

EQUITY IN HEALTH CARE: DOES FAMILY MEDICINE HAVE A ROLE?

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WHY EQUITY?

Health systems are invariably inequitable. Higher quality services are more available to the well-off, who need them less than the poor and marginalised.¹ Although the need for equitable health outcomes through addressing health disparities amongst populations of the world is widely acknowledged, there are presently no clear-cut mechanisms for achieving this goal at the global level.² This should be of critical concern to family physicians.

However, equity and inequity are terms that are rarely used in family medicine circles. An Internet search cross-referencing the terms 'family medicine' or 'family physician' with equity or inequity yielded only two references. These referred only to inequity in payment between family physicians and other specialists! An additional PubMed search yielded six articles: two related to employment issues, two to equity of access to general practice services and one to equity in training opportunities. The sixth article described an approach to developing community-based family medicine training in the Lao People's Democratic Republic, which provides an important model for what we will propose.³ Searching international equity websites produced no results with the keywords 'family medicine' or 'general practice' but there were 11 for 'district health'. In the current literature for family medicine, very little is found about inequity. A search in the *SA Family Practice* journal found only two references. One related to student perceptions about primary care and the other referred to the recent Rustenburg Resolution on Inequality of Health Care in South Africa. In this resolution, family physicians committed themselves 'to reflect, together with local health service teams, on our role in contributing to the inequity of resources and inequality of care in our various contexts and to endeavour to address these issues together.'⁴ Sadly, we are not aware of any concerted steps to take forward the lofty ideals in this resolution by the body representing family physicians in South Africa. We believe that family physicians should be concerned with the paucity of literature and discussion and should incorporate the ideals of equity in their daily work and professional goals.

WHAT IS EQUITY?

Equity has been defined as the absence of systematic inequality across population groups.⁵ Inequity in health is a state of non-random distribution of health status across and within populations. This is because of a complex set of influences that arise from inequalities in the economic, social and environmental determinants of health, in the policies that influence the distribution of these determinants and in the political and economic interests that shape these policies.⁶ The irony is that inequities in health systems are often made worse by the fact that more resources are available to more advantaged and healthier communities.

Several principles of equity are commonly discussed in the available literature.⁷ These include:

- equal access to health care for those in equal need of health care
- equal utilisation of health care for those in equal need of health care
- equal health outcomes.

Equity is not the same as equality. Equity is about ensuring equal outcomes. Striving for equity in health care is one aspect of the wider concept of equity in health status. It implies that health care resources are allocated and received according to need and financing is according to the ability to pay.⁶ Equity is very close to the ethical principle of distributive justice.

To achieve equity, additional resources must be allocated to those with sub-standard health status. These are generally the marginalised people in rural and neglected urban areas throughout the world, including Africa. The advantaged segments of our societies – the so-called 'haves' – have more access and can, therefore, benefit more from these resources. They have a theoretical shorter distance to travel in reaching the elusive destination of good health. It will take a massive input of resources to move poor, rural people further along this same road.

Equal health outcomes across societies would require restrictions on choice of lifestyle, which is impossible in democratic society. Thus, it has been suggested that the goal should be more equitable health outcomes.⁷ Equal access to health care for those in equal need is an important yardstick against which to measure family medicine. It is clear, certainly in Africa, that there is not equal access; the skewed distribution of all types of doctors on the continent is even worse for primary care physicians. When the other members of the primary care team – mid-level workers and nurse practitioners – are included, the maldistribution may be a little less but equal access is a very long way off. We might argue that this is the fault of governments but family physicians have surely colluded in this.

THE SITUATION IN SOUTH AFRICA

The major inequities in health care in South Africa provide a useful example of the problems seen throughout Africa in differing degrees. The three most important inequities of health care distribution are private-public care, urban-rural care and hospital-community care. These inequities are described in terms of what is available per person.

In the private-public care dimension, there are 3.34 doctors per 1000 people in the private sector (which equates to one doctor for 299 people), whilst for the state sector it is 0.34 doctors per 1000 people (which means one doctor for 2941 people). The public sector spends R875 (South African Rand) per person per year, whilst the private sector spends R6500 per person per year.

