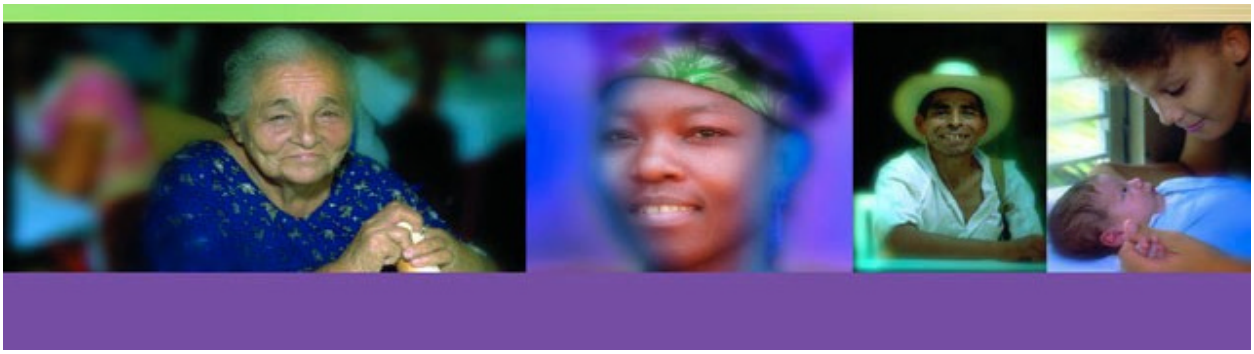
Regional Consultation on Policy Tools: Equity in Population Health Report

June 16th – 17th, 2002



Pan American Health Organization PAHO/WHO
The Rockefeller Foundation
Canadian International Development Agency (CIDA)
International Development Research Centre (IDRC)
Health Canada
Canadian Society for International Health (CSIH)
Institute of Population Health – University of Ottawa

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CONFERENCE RATIONALE AND OBJECTIVES

Background

Given the increasing global recognition and interest in the "population health approach", and specifically, Canada's recognition at the international level for its population health models and action on the broader determinants of health, this event allowed not only Canadians to share information on equity in health services, but also provided an opportunity for reciprocal exchange of best practices to improve the health systems and policies in Canada, and in other countries in the Americas. More importantly, the Conference began an important dialogue on how countries in the Americas can best access marginalized and vulnerable populations to insure that their needs are being met through national health systems and infrastructure.

This event directly related to the Final Declaration from the recent *Summit of the America's* in Quebec City, in which all countries

> "Emphasize[d] that good health and equal access to medical attention, Health services and affordable medicine are critical to human development and the achievement of our political, economic and social objectives."

As such, the Conference served as a concrete outcome and Canadian initiative in response to the Declaration made at the *Summit of the Americas*.

Objectives

Policy Tools for Achieving Equity in Population Health was a stand alone, one-time event that featured best practices and expert panel presentations, moderated discussions, as well as working groups. The Conference *wa*s premised upon three primary objectives:

(1) To provide a forum for presentation and review of policy tools to assist the development, implementation and/or evaluation processes associated with achieving health equity in the Americas.

(2) To produce publications on the state of the art policy tools for health equity that will be widely disseminated in the region, and globally, to assist policy makers and health service providers in developed and developing countries to implement public health policies aimed at achieving equity in population health.

(3) To establish a functional network of institutions, agencies and individuals to serve as a policy network/resource for health equity in the Americas.

What is equity?

Equity has a number of different meanings. The Equity Gauge is based on the following broad meaning: *Equity means "fair shares" and "fair opportunities" in the distribution and access of resources and provision of services.*

Equity is not synonymous with the concepts of "equal share" and "equal opportunity". Equity means that greater resources and more services should be made available to the most vulnerable and needy groups in society. For example, equal shares would mean every district having the

same amount of money to spend on each person. In contrast, equity would mean that districts with the most vulnerable populations and worst facilities receive more money that "better off" districts.

Equity is a measure that compares one group with another. For example rich with poor, black with white, rural with urban and women with men. The long-term goal of promoting equity is to improve the health of the most vulnerable groups.

Content

The policy tools discussed at the meeting included relevant instruments, methods and experiences for measuring and monitoring the social determinants of health disparities. It is expected that such methods will be useful in assisting member countries in developing and improving public policies aimed at health equity; promoting equity in the distribution of health services; and assessing the impact of health equity policies on other programs and initiatives.

In sharing information and best practices for policy tools aimed at achieving health equity, relevant experiences outside the PAHO region may also be utilised when appropriate. In this case, the working groups and/or plenary discussed the advantages, disadvantages, and applicability of such policy tools for PAHO member countries, and whether the models would be relevant and easily transferable to assist member countries in achieving equity in population health.

The Conference began by discussing the current socio-economic impediments to health equity and the problems that developing countries face in undertaking reform. The Conference focused on the major determinants of health inequities that countries in the Americas currently face, including, urban and rural poverty, migrant status, gender disparities, and racial/ethnic discrimination.

Positive Impact on Sustainable Development: Key Priorities and Social Development Frameworks:

The purpose of Canada's official development assistance (ODA) is to support sustainable development in order to reduce poverty and to contribute to a more secure, equitable and prosperous world. This Conference directly assisted in promoting sustainable development by facilitating the development of tools and resources for greater equity in health service delivery, programming and policy development in the Americas.

Through its focus on achieving equity in population health in the Americas, and by bringing together national and state/provincial health authorities, technical program directors, research centres, advocacy groups and policy makers from the national, regional and local levels, this forum created an effective regional network to develop and share knowledge, strategies, and policy tools with the objective of improving equity in population health in the Americas.

