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HISTORICAL DEVELOPMENT OF HEALTH EQUITY: LITERATURE REVIEW

Rula Al-Rimawi[1], Jafar Alshraideh[2] & Mahmoud Al-Hussami[3]

[1]Lecturer, School of Nursing, Al-Balqa' Applied University, Jordan

[2]Professor, School of Nursing, University of Jordan, Jordan

[3]Associate Professor, School of Nursing, University of Jordan, Jordan

ABSTRACT

Introduction

Equity is an important principle of all religions;Equity is a moral principle where people are treated equally or in the same manner as human beings. Equity is a needed principle throughout people's life; in religion, culture, law, education as well as health.

Aim

The aim of this review was to track main milestones in the journey ofhealth equity.

Search Strategy

A systematic search in the electronic databases of EBSCO and Google Scholar has been performed, the search were to all articles, reports and books that published in English language. Thirty results were revealed, from 1960 to 2014.

Results

The actual origination of equity in health is unknown, but in this review the start was with the publication of tittmus in 1960 and continues until the present time. The main mile stones of this journey were themed to the Origination, Alma-Ata and Beyond, The Black Report, Health Equity and Health Policy, Health Equity as a Concept, Health Equity and Social Determinants,And the Sustainable Development Goals and Beyond.

Conclusion

The historical development of health equity was tracked, the results revealed that health equity passed through important milestones. Despite the long journey, health equity is not yet proved in all countries, or in all component,. reaching health equity required a well-organized and a well-developed health system, and required a national and international cooperation.

KEYWORDS: *Equity, Health Equity, Health, Historical Development*

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INTRODUCTION

Equity is an important principle of all religions, Prophet Mohammad (peace upon him) called for equity since more than 1400 years when he refused to differentiate between people according to their race or origination; making piety as base of differentiation between people, he said "There is no difference between an Arab and an Ajami except with piety". And this is congruent with what Allah said in Quran "O mankind, indeed we have created you from male and female and made you peoples and tribes that you may know one another. Indeed, the most noble of you in the sight of Allah is the most righteous of you. Indeed, Allah is Knowing and Acquainted". (Surat Al-Hujurat, ayah 13)

Equity is a moral principle where people are treated equally or in the same manner as human beings (Jones, 2009) regardless of other differences. Equity is a needed principle throughout people's life; in religion, culture, law, education as well as health. Equity in health entails the absence of disparities in health and health outcomes that are systematically accompanying the social advantage/disadvantage (Braveman & Gruskin, 2003a)

Health equity is not only a pledge to diminish and eradicate disparities from health and its determinants, but also entails the striving efforts for reaching the Premier potential health standard for all people, taking in consideration the special needs of risk groups, grounded on social determinants(Braveman, 2014). Furthermore, equity required to guarantee that all individuals have equal access to prospects that enable them to manage their health.

Aim

The aim of this review was to track main milestones in the journey of health equity.

REARCH STRATEGY

A systematic search in the electronic databases of EBSCO and Google Scholar has been performed, using the following search terms and Boolean operators (Equity, Health Equity, Health, Historical Development), the search were to all articles, reports and books, that published in English language. Thirty results were revealed, from 1960 to 2014.

RESULTS

The actual origination of equity in health is unknown, but in this review the start was with the publication of Titmuss in 1960 and continues until the present time. The main mile stones of this journey were themed to the Origination, Alma-Ata and Beyond, The Black Report, Health Equity and Health Policy, Health Equity as a Concept, Health Equity and Social Determinants, And the Sustainable Development Goals and Beyond.

The Origination

The exact origination of equity in health is unknown, but it reverted to the 1960s when the national health services in London replaced a previously discriminatory doubled standard of services with a more public standard of services, irrespective of class, race or income.Titmuss (1965) describe this replacement as a positive move towards the principle of equality and welfare objectives, which insures equal, nondiscriminatory, non-judgmental access to all divisions of medical care by all populations. Despite this move, Titmuss (1968) clearly reported the presence of inequity based on social determinants, when he reflects on his experiences and readings, he said “We have learnt from 15 years' experience of the Health Service that the higher income groups know how to make better use of the Service; they tend to receive more specialist attention; occupy more of the beds in better equipped and staffed hospitals; receive more elective surgery;

have better maternity care; and are more likely to get psychiatric help and psychotherapy than low income groups – particularly the unskilled." (Titmuss, 1968, p. 196). Although his argument was convincing but he supported his argument with unconvincing data(Cartwright & O'Brien, 1974).

In 1970 the WHO Regional Office for Europe started The Equity in Health platform that concerned in unemployment, poverty and health, then extended to issues related to vulnerable groups. Four years later, Townsend (1974)stressed on the importance of studying the healthcare system considering its internal structure and external liaison. Furthermore, he acknowledged the presence of unequal dispersal of resources not only among population, but also among countries.

