4 The Achievement of Equity within the Health System

4.1 Overview

The goal of equity within the health system is regarded as fundamental and recognised universally as a cornerstone of health policy. However, equity needs to be clearly defined in order for it to have practical value in the determination of health policy.

The distribution of health resources within South Africa, both within the public sector and between the public and private sectors, demonstrate large variations that could be regarded as inequitable. Government policy has to determine when this variation acceptable and when unacceptable.

This section reviews the issue of equity and how an understanding of it can be used to underpin Government policy from a practical point of view.

4.2 Defining Equity

4.2.1 Review

Amongst the countries of Western Europe there is general agreement that the provision of health care services cannot be left to the unregulated market. If it were, health care would become very expensive resulting in significant and unacceptable gaps in insurance coverage. (Able Smith, 1992, p.217).

Able-Smith (1992, p.218) lists the following specific issues upon which there is consensus amongst the countries of Western Europe:

(a) Nobody is denied any important health care because of inability to pay. Dentistry, other than emergency dentistry, and optical care are often regarded as less important services, at least for adults, for which they can self-fund.

(b) With the possible exception of higher income groups, health insurance is prevented from developing risk-rating, either according to individual risks, or according to number of an insured person's dependants. Health insurance deliberately avoids applying strict actuarial principles.

(c) *National health insurance is very different from private health insurance.* With the possible exception of high-income groups, health services for the compulsorily insured are not left to the functioning of the unregulated market because three vital elements for the functioning of such a market are missing. The first is informed consumers, who know precisely what they want to buy. Secondly, the need for health care cannot be known in

advance and, when it comes, it can be very expensive. The third is the lack of separation between the functions of authorising purchase and supplying it. Consequently, health services are prepaid by some mix of taxes and health insurance contributions.

(d) A complex mix of regulation and control has emerged in each country with differences as to how each aspect is applied.

According to Roemer (1980, p.190), in spite of the counteracting pressures of an entrepreneurial ideology in all countries, the long-term trend appears to be in the direction of achieving greater equity through rational organisation. In other words, the entrepreneurial pressures for regarding health care as a commodity, i.e. a consumer good to be bought and sold in the market place, are gradually being overcome by the social pressures for the distribution of services according to concepts of equity, that is, according to each person's human needs.

All 32-member countries in the World Health Organisation (WHO, 1985) European Region adopted a common health policy in 1980, followed by unanimous agreement on 38 regional targets in 1984. The first of the targets is concerned with equity:

"By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25 percent, by improving the level of health of disadvantaged nations and groups."

Whitehead (1992) produced a discussion paper on the "concepts of equity and health" as part of the programme on Equity in Health in WHO's Regional Office for Europe. The paper represents an attempt to create a practical tool for policy-makers through distilling the collective wisdom obtained from the Equity in Health programme. The intention was to establish a working definition of equity as understood within the context of WHO's Health for All Policy. The conclusions of this paper and the inter-disciplinary advisory group that reviewed the initial draft are summarised below.

According to Whitehead, the term "inequity" as used in WHO documents refers to differences in health that are not only *unnecessary* and *unavoidable*, but in addition, are considered *unfair* and *unjust*. An important criterion used to determine which situations are unfair is the degree of *choice* involved. Where people have little or no choice of living or working conditions, the resulting health differences are more likely to be considered unjust than those resulting from health risks that were chosen *voluntarily*. The sense of injustice increases for groups where disadvantages cluster together and reinforce each other, making them very vulnerable to ill-health. From this view Whitehead arrives at the following working definition:

Equity in health implies ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that none should be disadvantaged from achieving this potential, if it can be avoided.

Based on this definition, according to Whitehead, the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level and quantity of health, but rather to reduce or eliminate those which result from factors that are considered to be both *avoidable* and *unfair*. Consequently, equity is concerned with creating equal opportunities for health, and with bringing health differentials down to the lowest level possible.

Whitehead criticises some potential definitions of equity on the basis that they do not satisfy a common sense understanding of equity. For example health services could be based on equal per capita expenditure. However, if this objective were achieved it would make no allowance for differential needs for care in different age and social groups in each region. Consequently such a definition could not be considered equitable. At the other extreme equity could be defined as the achievement of equal health status between all communities, age groups and social groups. This view is criticised as variations in health care services are only one of the many factors contributing to health differences between communities.

