SDC-IDS LEARNING TRAJECTORY ON ENSURING EQUITY AND INCLUSION FOR HEALTH

Agenda for Opening Webinar – 26 May 2016

1. Introductions and welcome
2. Key issues overview:
   - economic dimensions of equity and inclusion
   - political dimensions of equity and inclusion
   - social dimensions of equity and inclusion
   - intersecting inequalities
3. Key issues and questions identified by LT participants
4. The way forward: common themes and next steps

LT OBJECTIVES

- **Enhancing knowledge** of meanings, mechanisms, challenges and interventions
- **Building shared understanding** of concepts and key trends
- **Defining principles** for common approaches, standards and indicators
- **Sharing outcomes** across the Health network and more widely within SDC

LT ACTIVITIES
(May 2016 – April 2017)

- **Online learning activities** including launch webinar
- **Learning group projects** bringing together country and HQ level staff with IDS support
- **F2F sharing of project findings** with SDC colleagues at regional and network meetings
- **Production of guidance materials** incorporating LT outcomes
- **Electronic sharing** of findings and guidance materials via Shareweb and other resources
- **Wider dissemination** of process and lessons via Practice Paper and online resources

WEBINAR OBJECTIVES

- **Share recent thinking from IDS** on different dimensions of equity and inclusion for health
- **Identify key conceptual issues** and questions for further discussion
- **Identify key policy and practice challenges** with which LT participants wish to engage
- **Identify common themes** for potential collaborative work and peer learning
- **Agree next steps** and follow-up process

ECONOMIC DIMENSIONS OF EQUITY AND INCLUSION: TOWARDS UNIVERSAL HEALTH COVERAGE (UHC)

- UHC during rapid change
- Health insurance
- Government-funded programmes
- Improving the performance of health markets

UHC DURING RAPID CHANGE

- Reduce financial barriers to access to health care and reduce the impoverishing impact of medical expenditure
- Increase share of health finance from social funding (government or insurance) and reduce unnecessary out-of-pocket expenditure
- Understand the changing patterns of inequality and vulnerability in terms of place of residence, age, sex, employment, ethnicity
- Take into account changes in roles and relationships between organisations that finance, provide and regulate health services and changes in institutional arrangements and underlying social norms

EQUITY AND HEALTH INSURANCE

- Factors that influence coverage (type of employment, gender, informal sector, age)
- Services that the scheme covers (hospital, chronic disease, prevention and primary health care) and the distribution of benefits across social groups
- Geographic differences in the availability of services covered by insurance (urban/rural, regional development)
- Groups that have special difficulty accessing the services (ethnicity, disability, other aspects of vulnerability)
- The impact of formal or informal requirements for co-payment on the use of insured services
- The effect of the insurance scheme on health care costs
- Monitoring inequalities between beneficiaries and modification of scheme design on the basis of findings

GOVERNMENT HEALTH PROGRAMMES

- Public health, health promotion, primary health care, community and social support (often provided by local government)
- Programmes that focus on specific health problems or target vulnerable populations
- Capacity of local governments in poor and rich areas to finance and deliver health programmes and the roles of transfer payments from higher levels of government and national programmes.
- Coordination of government programmes and insurance schemes

