# Equity in Health Care - A Maltese Perspective

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Health Services everywhere are known to absorb a large share of national resources and Government health policies are increasingly directed towards setting limits on the resources allocated to Health Services. Generally, the scale of health expenditure is determined by the management of the economy and by its performance. Improving access to deprived groups of society and improving the well being of the population are the underlying objectives justifying increased public expenditure. Determining who will receive health care under what circumstances has become a controversial function of health services that will be addressed further on. It is also becoming increasingly evident that Health is the product of a number of factors, of which availability and consumption of health services is only one. In fact there are no causal links between levels of health care expenditure and states of health. The assumption that medicine equals health and that more medicine equals better health has recently being strongly contested.

The unequal distribution of health or illhealth among and between populations has for many years been expressed most forcefully in terms of ideas on inequality more often than not, outcomes which have been socially or economically determined. In discussing Equity in Health Care, one must not lose sight of the fact that while genetic and cultural or behavioural explanations play a substantial part in determining health or illhealth, the predominant or governing explanation for inequalities in health lies in material deprivation.(1) Inequalities in health are of concern to all countries and represent one of the biggest challenges to the conduct of Goverment Policy. However, the paper purports to review another dimension of health inequity, that relating to or derived from Health Care Systems.

A desirable health care system should be structured in an efficient and equitable manner in both financing and provision.(2) Difficulty arises in defining exactly what an equitable and efficient system is. The ideal system would also be endowed with various forms of efficiency, such as allocative, technical and operative. Experience from Australian and international health care systems indicate that an appropriate financing structure does not necessarily imply a good provision structure. In an ideal world, Rawl's Theory of Justice, where the optimal outcome is to maximise the benefit of the least advantaged, should prevail i.e. access should not be limited by an individual's ability to pay for health care services.

The 50th Anniversary of the British NHS reminds me of the grand vision of yesteryear to provide equal access to care, free at the point of use, to all people who need it. At the threshold of the second half century of this same service, there seem to be as many uncertainties in 1998 and in 1948, as we contemplate all our tomorrows. The Utopia of free and equal access to comprehensive health and social care from the cradle to the grave has eluded the British so far.(3) Over long periods since the inception of the NHS, there is little sign of Health Inequities in Britain actually diminishing; in fact in some cases they may be increasing.

Socialist policies in the past were aimed at creating a nationally uniform system where there would be an expectation that behaviours throughout society would be similar, values would be similar and responses would be similar.

The Socialist vision of a planned society, making rational provision on the basis of need, eliminating from society the driving force of profit is but a surviving fragment of a fallen utopia. Social programmes particularly those related to health and welfare must be designed to reduce the role of Government in people's lives and promote the virtues of self-determination, self-respect and self-sufficiency among recipients of welfare programmes. It behooves any government to inculcate a mentality, by deeds rather than words, which will dispel once and for all the Socialist myth of dependence of the individual on the State. There must be some stopping point, some rule by which Governments limit what they do for people. Not just because of budget constraints, not just because of infringements on freedom, but because happiness, the ultimate goal in everybody's life is impossible unless people are left alone to take trouble over important things.

Health services must no longer be viewed as another act in the political bag of tricks. Rather, the planning of Health Services should be delegated to experts in this field, who will be guided by national Socio-Economic needs and inspired by the ideological beliefs of the Government of the day.

It must be accepted that the circumstances that surrounded the launching of the welfare state many years ago have changed dramatically. The Welfare state in the Britain was born at a time when public expenditure was seen as an aid or adjunct to economic growth thus serving not just a boost to social services in the wake of mass destruction after

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World War II but also, as a major factor for the awakening of the national economy.

This is not to say that Governments should ever shirk their responsibility to provide a fair system by means of which those less well off are enabled by those in a position to help. Invariably, one finds that the question of inequalities of health care is more pronounced where there is a state-funded system, open universally to all irrespective of means and which does not acknowledge and encourage the value of alternative systems of health care which are entirely funded privately.

To define the various levels of inequalities that exist in any health care system would take forever, but perhaps it is worth just outlining the most important ones.

I would first classify Health inequity into real / tangible and perceived.

This distinction, I feel is important as many a time false accusations of inequity are leveled on the basis of personal prejudice and emotions. By way of a simple example, the efficiency or otherwise of orthopedic services cannot be measured simply on the basis of outcome; e.g. a successful hip replacement costing thousands of pounds may be deemed ineffective if the patient is still limping after the operation due to a corn on his little toe.

*Real inequities in health care I would classify as follows:*

- **Transnational** - Section II of the Health for All declaration, specifically lays down as an objective "health equity between and within countries". Everyone is aware of the great divide in the level of health care provided in different countries.

- **National** - National Policy determines developments in any health care system. The policy makers determine allocation of funds and resources, which may not always reflect the real needs of the system. It is debatable, e.g. whether it is in the best interest of the patient to invest millions of pounds in high tech hospitals and comparatively insignificant amounts on the development of Primary Care Services. In Malta a meager Lm3m is spent annually on a primary care system, which essentially functions as outposts for episodic care, failing to deliver the essence of the service, continuity of care and a gatekeeper role. Also relevant is the fact the present system is being utilised by only a 1/3 of the Maltese population, which begs the question, is the little money spent in this sector being well spent, when a multinational study of health care systems in Europe indicates that health systems with a comprehensive and strong general practice set up go hand in hand with relatively low national spending on health care? Among countries with a fairly similar, high western standard of living, a World Bank report shows that the estimated per capita cost of health care in 1990 was a lot higher in countries which did not have a well organised system of primary care, exercising a gatekeeper role.