In a study conducted to detect the presence of social class variation in the healthcare, the study revealed that the middle class are receiving and using better health care and more services than other classes, which justified by the presence of inequity in distributing health resources, and the presence of differences among population in communication skills and education(Cartwright & O'Brien, 1974)

Alma-Ata and Beyond

In 1978 the declaration of Alma-Ata with its goal "Health For All", asserted on the importance of developing and planning a primary healthcare, that is comprehensive and community oriented in enhancing the health of community, taking in consideration the vulnerable group's needs. Furthermore, the conference recommends the governments to advance its role in providing equal and adequate distribution of health amenities and resources according to their social context and objectives(WHO, 1978). Consequently this leads all the affiliates' states in the World Health Organization (WHO) to embrace a common public health policy in 1980, and to agree upon 38 targets within the "European Health for All" strategy, including equity as the uppermost target "By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups". This published in 1985 in the first series of the WHO regional office on Europe(Whitehead, 1991, 1998)

The Black Report

Another cornerstone in the history of equity was the publication of the black report on inequality in health in 1980; the report define inequality as the presence of differences not only in health status but also differences among classes, races, gender, and diverse age groups, furthermore, the report focuses on health outcomes variances that are man- made as social or economic determinants. Moreover, the report emphasize on the importance of occupation as the foremost of all indicators, the rationale of this consideration that occupation is a robust indicator of living standard, and historically was the most significant in statistical analysis(Black, Morris, Smith, & Townsend, 1980)

In one of the strongest cohort studies, Whitehall II study that started on 1985 for more than 20 years, on 1991 the study revealed the presence of variances on health status based on socioeconomic determinants, among these determinants the employment grade and income were having the strongest effect on health outcomes (Marmot et al., 1991), whereas on 2005 after the analysis of large data over 15 years, the study revealed a reverse association between socioeconomic determinants and the incidence of diabetes, coronary heart diseases (CHD) and metabolic syndrome(Brunner et al., 1997; Kumari, Head, & Marmot, 2004; Marmot & Brunner, 2005).

Whitehead (1991) wrote a paper discussed the concept of equity and its principles; she defined equity as "fair chance for all" which includes the lack of unnecessary and avoidable dissimilarities among population that considered discriminating and unreasonable. Moreover, in the paper the term equity in healthcare was leveled up to action by adopting a functioning definition entails not only equal access to existing health services for persons with equal need, but also involves equal opportunities for everyone, unbiased dispersal of services in easily access geographical area all over the country, and the elimination of the access barriers. Furthermore, Whitehead (1991) delineated the basic principles for action through developing and disseminating a research based Equity policies; these policies ought to improve the living and working conditions, empower people to embrace healthy lifestyles, enhance the conduction of health impact assessment, and build an excellence and accessible healthcare.

Health Equity and Health Policy

In 1998 the WHO started working on monitoring equity as a mean of implementing a viable health equity policies, reducing in equities on national and international levels, and attainment of the big scheme "health for all", WHO proposed eight steps policy model for monitoring inequity; The model started with identifying the social group (socioeconomic, age oriented, ethnic, gender, or geographical) under concern, identifying the major concern of differences between the social groups and the knowledge gap that defeated policy development, identifying the source of information related to social groups and problem under concerns, selecting a proper health indicators and determinants that is scientifically and ethically accepted and best reflects the equity gap in health status, describing the actual health equity situation in understandable language, describing the variations in health equity indicators overtime, reflecting a policy implication that best fit detected variation in health equity, and finally developing an action plan for implementing, monitoring, evaluation, and research considering the available resources and barriers (Venediktov, 1998). In this model, the socioeconomic factors and for the purpose of assessing health equity was classified to groups based on income, expeditor, or consumption; economic assets; level of education; occupational class; and micro geographic indicators (Braveman, 1998).

The WHO (2000) report regarding the world health, spotted the lights on the role of health system in providing health service all over the population health continuum, claiming that the public health sector are taking the responsibility of providing all health services to the vast majority of populations, the report go farther and discussed the health system responsibility in providing equitable and quality care, taking in consideration protecting the health of poor (based on socio economic differences), disregarding the GDP health expenditures as it have no evidence on extending the life expectancies of population, making an example of two countries with the same decreased GDP health expenditure, and different life expectancy, and assessing the viability of the health system by the overall health status of the country population.On the same year in a study conducted in Egypt, the study implies the impossibility of attaining the health status indicators based on dissimilarities in the income levels, and extended to value the judgment that the lower income populations need more health services based on the overall health status(Rannan-Eliya, Blanco-Vidal, & Nandakumar, 2000). On the contrary,on 2001 the WHO 2000 report were critiqued as presenting inconvenient measure of health inequalities among countries, and lack needed data for targeting national policy and guiding the resource allocation(Braveman, Starfield, & Geiger, 2001).