In doing so, this Consultation was reflective a key priority area - basic human needs - and also complements programming and policy work that the Agency undertakes with respect to women and development, and human rights, democracy and good governance. This is evidenced in the values and themes of the consultation:

Basic Human Needs

$ Health policy makers, researchers, service providers, and technical program directors have a role in developing and influencing social and health policies at all levels. This Consultation recognised that in order to ensure that the basic human need of primary health care is accessible to all people of the Americas more must be done to achieve greater equity in population health.

Gender Equality/Women in Development

$ The Consultation, similar to CIDAs health programming that is guided by the principles of Canada's foreign policy statement, focused on the need to examine, develop, and evaluate health care policies and programming based upon the principle of equity. More specifically, the discussions addressed gender equity in health sector reform, and recognize the role that women have in the not only the consumption of health services, but also their role (paid and unpaid) and employment in the health care and services industry.

$ By ensuring gender balance in the selection of participants, the Consultation reflected the fact that the full participation of women as equal partners is needed to promote sustainable development in their own societies, and to make certain that their particular needs in the health care systems are appropriately addressed and accounted for when discussing health equity and access to services.

Human Rights, Democracy and Good Governance

$ The 1995 Government of Canada foreign policy statement, *Canada in the World*, also underscores the fact that health is a human right, as does the *Universal Declaration on Human Rights*, and the *International Conference on Population and Development*.

$ The consultation also promoted good governance by highlighting the importance of sustainable, equitable, national health systems, and by developing and sharing tools and best practices to assist health sector reform and capacity development in order to enhance sustainability in the developing countries of the Americas.

By facilitating the development of a regional policy network including both developed and developing countries, this Consultation did not only contribute to the development of public policy premised upon equity in population health, but will also strengthened linkages between Canada and PAHO, and between Canadian population health experts, policy makers, and researchers and those in other PAHO member countries.

The complex issues that the current disparities in access to health and services forces us to confront, necessitates innovative action to counteract barriers to equity and to ensure access of all people to the basic human need of primary health care. This consultation offers one means of achieving this end through the formation of partnerships and regional collaboration on issues of equity in population health.

In summary, this forum:

i. Strengthened the linkages and partnerships between CIDA and PAHO member countries, as well as between policy makers, technical experts, and health care providers in the Americas.

ii. Facilitated the transfer of policy modules and tools related to health equity between developed and developing countries in the Americas.
iii. Promoted CIDAs key priority areas, and the ministerial interest in basic health and nutrition; and
iv. Assisted in the development of an expert/policy network through which to continue to address concerns and issues of equity in population health in the Americas.

Representatives and Participants
Approximately 165 people were invited to participate in the consultation, including 50 from developing countries. Participants from 26 countries were present (Argentina, Australia, Bangledesh, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Cuba, Ecuador, El Salvador, Finland, Handuros, Jamaica, Mexico, New Zealand, Panama, Peru, South Africa, Taiwan, Trinidad & Tobago, Venezuela, UK, USA and Zambia).

The main guest speakers included Juan Antonio Casas (PAHO/WHO), Tim Evans (Rockefeller Foundation), David Gwatkin (World Bank), Jan Hatcher-Roberts (CSIH), Andrew Jones (CIDA), Joe Losos (Institute of Population Health), Nick Previsich (Health Canada), Barbara Starfield (ISEqH), Christina Zarowsky (IDRC).

The participants from developing countries in the Americas added to the success of the event through their participation as panellists and experts, providing information on best practices of their respective countries in undertaking health sector reform, specifically, with the aim of achieving greater equity in population health. The participants from developing countries were fully integrated into the substantive content of the Consultation, as moderators, presenters and chairs of working groups.

Participants were from developing countries were chosen based on the following criteria:

$ As a group, the participants reflected a gender balance, and include representatives from minority/aboriginal populations.

$ There was proportionate geographic representation of the sponsored participants from developing countries, including Eastern Caribbean representatives; Cuba, the Dominican Republic; Mexico; Central America; and South America. There were also participants from the United States, from regions outside the Americas, PAHO staff, and Canadian participants.

$ The Conference organisers were actively encouraging the participation of a cross section of technical experts, policy makers, health service providers, researchers, advocacy group representatives; and provincial/state and national health authorities.

$ Participants had to commit or be in a position to share the information obtained from the Consultation with their colleagues upon return after the consultation, in order to disseminate as widely as possible the consultation outcomes, policy tools and best practices for improving equity in population health in the Americas.

Anticipated Results

As explained above, with the objective of sharing current best practices and beginning to develop new, more effective tools to improve equity in population health, this consultation could also have a positive impact on sustainable development. This could be achieved by improving equity in primary health care in the Americas; developing capacity and emphasising the need to improve access to health infrastructures systems for marginalized groups; thereby improving governance, democracy and human rights in the Americas through the delivery of more equitable health services and policy development.

Proposed Method of Evaluation

The consultation was evaluated through a two-fold approach:
At the completion of the consultation, an evaluation questionnaire was completed by the participants, and the results analysed and summarised in this consultation report. This evaluation questionnaire included questions on the logistics, relevancy of discussion, usefulness of the best practices shared/discussed, quality of the speakers, and overall impression.

Six months following the completion of the event, the consultation report will be mailed to all participants along with directions/instructions outlining the development of an electronic network. It is expected that this electronic list serve will encourage participants to share comments and updates on the usefulness of the information received form the consultation, and their success stories in implementing new policy modules to improve equity in population heath research and service delivery in their respective countries.

Finally, a twelve month evaluation form will be mailed to participants as a means to document success stories, barriers and plans for future work and research that was catalysed and developed as a result of the information and policy modules shared at the consultation. This evaluation phase will assess whether the consultation assisted participants in developing sustainable linkages and networks, and how beneficial policy changes or commitments may have developed as a result of the consultation. This information will then be compiled and distributed to all PAHO member countries/technical offices.

