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EQUITY IN HEALTH CARE

EQUIDAD EN SALUD

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Resumen

Es ampliamente conocido que un gran segmento de la población disfruta de un mayor status de salud y de una mayor calidad de cuidados para su salud que otros. Para resolver este problema, priorizar es inevitable, sin embargo el problema surge al pensar en la manera de llevar a cabo estas prioridades. Lo más racional sería buscar la equidad entre toda la población, la manera en que toda la gente reciba el mismo cuidado para la misma necesidad. Equidad en el cuidado de la salud es un imperativo ético no sólo por el valor intrínseco que tiene el poseer una buena salud, sino que sin una buena salud las personas serían incapaces de disfrutar de otros beneficios que la vida les puede proporcionar. Este artículo también explica cómo la eficiencia en el cuidado para la salud también es importante, pero al mismo tiempo, cualquier innovación y racionalización llevada a cabo para la provisión del sistema de salud debería estar basada en la dignidad humana, haciendo a la persona prevalecer sobre criterios económicos.

Por lo tanto, este artículo está basado en derechos humanos fundamentales. El principal objetivo es asegurar que aquellos que tienen deberes públicos implementen los derechos esenciales de la persona humana. Desde este punto de vista, equidad sugiere igualdad: igualdad en acceso a los servicios y tratamiento, e igualdad en la calidad del cuidado proveído. En conclusión, este artículo intenta poner juntos la dignidad humana y la eficiencia en el contexto de equidad reconciliándolos en un terreno común.

Palabras clave: Equidad, eficiencia y dignidad humana.

Abstract

It has long been known that a segment of the population enjoys distinctly better health status and higher quality of health care than others. To solve this problem, prioritization is unavoidable, and the question is how priorities should be set. Rational priority setting would seek equity amongst the whole population, the extent to which people receive equal care for equal needs. Equity in health care is an ethical imperative not only because of the intrinsic worth of good health, or the value that society places on good health, but because, without good health, people would be unable to enjoy life's other sources of happiness. This paper also argues the importance of the health care's efficiency, but at the same time, it highlights how any innovation and rationalization undertaken in the provision of the health system should be achieved from the consideration of human dignity, making the person prevail over economic criteria.

Therefore, the underlying principles on which this health care equity paper is based are fundamental human rights. The main aim is to ensure the implementation of these essential rights by those carrying out public duties. Viewed from this angle, equity in health care means equality: equality in access to services and treatment, and equality in the quality of care provided. As a result, this paper attempts to address both human dignity and efficiency through the context of equity to reconcile them in the middle ground.

Key words: Equity, efficiency and human dignity.

It has long been known that a segment of the population enjoys distinctly better health status and a higher quality of health care than the others. These disparities have been documented and have persisted for many years, most notably among those with limited income or education[1], the uninsured[2], those with limited access to care[3], those with language barriers[4] and members of certain racial and ethnic groups[5].

1 National Center for Health Statistics. *Death rates for all causes, according to sex, race, Hispanic origin and age: United States, selected years 1950-2001 and 1950-2000*. Hyattsville MD (2003): National Center for Health Statistics.

2 Institute of Medicine. *Care without coverage: too little, too late*. Committee on the Consequences of Uninsurance, Board on Health Care, Institute of Medicine. Washington DC (2002): National Academy Press.

3 Millman M ed. *Access to health care in America*. Washington DC (1993): National Academy Press.

4 Doty MM Hispanic patients' double burden: lack of health insurance and limited English. New York: Commonwealth Fund (2003).

5 Smedley BD, Stith AY, Nelson AR eds. *Unequal treatment: confronting racial and ethnic disparities in health care. Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health*

However, what is less clear, it is whether society at large appreciates the scope of the problem. For instance, in a 1999 survey of the public conducted by the Kaiser Family Foundation, 43% of respondents thought that the health care system rarely or never treats people unfairly based on race or ethnicity[6]. An even larger proportion of physicians, 69%, gave this answer in a 2001 survey, suggesting that the medical community is even less attuned to the problem[7]. Whereas 47% of the public believed that the health care system at least «somewhat often» treats people unfairly, based on race or ethnicity, only 29% of physicians thought so.

