REDUCING INEQUITIES IN HEALTHCARE: A PRIORITY FOR EUROPEAN POLICIES AND MEASURES

Aurora DRAGOMIRIȘTEANU – Public Health and Health Management Senior Specialist, PhD candidate – MPU Gr. T Popa, Iași

INTRODUCTION

The purpose of this article is to highlight the importance of health determinants and equity in healthcare in an international and European context, to provide an overview on health inequities and on how they correlate with the political decisions for the ethical allocation of resources in the healthcare system from Romania.

The ethical approach of resource allocation is meant to reduce the discrepancies between the development regions in Romania both in terms of health determinants and access to healthcare services. In the same time, a balance in access to services based on real needs can be provided so that every citizen can have real chances to treat his disease and to benefit of prevention.

METHODOLOGY

The distribution of socio-economic health determinants was assessed by using data from two studies conducted by the National Institute of Statistics – “Poverty, inequalities and social exclusion, Romania, 2000-2007” and “The activity of health units in 2009”.

Data for 2009 processed by NSPHHM1 were used in order to analyze the indicators regarding the main aspects of hospital activity and admitted morbidities.

Concerning the analysis of the main demographic aspects and the trend of health expenses at national and/or regional level, the utilized data came from NCOPIISH2 (for 2007), EUROSTAT (statistical database 2009) and from WHO’s National Health Account database. Absolute values were also used and rates for assessing inequalities and inequities in resource allocation in healthcare system (medical doctors, nurses, beds, high-tech medical equipment) were calculated per development regions.

Outcomes: The demand of healthcare services exceeds the ability to finance them from public funds (state budgets for health and social security funds). The share of out-of-pocket payments made by households in the total healthcare expenses is considerable (over 20%) This situation exposes households to a catastrophic risk (over 40% of the overall costs of a household). In the same time, decision makers face difficulties in a better understanding of the consumption causes in the healthcare system in order to create the premises of a better allocation of available resources. Inequalities between development regions are induced by: inequalities in health status and structure of risk factors to which the population from a certain region is exposed; inequalities in the need for healthcare services; inequalities in the service offer; inequality in providing service continuity; inequalities in the capacity of local authorities (DHA, DHIII, town-halls and county councils) to make organizational changes.

Key words: ethics of health resources allocation, health determinants, health equity, health equality.

BACKGROUND

A more obvious priority on the international agenda, both for EU and the World Health Organization (WHO), was to obtain the equity in health by influencing the social health determinants.

Over the last 20 years WHO sustained policies to promote equity in health. The World Health Report 2000 mentioned “A general comprehensive framework for assessing how well healthcare systems perform should meet four functions that help achieve this performance: organizing healthcare systems, generating resources, financing healthcare systems and healthcare system management”. In other words, a healthcare system must organize the necessary services, create the necessary

1NSPHHM = National School of Public Health and Health Management, Bucharest
2 NCOPIISH = National Center for the Organization and Provision of the Information and IT System in Healthcare, Bucharest.
resources to provide these services, *insure* the financing for these services and all these require good governance (leading/management). In 2005, it set up the Commission on Social Determinants of Health, the final report of which “Closing the gap in a generation”, published in 2008, constituted a notable progress in legitimizing the study of health inequalities and the relationship between policy and health. The 2008 Report of the Commission on Social Determinants specified: “The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon…. together, the structural determinants and conditions of daily life constitute the social determinants of health.”

In May 2009, the 62nd World Health Assembly adopted Resolution WHA62.14, whereby Member States are clearly called to take action to “reduce health inequalities through action on the social determinants of health”.

Health, health determinants and health equity have been introduced on the EU agenda. The Lisbon Treaty (2007) increased somehow the legal basis for harmonisation, strengthened the role of the Union in the coordination of Member States’ public health activities and clarified the mandate of Member States in the management and financing of health care services. In October 2009, the European Commission published a specific Communication on action for health equity: ‘Solidarity in health: Reducing health inequalities in the EU, adopted on the 20th of October 2009” that sets the specific actions to take for equity in resource allocation in health. The measures that will be taken by the European Commission will help to address the health inequalities and include:

- Collaboration with national authorities, regions and other bodies.
- Assessment of the impact of EU policies on health inequalities to certify that they contribute to reduce them where possible.
- Regular statistics and reporting on the size of inequalities in the EU and on successful strategies to reduce them.
- Better information on EU funding to help national authorities and other bodies to address the inequalities.

The following areas are stated as key issues:

- The link between health and wealth: an equitable distribution of health is an essential part of overall social and economic development;
- The improvement of data, are knowledge and mechanisms for measuring, monitoring, evaluating and reporting;
- A focus on policies in all sectors at all levels;
- Paying attention to the needs of vulnerable groups; and
- Developing the contribution of other EU policies.