Indicators Used to Measure Results

Quantitative scoring and qualitative comments will be used for the evaluation questionnaires, based upon the objectives and main component of the consultation. In the 12 month follow-up participants will be asked to supply information on changes to programs, research and service delivery inspired by the consultation outcomes, as well as numerical data concerning the number of new programs/policies/research initiatives to improve equity in population health. Thus, a quantitative summary can be made to compile scores, as well as a qualitative report summarising the accomplishments, barriers, challenges, experienced by participants since the consultation.

Role of Participants

As stated above, representatives should gain knowledge concerning best practices and innovative policy tools to improve equity in population health in their respective countries. Upon returning to their country of origin, it was expected that this knowledge would be shared with colleagues and used to improve policies and health service delivery in order to improve its effectiveness for all peoples and especially those often marginalized and with limited access to health care and

services. Through the reciprocal sharing of information at the consultation, participants from developed and developing countries learned innovative means to improving equity in population health, and were involved in the development of a policy network on health equity in the Americas. It is expected that this policy network will serve as an excellent resource long after the completion of the consultation, through which participants can continue a regional dialogue in order to implement the policy changes and program improvements needed to improve health equity in the Americas.

Management Plan

The Institute for Population Health created a tripartite advisory committee to undertake the planning and management of this event. Co-Sponsors/Organisers include The Institute of Population Health (IPH), Health Canada (HC), Canadian International Development Agency (CIDA), and the Pan American Health Organization (PAHO), Canadian Society for International Health (CSIH) and The Rockefeller Foundation.

The Advisory Committee, led by the Institute for Population Health, and in collaboration with IDRC, CSIH, PAHO and Health Canada worked together to finalize the consultation program, logistical management, facilitation of the consultation.

In Summary

On June 16th and 17th, in Toronto, Canada, an International Consultation was held to discuss and analyze policy tools for equity in health of the population. Targeted at the Americas, experts were drawn from international organizations, the academic sector and countries around the world to add to the experience and expertise of the discussion.

The Consultation was co-hosted by the Pan American Health Organization, The Rockefeller Foundation, the Institute of Population Health at the University of Ottawa with sponsorship from PAHO, CIDA, CSIH, Health Canada, IDRC and the University of Ottawa.

The Consultation addressed four (4) main issues relating to inequity in health:

- Determinants of Health Inequalities: Identifying, Measuring, Monitoring, Intervening
- Targeting the Poor
- Allocation of Health Resources
- Health Impact Assessment

Expert papers were presented and smaller discussion groups analyzed each issue. Papers and discussions are presented in the Sections of this report.

Health Inequity is not a new concept, nor a new eneavor. There is a pressing need, however, to renew efforts in this field and develop tools, which will affect equity from the perspective of individual practices, research and measurement tools and decisions by individual people, communities, governments and international organizations.

Many initiatives targeted at reducing inequities have been tried and have failed. We need to know why this was the case and were there competing priorities. The real determinants of inequities must be studied to determine why they happen. Research must target distribution of inequity geographically and through strata of society. Measurements of determinants are needed

to determine what might be done, what human resources will be needed and how investments should be made.

Political will to address inequity is a vital component. Decision-makers must understand the cost-benefits of interventions and resource allocations and be convinced of the need for sustainability of programs with a positive impact. Communities must be involved in the planning and decision-making of programs to reduce inequity. Regional variations make this especially important.

New tools and more tools are needed to influence policy decisions at all levels of society and government. Such tools must be based in sound research. At the same time, they must be adaptable to regional and local conditions, sensitive to societal, cultural and political realities and variations.

Once developed and implemented, policy tools must be evaluated to ensure that the intended impact is achieved. Their effect of health systems, decentralized jurisdictions, welfare systems and vice-versa, must be determined. Tools should be targeted at the appropriate level of policy; nationally, to overcome inequity, allow for reform and regulation; internationally, to allow for dissemination of elements applicable to many, or all jurisdictions.

The following papers and discussions focus on many of these issues. They address methodological complexities, define experiences from various jurisdictions and address future research questions, which must be unraveled. Conceptual models will be analyzed and discussed and possible models, tools, approaches and methods of evaluation will be presented.

REPORT SESSION 1: DETERMINANTS OF HEALTH INEQUALITIES: IDENTIFYING, MEASURING, MONITORING AND INTERVENING

Sunday June 16th, 2002
Co-Chairs:
Norberto Dachs, USA
Peter Tugwell, Canada
Report Coordinator: Martin Valdivia, Peru
Breakout Group Facilitators:
Carmen Elisa Florez
Philippa Howden-Chapman (New Zealand)
Sharmila Mhatre (Canada)

1. Session Methodology
The "Determinants of Health Inequalities" session started with the presentation of a paper by Dr. Jeanette Vega from Chile entitled "Disentangling the Pathways to Health Inequities: The Chilean Health Equity Gauge"

Chile is an intermediate-development nation located in the southern cone of South America. According to its latest census (2002), the country has a population of 15,050,341. Half of the population is concentrated in two of Chile's 13 political and administrative regions - Valparaíso and metropolitan Santiago - which represent only 4% of the national territory.

Since March 2001, a team of health and social science professionals, with the support from Rockefeller Foundation, has been working to develop a Chilean Equity Gauge. An Equity Gauge is a concept derived from the work of the Health System Trust in South Africa[1]. It implies an active approach to monitoring health inequities and addressing inequity in health and health care, moving from description or passive monitoring of equity indicators to a set of interventions to generate changes in reducing unfair disparities in health and health care. An Equity Gauge is an approach consisting of a set of interconnected and overlapping actions, and is not just a set of measurements. For example, the selection of equity indicators to measure and monitor should be informed by the views of community groups and by a consideration of what would be useful from an advocacy perspective. In turn, the advocacy pillar relies reliable indicators developed by the measurement pillar and may involve community members or public figures. The media participation is essential to inform the community and all sectors about actions.