- **Sectorial** - Some general dilemmas exist at this level where different groups of people, with different special needs may feel disadvantaged. Specific examples include:

  - The elderly having less priority than the young in getting lifesaving cardiac surgery but benefiting from services that enable them to remain active members of society and avoid institutionalization
  - Limiting access to and the availability of specific procedures and drugs for HIV patients
  - Physically handicapped persons may find that access to some of the health care facilities is inadequate because proper ramps are not available.
  - Clinical discretion - very often clinicians exercise their discretionary prerogative judiciously. But in the absence of national decisions, equity may be in danger. On the other hand, in the absence of discretion injustice may be done to individuals. Since medical necessity is such a flexible concept, too much discretion may subvert national policy.

- **Individual** - In the UK mortality differentials according to poverty have increased steadily. There is no doubt that the single, most important determining factor in health inequalities is one's social and poverty status. This is usually linked not only to low income, which in itself propagates disparity in obtaining health care, but also a low level of education which compounds the situation. A study by the World Bank shows that the 'poor' devote as large a share of household expenditures to health care as the 'better off' do.(4) But the quality of health care the poor receive is somewhat lower, in part because they often visit public health facilities, while the better off rely more on private health facilities.

The second conference on priorities in health care held in London a few months ago provides a reminder that the phenomenon of rationing is indeed international and not just the byproduct of the way a system of health care is designed or funded.(5)

Countries with different health care systems are all grappling with the problem of how to reconcile growing demand and constrained resources. It

comes as no surprise that the equation which has infinite (services) on one side and finite (resources) at the other still has to be invented. Furthermore, the process of priority setting is invariably difficult in view of ethical, practical, logistical and other considerations.

Tony Blair, UK Prime Minister is on record as having said, "I believe in greater equality. If the labour government has not raised the living standards of the poorest by the end of its time in office, it will have failed". The solution is for Governments to acknowledge the importance, and reversibility of health inequalities and introduce redestributive social policies.

The challenge everywhere is about how to organise and orchestrate what, for the foreseeable future, will be a continuing dialogue between politicians, professionals, and the public about the principles that should be invoked in making decisions about rationing and about how best to reconcile conflicting values and competing claims. Although this may seem to be a negative conclusion it must be accepted that setting priorities is inescapably a political process - it involves making painful decisions socially acceptable and moblising consent among both the health professionals who have to implement them and the public who are affected by them. Under the circumstances the appropriate step to take is to devise the right mechanisms for doing so.

There is no doubt that the starting point must surely be open acceptance of the fact that rationing- denial is not an option. Once the inevitability of rationing is accepted, we can all get down to the serious business of discussing how to devise the appropriate mechanisms and addressing some of the intractable questions involved.

One of the most controversial problems facing health care systems of all types is to determine mechanisms of allocating limited health care resources in relation to competing demands. Rationing is an emotive term and suggests a process of explicit and deliberate decisions about resource allocation. As medical technology continues to develop and new treatments and health care costs escalate, governments all over the world must devise more morally explicit principles whereby health care resources are allocated. Unfortunately these principles may conflict with each other e.g. patients whose current treatment is ineffective would be denied treatment if effectiveness were strictly applied whereas they would receive services under principles of need or equity. All principles are difficult to operate. Any Health System is therefore likely to have to make trade-offs or compromises between principles rather than rigorously adhering to one. If the public were to be consulted about how health services should be prioritised, problems would arise when the public makes choices on different principles from those considered important by doctors or managers. There are therefore no simple solutions to the problem of providing health services that meet every desirable objective for health.

No longer is the search for a rational set of decision making rules thought adequate. The process is seen to be more complex. The public may not understand that an affluent society cannot give sufficient health care to all those in need. Perhaps the emphasis should now shift from the **product** of priority setting to the **process** of priority setting.(6) While as clinicians we must do as much as is possible for each patient, as truly responsible citizens we must do as much as possible for the population's health within the available resources. Setting priorities and rationing should be a transparent process, since withholding benefits is socially divisive, and patients would much rather see clinicians giving rather than withholding. Setting priorities is an unavoidably messy, conflict ridden, ultimately tragic social process and different societies will conduct this process in accordance with their culture. Our distress with priorities and rationing must be understood as crucial data on a social process, not as a resistance to be overcome.

Perhaps the setting up of a "Council for Health Care Priorities" would provide the institutional setting for the rationing debate.

I do not anticipate that this council would simply provide a forum for analysis and debate. Nor that it should be on an ad hoc basis to discuss specific issues e.g. whether Viagra should be provided on Schedule V or not.

I think in the first place, it should review the priorities implicit in the existing distribution of resource in our health care system as a whole. The Council would set the tiers of priorities that need to be addressed, pyramid fashion from the top to the bottom, dispelling the existent myth that the present situation needs only to be improved on, rather than being changed.

It should review the existing distribution of resource in the State Health Service and establish policy as an experimental and incremental process, which international experience has confirmed to be a more realistic and sophisticated form of rationality than attempts to devise technical plans.

The dilemmas about health equity have been with us a long time now. They obviously demand addressing by an ongoing debate, along with a warning against optimism about their early resolution. The key requirements are an expanded healthcare ethic and courageous political leadership.(7)

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