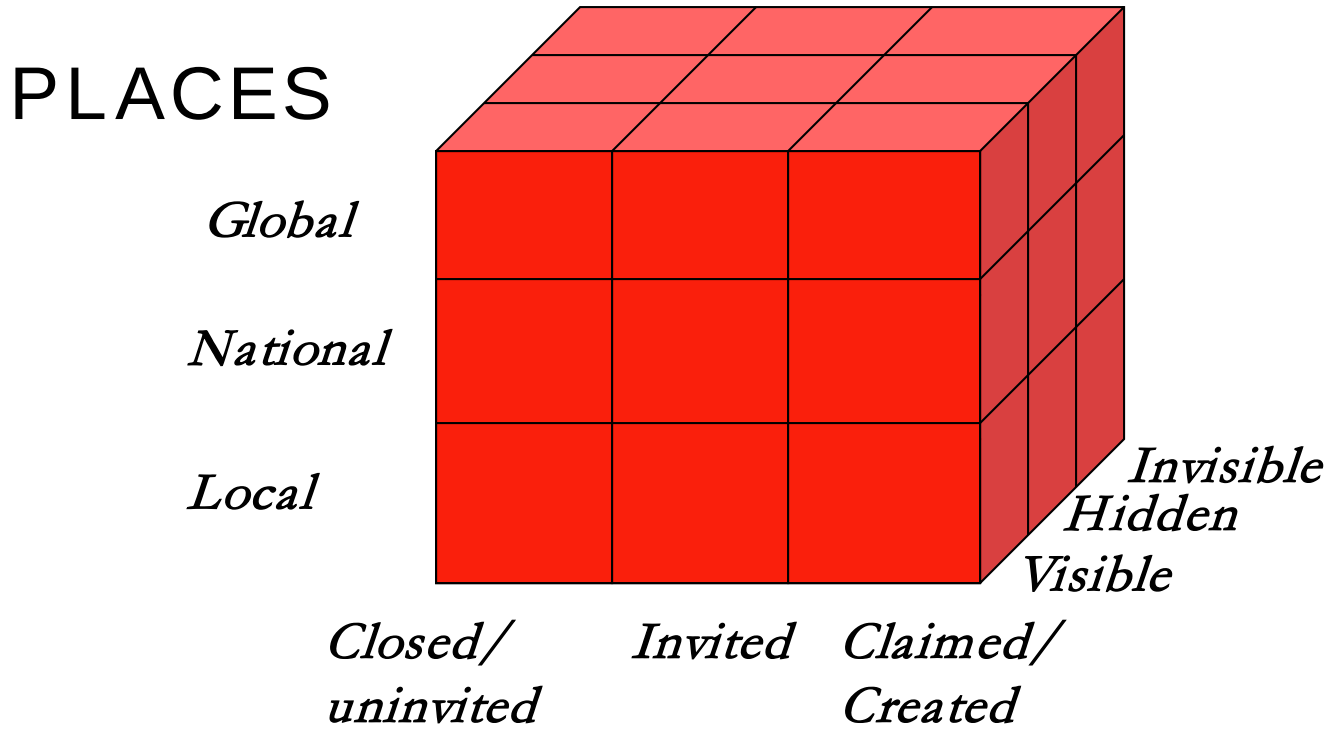
IMPROVING THE PERFORMANCE OF HEALTH MARKETS

- Poor people seek care from private providers or drug sellers (formal or informal) and make informal payments to government health workers
- Problems with drug quality and with high costs
- Unnecessary expenditure on drugs
- What measures can governments take to encourage the provision of effective treatment and reduce problems with wasting money?
- Should services or drugs supplied by private providers be eligible for public subsidy?

POLITICAL DIMENSIONS OF EQUITY AND INCLUSION: DIFFERENT FORMS OF POWER, DIFFERENT PATHWAYS TO ACCOUNTABILITY

- *Shaping health status*: power inequalities as social determinants of health
- *Shaping health spending*: health as an electoral issue or a focus for lobbying
- *Shaping health compacts*: power relations among bureaucrats, professionals, service users
- *Shaping health regulation*: from drugs policy to public health actions
- *Shaping health system performance*: reducing or increasing inequity of access and outcome

MAPPING DIFFERENT FORMS OF POWER: THE 'POWER CUBE'



Source: Gaventa, J. (2006) 'Finding the Spaces for Change: A Power Analysis', *IDS Bulletin* 37(6): 23-33.