An Equity Gauge is based on three "pillars of action" each considered to be equally important, complimentary and essential to a successful outcome. The three pillars are:

1. Research and monitoring to measure and describe inequities.
2. Advocacy and public participation to promote the use of information to effect change involving a broad range of stakeholders from civil society working together in a movement for equity.
3. Community involvement to involve the poor and marginalized as active participants rather than passive recipients.

The Chilean Equity Gauge has added a four pillar : Human Resource Training to enhance local capabilities in research, surveillance and interventions to reduce health equity gaps.

The four pillars the Equity Gauge are not related in temporal sequence because a typical linear approach is often ineffective to promote significant social changes. In the Equity Gauge, the actions of all pillars happen concurrently, taking advantage of addressing different audiences for different purposes.

The **second** paper in this session was presented by Dr. Peter Tugwell entitled "**An Evidence-based approach to the reduction of inequalities in health: A measurement toolkit for assessing the impact of policy tools.**

In 2001 at a consultation organized by the Rockefeller Foundation, in collaboration with the World Bank, participants agreed on a need for health equity research 'to shift the present static emphasis on measurement and analysis of health inequities towards dynamic identification and evaluation of policy measures that can effectively bring about greater equity' (Gwatkin, 2001).

The equity gauge initiative (Equity Gauge Report, 2001) was intended as one such policy tool that links the measurement and analysis with dynamic identification and evaluation of inequity-reducing policies involving both community mobilization and policymaker participation. It is currently under development at national or subnational level in several countries (Bangladesh, Cape Town Chile, China, Ecuador, Kenya, Philippines, South Africa, Thailand, Uganda, Zambia and Zimbabwe). The gauge in these countries contains three 'pillars': [i] measurement, [ii] advocacy and [iii] community mobilization. In Chile, human resource development is a 4th pillar as described in the paper presented by Jeanette Vega.

This background paper described the plans for an Equity Oriented Research Toolkit, with some examples of component instruments developed by or involving individuals associated with the University of Ottawa Institute of Population Health that can also contribute to policy tools such as the Equity Gauge.

Two examples of tools/instruments were presented:
A) CIETmap (Community Information and Epidemiological Technologies)
The popularization of geographic information systems (GIS) opens a new horizon for evidence-based health planning. More complex data can be portrayed attractively and, as a consequence, more people can participate in evidence-based decision taking. Planners needs to identify the mix of circumstances under which a health intervention is effective, to quantify the gaps between the intended and the actual, and to present alternatives for closing them. CIETmap is a free geomatics and epidemiology software developed by the CIET group. The push button mapping and analysis software allows users to generate maps as evidence-based decision aids directly from survey or routine institutional data. It combines raster and vector mapping techniques with epidemiology analysis tools. While no hardware or software can replace a solid practical training in epidemiology - and no technical training can replace a commitment to equity -- customized epidemiological mapping software can provide an important tool for studying and comparing health indicators among and between different population groups.

B) Decision Aids, Shared Decision Making, and the Health Coach Initiative

One equity-oriented strategy is the use of 'health coaches' to help disadvantaged populations to become better decision makers, negotiators, and navigators of the health system for their own health benefit. In a CIDA funded-project in Chile, Annette O'Connor and colleagues have partnered with the Pontificia Universidad Catolica de Chile (PUC) School of Nursing and the municipality of La Pintana to develop a proof-of-concept decision support program for disadvantaged women. The objective is to enhance women's evidence-based decision-making capacity in managing their own health and the health of their families. The project also trains nurses to assess the decision making needs of targeted populations and to work with women and the municipality in designing and evaluating decision support strategies. Nursing students, primary care health professionals and individuals from the community receive training in 'coaching' rather than 'advising' to develop decision making capacities rather than to create dependency relationships. Health coaches have access to evidence-based health information and decision aids. They provide information, clarify values, and develop skills in deliberation, communication, and behaviour change. Delivery of coaching and decision support can take the form of self-care manuals, online health information and decision aids, individual and group patient education and coaching sessions, skills training of primary care professionals, and population-based telephone call centers.

*Another tool to be included in this Toolkit, RAHEST (Resource Allocation for Health Equity Support Tool) is being presented in another session of the Consultation 'Allocation of Resources'.

It was fully intended that the participants at this Toronto Consultation would comment on how this Toolkit could be improved, field opportunities to test it and instruments/tools that would be explored.

2. General Discussion

There was a general consensus that this is not an easy topic to analyse in detail that there is a bigger need to discuss a global model of equity. There were different opinions in the Group but general consensus around the need for a model which includes common regional elements. It is not feasible to have a global model without common agreement on the model. There is a need for an in-depth understanding of determinants of health incorporating and taking into consideration the context, in particular, the macro context and political issues.

Overall, there was some discussion around

Two (2) Levels of Action

National:

- Overcome inequality
- Health system reforms
- Need for more regulation

International:

- Tools: Reduction to epidemiological focus can lead to limitations

- Political context influence: Impacts of the current believes in Latin America on equity

3. *Process*
   - Involve all the stakeholders and processes to make that happen
   - Political will must be acknowledged
   - Involve communities in planning and identification of needs
   - Tools need to be tailored to user needs and look at balance (versus other priorities)

4. *Research Questions*

   A number of future research questions were identified including:

1. What are the key factors that lead to failure (some successes) of previous initiatives?
2. What are the real determinants of equity and its impact (not just health) and how do we measure them?
3. What are the barriers to achieve equity (within and outside the health sector)?
4. Need cost effectiveness of interventions to reduce inequities
5. How do we manage competing agendas? What are the impacts of competing agendas?
6. Who are the key decision-makers and how do they, or will they use evidence? What is the impact of such a process?
7. What is the impact of a policy on a widening or narrowing equity gap?
8. How has the health reform impact on Human Resources?
9. Have existing policies been implemented?