In the rural-urban dimension, the typical urban province has 30 generalists and 30 specialists for each 100 000 people not covered by medical aid, whilst there are an average of 13 generalists and two specialists available per 100 000 people in rural provinces.¹²

The difference between care for people in hospitals and people in the community is even more pronounced. In the private sector, of every R100 that is spent on health care, R36 is spent on hospitals, R27.70 on specialists but only R7.70 is spent in general practice. In the public sector, 95% of doctor time is spent in hospital; this means that on average for every 50 000 people dependent on the public health care service, there are 16 doctors in the hospital and there is one doctor in the community. These disparities are even greater as one moves further north in Africa.

EQUITY AND FAMILY MEDICINE

Family physicians often describe themselves as having a commitment to the population beyond the individual patient and thus to distributive justice, equality and making a difference to the poor and underserved. But how does this occur in practice and have we successfully made the link between caring for individuals and populations?

Family medicine is the specialist medical discipline of primary care and it is primary care and not speciality care that makes the greatest contribution to the health of populations.⁸ Primary care clinicians, especially family physicians, deliver a disproportionate share of ambulatory care to disadvantaged populations.⁹ Family physicians are personal doctors, primarily responsible for providing comprehensive and continuing care to every individual seeking medical care, irrespective of age, sex and illness. They care for individuals in the context of their family, their community and their culture and have a professional responsibility to their community. All of this is important for achieving equity in health care, but are these activities and contributions enough?

Family medicine doctors must actively redress inequity and focus on those people in most desperate need. This focus does not neglect the advantaged population in a society; their access to resources will ensure that they receive health care. We have to move beyond the concepts of fairness and individual patient autonomy as a priority, to equity and justice as the highest values. This clearly aligns family physicians with the poor and the marginalised, with rural and isolated communities, with migrants and street people. It is unclear, however, whether such alignment will be enough to address the fundamental problem of inequity which is systemic in nature.

THE EQUITY PROBLEM

From a system point of view, it can be argued that family physicians have no impact on equity. We are too focused on the care of individuals to make a difference to the pressing needs of our individual patients. Even using a bio-psychosocial perspective makes it difficult for us to move into the arena of public health systems change, advocacy and policy development.

In the Rustenburg Declaration, it was acknowledged that family physicians have failed, individually and collectively, through the system and structures we are part of, to provide high-quality, affordable health care to our patients. We have failed to stand up for the 'have-nots', but have instead entrenched the privileges of the 'haves.' We have not provided sufficient care to the most vulnerable in society.⁴ A different approach is long overdue.

At a practical level, this means that family physicians must get involved in primary health care at district level. We need to become collaborative partners in the health care team including community health workers, nurses, clinical officers and other health workers. It is necessary that we support other health workers and their training, instead of jealously guarding our turf. We need to get involved in health system restructuring and reform. To sit on the sidelines and watch health systems transform in unjust ways or, worse, research how they are collapsing as some of our colleagues have done, is unacceptable.

Family physicians are well placed to do this. We can work with and gain support from our communities. Community-orientated primary care is an effective approach that will help transform the practice of family medicine towards this goal.

STATEMENT OF PURPOSE – THE WAY FORWARD

Our voices will not be heard until we show that we are making a difference at the community level. We know of family physicians who are ignored at management and policy level, not because of their lack of intelligent argument or research data, but because their patient-centred practice and undocumented impact on health outcomes lack focus and credibility. If our arguments have always been about remuneration and employment issues, how can our policy proposals for greater equity have an impact?

We believe there needs to be a fundamental re-orientation of our approach to family medicine in Africa. We need to state unequivocally that we stand for, as a minimum, equity of access to health care for all people in Africa. Whilst family physicians will continue to care for individuals and their health, our primary concentration shifts to social justice and equity in access to quality health care.

These principles must be implemented where we practice and where we teach. We need to collaborate with the other clinicians, health workers and managers in communities and districts, ensuring the delivery of health care that produces equitable outcomes.

Finally, we remain humbly aware that health inequity is part of a much broader inequality in society. The same social determinants that affect health and illness also contribute to high levels of violence, school failure, obesity, mistrust and a range of other social problems.¹⁰ Our contribution, though small, should be part of a larger movement towards a more just and less unequal society. This will include supporting public policies that reduce inequity in health through improving the distribution of health in and across societies.¹¹

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