In order to improve the situation, many options are being considered to make the health care system better, but the need to choose among them is unavoidable. Not every problem is correctable at once, and resources for improvement—time, human energy, and money—are limited[8]. Prioritization is thus inescapable, and the larger question is how priorities are set. This raises policy questions about what makes some people more deserving of health care than others.

Rational priority setting would seek the ideal balance between what the World Health Organisation terms the 'goodness' and 'fairness' of health systems[9]. The first is the extent to which a system improves health, on average, for the population. The second addresses equity, the extent to which people receive equal care for equal need.

It is the aim of this paper to address together both human dignity and efficiency through the context of equity to reconciliate them in a middle ground.

This paper is arranged as follows. In section 1, this document will focus on defining equity and illustrating key concepts of equity in health. This section is of particular relevance, given the growing interest in equity among national and international health org anizations[10,11,12,13]. In section 2, it will explain why there should be a concern

Care, Board on Health Science Policy, Institute of Medicine. Washington DC (2003): National Academy Press.

6 Kaiser Family Foundation. *Race, ethnicity & medical care: a survey of public perceptions and experiences*. Menlo Park CA (1999): Henry J. Kaiser Family Foundation.

7 Kaiser Family Foundation. *National Survey of Physicians. Part I: Doctors on disparities in medical care*. Menlo Park CA (2002): Henry J. Kaiser Family Foundation.

8 Almeida C, Braveman P, Gold M, Szwarcwald C, Ribeiro S, Miglionico A, Millar J, Porto S, Costa N, Rubio V, Segall M, Starfield B, Travessos C, Uga A, Valente J, Vicaba F. «Methodological concerns and recommendations on policy consequences of the World Health Report 2000» *Lancet* 357 (9269) (2001), 1692-7.

9 World Health Organisation. *World Health Report*. Geneva (2000).

10 Acheson D, Barker D, Chambers J, et al., *The report of the independent inquiry into inequalities in health*. London (1998): The Stationary Office.

11 Evans T, Whitehead M, Diderichsen F, et al., eds. *Challenging inequalities in health: from ethics to action*. Oxford University Press, New York, (2001).

12 Braveman PA, Tarimo E «Social inequalities in health within countries: not only an issue for affluent nations». *Sociology Science Medicine* 54, (2002), 1621-35.

13 Kawachi I, Kennedy BP. *The health of nations: why inequality is harmful to your health*. The New Press, New York, (2002).

about equity in health care. Section 3 will describe some of the assumptions and implications that are embedded in equity-efficiency trade-off. It will be particularly interesting to identify some circumstances under which equity and efficiency may not trade-off against each other. Finally, it is worth pointing out some ideas about the relationship between equity and human dignity. This section will also address the concern to inequalities between age groups. A brief discussion and thoughts arising from this essay will be carried out at the end.

1. Equity

Equity in health has been conceptualized and defined in several ways, as its principles derive from the fields of philosophy, ethics, economics, medicine, public health, and others. Common to most definitions of health equity is the idea that certain health differences (most often called inequalities in health) are unfair and unjust. Equity in health means equal opportunities to be healthy, for all populations groups[14,15]. Equity in health thus implies that resources are distributed and processes are designed in ways most likely to move towards equalising the health outcomes of disadvantaged social groups with the outcomes of their more advantaged counterparts.

Moreover, it is important to distinguish between equity and equality. The concept of equity is inherently normative—that is, value based[16,17] while equality is not necessarily so[18,19,20,21]. Often, the term *health inequalities* is used as a synonym for *health inequities*, perhaps because *inequity* can also have an accusatory, judgemental, or morally charged tone[22]. However, it is important to recognise that, strictly speaking, these terms are not synonymous. Equity means justice, giving everyone what belongs to them, and recognizing the specific conditions or characteristics of each person or human group/sex, gender, class, religion or age. It is recognition of diversity, without this providing a reason for discrimination.

14 Ngwena C «The recognition of access to health care as a human right in South Africa: is it enough?» *Health Human Rights* 5, (2000), 26-45.