International conventions are binding! The allocation of health resources should be done in accordance with the principles and recommendations from international conventions, the most relevant including:

1. Universal Declaration of Human Rights - article 25. 2. (D) – “Creating the conditions that would insure the provision of medical service and medical care in the event of sickness”;
2. International Covenant on Economic, Social and Cultural Rights – article 12 paragraph 2.d: “The right to health is not to be understood as a right to be healthy …the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health (UN Committee on Economic, Social and Cultural Rights (2000), General Comment 14);
4. International Convention on the Elimination of All Forms of Racial Discrimination — article 5;

**OUTCOMES**

The most pressing problem in the healthcare system from Romania, like in many developing countries, comes from the ability of providing a minimum set of equitable and efficient interventions for the high incidence of transmissible and non-transmissible diseases in a transition economy. In 2007, the total health expenses per capita were US$ 369, placing Romania on the last position among the European Union members states (Figure1).

*Figure 1 - Health expenditure per capita (current US$), 2007*

(Date Source: WHO's National Health Account database)
The trend in public and private expenditure for health, compared to the share of health expenditure in the GDP between 2000 and 2008 is plotted in Figure 2 – showing the increase of health expenses over the past several years, but a lower increase compared to the GDP increase.

**Figure 2 – The trend of public and private expenditure on health, comparative with % of expenditure on health from GDP, period 2000-2008**

The value of Gross domestic product (GDP) per capita, for each development regions is shown in Figure 3.

**Figure 3 - GDP per capita, by development regions, year 2005**

The demand of healthcare services exceeds the ability to finance them from public funds (state budgets for health and social security funds). As a result, we observe that the share of out-of-pocket payments made by households in the total healthcare expenses is considerable (over 20%) and healthcare providers, especially hospitals, started to build up debts. This situation exposes households to a catastrophic risk (over 40% of the overall costs of a household). In the same time, decision makers face difficulties in a better understanding of the consumption causes in the healthcare system in order to create the premises of a better allocation of available resources.

The assessment of the available data revealed multiple sources of inequality/inequity in healthcare. Inequalities between development regions are induced by:

- **Inequalities in health status and structure of risk factors** to which the population from a certain region is exposed; health determinants have a direct impact on health, as they predict wide variations in health status (inequity in health). Health determinants interact each other to produce health and their structure generates the behaviors towards the health status.

The level of education is an important determinant because it affects physical and mental health, as well as income, employment and quality of life. The relevant indicator for education results is the education enrollment rate. Figure 4 indicates a large discrepancy between regions.

**Figure 4 - Education Enrollment Rate, by development regions, year 2007**

Thus, for this indicator, the Bucharest-Ilfov region reports values that are much higher than in other development regions (99.2% compared to the national value of this indicator, which is 65.6%). These inequities are even more obvious in rural areas. This situation of the pupils from rural areas is generated mainly by the precarious material conditions, as well as by the mentality of their families with regard to the education system.

Poverty is one of the major social determinants of health. Poverty is associated with a high child mortality and morbidity rate, especially hospitalized morbidity. In case of sickness, poor persons incur direct expenses for healthcare and associated services that exceed 40% of their total household expenses. As a result, they risk to not benefit by their right to health due to their inability in paying the private expenses related to healthcare. In development areas where the poverty rate exceeds 25% (Figure 5) the causes of poverty should be measured and
Specific interventions should be carried out in order to reduce socio-economic inequities.

The residence environment impacts the health status by lack of drinking water and sewage, lack of electricity in certain localities, precarious conditions in houses, poor state of the roads and poor access to information. For instance, at the end of 2007, only 2.3% of the households in rural areas had internet access, while the share of households with internet access in urban areas was 27.25%.

In 2007, the average life expectancy was 1.7 years lower for people in rural areas compared to people living in urban areas (Figure 6).

**Figure 6 - Life expectancy (years), by sex and residency, year 2007**

Date Source: NIS - Statistical Yearbook Romania – 2008

- Inequality in the need of healthcare services: For instance, every county/region has a certain structure of risk factors and morbidities that require healthcare services adjusted to the real health needs (from specialized care in hospitals to chronic patients care and home care etc.). The child mortality rate is a relevant indicator for the need of healthcare services. In 2009, the child mortality rate indicated significant variations between regions (the variation coefficient is 97.2%). As shown in Figure 7, the

**Figure 7 - Infant Mortality Rate, by development regions, year 2007**

Date Source: NIS - Statistical Yearbook Romania – 2008

North-East region has the highest value for this indicator (14.2%), compared to the national average (12%).

Also, in rural areas the infant mortality rate has the highest value compared with urban areas (Figure 8).

**Figure 8 - Infant Mortality Rate, by sex and residency, year 2007**

Date Source: NCOAPIISH - Health Statistical Yearbook – 2008

- Inequality in the service offer: For instance, there is a big difference between counties/regions with regard to the healthcare network (medical staffing, advanced medical technologies, diagnosis and treatment services, dental medicine, home care, recovery etc.). Some counties also provide services for neighboring counties (dialysis services, cardiovascular surgery, transplant, level 3 maternities, etc.), while other regions are not able to provide certain services (for instance, mammography in South-West Oltenia).