REPORT SESSION 2: TARGETING THE POOR

Monday June 17th, 2002
Co-chairs:
Annette O'Connor, Canada
Cesar Vieira, USA
Report Coordinator: Adolfo Martinez Valle, Mexico
Facilitators:
Armando de Negri, Brazil
Alex Jadad/Andrea Cortinois, Canada
Gladys Faba, Mexico

1. Session Methodology
The "Targeting the Poor" session started with the presentation of a paper that outlined the major equity-oriented targeted programs that are currently being implemented in Mexico by the Ministry of Health. Furthermore, this paper set a background for a general discussion in which three major issues were addressed: Are universal and targeted programs mutually exclusive? How can targeted programs be better implemented in the context of decentralization? Does targeting on vulnerable groups threaten the universality of social rights?
Finally, this overall discussion led to the breakout sessions in which weaknesses and strengths of targeting the poor as a health equity decision support tool were identified, research questions were made and recommendations were proposed.

- Project of society (where we are headed)
- Response differs in areas of country for equity
- Do not focus only at the poor – various strata
- Research on real effect of reduction of equities
- RHA's – could complicate inequity and accountability
- Sustainability – financial vulnerability
- Focus program on universality of rights
- Evaluate existing programs
- This Conference should introduce new concepts, not go over old ground

2. The Paper
Dr. Cristóbal Ruiz Gaytán presented a paper which briefly described two major health programs targeted to the more relatively deprived groups in Mexico: the Health Quality, Equity, and Development Program (PROCEDES) and the Human Development Program (OPORTUNIDADES).
PROCEDES aims to increase access, equity and quality in the provision of health services for areas that are highly deprived of basic sanitation, housing and public health services as well as for specific native groups whose first language is not Spanish. More specifically this targeted program seeks to increase both access and quality of care to primary units and community hospitals in rural areas as well as improve health of the poor population living in highly deprived urban areas. The size of this targeted population is 13.6 million individuals who include 9.6

million individuals living in 908 highly deprived urban and rural areas as well as nearly 4 million people whose first language is not Spanish.
OPORTUNIDADES is an equity-oriented human development program whose responsibility is shared by both the beneficiaries and the three levels of government (Federal, State, and Municipality). It is family focused and promotes both social and community participation. It is gender-focused and promotes women leadership. Its target population has grown from less than 2 million families in 1998 to little more than 3 million in 2001 nationwide covering more than 2 thousand municipalities. Among its major achievements is increasing access to a basic health benefit package, reducing children morbidity rates as well as increasing children average heights in rural zones, and reducing malnutrition through a food supplement program.

3. General Discussion

The presentation of the paper was followed by a general discussion that addressed three main issues. One of the issues discussed was whether these targeted programs were substituting universal programs. To answer this question two opposing arguments were raised. One which considered targeting the poor as a complementary strategy aimed towards universality. Related to this, but somewhat different was the argument that stated that is better to implement targeted programs that benefit a few that not implementing a universal program which would not help anyone. The opposing argument stated that focusing on targeted avoids addressing the issue of guaranteeing social rights to everyone.
The second issue raised was the context under which these targeted programs are implemented. It was discussed that decentralization made it more difficult to redistribute resources from the richer to the poorer areas, but it promoted local decision making and participation of the beneficiaries.

Finally, it was discussed whether targeting programs to specific social groups led to a segmentation of social rights instead of promoting universal social rights.

Next Steps

- Health care tech can spread
- Include HR training (scarce Human Resources)
- Include health and education of girls
- Use technology with Nursing

4. Health Equity Decision Support Tool Strenghts

- Targeting fosters investment at local levels and promotes local decision making and community participation.
- Targeting strategies are adaptable because they are responsive to local political and social contexts.
- Targeting provides a flexible framework for discussion among policy makers with different backgrounds that facilitates resource allocation decisions.
- Targeting has broad institutional bases: both governmental and non governmental.
- Giving money to mothers
- Investment of the State
- Local decision-making

5. *Health Equity Decision Support Tool Weaknesses*
   - Targeting specific groups may be difficult and its impact may yield poor results if these low-income groups are not properly identified.
   - Given that targeting does not include all social groups, this could lead to an imbalance of the social system as well as lack of support from the middle class.
   - Targeting may have the unintended negative externality of labeling or stigmatizing of the poor.
   - If used as a paradigm for achieving equity it may substitute universality as a goal.
   - It fosters a segmented social system which in turn makes it more difficult to achieve universality.
   - Targeting is usually promoted by international financial agencies which are not necessarily in the best interest of the national social policies of the country that receives a loan.
   - Targeting may be successful at the local level, but it may sacrifice valuable resources for other policies that may have a greater impact at the national level
   - Its effects on equity may be limited and unsustainable if the program ends.
   - It may raise high expectations with no human resources to meet the demand.
   - Sustainability of equity after program stops
   - Unrealistic raising of expectation (and resources)
   - Not inclusive of all parts of society, imbalance of society

6. *Research Questions*
   - Explore the determinants of inequity with a policy-oriented approach.
   - Will use of decision support tools help women make cost-effective decisions?
   - Is targeting the poor an effective strategy to improve equity at the national level?
   - As a social experiment, what would happen if women were allowed to pool resources? Would they invest in determinants of health?
   - How many resources would be necessary for implementing and sustaining health care models?
   - Who are vulnerable and how do we deal with it?
   - How to promote a shift to a needs-based system with strong accountability to ensure efficiency?
   - How to include other voices (community based)?
   - How to promote sustainability and ongoing review of the programs
   - How can we use technology (e.g., Telehealth) and efficiently link it to the system?
   - How can we promote collaboration and mutual learning?
   - What additional resources would be necessary for achieving such a goal and what would their main sources of financing be?
   - Conduct studies comparing the performance of universal health systems versus targeted programs in terms of equity, cost, as well as health and social impact.