15 Torres M «The human right to health, national courts and access to HIV/AIDS treatment: a case study from Venezuela». *Chicago Journal of International Law* 3, (2002), 105-14.

16 Whitehead M «The concepts and principle of equity in health». *International Journal of Health Services* 22, (1992), 429-445.

17 Braveman P, Starfield B, Geiger HJ «The World Health Report 2000's 'health inequalities' approach removes equity from the agenda from public health monitoring and policy» *British Medical Journal* 323, (2001), 678-81.

18 Whitehead M. *The concepts and principle of equity and health. Regional Office for Europe*. Copenhagen World Health Organisation (1992).

19 Evans T, Whitehead M, Diderichsen F, et al., eds. *Challenging inequalities in health: from ethics to action*. Oxford University Press, New York (2001).

20 Braveman P, Starfield B, Geiger HJ «The World Health Report 2000's 'health inequalities' approach removes equity from the agenda from public health monitoring and policy». *British Medical Journal* 323, (2001), 678-81.

21 Chang W-C «The meaning and goals of equity in health». *Journal of Epidemiology of Community Health* 56, (2002), 488-91.

22 Braveman y cols., op.cit. 20.

On the other hand, equality refers to the similarity of one thing to another in terms of quality and quantity. The achievement of the object of equality is more than the absolute prohibition or elimination of discrimination. To provide equality it is necessary to make a constant and dynamic effort.

In addition, the WHO[23] defined inequity as differences (in health status), which are unnecessary and avoidable, but in addition are considered unfair and unjust. Some disparities result from genetic variation and other non-modifiable factors[24]. In others words, of the determinants of health differentials between populations groups or individuals, those related to biological variation and freely chosen health-damaging behaviour are not likely to be considered inequitable because they are either unavoidable or «fair». However, differentials due to health damaging behaviours not based on informed choices, exposure to unhealthy living and working conditions, or inadequate access to health and social services are more likely to be judged avoidable and unfair and thus constitute health inequality[25].

But at the same time, inequality with respect to something else might be a prerequisite of equity. Moreover, the achievement of equity through equality of something among individuals or groups might require inequality in something else among the *same* individuals or group[26]. For example, one equity principle in a system of taxation might be to impose equal rates of taxation of all individuals. But where income differs among individuals this equity principle would imply unequal burdens of taxation among individuals.

Considerations such as these have lead to the separate but related concepts in the research literature of 'horizontal' and 'vertical equity'. Horizontal equity requires the like treatment of like individuals and vertical equity requires the unlike treatment of unlike individuals, in proportion to the differences between them[27]. The former of these is concerned with ensuring that two individuals, who are alike in all respects, including their health status, are treated equally. The latter is concerned with the extent to which individuals who are unequal should be treated differently. In health care it can be reflected by the aim of unequal treatment for unequal need[28], i.e. more treatment for those with serious conditions than for those with trivial complaints.

23 World Health Organisation (2000) *World Health Report*. Geneva

24 Buchard EG, Ziv E, Coyle N, et al. «The importance of race and ethnic background in biomedical research and clinical practice» *New England Journal of Medicine* 348, (2003), 1170-5.

25 Whitehead M «The concepts and principle of equity in health». *International Journal of Health Services* 22, (1992), 429-445.

26 Birch S, Eyles J, Newbold B «Equitable access to health care: Methodological extensions to the analysis of physician utilization in Canada». *Health Economic*, (1993), in press.

27 Culyer AJ «Equity-some theory and its policy implications». *Journal of Medical Ethics* 27, (2001), 275-83.

28 Raine R, Hutchings A, Black N «Is publicly funded health care really distributed according to need? The example of cardiac rehabilitation in the UK». *Health Policy* 67, (2004), 227-35.

In order to explain the global preponderance of health inequities, many authors have attempted to elucidate the pathways by which inequities in health come to be and are perpetuated. One of the most prevalent theories concerns the role of socio-economic status, measured by education[29], occupation[30], and/or income[31]. Other explanations involve social discrimination based on gender[32,33,34] or race/ethnicity[35,36]. Proposed pathways include the environment in which people live, such are their living conditions and the distribution of income in their country or state[37,38,39]. Still other hypothesized pathways involve the political and policy context, including the extent of primary care[40], the geographic distribution and mix of health services[41,42,43,44], the fairness

29 Mackenbach JP, Kunst AE, Groenhof F, Borgan JK, Costa G, Faggiano F, et al. «Socioeconomic inequalities in mortality among women and among men: an international study». *American Journal of Public Health* 89 (12), (1999), 1800-6.

