Exploring Inequity in Health; an Ecological Approach

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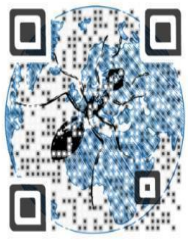

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ABSTRACT

Introduction:

Inequity in health is characterized by inadequate allocation of both maternal and human resources to the extent that differences remained between rural and urban health services in terms of access and quality of services. Changes in social sector have further fuelled inequity as social reforms have been interspaced with fiscal crises and wars.

Results:

These crises have resulted in widening income distribution, poverty, and decreased employment. At the centre of inequity in health is the fundamental respect for human rights, regardless of age, colour, creed, culture, gender, sexual orientation and social status.

Conclusion:

This paper out-lines an ecological framework to increase our understanding of the magnitude and nature of the problems caused by inequity in health. The current challenge demands innovative ideas, creative thinking and action, aimed at bridging the ever widening gap in health care delivery system of the country

Keyword:

Inequity in health, ecological, health care

INTRODUCTION

Human health has probably improved more over the past half century than over the previous three millennia. This is a stunning achievement, despite the devastating impact that human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) is having in Africa and other part of the world. A dark cloud, however, threatens to blot out the sun from this landscape. Almost everywhere literature is replete with the fact the poor suffers poor health and the very poor suffer appallingly. The view that poor health contributes to impoverishment is not new. WHO considers it firm enough to suggest that because ill-health traps people in poverty, sustained investment in the health of the poor could provide a policy lever for alleviating persistent poverty [1]

This perspective emphasizes ill health as an obstacle to economic progress. Nevertheless, this does not mean that the condition of poverty do not lead to disease or ill health. Causality almost certainly runs in both directions generating a mutually reinforcing vicious cycle. In addition, the gap in health between the rich and poor remains very wide as it does also between other advantaged and disadvantaged groups defined, for example, by ethnicity, caste, or place of residence. Addressing this problem

between and within countries poses the greatest challenges of the new century to all health workers. The premise is that failure to do so properly will have dire consequences for the global economy, for social order and justice, and for civilization as a whole.

In this paper inequity is used rather than inequality, in that the former refers to inequality that are judged as unfair and unjust leaving out inequality that are biologically and socially inevitable [2]. The following assumptions are made in the paper:

- That inequity in health care is undesirable and should be red
- That inequity in health may be a cause of social instability as it can ferment discontent and intergroup conflict that may disturbs the social order in a country.

The objective of this paper therefore is twofold, first is to increase our understanding of the magnitude and nature of the problems caused by inequity in health. Secondly to stimulate the necessary movement from analysis to action in order to correct the problems identified by research literature.

Analysis of inequity in health in health care

Several definitions of equity appear in the health-related literature. Equity implies an approach that gives more to those who have little, and thus less to those who have much[3]. Equity, thus infers fairness in the way that resources and burdens are distributed across the population, and reducing inequities in that distribution. A philosophical viewpoint of equity focuses equity on the ethical principle of justice, [4] while an economic perspective focuses on how an individual income and wealth can directly influence their health status. [5] These definitions illuminate the complexity of the concept, in that, though equity is about fairness and justice it can mean one thing to one person and something completely different to another. Thus, it can be argued that equity within the context of health care services is not to eliminate all health differences so that everyone has the same quality of health but rather to reduce or eliminate those which result from factors which are considered to be avoidable and unfair. An equity approach stands in contrast to a 'basic needs approach' or 'poverty approach' which focuses on the poor and the disempowered without relating their condition to the rich and the powerful. The premise that some individuals and communities are disadvantaged not through choices but as a result of structural inequalities such as housing, education, income and employment.

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Ecological approach to understanding health inequity

Inequity in health is an extremely complex phenomenon that has its roots in the interaction of many factors, biological, social, cultural, economic and political. An ecological model is used. The model was first introduced in late 1970's for the study of child abuse [6]and has been used in other field of violence research. The major advantage of the model is that it helps to distinguish between the myriad of influences on equity in health while at the same time providing a framework for understanding how they interact.

The model is composed of four levels. The overlapping in the model illustrates how factors at each level are strengthened or modified by factors of another. The first level identifies biological and personal factors that can influence health of an individual. Each individual has a number of characteristics and attributes that can affect his/her health status. These include their income and wealth, their educational level and knowledge on health issues, their use of health services. At this level, there are also a number of behaviours that can directly enhance health - such as exercise, health care seeking - or directly harm health - such as smoking, alcohol abuse, and obesity. These factors are particular to each individual and, for the most part, do not have a health effect on those around them.