EQUITY, INCLUSION AND DIFFERENT FORMS OF POWER

- *Visible power* includes discriminatory legislation, coercive imposition of policy measures that limit health spending or use of armed force to block access to services
- *Hidden power* includes social norms that legitimate discrimination, back-room deals to keep issues off the policy agenda and informal political relations that affect resource allocation and regulatory decisions
- *Invisible power* includes internalised inequality and may shape understandings of health rights, health seeking behaviour and health status (including mental health)

EQUITY, INCLUSION AND DIFFERENT PATHWAYS TO ACCOUNTABILITY

- Power inequalities can lead to the accountability failures which remain a major driver of health inequity (cf. WDR 2004)
- Information asymmetries and being reduced by social, political and technological change (education, rights awareness, Freedom of Information laws, mobile phones, Internet), but greater transparency does not automatically lead to greater accountability; this depends on 'Accountability Politics' and requires strategic approaches (Fox 2007; 2015)
- Health systems have invested in promoting inclusion via participatory institutions (health councils, committees, user groups etc.), but unless these spaces are designed and facilitated in a way that addresses power inequalities (along ethnic, gender, class and other lines) they are unlikely to contribute effectively to improving equity
- In complex, increasingly marketised health systems, achieving accountability for health equity requires a combination of social, political and managerial strategies

SOCIAL DIMENSIONS OF EQUITY AND INCLUSION

- People can be excluded explicitly from health care
  eg racially differentiated care in Apartheid South Africa,
  eg care for migrants

- People can be excluded implicitly as a result of societal attitudes and behaviour
  eg young unmarried people not offered SRH care

- People can be treated differently because of moral judgements of 'good' and 'bad' patients within the health system
  eg differentiated care for 'stable', 'responsible' HIV positive patients

- Trying to reach stigmatised groups can make them visible and intensify discrimination
  eg attempts to provide care for sex workers

THE HEALTH SYSTEM AND EXCLUSION

- Much literature on individual level factors that limit access to health services or access to good quality care

- Less attention to institutional level factors that limit access or quality of care and affect trust of the system

  eg health care workers and attitudes to HIV positive women and how influences quality of care and access to services

  eg of waiting times, informal payments

- Health care workers can be influenced by the prejudices of their society – blatant discrimination, or influences cultures of biomedical care to introduce inequalities.

  eg who is more 'deserving' of care or social protection for mental illness

- Do audits of clinical care include the patient perspective and assess of quality of care? Do patients have recourse to complain without fearing the withdrawal of care?

MULTIPLE DIMENSIONS OF EQUITY AND INCLUSION: UNDERSTANDING INTERSECTING INEQUALITIES

- Power and politics shape the economic and social dimensions of equity and inclusion as well as health policy and institutions
- Intersecting aspects of social difference: gender, ethnicity, social class, age, religion, disease, disability, occupation
- Goffman's concept of 'spoiled identity': the origins of stigma and assumptions of difference and inferiority which can be internalised
- The most marginalised people tend to be affected by intersecting inequalities, which reinforce one another at multiple levels (international, national, community, household)
- Promoting inclusion for health equity therefore requires strategies that address multiple dimensions of inequality across different levels

NCD CARE IN SOUTH AFRICA

- Concern to spread resources more equitably in the public sector and share the HIV experience and models of care
- Disease registers and an HMIS for NCD very limited
- No system to ensure retention-in-care or continuity of care – who drops out?
  eg comorbidity and mental health: who gets excluded from care?
- Framed as 'chronic diseases of lifestyle': is this as much about conditions of life as about lifestyle?
- Going beyond individual behaviour to address the political economy of NCD: policy to influence the food environment or create safe spaces for exercise
  eg smoking restrictions, salt and fat labelling or regulation

LT PARTICIPANTS' ISSUES AND QUESTIONS

- What examples have you found in your work of inclusion issues that are affected by intersecting inequalities?
- What are the key questions that you would like to investigate further in relation to equity and inclusion?

LT NEXT STEPS

- Follow-up with colleagues who weren't able to join
- Forming the Learning Groups
- Using the Shareweb and virtual meetings
- Preparing for the Tirana meeting (9 September)
- Timing and focus of our next learning activity?