30 Sacker A, Bartley M, Firth D, Fitzpatrick R «Dimensions of social inequality in the health of women in England: occupational, material, and behavioural pathways». *Social Science and Medicine* 52, (2001), 763-81.

31 Turrell G, Mathers C «Socioeconomic inequalities in all-cause and specific-cause mortality in Australia: 1985-1987 and 1995-1997». *International Journal of Epidemiology* 30 (2), (2001), 231-9.

32 Standing H «Gender and equity in health sector reform programmes: a review». *Health Policy and Planning* 12, (1997), 1-8.

33 Mackenbach JP, Kunst AE, Groenhof F, Borgan JK, Costa G, Faggiano F, et al. «Socioeconomic inequalities in mortality among women and among men: an international study». *American Journal of Public Health* 89 (12), (1999), 1800-6.

34 Kawachi I, Kennedy B, Gupta V, Prothrow-Stith D «Women's status and the health of women and men: a view from the States» *Social Science and Medicine* 48 (1), (1999), 21-32.

35 Davey Smith G, Neaton JD, Wentworth D, Stamler R, Stamler J «Mortality differences between black and white men in the USA: contributions of income and other risk factors among men screened for the Multiple Risk Factor Intervention *Trial* (MRFIT)» *Lancet* 351 (9107), (1998), 934-9.

36 Mclntyre D, Gilson L «Redressing dis-advantages: promoting vertical equity within South Africa» *Health Care Analysis* 8 (3), (2000), 235-58.

37 Wilkinson RG «Income distribution and life expectancy» *British Medical Journal* 304, (1992), 165-68.

38 Ross N, Wolfson M, Dunn J, Berthelot J, Kaplan G, Lynch J «Relation between income inequality and mortality in Canada and the United States: cross sectional assessment using census data and vital statistics» *British Medical Journal* 320, (2000), 898-902.

39 Lochner K, Pamuk E, Makuc D, Kennedy B, Kawachi L «State-level income inequality and individual mortality risk: a prospective, multilevel study» *American Journal of Public Health* 91 (3), (2001), 385-91.

40 Shi L, Starfield B «Primary care, income inequalities, and self-rated health in the United States: a mixed-level analysis» *International Journal of Health Services* 30 (3), (2000), 541-55.

41 Braveman P, Tarimo E «Health screening, development and equity» *Journal of Public Health Policy* 17 (1), (1996), 14-27.

42 Kinman E «Evaluating health service equity at a primary care clinic in Chilimarca, Bolivia» *Social Science and Medicine* 49 (5), (1999), 663-78.

43 Hippisley- Cox J, Pringle M «Inequalities in access to coronary angiography and revascularisation: the association of deprivation and location of primary care services» *British Journal of General Practice* 50 (455), (2000), 449-54.

44 Gravelle H, Sutton M «Inequality in the geographical distribution of general practitioners in England and Wales 1974-1995» *Journal of Health Services Research & Policy* 6 (1), (2001), 6-13.

of health finance[45] and political, social and economics relationship[46,47].

As a consequence, it is not appropriate to determine for instance, access to care by willingness and ability to pay nor merits of individuals based on judgements about their contribution to society. However this can be replaced by a rationing mechanism based on 'need'[48,49,50]. Unfortunately, as numerous authors have noted, the concept of 'need for health care' is far from unambiguous[51]. However, it can be concluded that *need* refers to some circumstances requiring some course of action, particularly in health, some care or treatment[52,53].

A more final distinction has to be made among 'need' for medical care, 'demand' for care and form of use of services or 'utilisation'. Maynard[54] stated that a need for medical care exists when there is an effective and acceptable treatment or cure. However, a demand for care exists when an individual considers he has the need and wishes to receive care. Utilisation is understood when an individual receives the care needed. Need is not necessarily expressed as a demand, and demand is not necessarily followed by utilisation, while, on the other hand there can be a demand and utilisation without a real underlying need for the particular services used. In Spain, for example, the utilisation of health system without a real necessity can often be seen in the case of older people when visiting GPs, where the 'need' could be many times questionable[55].