7. *Recommendations*
   - Our goal should be optimal health for everybody, rather than “targeting the poor”
   - Many projects have backfired with increased inequity as a result.
   - We may need to target inequity and gaps, rather than specific groups. However, this may be unfeasible, as groups of vulnerable people will need to be identified.

- Define a common conceptual framework for discussion
- More sound evaluations should be conducted to better assess the impact of targeting policies.
- Long-term indicators should be included in the evaluations of these programs to better assess their impact on the quality of life of its beneficiaries.
- Targeting should focus on addressing inequity and gaps rather than on specific social groups.
- Targeting should be complementary policies for achieving equity rather than supplementing more universal policies.
- Health care technology could be used to spread scarce human resources.
- Targeting policies or programs should include human resource training.
- Information should be spread among communities for enabling them to make better decisions.

REPORT SESSION 3: ALLOCATION OF HEALTH RESOURCES

Monday June 17th, 2002
Co-chairs: David Gwatkin, World Bank, USA
George Wells, Institution of Population of Health, Canada
Report Coordinator: María Helena Jaén, Venezuela
Panel Discussants:
Oscar Cetrángolo (Argentina)
María Helena Jaén (Venezuela)

1. Session Methodology
This session has a different methodology of the rest of the sessions. Instead of having "Facilitators for the Breakout Sessions", the session on allocation of health resources has a main paper (Jan Hatch-Roberts and Stan Scheyer) and two panel discussants (Cetrángolo and Jaén). Therefore, the report mainly represents the conclusions and comments of the speakers and discussants of the key aspects of the session.

Research Questions
1. Impact of resource allocation decisions
2. Interaction between descriptive and normative judgments in interventions – trade-offs
3. Policy research costs of doing and **not** doing various policies
4. Monitoring natural experiments
5. The impact of political systems on welfare, health systems

2. The Paper
Health Equity Decision Support Tool (Scheyer, Stan and Hatcher-Roberts, Janet)

"Resource Allocation for Health Equity Support Tool (RAHEST): Adapting and Utilizing Decision Support Tools for Planning and Allocation. Adapting and institutionalizing equity-oriented, evidence- based approaches for planning and resource allocation", with the support for development from PAHO and Chile Ministry of Health.

POLICY TOOL ASSUMPTIONS (1)

i. Many countries are undergoing health and social reform and renewal processes which require programming and policy options that take health implications into consideration. The Southern countries are facing an unsteady environment since a four-pronged transition - economic, political, demographic and epidemiological – is occurring simultaneously and rapidly. In this complex environment, economic development and political considerations often take priority over social and health concerns, and short-term gains/expectations can override long-term social, environmental, and health concerns. Nevertheless, there is a recognition that these countries need to build the capacity to develop, adapt and translate sustainable, integrated and intersectoral approaches and reforms for the promotion and maintenance of health and well-being. One of the challenges in this health reforms is to develop decision making support mechanisms and strategies that will aid in addressing the extent of the disparity, the impact of these inequities and support planning and resource allocation approaches for intersectoral

interventions based on best practices and evidence which will diminish such gaps over time.

ii. There is a rationale behind the use of policy tools as "Health Equity Decision Support Tool", which is that solutions to current health challenges will depend on the strength of partnerships that are created amongst policy makers, donor organizations, NGO's, research oriented bodies and universities and communities (10/90 Report).

The policy tool (2)

"The generic software of the toolkit is called MapDecision and it is rapid assessment communication decision support integrated software that has been used in a variety of projects funded by the World Bank, USAID and the Japan Government. It has been applied in the areas of education, public health, social assistance, environment and economic planning. In Chile, PAHO is developing a project jointly with the Gov. of Chile, to link health and education information by municipalities, in order to identify, and geographically pinpoint, areas of social disparities and deprivation, with a view to allocating public resources with greater equity. The toolkit was recently demonstrated to the Chile Ministry of Health and a decision was made to implement the health equity decision support system at the national level and initially, in two health districts."

3. General Discussion

i. The issue on resource allocation for health equity can be seen from different points of view. One is the perspective of the speakers (Scheyer and Hatcher-Roberts) in the oral and written presentation made in the Regional Consultation on Policy Tools, focusing micro level (3) with a methodological approach, oriented to use a toolkit with the purpose to allocating public resources with better equity. The other one is the macro level, and this is the one where panel discussants (Cetránoglo and Jaén) focused their presentation. The discussants illustrate that Venezuelan (4) and Argentinean (5) financing trends shows signs of essential inequalities that shape the way the financial resources are allocated. Therefore the focus was placed on equity in the general finance of health systems in Venezuela and Argentina, specifically who finances and pays for the health system and services, how to assure financing solidarity, where the public resources go, how they are allocated, and who has access to health system. Even more, the three crucial issues the Argentinean and Venezuelan policymakers are currently facing regarding resources allocations are:
   - How to develop effective actions such as allocated health resources to risk groups and high-priority programs?
   - How to assure universal access to a mandatory health plan?
   - How to build a system to assure universal access to quality health services?

ii. The use of a resource allocation tool for health equity and specifically for planning and allocation of resources must be preceded by a political decision and based on a public policy. For example, the policy of the government and the principle objective of the Chilean Ministry of Health's Plan for Equity are to prioritize interventions and assign resources to populations with the greatest need and burden of disease.

