Reducing inequalities in healthcare

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Background

Equity in health and reducing inequalities are considered as the main goals of all health systems (1) which is the absence of systematic disparities in health or in the social determinants of health between social groups with different levels of social advantage(2). Health inequalities are structural and systematic differences in health status between and within social groups in society. There is a difference between the inequality and inequity in health so that inequity is regarded as avoidable inequalities (3). The term “ health inequity” has been recognized as a root cause affecting health and is closely related to “ social determinants of health (SDH)” including place of residence, race/ethnicity/culture/language, occupation, gender/sex, religion, education, socioeconomic status, and social capital requirements. Inequity in health is more important than other inequities because the health is the first prerequisite to achieve other capacities(4, 5). Studies, for example, show that the richer individuals are healthier than the poorer ones(6). However inequalities do exist in health care (notably in access to care), they should not be considered as the principal cause of inequity in health status(7).

In response to growing concern over the continuation and expansion of these inequalities, the World Health Organization Commission on Social Determinants of Health was established and made recommendations to develop and systematically monitor the equity in health and social determinants of health at the local, national and international levels. They may lead to design appropriate interventions and facilitate evidence-informed policy-making process(8).

Monitoring health inequalities through producing appropriate evidence can promote accountability and continuously improve equity-oriented health plans including moving toward universal health coverage(9). Given the importance of the issue, various countries have initiated the development of such surveillance systems(10). Health equity surveillance systems include the analysis of groups in terms of socio-economic status, age, gender, race, ethnicity, residence and other key factors determining socio-economic advantages or disadvantages (11)

The above list of factors identified may not include the underlying causal factors and pathways of health inequality from the developing countries perspective. As there are differences from country to country, addressing health inequalities may need country-specific indicators. Identifying causal factors at country level is essential for prioritizing policy interventions (12).

The accurate selection of appropriate indicators can affect the proper and reliable measurement of inequality rate. General important considerations for selection the indicators include the cost of data collection, data quality issues, availability of data for monitoring at proper time intervals, cultural appropriateness, sensitivity to the policy interventions and the required technical capacity for the analysis(13, 14).

Some countries use the World Health Organization’ health equity indicators. In Iran, the basis for development of health equity indicators was the Urban HEART (urban health equity assessment and response tool) indicators. Urban HEART, developed by WHO, is a simple tool and guide to identify health

inequity in urban areas which was tested in some countries including Tehran (Iran)(15, 16).

In this regard, In Iran the responsibility of the development of health equity indicators was delegated to the Ministry of Health and Medical Education. To develop these indicators, several expert meetings were held and 52 indicators were determined using the Urban HEART and after several refinements. Some of these indicators are international and some other are based on the local circumstances of Iran. The indicators have been determined in five domains including health (20 indicators), human and social development (17 indicators), economic development (4 indicators), physical environment and infrastructures (7 indicators) and governance (4 indicators). In addition, appropriate practical classification variables to calculate were determined for each indicator. Data associated with 12 indicators will be collected using survey studies while data related to 40 other indicators will be gathered through the routine data recording system(14). To ensure the enforcement of the health equity indicators, they were announced to the relevant organizations after its approval.

In order to plan for reducing inequalities, stakeholders should have sufficient knowledge and awareness of the issue of the equity in health and its indicators and reach a consensus about the system for monitoring these factors. It is necessary to clarify challenges and consequently relevant scientific and practical solutions can be applied using the international, national and local evidence.

Objectives

Given the importance of awareness of the health equity indicators and its implementation challenges and lack of study in this area in the country, this study aimed to investigate stakeholders' perspective on equity in health and its 52 indicators in Iran. The results of the study can help policy makers to better understand the issue in order to effectively plan and implement the health equity indicators.

Materials and Methods

In this qualitative study, data were gathered through semi-structured interviews and the review and analysis of relevant documents including meetings minutes, working plans and working progress reports. The interviews were conducted using a topic guide developed according to a literature review and expert opinion. It was pilot tested using interviews with three policy makers and executives and based on their comments it was revised and finalized. The participants were given the information sheet and consent form prior to the interviews. After research ethics committee approval, interviews conducted in-person on a one-to-one basis after consent was provided by the research director and two trained colleagues. All interviews were recorded and later transcribed verbatim. A framework analytical approach was used for data analysis.

Participants were selected using purposive sampling method and were policy makers involved in developing the indicators and executives responsible for implementing and calculating the indicators. A total of 23 individuals were invited, 8 of whom refused to take part in the study for various work-related reasons or the lack of willingness to participate. There were five policy

makers and 10 executives. Among the executives, two were governors of major cities. Interviews continued until data saturation was reached and no new code was found.

The focus of the policy makers' interview questions was primarily on the process of indicators development and participation and interaction of various sectors in this process the developing indicators as well as steps of indicators development process. Executives answered questions mainly regarding their perception of the health equity and related indicators' calculation and implementation processes.

The member check strategy was used and the comments were incorporated in the final analysis. It helped to ensure that the findings were congruent with participants' perceptions, beliefs and opinions. All the stages in the study were recorded to make it possible to track of each stage and clarify the procedures.

Discussion

The equity and equity in health are not only the issue of international interest but also have been considered in Iran development plans. Furthermore, committee on social determinants of health in the final report from the World Health Organization (2008) titled " closing the gap in a generation" emphasized on national and global health equity surveillance systems for routine monitoring of health inequity(8).