2. Why there should be a concern about equity in health care?

Given the above distinctions, it is time to reflect on some foundational questions. Why be concerned with equity in health care? Should we be more concerned about inequalities in health care than about inequalities in other dimensions such as income?

Part of the first answer is that health care serves a significant mean to recover or maintain individuals' health[56]. In

45 Rice N, Smith P «Capitation and Risk Adjustment in Health Care Financing: An International Progress Report» *The Milbank Quarterly* 79 (1), (2001), 81-113.

46 Navarro, V «Health and equity in the world in the area of «globalization». *International Journal of Health Services* 29(2), (1999), 215-26.

47 Lynch J, Davey Smith G, Hillemeier M, Shaw M, Raghunathan T, Kaplan G «Income inequality, the psychosocial environment, and health: comparisons of wealthy countries» *Lancet* 358, (2001), 194-200.

48 Culyer AJ Need and the National Health Service. Martin Robertson, London, (1976).

49 Braybrooke D Meeting Needs. Princeton University Press, Princeton, (1987).

50 Goddard M, Smith P «Equity of access to health care services: theory and evidence from the UK» *Social Science & Medicine* 53, (2001), 1149-62.

51 Culyer AJ «Need — the idea won't do— but we still need it» *Social Science & Medicine* 40, (1995), 727-30.

52 Guillon R *Philosophical Medical Ethics*. Wiley, New York, (1985).

53 Braybrooke D, op.cit. 49

54 Maynard A «Rationing health care: an exploration» *Health Policy*, 49 (1-2), (1999), 5-11.

55 Fernández-Mayoralas G, Rodriguez V, Rojo F «Health services accessibility among Spanish elderly» *Social Science & Medicine* 50, (2000), 17-26.

56 Culyer AJ «Equity- some theory and its policy implications. *Journal of Medical Ethics* 27, (2001), 275-83

general, through the ages, health has been considered a precondition for happiness. Descartes[57] asserted that health is the highest good. In «*Discours de la Méthode*» Descartes writes: «…the preservation of health is …without doubt the first good and the foundation of all the other goods of this life.» Culyer[58] has argued that good health is in general a necessary precondition for the attainment of happiness. Thus, equity in health care is an ethical imperative not only because of the intrinsic worth of good health, or the value that society places on good health, but because, without good health, people would be unable to enjoy life's other sources of happiness. From the second half of the XX Century most of the states in the Western World assume the responsibilities to provide the health care which was before on the hands of religious institutions, charities, family or private practitioners. According to this point of view, society would have an ethical duty to provide health care.

So, equity in the health care sector is also really essential because the scarcity of resources means that choices have to be made about who will be given the 'right' of access to care and who, as a result of negation, will be left in a painful situation, and, in the worst case, to die[59]. Health care can extend the lives of children and of older people. It can make it possible for a person to walk, when, without health care, that person would be permanently bedridden and, as said above, health care can reduce the pain and distress of people who are terminally ill.

As a result, these arguments give the answer to the second formulated question in this section as well. Health is a special good, which has both intrinsic and instrumental value. Health is regarded to be critical because it directly affects a person's well being and is a prerequisite to their functioning as an agent. Inequalities in health are thus closely tied to inequalities in the most basic freedoms and opportunities that people can enjoy. In contrast, for instance, there are reasons to recognise income inequalities.

There are economic reasons why income inequalities must be accepted. Economists often assert, with some justification, that income incentives are needed to elicit effort, skill, enterprise and so on. These incentives—and the implied income inequalities-have the effect of increasing the size of total income from which, in principle, the society, as a whole, can benefit (for example, through taxation).