The second level deals with determinants of health that arise from inter-individual relationships. This refers to factors that affect health that are particular to the individual's position in society with respect to those around him. This may include rank, distance and networks. Rank is an individual's position in the social hierarchy. Distance is a measure of how far individual A is from all those above

him. This is very important in Africa with the extended family social structure.

The third level explores the community context in which social relationship occur, such as schools, workplace and neighbourhood. This level also seeks to identify the characteristics of these settings that increase inequality in health. Inequality in health at this level can be influenced by socio-cultural factors such as population density of a particular community, high level of unemployment, child abuse, drug trafficking, etc.

The fourth level looks at the broad societal factors that help create inequality in health. These include political and environmental factors. Social and cultural norms are not left out either. Example of such factors would include the structure of the health system, norms that entrench male dominance over women and children, and those that support political conflict. Large societal factors would include economic, educational and social policies that help to maintain economic and social inequality.

Underpinning the ecological approach is the general system theory in which levels one to four are treated as subsystems with semi permeable boundary that permits the process of adaptation to other systems and environment. Each sub-system must interact to achieve the ultimate goal of the system, which in the context of this paper equity in health. The implication is that the implementation of health care delivery system must take cognizance of the ecological factors in order to reduce inequality in health. Thus, the survival of Nigerian health care as a social and open system must be flexible and innovative, and consumer-centered.

Equity is closely related to the concept of equality. Equality is essentially concerned with universality and does not take cognizance of individual characteristics and merely demands that everybody be treated the same way. In actual practice, this is impossible because it has failed to recognize the biological and societal factors that may limit the use of that particular services/intervention. The inverse care law [7], which says that the availability of good medical care tends to vary inversely with the need of the population served, succinctly demonstrates this. A possible corollary to this law is that new health intervention will tend to increase inequities. Since they will be applied preferentially to those with better baseline health status and therefore will tend to increase existing gap at least initially.

How the Health System Can Contribute To Inequity

At this junction it is pertinent to explore how the health system can contribute to inequity. The health care system of United Kingdom (UK) and sub-Saharan Africa especially Nigeria are used to illustrate this.

The United Kingdom National Health Services (NHS) "market-led" reforms has been criticized for its inability to decrease equity in health care despite the fact that the original interest embodied universalist principle that explicitly sought to redress existing inequalities.. The design of UK NHS embodies (i) an explicit compromise with the organized medical profession, (ii) has a social hierarchy, (iii) the funding systems favour hospitals treatment though there is a cosmetic appeal to preventive care, (iv) there is a strong evidence that variability in access and quality of curative care favour the middle class.

The health system structures in the sub-Sahara Africa parallel that of UK in terms of inequity in services provided. The health system followed a prescribed model and is strongly controlled by donor agencies and the World Bank. The demand and cost of medical training as well as financial reward imply that doctors tend to be drawn from the more privileged social group and are better rewarded. Big differences remained between rural and urban health services in terms of access and quality of services. Though there is eloquent display of the natural philosophy, subsidy pattern that focused on the treatment of public servants and the military favour the better off. There is inadequate allocation of both maternal and human resources. Other characteristics of the system include; Inadequate funding which has led to infrastructural decay and low morale of health personnel who have no tools to work. The payment of the salaries is left to the whims and caprices of administrators and politicians. This inadequacy of fund, to which is further compounded by inefficient fund utilization, bribery and corruption, over invoicing, cost overrun over inflation of contract.

A significant proportion of Nigerian population does not enjoy a level of health that will enable them to achieve socially and economically productive life. Women and children are the worst hit in the web of poverty. Women are raped and tortured, while planned and funded immunization of children has been turned into a political rally to win a vote or support from the community. Politicians and their wives are often videoed immunizing children in a most awkward process. Poverty causes pain and reduces energy that is needed to be economically productive.

In Nigeria the health sector reform tend to be prescriptive in content, which implies that they favor inequity in health. The reform is strongly driven by donors agencies whose operations are often vertical rather than being horizontal. In this context the donors' objectives explicitly include targeting public c sector, resources to where they will most reduce the disease burden, and filling gaps in the primary and preventative care system for the poor in order to do this. Improving the allocation of health care resources and improving equity are both highly desirable objectives. But, the prescriptive approach it can be argued is legitimizing

existing and emerging structural market-based inequity within the health care institutions.