The issue of stewardship in health equity is a matter of great importance. Health system need to lead by taking a stewardship role in supporting a

cross-government approach that focuses on the social determinants of health and performing as catalysts to all society. The Health in All Policies programs of the European Unionand South Australia promote inter-sectoral collaborations to health equity (17). The establishment of a common language for health sector and other agencies is considered as an important challenge in its leadership. Gopalan et al. suggested that a lack of awareness among stakeholders restricted the inter-sectoral convergence on combating health inequities(18).

In Iran, the Ministry of Health is the steward of health equity goals and it is suggested that a secretariat or an independent office be established for health equity.

According to the definitions of equity concepts provided by the stakeholders, the difference between viewpoints is obvious and their perceptions on the main concepts of equity in health are different from each other. This study showed that many executives and some policy makers disagreed on key concepts of equity in health and the executives had insufficient information about the concept of equity in health as desired by the policy makers. In general, many executives considered the equity in health mainly as fair access to and distribution of health system resources. Also, Low study showed that access to health services alone is not sufficient to achieve equity in health(19). However city governors and medical science universities are executives responsible for implementing the indicators in the region, they lack sufficient attitudes and awareness towards the issue of equity in health. It seems that orientation programs by the Ministry of Health should be more comprehensive and with an aim of emphasizing a higher

priority of the issue for executives. The establishment of these indicators requires capacity building, training and shifting the attitudes of the executives implementing this program. So training and improving the awareness of the key actors are main effective steps for the establishment of health equity indicators. Training and improving the awareness of executives are facilitated by providing regulatory requirements helping the decision-making.

Beheshtian et al suggested that the Consensus-Oriented Decision-Making (COMD) model for more intersectoral collaboration and consensus among other areas can be used in Iran (14). After the development of the indicators and in the establishment step, interaction between politicians, policy makers and regulatory authorities is essential in order to establish these indicators.

There are some challenges regarding the calculation of the health equity indicators in the country. However 40 out of 52 health equity Indicators are collected through routine system, investigation and survey are needed for remaining 12 indicators. The routine system itself needs to be reformed and improved including hardware and software improvements. Furthermore, the preparation and participation of organizations to change their statistics and reporting systems are also required. Therefore, gaining a wide intra and intersectoral participation is needed to collect data for the indicators and change statistical forms. This participation should be established at levels of policy makers and high authority officials.

In addition to the above mentioned issues, creating the infrastructure for electronic data recording and defining access level may help to the establishment of the indicators.

The establishment of indicators requires financing, training and empowerment of organizations employees, legal requirements, and finally a clear action plan. A report from the Pan American Health Network on the development of health equity indicators in Canada also cited the similar challenges such as the need for financial resources, being time consuming as well as limitation of sources of information (20).

As the establishment of the indicators is in its the primary steps, so the executives responsible for implementing the indicators have not had the possibility for complete and necessary adaptation to ministry of health instructions and gaining more support for the executives, training them as well as laying the proper groundwork for calculation these indicators are obviously necessary.

It is debatable whether these indicators show the extent of the health equity in the country. Many policymakers stated that the World Health Organization and international indicators provided the basis for the country indicators but some changes were made in them according to cultural and social conditions of the country. In this regard, an important point mentioned by the policy makers is that as these indicators had not previously been identified, so the development of them can be considered as a positive step and they will be revised in the future according to feedbacks from universities and other organizations. Braveman in his study argued that data utilization to develop

interventions is far more important than data collection itself(2). The results of this study are in consistent with those of current study, because many policy makers argued that the establishment of these indicators can be helpful if appropriate interventions are developed based on information they provide. It is, therefore, necessary to specify solutions for using the indicators in decision making. Policy making for reducing inequity in health is too difficult because it is an intersectoral policy making requiring various areas and organizations involvement and this, in turn, demands the specification of common goals, integrated accountability and increased organizational responsibilities (14).

Overall, the results of the study showed the inadequate awareness of stakeholders on equity in health, lack of proper infrastructure and insufficient support from stakeholders are the important challenges regarding the establishment of the indicators; these findings are consistent with those of a study by Gopalan et al(18).

Limited access to some policy makers and executives was a limitation. A small number of the governors and executives were interviewed while there were more policy makers and stakeholders participating in the development of the indicators.

Conclusion: As the establishment of the indicators is in its the primary steps, so the executives responsible for implementing the indicators have not had the possibility for complete and necessary adaptation to ministry of health instructions and gaining more support for the executives, training them as well as laying the proper groundwork for calculation these indicators are

obviously necessary. The development of the indicators requires a shared understanding among policy makers and executives. As the attention has been focused recently on the issue, in addition to knowledge improvement, proper solutions with intersectional collaboration approach in order to tackle challenges should be considered.

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Acknowledgements

The authors would thank people who participated in this study and Iran University of Medical Sciences for financial support.

Financial Disclosure

There is not any conflict of interests.

Funding/Support

This work was supported by Iran University of Medical sciences [IUMS/SHMIS-15748].

Authors’ Contributions

Ravaghi and Oliyaee Manesh jointly designed the study. Arabloo and Goshtaei collected the data. Ravaghi, Goshtaei and Oliyaee Manesh contributed to data analysis and interpretation of the results. Arabloo, Goshtaei and Abolhassani prepared the manuscript. All authors read and approved the final manuscript.