But this incentive argument would not seem to apply in the case of health. Inequalities in health do not directly provide people with similar incentives to improve their health from which society as a whole benefits. The problem appears when, as the empirical literature

57 Descartes R Discours de la Mèthode, Sixième Partie. Paris. éd. Descartes: (Euvres et Lettres), (1637)

58 Culyer AJ «The rationing debate: Maximising the heath of the whole community: The case for» *British Medical Journal* 314, (1997), 667-69.

59 Culyer AJ «Equity- some theory and its policy implications» *Journal of Medical Ethics* 27, (2001), 275-83.

demonstrate[60,61,62], inequalities in income do produce inequalities in health–with richer people generally having better health[63]. One of the reasons for this can be that low income leads to poor living circumstances, less awareness of health and higher level of risk. For instance, tobacco and alcohol are consumed more by low social classes than higher classes, which constitutes a high risk for health[64].

3. Equity-efficiency trade-off

Health care policy makers consider as goals of health services: efficiency (the production of health status improvement at lower cost), benefit and equity ('fairness')[65]. The efficiency of an activity is determined by the extent to which the objective of the activity is achieved and the cost of resources used in undertaking the activity[66]. On the other hand, health benefit can be measured in units that reflect the preferences of the community, considering their desire for increased longevity but also the value they place on limitation of function, pain and other dimensions of health-related quality of life[67]. This procedure weights the health gains of each individual equally and leads to a maximization of health gains.

Considering the following scene could be helpful for discussion. Observed flaws in tests and treatment for a patient's heart disease were claimed to have derived from the attitudes of the health care staff towards the patient's age and dementia (there were undoubtedly shortcomings in the treatments provided, but these could not be shown to derive from the reasons claimed; admittedly, one of the doctors who had treated the patient said in defence of his own conduct that the hospital did not have the financial resources to implant a pacemaker in every «demented old person»). The «demented old person» in this case was actually a 60-year-old employed woman whose paramnesia was largely due to her depression, and partly to her chronic heart disease, of which she later died.

60 Ross N, Wolfson M, Dunn J, Berthelot J, Kaplan G, Lynch J «Relation between income inequality and mortality in Canada and the United States: cross sectional assessment using census data and vital statistics» *British Medical Journal* 320, (2000), 898-902.

61 Lochner K, Pamuk E, Makuc D, Kennedy B, Kawachi L «State-level income inequality and individual mortality risk: a prospective, multilevel study» *American Journal of Public Health* 91 (3), (2001), 385-91.

62 Mellor JM, Milyo J «Re-examining the evidence of an ecological association between income inequality and health» *Journal of Health Politics, Policy and Law* 26 (3), (2001), 487-522.

63 Lochner K, Pamuk E, Makuc D, Kennedy B, Kawachi L «State-level income inequality and individual mortality risk: a prospective, multilevel study» *American Journal of Public Health* 91 (3), (2001), 385-91.

64 Rodriguez E, Pinto JL «The social value of health programmes: is age a relevant factor?» *Health Economics* 9, (2000), 611-621.

65 Baiman R «Why equity cannot be separated from efficiency: the welfare economics of progressive social pricing» *Review of Radical Politics Economics* 33, (2001), 203-221.

66 Birch S, Eyles J, Newbold B «Equitable access to health care: Methodological extensions to the analysis of physician utilization in Canada» Health Economic, (1993), in press.

67 Patrick DL, Erickson P *Health status and health policy: allocating resources to health care*. Oxford University Press, New York, (1993).

In this case, it can be noticed one of the perversions of costs rationalization when affecting human beings forgetting that they are persons. Indeed, to rationalize the costs has the benefit of saving money that can be applied to aiding more patients. However, the saving must not be done at the cost of other patients' health and without objective criteria. In this example, to declare a woman of 60 years old and to reserve care for younger people is a mistake. Nowadays, it is acknowledged that due to the increase of the life expectancy and to the aging of the population in the European countries, 60 years old is a medium age.

When considering efficiency, it also worth paying attention to the issue of quality of care. For example, considering two equal sized groups of doctors seeing the same number of patients, it is easy to think that both of them are working with the same level of efficiency. But it could the possibility exist that patients in one group recovered from their illness immediately, while those in the other group died. Did they work with the same efficiency? So, as a result, the doctor's productivity will depend on the supply, quality and use of other inputs (services provided)[68] such as the number of nurses, equipment, patient compliance, etc. In general, it will depend on the quality of care and not only of the number of patients attended.