Changes in social sector have further fuelled inequity. Social reforms have been interspaced with fiscal crises and wars. These crises have resulted in widening income distribution, poverty, and decreased employment, etc. What then is the way out?

Way forward

At the centre of the discussion of equity is fair allocation of shares to the extent that a basic level of services is available to **all persons** and are able to benefit from it. The question then is how to ensure allocation of fair shares. Osterle [8] articulated a framework for achieving equity. This includes;

- **WHAT is to be shared (e.g. resources, burdens);**
- **Among WHOM (the recipients); and**
- **HOW (the principles)"**
  Achieving equity in regard to "what

This infers defining a minimum set of services or level of resources that it is reasonable and acceptable for persons to have access to. This may also involve defining the particular quality standards or expectations, the level of satisfaction, the level of involvement in decision making, or empowerment

Achieving equity in regard to the "whom"

This implies that all persons should receive an equal share, but in realities some people may be excluded from these services through social circumstance, geographical location or other factors. The ability to achieve good health or, conversely, the risk of suffering ill health, is affected by socio-economic status, geography, labour market participation, education, gender, sexual preference and a host of other elements that impact, both directly or indirectly on one's ability to achieve and maintain good health.

Achieving equity in regard to the "how" Central to this is the extent that the amount of resources allocated should in some way reflect the "need" of the people, so that "if the needs of A and B are unequal, they should receive an unequal amount of treatment or support. However it can be argued that need is a relative term in itself, and can be measured in different ways, such as mortality, morbidity or quality of life.

Implication

Empowerment of Patient

Patients should be given more power to choose the treatment they receive, not only in term of which doctors or hospital treats them, but also the type of treatment used (extending also to alternative or complementary medicine), and, where possible, the time and place of treatment or consultation The professional-dominated health care system does not encourage individuals to believe that they have much or any control over their own health. The prevailing medical models, has discouraged people from feeling responsible for their own health. Health workers have a major role to play in dispelling this illusion, through adopting models of health promotion and beginning to run a health service rather than a sickness service with the patient or client as a partner in care. The value of this radical change in practice is amply borne out by indications that, when given the information and opportunity, patients do correctly self-diagnose and choose appropriate treatment.

Exerting Influence

In many countries there is external influence on health often by politicians. This poses continuing problems and the use of power and politics is central to rectifying this imbalance. Health workers should be able to use effective strategies to manage these situations and present their particular point of view. Techniques such as networking, creating alliances, negotiation, and management of conflict and confrontation should become part of the armoury of every health worker in a leadership position. Education in these skills should take place in a variety of settings during educational courses, through in-service training, in political workshops, as well as in the family/community environment.

Intervention and strategies that cut across different levels as depicted in the ecological model.

These should include: Addressing the larger cultural, social and economic factors that affect access to health and taking steps to change them, including measures to close the gap between the rich and the poor and to ensure equitable access to goods, services and opportunities; public education campaign using the media to target entire communities or educational campaigns for specific settings such as schools, workplaces, and health care and other institutions; Government should provide the basic infrastructures in the rural area and take health care services to the people wherever they are. Provision of the basic infrastructures that is not only functional but be user-friendly and user-procured; Effective poverty alleviation strategies. "Top-Down" approach to fighting poverty has failed. One theme that is emerging from researches on poverty alleviation [2 , 5]Leon and Walt. 2001; UNDP 2002) has been the importance of a "Bottom Up" participatory approach that listens more to the poor themselves, and that allows all stakeholder to come together to solve development problems. "The Bottom-Up approach, it can be argued creates much stronger ownership among beneficiaries and stakeholders, which traditional top-up

approaches have lacked. Adopting the new approach by Nigeria in effect means abandoning past approaches in which government, specially the central government, alone decided what the development challenges were, what the needs of the poor people were, what needed to be done about this and how this be done. The new approach actually requires committed, clear-minded leadership by health professional for it to be effective. Perhaps, there is an even more critical role for nursing in the sense that nurses must act as advocate for the disadvantaged in the society.

In this paper attempts have been made to explore the concept of inequity within the context of health and its influence on heath care of the masses. An emerging fact is that inequity in health is not static it is dynamic and driven by the interplay of biology, social organization and health system. The challenge is that all health workers must be equipped with the knowledge and skills that ensure care provided is acceptable, efficient and accessible.

It is hoped that this paper will stimulate all health workers to take a fresh look at the problems of the triad- inequity, poverty, and health and in so doing contribute their quota in tackling this health issue.

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