Health Equity as a Concept

(Braveman & Gruskin, 2003b) explored the association between health, poverty, equity, and human rights as concepts, and revealed that these concepts are strictly connected to each other conceptually and operationally as both equity and human rights principles are striving to decrease discrimination and marginalization among disparities risk groups through providing equal opportunity for health for all, reducing differences between populations in the underlying circumstances necessary to health such as- education, living standards, and environmental exposures-, and working on poverty leading conditions. Furthermore, they stated that poverty was a result man-made through the action and in action, and recognizing inequities is a rudimentary human right. On the same year Braveman and Gruskin (2003a) for the purpose of operationalizing equity, and differentiate between equity and equality and presented them as two different concepts, they defined equity as "the absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage/disadvantage". They extended to say that equity not only requires dispersal of healthcare assets, but also all assets with an imperative effect on the population health as (resources, policies, and programs) (Braveman and Gruskin, 2003a).

Health Equity and Social Determinants

Wilkinson and Marmot (2003) stated that being poor means living less, this inequities grasp their attentions, the policy makers and government to consider the social determinants of health, tackling the socio economic determinant might be beneficial in implementing policies able to reduce inequities and enhance the health of people that rooted with in the socioeconomic process. Furthermore, they provide evidence that the social determinants of health are affected by (the social gradient, stress, early life, social exclusion work, unemployment, social support, addiction, food and transport); each one can affect the health throughout the people life cycle, extra lower the social rank and double the risks of illnesses and death(Wilkinson & Marmot, 2003).

In 2004 in a project funded by the Australian government, an Equity Focused Health Impact Assessment Framework (EFHIA) were developed and used in identifying unplanned health inequities at the organizational level. Through using The HIA framework by decision makers, the framework will enable them to consider equity and health through the process of decision making and policy development and subsiding unplanned inequities (Mahoney, Simpson, Harris, Aldrich, & Stewart-Williams, 2004). Since its development the frame work were used broadly in Australia and New Zealand.

(Harris et al., 2013) conducted a systematic review to evaluate the effectiveness HIA framework in informing decision making, policies and project between the years (2005-2009) in both Australia and New Zealand. The review revealed that HIA were somehow effective in some organization, where it is not that effective on others, the reason behind that were the presence of reciprocal reaction between HIA and the organization, furthermore, the effectiveness of HIA necessitate early liaison with in the decision-making process to enable the process to fit the HIA and vice versa (Harris et al., 2013).

In 2005 the WHO established the Commission on the Social Determinants of Health (CSDH) with the purpose of shaping the future strategy of health promotion, ready to take the best action that lessen inequities and guarantee a nondiscriminatory globalization.

Marmot (2005) revealed on two hot problems facing the globe, a twenty years gap in life expectancy between countries, and poverty. Both are considered problematic as the rich countries are getting older and facing the escalation of non-communicable diseases (NCDs) which burden the healthcare systems, while the poor countries are facing the high incidence of infant mortality. Marmot suggested that measuring health status is the best way to stop inequities, claiming that convincing health personnel to do so is a piece of cake as that what they already do, but convincing the policy makers that measuring health can determine the area of dearth to work on is the hardest (Marmot, 2005).

Irwin and Scali (2007) reported that the historical development of the act on the social determinants of health prove that accomplishing certain empowering condition, will possibly show the effectiveness of national policymaking on social determinants of health. On the same yearSolar and Irwin (2007) developed an" action-oriented framework", with the purpose of supporting the CSDH recommendations to endorse change in confronting SDH through policies. This framework is considered a pathway of shifting the focus of policies from illness to wellness, and to emphasize on prevention of illness and chronic disease. Furthermore, the framework had drawn its Sensitizing concepts from the social-determinants of health (Hossen & Westhues, 2011).

On 2008, the CDSDH on its report revealed the presence of wide variety in equity indicator not only between countries but also between cities with in the same country, increase of death rate as a result of drastic escalation of both communicable and non-communicable disease, and climate changes, these challenges required the integration between economic and social policies to enhance the health of population and ensure health equity(Marmot et al., 2008).the conclusions and recommendations of this report were critiqued as being general, the rationale behind this is the global language the report speaks, leaving the “translation” into specific policies within the context on the shoulders of policy maker in the countries(Marmot & Bell, 2009).

Sustainable Development Goals and Beyond

In 2014 the UN General assembly's open working group on sustainable development goals, proposed 17 sustainable development goals (SDGs), concerned with health and most of its social determinants, the health equity is the third goal(Assembly, 2014).

Since addressing the equity in health and healthcare as an basic issue and a fundamental right to population all over the global, each country is working hard to improve health services, condenses the burden of disease and the cost of care, set priorities, and develop health indicators and strategic plan.