As a conclusion, as many authors state[69,70] it can be said that the goal of efficiency (in this context maximizing aggregate welfare) cannot be obtained without attention to equity (cross-individual welfare comparison).

Moreover, it is known that inevitable inequalities are going to exist always. For instance, even if the cost of health care at the point of delivery is equal throughout a country, patients in predominantly rural populations will, on average, have to travel further to the hospital than patients in urban populations. Furthermore, even if the 'time and disruption' costs are the same, the proportionate burden of these costs on the patient may differ (e.g. €15 is a much more significant burden to a poor patient than to a rich patient).

Health's services have traditionally in Europe, for about 50 years, been a function provided by the State to socialize the medical care, which before was only accessible to the more favoured layers of the society[71]. The national services of health were created at the same time as

68 Brommels M, Jaaskelainen M «Measures of equity and efficiency in medical manpower planning. A prediction of internists needed in the Finnish National Health Service» *Health Policy* 4, (1984), 3-11.

69 Feldstein MS «Equity and efficiency in public sector pricing: the optimal two- part tariff» *The Quarterly Journal of Economics* 86 (2), (1972), 175-187.

70 Baiman R «Why equity cannot be separated from efficiency: the welfare economics of progressive social pricing» *Review of Radical Politics Economics* 33, (2001), 203-221.

71 Bach S *Employment Relations and the Health Service. The Management of Reforms*. Routledge, London, (2004).

other national industries and with the same inspiration, raised by the increased organizing capacity of the states after the Second World War. The system was called 'welfare state'.

After few decades of welfare state it was acknowledge that the nationalized industries were highly expensive and inefficient, mostly because they did not have to compete in costs or in innovation with other companies. Therefore the process begun by which, to make these industries more effective, they were privatized or organized according to private owned industries criteria. The tendencies that have affected other industries, have also affected the national health systems in which policy makers have intended to achieve rationalization and effectiveness through different means, institutions and polices (Trust, Foundation Trusts, Modernisation Agenda, etc in the UK)[72].

As it has been seen above, the rationalisation of the cost is positive. With the same amount of money spent in a rational and efficient way, it is possible to provide the same care to a greater number of patients, that is to say, the money is more effective. Nevertheless, it has been observed that sometimes the rationalization criterion is carried out in practice with a merely business perspective. Therefore, it is essential to consider that in healthcare, decision makers do not deal with goods or products, but with human beings.

Human beings have to be treated like aims in themselves, not like expenses that can be eliminated to close a balance sheet. Any innovation or rationalization undertaken in the provision of medical care should be achieved from the consideration of the human dignity, making the person prevail over economic criteria.

4. Equity and human dignity in health care

Human dignity lies at the heart of all health care, constituting both its base and its purpose. Care systems, philosophies and traditions have originated because individual human beings have been considered so valuable that they cannot just be left to the mercy of their suffering and sickness.

One shade hanging over human dignity is the public conception that only productive, ambitious, independent, economically self-sufficient and independent people really matter. The increasing acceptance of this way of thinking means a growing burden of emotional and mental distress for certain individuals and groups in society. The human capital approach seems to value young peoples' lives over older people, and men's over women's[73,74]. This kind of

72 Bach S, op.cit. 70

73 Dolenc ED, Schneiderman LJ «Cost-effectiveness analysis in health care». *Hastings Center Report* 19, (1989), 8-13.

74 Williams A «Cost- effectiveness analysis: is it ethical?» *Journal of Medical Ethics* 18, (1992), 7-11.

argument could not only contradict the basic human right. In fact, human dignity of people in long-term geriatric care can easily make themselves feel a burden and abandoned.

This could be because, in practice, issues of principle relating to equity and non-discrimination arises in individual decisions on care, in questions such as weather a person has been left without a certain treatment on the grounds of age, mental handicap or multiple disability. The risk of treatment can increase with age, and some treatments are not suitable for old people, but leaving someone without treatment purely on the grounds of age is clearly discriminatory. At other times, decisions are taken not to resuscitate very old people or terminally ill patients.