Based on the earlier working definition, and accounting for the short-comings of alternative definitions, the following definition is adopted by Whitehead:

- *Equal access to available care for equal need*: This implies equal entitlement to the available services for everyone, a fair distribution throughout the country based on the health care needs of access in each geographical area, and the removal of barriers to access.

- *Equal utilisation for equal need*: Care needs to be taken in interpreting this goal. If differences are found in the rates of utilisation of certain services by different social groups, this does not automatically mean that the differences are inequitable. Rather it is an indication that further research is needed to ascertain why the variations exist.

- *Equal quality of care for all*: It is important that every person has an equal opportunity of being selected for attention through a fair procedure based on need rather than social influence. This issue is most important when resources are scarce or are being cut back. In such a climate it will appear unfair to many if members of particular, social, ethnic, or

racial groups were consistently regarded as the lowest priority when it came to medical treatment. Equal quality of care for everyone also implies that providers will strive to put the same commitment into the services they deliver for all sections of the community, so that everyone can expect the same standard of professional care.

4.2.2 Equity Subject to a Budget Constraint

The emerging consensus is for a substantial quantity of health care services to be provided on an equitable basis. However, all systems face a budget constraint. Constant improvements in medical technology may effectively increase the needs that can be satisfied using health care. The introduction of new technology often adds costs to a health system without making a major contribution to health outcomes. Furthermore, new interventions, being expensive, cannot be afforded for an entire population, especially in developing countries. In developing countries, given their budget constraint, this often obstructs the development of priority services, as the new technology drains financial resources, which could contribute to a deterioration in the population's health.

Mahler (1975) draws attention to the increasing disparity between the tendency to expand health care coverage, often to universal access, and the restrictive application of high technologies to specialised curative services. In other words, the higher the peak becomes, the more difficult it is to provide a universal system. Furthermore, the creation of a peak directed towards the few is selected not so much by social class or wealth, but by medical technology itself. (Kleckowski, 1980, p.101).

Consequently, the achievement of equity within the context of a budget constraint implies the conscious application of a limit on the services that are made available on an equitable basis. In addition, the introduction of new services would have to be on the basis that they lower the costs and improve the outcomes of existing interventions. As the wealth of a country increases, it will become feasible to increase the amount of services provided on an equitable basis.

4.2.3 Understanding a Definition Within the South African Context

Creating a practical definition of equity for use in developing policy in South Africa has to focus on defining both principles and mechanisms for achieving the goal of equity taking account of substantial disparities in income and relative needs and demands for health care. On the one hand the system cannot unfairly deny services from groups unable to afford the cost of health care. On the other, certain services cannot be denied to groups who are able and willing to pay for them.

The following are therefore a set of guidelines for the purposes of this report that can aid in establishing a useful definition:

- *General policy principle*:The guiding principle of policy needs to focus on providing an equal entitlement to the available services for everyone, a fair distribution throughout the country based on the health care needs of access in each geographical area, and the removal of barriers to access.

- *Constraints*: There has to be a clear recognition in policy of the existence of resource constraints and how policy has to react to ensure that equity is not compromised through a failure to adequately prioritise services. Government will have failed in its task of achieving equity if it lacks a rational approach to defining what services must be available to all within existing financial constraints. Defining and costing universal minimum service requirements irrespective of income, funder or provider, is an effective way of ensuring that resource constraints are rationally and fairly accounted for in policy.

- *Income cross-subsidies*: Income differentials are a fact of life and must become part of the rational design of health systems. Government has to establish a clear policy on how a system of income cross-subsidies is to be achieved, both in funding the non-contributory sector as well as the private sector. Where higher income groups diminish the availability of health services within the non-contributory public system, policy measures and instruments will have to protect the availability of services.

- *Health-related cross-subsidies*: Different groups have different needs for health services based either on factors such as age or gender, and because of socio-economic differences. Policy responses have to define how it will balance these differences through explicit resource allocation within public sector systems, or ensure cross-subsidisation from healthy to sick within insurance systems.

