

Discussion paper

The relevance of equity in health care for primary care: creating and sustaining a 'fair go, for a fair innings'

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ABSTRACT

This paper provides an 'equity lens' through which practitioners, policy makers and researchers can measure and monitor the equity of healthcare services provided. An argument is put forward which shows that services need to be assessed in terms of inequities, as opposed to the more often used terms of inequalities or disparities. This is not just a semantic argument, rather it is based on the foundations that service provision should be *socially just*. The paper then outlines some of the key domains involved in

measuring the equity of health care – access, need and utilisation. The paper concludes with some of the reasons for the current equity problems in healthcare services and suggestions for ways forward in terms of developing more equitable healthcare services.

Keywords: access to healthcare, equity of healthcare, healthcare need, healthcare utilisation

How this fits in with quality in primary care

What do we know?

There is a relatively large amount of research literature on variations or inequalities in access to, and provision of a wide range of healthcare services. However, much of this empirical research does not provide either a theoretical framework to understand these inequalities (termed inequities in this paper) or potential ways forward to address and ameliorate them.

What does this paper add?

This paper provides a synthesis of theoretically informed literature on the concept of 'equity' (as distinct from equality), in addition to ways in which practitioners and researchers can measure and monitor the equity of the services they deliver (through measuring concepts such as need, access and utilisation). In addition, the paper also justifies the central role of primary health care in developing equitable health care and ultimately equitable health.

Introduction

One of the most important and underpinning principles of healthcare systems in the developed world is based around the notion of equity, whereby healthcare services should be provided solely on the basis of clinical need. However, there is a huge research literature demonstrating that access to, quality of, and outcomes

from health care are inequitable across a number of clinical areas, including screening for a variety of cancers,^{1,2} surgical interventions,^{3–5} and primary care prescribing.^{6–8} These examples reflect or even fulfil Julian Tudor Hart's notion of the 'inverse care law',⁹ whereby the groups with the greatest levels of

healthcare need receive the lowest levels of service. The main purpose of this paper is to provide an overview of some of the conceptual tools involved in measuring the equity of healthcare services. Obviously, the main readership of this journal will be primarily interested in the equity of primary care services, although these concepts can be, and have been, applied to a variety of healthcare services.

While much of the public health research literature on equity focuses on *equity in health* (i.e. in terms of morbidity, mortality, and proxies of illness/wellbeing using measures like quality-adjusted life years and disability-adjusted life years), this paper focuses attention on *equity in health care*. The definition of health care used in this paper is fairly wide, and includes preventive services, treatments, acute and chronic services, and services provided by a vast array of medical, allied health and social care professionals

The link between 'healthcare equity' and 'health equity' in primary care

By striving for a goal of 'equity in health', healthcare systems need to strive for the elimination of all systematic differences in health status between groups on the basis of socio-economic status (SES), ethnicity, age, gender and so on. Therefore, the goal of equity in healthcare is to closely match services to levels of need within communities. Obviously this may result in large differences in access and use between different socio-economic groups, favouring those groups in greatest need. This is the concept of 'vertical equity', which is outlined later in the paper.

There is substantial epidemiological evidence on the nature and extent of the impact of different levels of healthcare systems on health.¹⁰ This evidence points to the fact that both healthcare systems and services promote population-level health, independent of other influences. Compelling evidence is also provided on the specific role and impact of primary care on population health: population health is better in areas with more primary care general practitioners (GPs); individuals who receive care from primary care GPs are healthier than those who do not; there is an association between preventive care and improved health; and countries with stronger primary-level care services have populations with better health, especially when health policy is supportive of primary care.¹¹⁻¹³

Numerous epidemiological studies and policy documents point to the effectiveness of investing in illness-prevention programmes across a whole range of cancers.^{14,15} A number of studies from the United States

have found that increasing access to primary care is associated with decreasing (avoidable) hospitalisations, and more equitable health outcomes.^{11,16,17} These studies highlight the positive impact of investing in primary care on avoidable hospitalisations, and also the equitable impact that primary care has on vulnerable groups. An Australian review of primary and community health services found positive and equitable impacts of a primary care approach on patient and community wellbeing, reduced mortality and morbidity, and also reduced healthcare expenditures.¹⁸ There is considerable justification for the positive impact of investing in equitable primary health care on both overall health and more equitable health outcomes through the reduction of health inequalities. Therefore, healthcare planners and providers now have the evidence to defend the planning and provision of equitable healthcare services and systems, on the basis of improving overall population health in addition to lowering the gap between those groups with the best and worst health outcomes.

Inequity, inequality and disparity – what's the difference?