However, it is perfectly reasonable to choose the perceived importance of age as a criterion for assigning health care resources according to intervention type[75]. For instance, in some clinical contexts, such as organ transplantation, the age weight would understate the perceived importance of favouring younger patients. For these reasons egalitarian views typically say that inequalities between age groups are not in themselves unjust[76]. It is difficult to imagine a health system that reserves the largest shares of resources for its very oldest members. Only a handful of people will live long enough to enjoy these advantages, so this practice would be unfair. Therefore, these criticisms do not imply that inequalities between age groups are intrinsically unjust; they are unjust only if they contribute to inequalities between complete lives.

5. Discussion and conclusion

Few would disagree that equity, or fairness, should be a goal of any health care system. Equity in health is an ethical value, inherently normative, grounded in the ethical principle of distributive justice and consonant with human rights principles.

The main aim of this essay is to bring together both human dignity and efficiency in the context of equity to reconciliate them in a middle ground. To take human dignity to the extreme of eliminating efficiency would reduce the right for some people to access health care. On the other hand, to take efficiency to the other extreme would mean reducing individuals to mere material subjects, i.e. with limited rights as individuals. This would mean focus on the economic implications of disease, and ignores other aspects of health such as 'pain and suffering' and other intangibles. The advice to any decisions makers (doctors and nurses specifically), based on this principle, is that they should be specifically reluctant to deny patients live-saving treatments in the name of economic efficiency, although efficiency has to be considered. Medical

75 Rodriguez E, Pinto JL «The social value of health programmes: is age a relevant factor?» *Health Economics* 9, (2000), 611-621.

76 Rawls J A Theory of Justice. Harvard University Press, Cambridge, Mass, (1971)

practice has to focus on the individual, rather than the aggregate health of the unidentified public as required by the cost-effectiveness paradigm.

Under unlimited resources, bringing together human dignity and efficiency, the ideal view of equity would be health care for everyone. However, an important first step is to move beyond idealised visions to a clear acknowledgement of reality and of the strategic options for change. So, under limited resources the ideal of equity is health care for as many as possible, taking into account the person and his/her dignity but not his/her merits, economic situation or ethnicity. If other aspects different of human dignity are considered as the most important issues to allocate health care, this approach would imply that, for example, wealthy, economically productive peoples' health is worth more than other peoples', hence that wealthy peoples' lives are more valuable. As a result if health care resources were allocated based primarily on productivity concerns, then a vicious circle would be perpetuated, in which already economically (or racially, physically, etc) privileged persons would receive better health care, leading to enhanced productivity and further economic gain for themselves and their children.

However, as stated above, some inequalities will always exist since resources will be limited, so how is it fairer to choose one patient among many? There will be moments, as some defended in this essay, where to take into account the age could be worthy and sometimes definitive (e.g. organs' transplants). However, considering clinics data will be decisive on other occasions. The patient who presents better prognosis or longer life-expectancy should be chosen to receive certain treatment. In the presence of this clinical-ethical decision, it should be really important not to forget the other patient and be able to proportionate individuals the best way to guarantee their quality of life if this is possible. As a result, health's professionals should offer a care which reduces the number of diseases, or eliminates destructive influences on the quality of living or improve the capacity for savouring all that life for everybody, even when this is only a preparation for death.

To summarise, a number of WHO publications also set out from the principle that equity in health care means equal access to the available treatment for those with equals needs, equal use of services by those with equal needs, and equal quality of care for all. The point of equity as an objective is to reduce unnecessary, avoidable, unreasonable and unfair differences in health[77].

The underlying principles on which this health care equity paper has been based are fundamental human rights. The main aim is to ensure the implementation of these essential rights by those carrying out public duties. Viewed from this angle,

77 Whitehead M *The concepts and principle of equity and health*. Regional Office for Europe. Copenhagen World Health Organisation (1990).

equity in health care essentially means equality: equality in access to services and treatment, equality in individual treatments solutions, and equality in the quality of care provided. Equality is particularly important for members of vulnerable groups: people who are weak or vulnerable for a variety of reasons, old or disabled people, children and all who are unable to take care of themselves.

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