4. Health Equity Decision Support Tool Strenghts

i. This is a policy tool sustained on the equity policy principles.

ii. It is a planning and resource allocation support tool that is used by a government that has equity on health as an explicit public policy. In fact, the Chilean Ministry of Health has as its specific objectives in this priority area to:
    - Identify the gaps in inequities
    - Establish a mechanism to close the gaps
    - Define methods to monitor and evaluate such progress by integrating decision making support processes into the regular planning, programming and policy development processes at the national, district and local (communa) level.

iii. It is a tool based on a partnership amongst policy makers, donor organizations, NGOs, Universities and communities.
    - Canada and Chile have enjoyed a history of international cooperation and common philosophy in terms of health and social welfare. Common goals for equity based health reform have been shared over time.
    - The WHO Collaborating Centre for Health Technology Assessment, Institute for Population Health at the University of Ottawa, has, as its mandate to promote, develop, implement and disseminate equity oriented, evidence based approaches to interventions, priority setting, and policy development.
    - CIDA has approved the development of a proposal for a partnership between the University of Ottawa, Institute of Population Health, and the Ministry of Health (Chile) to implement and institutionalize a resource allocation health equity (decision) support tool which will:
        - Support planning and resource allocation decisions at the Ministry (national) and district (servicios de salud) and in selected cases the communa level.
        - To explore and evaluate the role of this tool in improving decisional processes which address inequities
        - To explore and evaluate the role of the decisional framework in terms of supporting the various pillars of the Equity Gauge including capacity building
        - Institutionalize a decisional framework and process based upon inequities defined through the Equity Gauge.

iv. This tool uses available data and information to understand inequities in order to support decisions and to address health inequities. Therefore, this tool might support:
    - Policy Monitoring and Evaluation
    - Setting Standards
    - Performance Ranking
    - Targeting
    - Resource Allocations

v. This tool allows policy maker to:
    - Measuring inequity
    - Establishing standards and benchmarks
    - Monitoring change and performance
    - Developing indices and composites
    - Identifying regional and sector problems
    - Playing what-if scenarios
    - Targeting based on criteria of need and resources
    - Index-based resource allocation
    - Index-based cost-sharing

- Exploring local trade-offs

vi. Accordingly to Scheyer (July 22nd, 2002) "RAHEST can best be applied at the micro level but it is also is useful in presenting and communicating disparities at the macro that can help lead to policy reforms more consistent with equity".

5. *Health Equity Decision Support Tool Weaknesses*
   i. It is only a support health policy tool, and must be preceded and accompanied by a public policy regarding equity on health financing system. For example, in Venezuelan and Argentina cases, the main questions are who finances and pays for the health services, who manages and pools the available resources to assure solidarity, where the public resources go and how well the available resources are allocated amongst population.
   ii. Specifically concerning the tool presented, one of the participants raised the question regarding the perception of equity behind this tool. It was alleged that it is not very clear how equity guided the construction of the tool. It was proposed that it would be necessary to define what we understand for resource allocation in order to accomplishing equity in health using tools like the one discussed (6).
   iii. This tool requires quality, reliable and valid data and information, and also reliable database and accurate information systems.
   iv. This is necessary to take into consideration the cost of setting up and maintaining the system and the support tool.
   v. Another issue is that the tool needs well-trained professionals.
   vi. One of the questions raised regarding the tool was the time needed to design and launch the policy tool.
   vii. Finally, one of the concerns is the sustainability of the tool in Latin-American countries.

6. *Research Questions*
   i. Is it possible to use the tool analyzed in a complementary way and subordinate to a policy of equity in health?
   ii. What is it the risk that this type of tools overrides the policy key questions of health resource allocation for the achievement of equity?
   iii. Even though the macro level discussion on resource allocation such as the cases of Argentina and Venezuela: Is it possible to use a tool like the one described at local level for available resource allocation for health equity purposes?
   iv. Does the use and applicability of RAHEST depend on the political and federal organization of each country?
   v. Given the mentioned weaknesses: In which countries can this tool be applied in a suitable way and on behalf of equity on health?
   vi. What are the effects or impacts of the economic, fiscal and political crisis on the financing and provision of health, and how they affect equity in health?

7. *Recommendations*
   i. The "Resource Allocation for Health Equity Support Tool" should be applied in the context of an explicit health policy to reduce iniquities in health.
   ii. Since the title of the presented tool it is specifically Health Equity Decision Support Tool, it is necessary first to settle down that we understand for equal assignment and then identify the tools needed for achieving equity in health through resource allocation.

iii. In order to face inequalities in health financing, tools like the one discussed, must be accompanied by crucial policy questions related with resource allocation and never replaced questions regarding essentials inequalities, such as: Who finances and pays for the health system and health services in the countries, and at the end, who has access to health system.
iv. Before the promotion of the use of this tool by the donors` organizations, it is necessary to evaluate the cost of developing and maintaining the system and this health equity support too.
v. Regarding policy tools, it would be advisable to utilize:
    - Policy analysis
    - Stakeholder analysis
    - Strategic communication
    - Advocacy
    - Building consensus, and
    - Conflict resolution and negotiation

References

1. Based on: Scheyer, Stan and Hatcher-Roberts, Janet power-point presentation (June 17th, 2002).

2. Based on: Scheyer, Stan and Hatcher-Roberts, Janet "Health Equity Decision Support Tool", 2002 and power-point presentation.

3. It is important to mention that accordingly to Scheyer, "RAHEST can best be applied at the micro level but it is also is useful in presenting and communicating disparities at the macro that can help lead to policy reforms more consistent with equity".

4. Jaén, María Helena, Salvato, Silvia y Daza, Abelardo. "Resource allocation: Starting from the very beginning: The Venezuelan case". June 17th, 2002.

5. Cetrángolo, Oscar and Devoto, Florencia. "Health Organization in Argentina and Equity: A review on the Reforms of the Nineties and Impact of the Current Crisis" (Organización de la Salud en Argentina y Equidad: Una reflexión sobre las Reformas de los años Noventa e Impacto de la Crisis Actual). June 17th, 2002.

