suggested but none has been developed for application[14,15]. Such an indicator should be usable for comparison with both types of standard, external and internal potential, and possess the flexibility for further analysis by individual characteristics. There is emerging work that provides hope in this direction[11,14].
The infusion of resources does not lead directly to the production of health and that production does not have a proportional relationship with the input. This means that the same resources in different groups will lead to varied levels of improvement. This is a result of several factors that determine the efficiency of health production, similar to those that determine opportunity for health. The distribution of resources may lead to a further deterioration of inequity if those already better off produce more health from the same amount of resources than those less better off in the country.
If one evaluates the scenarios described above with oilier principles of biomedical ethics, then they become more complex. In one case good is done to all groups (beneficence) while harm is not done to any (non-maleficence), while in the other although good is done to all, it is unequal. This could mean that resources have been taken away from the rich and given to the poor and so this may qualify as harm to the rich. Whether this is morally accepted based on another principle is a decision that would need to be taken. It is thus clear that different moral claims may yield different results and it is imperative to be cautious of maintaining a balance between competing arguments.

**Implications for the Future**

This conceptual investigation reveals a number of key issues where biomedical ethics and health care will need further work. In this effort the development of better strategies and tools to monitor inequity will be critical. It means the development of epidemiologically based parameters that are useful in measuring both the health status and its change from interventions. Indicators that reflect geographical, gender, ethnic and socio-economic inequities need to be used for documenting the existing situation both within and between regions.
The reasons for inequity in health need further study with the perspective of developing interventions to reduce them. Overall levels of poverty, persistence of social classes[8], maldistribution of resources and oilier factors all contribute. The primary sets of masons will differ depending on location and setting but all need analysis for their contribution in the creation of inequity.
Decision making within the health care arena should become more transparent and morally based using available resources. Making the criteria for decisions more explicit and the using quantitative criteria has been called a great step in improving global health[4,16]. This calls for scientific justification of decision needs to be augmented with a stronger call for the moral justification. Ethics, especially concerns for equity, should color the decisions about the way and means of spending scarce resources for health.

## Conclusion

Equity could become an operational objective and a guiding principle for global health efforts. It must be recognized that there are a host of question raised by the application of moral principles. There are different levels at which the search for inequity can be pursued including national and global. There are any socio-economics, health and demographical variables by which this search needs to be done. As the developed and developing world are considered, another issue is that of scale. The magnitude of the inequity and die level at which these differences become acceptable will all need to be deliberated. At the current stage of global health development it would be a start to actively consider equity concerns within national health care debates and policies.

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