Across the World, terms like 'inequalities', 'disparities' and 'inequities' are often used interchangeably in academic and policy literatures,¹⁹ and even when they are defined, there seems little consensus about their meaning or measurement.^{12,20} The terms 'inequality' and 'disparity' tend to be used in different geographical contexts, with 'inequality' being preferred in Western Europe, whereas 'disparity' tends to predominate in the US.²⁰ Nevertheless, the two terms are very similar in meaning – essentially they are defined by 'difference' with no reference to the context, nature or direction of the difference or who may be adversely affected by the difference. In this way, disparities or inequalities in health care may simply refer to differences in the use access, availability or quality of health care for different groups.

The central ingredient missing from definitions of inequality or disparity is the idea of 'social justice' or 'fairness'. This is where 'equity' becomes particularly useful, since it focuses research, policy and practice on exploring, attending to and monitoring health care, which is deemed to be 'unfair'. There may be differences in healthcare use between groups, but is it fair? For example, we may find that older people use particular healthcare services more than younger people – but that does not necessarily mean that access to those services are inequitable (i.e. unfair to younger people). It may just be the case that the older people are in

greater need for the specific services. Indeed, it may actually be the case that the older people are not in fact receiving high enough levels of those services, and therefore, the services may be inequitable in the opposite direction. Nevertheless, 'fairness' or 'social justice' is the key area of concern.

Defining, measuring and monitoring the equity of health care

There is a large amount of literature around how to define, operationalise and measure equity in relation to primary healthcare services,^{12,13,20–22} where equity is generally taken to mean 'fair' or 'socially just'. Equity has been generally conceptualised as either *horizontal equity* or *vertical equity*. Vertical equity works on the principle that individuals/groups that are 'different' should be treated differently, according to their levels of healthcare need. While this is fairly uncontroversial, it is not straightforward to operationalise and monitor in a public health context. Horizontal equity works on the principle of equal treatment for individuals or groups with the same (or similar) levels of healthcare need. For the example of cervical cancer screening, the major determinants of 'need' for population-based screening would be age and sex. Therefore, using the framework of horizontal equity, one may expect that the provision, access and uptake of cervical cancer screening services would be similar between a group of 50–60-year-old women in one town and a similar group of women in another town. If there were systematic differences in uptake of cervical cancer screening services (i.e. differences in terms of social class, ethnicity etc), then we could suggest an inequitable uptake.

Equity of health care has been divided into three domains: equal *access* to health care for people in equal need; equal *treatment* for people in equal need; and equal *outcomes* for people in equal need.²¹ While this is a simplification of the nature of equity, it is useful in delineating the various domains in which inequities may arise. However, implicit in these domains of equity are terms which themselves require definition. For the purposes of this paper, we briefly mention two of these terms – access and need.

In a seminal paper, Aday and Andersen outlined different mechanisms for understanding and defining access.²³ They coined the terms 'potential access' and 'realised access' to differentiate between providing the mechanisms for people to access services (e.g. culturally appropriate information, adequately located services, appropriately staff mix etc) and the actual utilisation of those services. Goddard and Smith have built on

this definition of access, to provide the following:²¹ 'the ability to secure a *specified* range of services, at a *specified* level of quality, subject to a *specified* maximum level of personal inconvenience and cost, whilst in possession of a *specified* level of information' (p. 1151, italic added). This definition begins to make 'access' amenable to policy makers, since the word 'specified' allows them to shape access in relation to local circumstances (i.e. allow for differences).

In terms of defining 'need', we can only scratch the surface here. There is a huge amount of literature spanning philosophy, social policy, economics and public health, which covers everything from basic human needs,^{24,25} through human rights and capabilities,^{26–28} through to health needs assessment.²⁹ For our purposes, a useful way of conceptualising healthcare need is the 'taxonomy of need',^{30,31} which is widely used in healthcare needs assessment. This taxonomy has four domains of need, each of which represents a different dimension of need which can be studied separately, although when combined, Bradshaw states that we can get somewhere close to understanding overall need.^{30,31} The first domain is 'normative need' which is that defined by an 'expert'. This 'expert' may be in the form of a local GP, school teacher or evidence-based guidelines for the treatment of a particular group of people (e.g. risk factors for lung cancer). The second domain is 'felt need', which is determined by asking people what they feel they need (i.e. akin to 'wants'). This domain assumes perfect and equal information across groups in society about what services are available, which is obviously contestable.^{32,33} The third domain is 'expressed need', which may also be conceptualised as 'service utilisation'. This may be measured through activity statistics, prescribing data, surgical statistics, etc, although not all 'felt need' gets turned into 'expressed need' – there will be groups of people who experience unmet need. The fourth domain is 'comparative need', which is akin to horizontal equity. Comparative need is determined by studying the characteristics of differing populations in receipt of differing levels of a service (e.g. differing rates of cervical cancer screening). Using the example of cervical cancer screening, a comparative approach to need would assess the differences in screening rates between population A and population B, weighted to take account of the relevant risk factors in the patient populations. However, it needs to be remembered that this approach is purely comparative. Therefore, if population A is deemed to be in need in comparison to population B, this does not necessarily mean that population B is not in need – the screening rates of population B may not be at an adequate level. This approach merely attempts to assess comparative need (or equity), and makes no judgements about the appropriateness of screening rates.

