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EQUITY IN HEALTH - A PUBLIC HEALTH CHALLENGE

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Equity in Health has been a long-standing issue in healthcare delivery system since the Alma-Ata declaration 1978. Literally 'Equity'

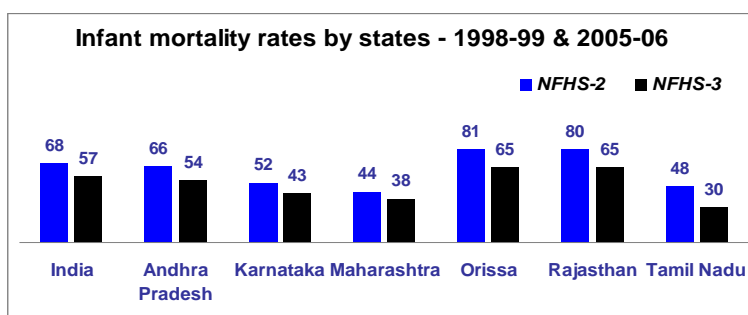
(Latin: aequus = Fair) means the quality of being fair and impartial. Equity in health is the absence of systemic disparities in health or in major social determinants of health. Inequality in health status of people is politically, socially and economically unacceptable.

The International Society for Equity in health defined 'Equity' as: "the absence of potentially remediable, systemic differences in one or more aspects of health across socio-economically, demographically or geographically defined population groups or subgroups."

Dimension

Equity compares various attribute of a different background i.e. financial or social. An equity stratum encompasses sex, race, and ethnicity, place of residence, region, education and occupation. Dimensions of health status across which inequities exist are risk of disease, social consequences of illness and in a large country of ours there are huge disparities across states and regions in term of performance of the Millennium Development indicators.

Evidences of Disparity by Region



Evidence of Disparity in Population Groups

	Infant Mortality/1000	Under 5 Mortality/ 1000	% Children Underweight
India	70	94.9	47
Scheduled Castes	83	119.3	53.5
Scheduled Tribes	84.2	126.6	55.9
Other Disadvantaged	76	103.1	47.3
Others	61.8	82.6	41.1

Evidence of Disparity in prevalence of Anaemia

Back ground Characteristics	Women Anemia (<12.0 g/dl)	Men Anemia (<13.0 g/dl)
<i>Castes / Tribes</i>		
Scheduled Caste	64.2	35.6
Scheduled Tribe	73.8	53.6
Other Backward Caste	58.6	25.4
Others	53.4	23.2
<i>Wealth Index</i>		
Lowest	69.2	49.6
Second	61.4	31.3
Middle	59.7	26.4
Fourth	52.8	19.4
Highest	47.9	19.5
Total	61.2	33.9

Healthcare inequities are evident from Life expectancy at birth of a girl in one part of world is 40 years less than another, variation of IMR from 20 to 120 per 1000 live-births and life-time risk of maternal death varies from 1 in 8 (Afghanistan) & 1 in 17400 (Sweden).

Immunization coverage strongly correlates with socio-economic status. Rich consume more hospital and public health care services than the poor.

Inequality exists by (Progress such as) **p**lace of residence, **r**ace, **o**ccupation, **g**ender, religion, education, socio-economic status & **s**ocial capital etc.

Target

The equity can be achieved through efficient and equitable health systems with universal coverage, improvement of data quality and monitoring health inequalities. Pro-poor approach and Public-Private partnership would help to reach target population.

The health care services are consumed more by economically stable population and the poor bears the risk of medical impoverishment or does not have access to health care services.

Evidence of Disparity in different wealth index.

Background Characteristics	% who delivered in a health facility
<u>Wealth Index</u>	
Lowest	15
Middle	54.2
Highest	86.1

The purpose of minimizing health inequities is to contribute to poverty reduction and promotion of economic development.

Strategy

The strategic approach should be to mainstream equity into the health system and to forge cross sectoral support on tackling the determinants of health and to scale up investments in most disadvantaged areas to fast track improvements in service delivery.

Financial (out of pocket spending) cost, poor connectivity / transport have dampening impact on health care service utilization. Increase the accountability of the healthcare services to the poor and excluded with strengthening the capacity of poor and excluded to make informed choice about prevention-treatment-care.

Concerted effort from committed political and policy levels to redress disparities in health and its determinants are essential. The preventive-promotive health care must be institutionalized in private healthcare sector along with government system.

Thematic areas to improve equity such as; Leadership, Systems, Services, Accountability & Citizen's capacity to be looked into.

There are seven principles of action for addressing global health inequities. They are as follows:-

- I. Improving living and working conditions
- II. Enabling healthier lifestyles
- III. Decentralizing power and decision-making and encouraging citizen participation in policy-making
- IV. Conducting health impact assessments of multi-sectoral actions
- V. Keeping equity on the global health agenda
- VI. Assuring that health services are of high quality and accessible to all
- VII. Basing equity policies on appropriate research, monitoring and evaluation.

Equity can be achieved if attention is drawn on the following:-

Pro-poor approaches and scaling up options, strengthening health systems, moving towards universal coverage, broader determinants of health, improving data quality and monitor for health inequalities & address measurement issues.

Vision

Equity has become a long-standing issue in health and health care delivery since the Alma-Ata Declaration in 1978. The World Health Report 2000 reiterates this issue by taking equity and efficiency as the most salient features of Health System Performance.

WHO report by commission on social determinants of health can be cited as “reducing health inequities is an ethical imperative. Social injustice is killing people on a grand scale.”

By the year 2015 every country should have an integrated system for monitoring health system in equities that inform monitors and evaluates health and other socio-economic policies.