4.3 Strategic Elements of the Health System Affecting Equity

4.3.1 Overall level of funding for the health system

The overall level of funding going to health care is determined partially by government policy and partly by voluntary contributions. Where funding is either tax-based or mandatory, services are largely shared. Where voluntary contributions occur services are provided on an exclusive basis. The overall level of funding within tax-based or mandatory systems can have a significant effect on whether services are accessed on a shared or on an exclusive basis. If funding levels are too

low, more services will be available in the exclusive rather than the shared public system. Apart from the equity considerations, this could also result in significant organisational inefficiencies and additional costs.

Government can impact on this area by:

- Directly taxing income earners more to fund an increased public service;
- Create a mandatory contributory environment in which a greater degree of equity is achieved within specified income groups; and
- Permit the use of funds from the voluntary contributory environment to promote the expansion of services in the shared service or public environment.

There is no apparent strategic focus by Government which attempts to understand the implications of higher or lower levels of funding for the public system.

4.3.2 Income-based cross subsidies

Income-based cross-subsidies are generally achieved through the tax system, or mandating insurance in a manner that closely follows normal tax principles. *In essence people pay according to their means, but receive benefits according to their needs*. The following instruments are important within the South African context:

- The level of general tax funding for public services;
- Subsidies to the private sector (tax subsidies versus on-balance sheet per capita subsidies);
- Contributions to medical schemes (flat-rate versus income-based); and
- Mandating contributions to either social health insurance or medical schemes.

The redesign of the income tax subsidy represents the only viable short- to medium-term measure for achieving minimum required income-based cross-subsidies across the entire health system, both public and private.

4.3.3 Health-related cross-subsidies

Health related cross-subsidies are achieved differently in the public sector settings where services are subject to physical planning process, and insurance environments where access is entitlement-based.

The objective of the public sector is to achieve an equitable distribution of services on a regional basis within budget constraints.

Within insurance-based systems there is a need to protect cross-subsidies from those who are healthier to those who are sicker to prevent their systematic exclusion from cover. Health funds (medical schemes) must also be protected from the consequences of having disproportionately sicker groups of people where this arises.

The public sector has the following instruments:

- *Inter-regional resource allocation*: However, the current fiscal federal environment prevents this from being achieved on an inter-provincial basis through national policy. There is also no clear framework for dealing with local government and district services.
- *Minimum norms and standards*: This instrument can be used to create and implement a national policy framework, or to impose conditions on provinces limiting their discretion to allocated funds elsewhere.
- *Conditional grants*: Conditional grants can be used to ring-fence allocations consistent with policy objectives linked to the achievement of equity.

Within the contributory environments the following instruments are available:

- Open enrolment: which prevents any individual or group from permanent exclusion from cover;
- Community rating of schemes: which prevents exclusion on the basis of health risk status (as contributions are determined on the basis of the average cost of the group and not of the individual); and
- Risk-equalisation between schemes: which balances out the implications of uneven distributions of sicker groups between schemes.

4.3.4 Basic essential service and benefits

In order for equity to have practical meaning it must be expressed in terms of actual services or conditions which must be provided on an equitable basis. Policy instruments may differ between public non-contributory and private sector settings. Nevertheless, the principles remain the same.

4.3.5 Public sector

The public sector will have to define minimum services primarily through the establishment of a minimum basic package of services. This can be expressed practically in terms of policy through the establishment of service norms and standards.

4.3.6 Private sector

The Medical Schemes Act No.131 of 1998 introduced prescribed minimum benefits as a policy instrument for defining minimum allowable levels of medical scheme cover. This involves a positive list of conditions and treatments.

4.3.7 Requirements for the future

There is no coherent approach as yet to defining the basic essential minimum services between the public and private sectors. Ultimately both systems will need to provide a minimum core set of services which are consistent with one another. Once rationally defined, Government will have to establish clear mechanisms for ensuring that the desired entitlements can be met in an equitable manner in both settings.

4.4 Concluding Remarks

Given that South Africa is a developing country, it has to confront great income disparities, and resource constraints. The set of required instruments for achieving a coherent and integrated system of subsidies needs to cater for complex relationships between and within the public and private sector settings. The nature of health care provision is such that it naturally diverges from equity irrespective of whether publicly or privately funded.