In summary, understanding the equity of primary healthcare services requires us to also understand the related concepts of access, need and utilisation of those services. In order to fully understand the equity of primary healthcare services and respond to any areas of inequity, we need to be able to measure and monitor both need for those services and access (potential and realised) to the services.

Some evidence on the (in)equity of primary healthcare services and suggested reasons for inequitable healthcare systems

Evidence on uptake rates of screening for cervical, breast, bowel and skin cancer suggest inequitable patterns on the basis of a variety of factors such as gender,^{34,35} ethnicity,^{36,37} and socio-economic status.^{2,38} With respect to bowel cancer, incidence does not vary greatly between socio-economic groups, although survival shows a distinct gradient whereby patients in higher socio-economic groups survive longer than those in lower socio-economic groups.³⁹ In addition, incidence of bowel cancer is lower in indigenous groups than non-indigenous groups, although mortality rates are actually higher in indigenous groups.^{40–42} One of the reasons for this may be that people in lower socio-economic and indigenous groups present at a later stage of many cancers compared to other patients,^{41,43} which may be partly due to inequitable access to cancer prevention (including screening) and treatment in these groups.^{2,38,42} In addition, inequitable bowel cancer screening in general may reflect differing cultural expectations of cancer screening^{44–47} and preventive health care,^{48–50} and also different cultural meanings regarding both cancer^{49,51,52} and parts of the body often regarded as ‘dirty’.^{53–55} Research is required to understand differing views, perceptions and potential enablers and barriers to bowel screening, in addition to its meaning and cultural appropriateness.

A number of reasons have been put forward for the ‘equity problems of health systems’.¹⁰ Firstly, most health systems have weak population health and health-equity orientation. With only limited and unsustainable efforts being made at developing equitable health systems, the result is often the exclusion of socially and materially disadvantaged groups. Secondly, health care is rarely pro-poor, which means that services and systems are not necessarily offered on the basis of healthcare need, which is often highest in materially disadvantaged groups. There is a great deal of evidence that higher-income groups make more use

of services, get better access to services, receive higher-quality services and get better health outcomes on the basis of these services. Finally, it has been suggested that socially marginalised groups often experience health care as demeaning and exclusionary, which results in poorer health outcomes, lower self-reported health status and a denial of dignity and basic human rights.

The driving forces behind the problems outlined above are often more macro in orientation, but can be conceptualised by two main forces: commercialisation through a neo-liberal economic agenda; and public sector organisational culture and capacity. Health systems are obviously not immune to the globalised push towards a market-driven economy, whereby governments privilege privatisation, consumerism, and commercialism. Both internally and externally, health systems that are funded by governments have to buy into these ideologies, and this can be seen internally by the increase in private health insurance, and increased competition between healthcare providers. Externally, the health system is in competition with other systems and organisations for scarce resources, which makes notions of ‘intersectoral working’ or ‘whole-of-government’ thinking more difficult. The increased impact of commercialisation has been linked to worse and more inequitable access to healthcare services, and the greater reliance on private healthcare providers has been linked to increased inequities in treatment rates and outcomes between socio-economic groups.¹⁰ There is also evidence that current levels of inequity in health care (and hence health) are compounded by organisational culture within public sector organisations internationally.¹⁰ Such cultures are conceptualised as hierarchical, rule-bound and rigid, which impedes innovation such as intersectoral working and action. Also, such cultures often facilitate and maintain power and decision making with medically trained doctors, who are trained to look at individuals (or their organs or diseases) and provide curative care, rather than preventive care for populations and sub-groups of populations with the highest levels of need, which does not enhance the potential for health systems to focus on either population-based approaches or, more specifically, on an equity-based approach to policy and practice.¹⁰

Conclusion

This paper has set the context for research, policy and practice around the equity of health care within the broader theoretical framework of the social and economic determinants of health. In other words, striving for a more equitable society means striving for equity

within all social systems (e.g. legal, medical, economic, political, etc). The paper then went on to outline the differences between inequality and inequity and to provide a framework for conceptualising, operationalising, measuring and monitoring the equity of health care. The paper then went on to justify the central role of primary health care in developing equitable health care and ultimately equitable health. Elements of this primary healthcare approach should include intersectoral action to address the social determinants of health and focus on health equity, individual and collective participation by all groups, organised ways of guaranteeing universal coverage and service acceptability/appropriateness, and the emphasis of promotion and prevention. Overall, this would help to address the current inequities in health care outlined throughout this paper and focus on creating and sustaining health equity, or as one might say, 'a fair go, for a fair innings'.

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CONFLICTS OF INTEREST

None.

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