The assessment of the medical staffing per types of residence environment reveals significant inequalities for certain categories of personnel. Thus, 63.0% of total general practitioners, 87.5% of dentists and 84.8% of pharmacists work in urban areas. In 2009, the number of hospital beds was 6.5 per 1,000 inhabitants (including healthcare
centers). The assessment of the geographic distribution of hospital beds indicates inequities between regions, with a 51.7% variation coefficient for the number of beds between regions. Thus, the number of beds per 1,000 inhabitants in the region’s population is 10.03 for Bucharest-Ilfov compared to only 4.86 for the North-East region (Figure 9). The fact that 48.78% of the patients treated in Bucharest come from other counties means that this aspect must be considered when adjusting the number of beds.

**Figure 9 - Number of hospital beds per 1000 inhabitants, by development regions, year 2009**

![Figure 9 - Number of hospital beds per 1000 inhabitants, by development regions, year 2009](image)

The inequity in the North-East region relates to the number of available beds, which is with 32.9% below the national average, while 56.98% of the admitted patients come from rural areas and 10.4% of the services are provided to patients from other counties. The number of beds per type of hospital wards varies a lot between regions, especially for certain specializations: nephrology, neurosurgery, oncology, endocrinology, geriatrics and gerontology, neuro-psychomotor recovery, cardiovascular surgery, urology, child surgery;

The assessment of the distribution of high-tech medical equipment per regions at the end of 2009 reveals inequities between development regions. As a result, we can state that the access to breast cancer diagnosis services is limited in the South-West region – there is one mamograph for a population of over two million inhabitants; also, the treatment of renal lithiasis by lithotripsy cannot be performed, as the medical units are not equipped with such a device. The access to general and interventional angiography, heart angiography and neuro-angiography is limited, especially for people who live in the North-West and South Muntenia regions. As for the covering with radiotherapy services – southern regions are in disadvantage (Figure 10, 11 and 12).

Magnetic resonance imaging (MRI) and Positron emission tomography (PET) equipment is insufficient. According to the recommendations of World Bank experts, one PET device is needed for every 3 million inhabitants, which means seven PET devices countrywide, and we currently have only two (in Bucharest and Oradea).

- **Inequality in providing service continuity** In certain counties, the number of primary healthcare providers is...
too high, while other areas don’t have such providers, especially in rural areas. At the end of 2009, 45% of Romania’s population lived in rural areas. People living in rural areas have limited access to hospital services. There are several causes that lead to inequities in the access to these services for the rural population:

- Geographical access – only 7.8% of the total number of hospital beds for continuous admission and 1.5% of hospital beds for one-day admissions are available in rural area; many rural localities have no general practitioner; only 1,558 dentists work in rural areas etc.
- Economic access: additional costs for transportation, post-admission monitoring visits etc.

- Inequality in the capacity of local authorities (DHA, DHIH, town-halls and county councils) to make organizational changes. There are differences between the flexibility of public authorities responsible to adapt to changes, starting with the people’s mentality and ending with their real participation and involvement in achieving the necessary reforms.

The management function of the healthcare system, being in the citizens’ benefit, must be based on ethical decisions because the citizens’ interest prevails over the interest of individuals or organization in power. The management of the healthcare system is diverse as it involves a wide range of interventions and various activities. The responsibility of creating a balance in the healthcare system must start with the government’s responsibility: political statement, a new policy to be collected not only on ill health outcomes but also on decision makers and citizens. Data and information also need to be collected not only on ill health outcomes but also on policies and measures and on health outcomes.

1. General policies must specifically address the development areas with a higher burden of socio-economic determinants of health (high share in rural areas, high unemployment rate, high percentage of people living in poverty, high percentage of overcrowded households or households made of single persons, percentage of disabled persons, low education enrollment rate and high school dropout rate etc.). A balanced socio-economic development reduces the risk factors and has a positive impact on public health.

2. In three development areas – North-East, South-West and South, the indicators that are relevant for health determinants show alarming values: high values of the variation coefficient between these regions and the remaining development regions, high poverty rate, GDP per capita, education enrollment rate, child mortality rate, indicate the presence of health inequities.

3. Universal access to health services and high-quality primary care for all children has proved effective in reducing child health inequalities.

4. In order to provide equitable access to healthcare services, resource allocation in health must meet the health needs and not the demand.

5. The allocation of resources (financial, human, medical technologies) must reduce the differences between regions in order to provide balance in the access to services, depending on the real needs, so that every citizen has real chances of treating their diseases and benefiting from prevention.

**Conclusions**

The European Union’s increasing commitment to work on health equity is remarkable. In order to turn this political commitment into action that also genuinely covers the core areas of European Union policies, it is necessary to include good data collection, data analysis and its presentation to decision makers and citizens. Data and information also need to be collected not only on ill health outcomes but also on policies and measures and on health outcomes.

References

8. Baza națională de date privind conturile de sănătate a OMS (NH), cele mai recente actualizări ale acestor date sunt disponibile pe pagina http://www.who.int/nha/en/.