CONCLUSIONS

The historical development of health equity was tracked. Results revealed that health equity passed through important milestone. Although the long journey of health equity is not yet proved in all countries, or in all components, reaching health equity required a well-organized and a well-developed health system, and required a national and international cooperation.

REFERENCES

1. *Assembly, U. G. (2014). Report of the Open Working Group of the General Assembly on Sustainable Development Goals. General Assembly Document A/69/970, New York, 12.*
2. *Black, D., Morris, J., Smith, C., & Townsend, P. (1980). The black report. Inequalities in Health, Peter Townsend, Nick Davidson, and.*
3. *Braveman, P. (1998). Monitoring equity in health: a policy-oriented approach in low-and middle-income countries. Geneva: World Health Organization.*
4. *Braveman, P. (2014). What are health disparities and health equity? We need to be clear. Public health reports, 129(1_suppl2), 5-8.*
5. *Braveman, P., & Gruskin, S. (2003a). Defining equity in health. Journal of epidemiology and community health, 57(4), 254-258.*
6. *Braveman, P., & Gruskin, S. (2003b). Poverty, equity, human rights and health. Bulletin of the World Health organization, 81(7), 539-545.*
7. *Braveman, P., Starfield, B., & Geiger, H. J. (2001). World Health Report 2000: how it removes equity from the agenda for public health monitoring and policy. British Medical Journal, 323, 678-679.*
8. *Brunner, E., Marmot, M., Nanchahal, K., Shipley, M., Stansfeld, S., Juneja, M., & Alberti, K. G. (1997). Social inequality in coronary risk: central obesity and the metabolic syndrome. Evidence from the Whitehall II study. Diabetologia, 40(11), 1341-1349.*
9. *Cartwright, A., & O'Brien, M. (1974). Social class variations in health care and in the nature of general practitioner consultations. The Sociological Review, 22(S1), 77-98.*
10. *Harris, E., Haigh, F., Baum, F., Harris-Roxas, B., Kemp, L., Chok, H. N.,... Harris, M. (2013). The Effectiveness of Health Impact Assessment in New Zealand and Australia: Citeseer.*
11. *Hossen, A., & Westhues, A. (2011). Improving access to government health care in rural Bangladesh: the voice of older adult women. Health care for women international, 32(12), 1088-1110.*
12. *Irwin, A., & Scali, E. (2007). Action on the social determinants of health: a historical perspective. Global Public Health, 2(3), 235-256.*
13. *Jones, H. (2009). Equity in development: Why it is important and how to achieve it: Overseas Development Institute (ODI).*
14. *Kumari, M., Head, J., & Marmot, M. (2004). Prospective study of social and other risk factors for incidence of type 2 diabetes in the Whitehall II study. Archives of internal medicine, 164(17), 1873-1880.*
15. *Mahoney, M., Simpson, S., Harris, E., Aldrich, R., & Stewart-Williams, J. (2004). Equity-focused health impact assessment framework.*
16. *Marmot, & Bell, R. (2009). Action on health disparities in the United States: commission on social determinants of health. Jama, 301(11), 1169-1171.*

17. Marmot, & Brunner. (2005). Cohort profile: the Whitehall II study. International journal of epidemiology, 34(2), 251-256.

18. Marmot, Friel, S., Bell, R., Houweling, T. A., Taylor, S., & Health, C. o. S. D. o. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. The Lancet, 372(9650), 1661-1669.

19. Marmot, Stansfeld, S., Patel, C., North, F., Head, J., White, I.,... Smith, G. D. (1991). Health inequalities among British civil servants: the Whitehall II study. The Lancet, 337(8754), 1387-1393.

20. Rannan-Eliya, R. P., Blanco-Vidal, C., & Nandakumar, A. (2000). The distribution of health care resources in Egypt: Implications for equity. Boston: Harvard School of Public Health.

21. Solar, O., & Irwin, A. (2007). A conceptual framework for action on the social determinants of health.

22. Titmuss. (1965). The role of redistribution in social policy. Soc. Sec. Bull., 28, 14.

23. Titmuss. (1968). Commitment to welfare.

24. Townsend, P. (1974). Inequality and the health service. The Lancet, 303(7868), 1179-1190.

25. Venediktov, D. (1998). Alma-Ata and after. Paper presented at the World health forum.

26. Whitehead, M. (1991). The concepts and principles of equity and health. Health Promotion International, 6(3), 217-228.

27. Whitehead, M. (1998). Diffusion of ideas on social inequalities in health: a European perspective. The Milbank Quarterly, 76(3), 469-492.

28. WHO. (1978). Alma Ata Declaration. Geneva: World Health Organization.

29. WHO. (2000). The world health report 2000: health systems: improving performance: World Health Organization.

30. Wilkinson, R. G., & Marmot, M. (2003). Social determinants of health: the solid facts: World Health Organization.