In this sense, to be able to make an assignment of the resources based on equity principle, it should be made based upon demographic criteria with two adjustments: the first one, in function of the inequalities in the demographic structures according to sex and age, and the second, using a proxy of population needs taking into consideration biological, epidemiological and socio-economic indicators

REPORT SESSION 4: HEALTH IMPACT ASSESSMENT

Monday June 17th, 2002
Co-chairs:
Juan Antonio Casas, UK
Vic Neufeld, Canada
Report Coordinator: Daniel Maceira, Argentina
Facilitators:
Francisco Armada, Venezuela
Silvia Porto, Brazil
Jerry Speigel, Canada

1. Session Methodology

i. Involvement of all stakeholders (mechanisms)
ii. Acknowledgement of political will
iii. Community participation and decision-making in local planning
iv. Appropriate tools → balance

2. The Papers

The following papers were presented.
Health Impact Assessment and Health Inequalities by Ruth Barnes and Alex Scott-Samuel, The Ferrier Estate: Health Impact Assessment by Ruth Barnes, Karen Macarthur and the Concepts and Principles of Health Impact Assessment by Ruth Barnes, Alex Scott-Samuel.

3. General Discussion

There was a general discussion around the need to develop matrix of evaluation factors including:

1. **<u>Policy Development</u>**

    - Inter-disciplinary think-tanks
    - Involve community
    - Policy needs to be developed at different levels from national to local

2. **<u>Implementation</u>**

    - Research financing to community groups who sub-contract academics
    - Awareness of levels 'high' level political to community

3. **<u>Evaluation</u>**

    - Replicability of results – reliability
    - Should include cost-benefit analysis, if possible

- Should indicate range and level of skills required
- Level of operation, power of small-area explanations

It was noted that this is not a new idea.

→ HFA
→ PHC

But there is a definite lack of implementation of policies.

4. Research Questions
A number of research questions were proposed including to look at

i. Comparisons between and within countries
ii. Impact of resource allocation decisions
iii. Interaction between descriptive and normative judgments in interventions – trade-offs
iv. Policy-based research costs of doing and **not** doing various policies, and on economic incentives (positive and perverse)
v. Monitoring natural experiments
vi. The impact of political systems on welfare, health systems
vii. Area-based deprivation measures to explore resource allocation

5. Recommendations
Key Concepts Covered

1. Why previous initiatives failed?
2. Examining the "real" determinants of equity
3. Impact
4. "Cost-effectiveness" of interventions to reduce inequities
5. Managing competing agendas / priorities
6. Human Resources:
    - Roles
    - Integration into delivery models

SUMMARY

In closing a representative from each of the funding organizations thanked everyone for this process and for the extremely hard work they had put into the interactive breakout groups. A number of the players had an opportunity to interact and provide feedback on the meeting.

Our funding agencies expressed their appreciation for having the opportunity to provide funding for such an important meeting on equity in health, which covers an area of great importance. Especially for a number of the agencies, the solutions to reduce these inequities, both in policy and programming are what draws our greatest attention. The key here is also that we define equity – which forms of inequality are acceptable and which are not. Governments and policy makers need to make the achievement of equity an explicit objective, not just for healthcare, but for society more broadly. Clearly, the multi-faceted determinants of equity within society necessitate an examination of how policies from other sectors impact upon health as well. In addition, we must look at sound public policy and identify how to bridge the gaps between policy and implementation to ensure that we actually reduce inequities. There are also lessons to be learned for donor agencies in perhaps expanding our concept of vulnerable populations rather than simply focusing on the poor. As outlined in our Action Plan on Health and Nutrition, the agencies very much supports the clear need for community participation and local decision-making in order to ensure the system targets those who need it most. We think it is also critical not only to define the determinants of inequality and inequity but also to examine the cost-effectiveness of interventions necessary to alleviate these problems ensuring the best allocation of scarce resources.

Health Canada provided input from the Canadian Perspective informing the participants that Canada has a predominantly publicly financed health care system which assists in the goal of providing health services in an equitable and affordable fashion. While many, if not all, countries in Latin America and the Caribbean have a tiered health system that allows segments of the population to access differential health services on the ability to pay, Canada has steadfastly refused to allow a two-tiered health system to provide medically necessary services. However, some health services are provided for which people pay directly or are paid for through the provision of private health insurance. It is important to note that these kinds of "pay-for" services are largely considered non-medically necessary such as: cosmetic services, dental services, some forms of fertility treatment, some forms of vision care, etc.

The Canada Health Act establishes criteria and conditions related to insured health care services and extended health care services that the provinces and territories must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST). The aim of the Canada Health Act is to ensure that all eligible residents of Canada have reasonable access to medically necessary insured services on a prepaid basis, without direct charges at the point of service.

The federal government's role in health care includes the following:

- setting and administering national principles or standards for insured health care services through the Canada Health Act;
- providing funding assistance to provincial/territorial health care services through fiscal transfers;
- delivering direct health services to specific groups of Canadians including veterans, Indigenous people living on-reserve, military personnel, the RCMP and inmates of federal prisons;
- fulfilling other health-related functions such as health protection, health promotion and disease prevention.

The administration and delivery of health care services is the responsibility of each individual province or territory. Provinces and territories plan, finance (assisted by federal funding), and evaluate the provision of hospital care, physician services, public health and some aspects of prescription care.

Canada has recently undertaken two major national reviews of the state of the health system and the sustainability of what we refer to as "medicare." At the core of these reviews is the debate on whether parts of the publicly financed and administered health services should be open to the private sector. A number of variations of the public-private mix have been discussed. Most experts agree that if the private sector is permitted access to the health system - for the provision of medically necessary services, the delivery of an equitable health system will be difficult. The conclusion of the Commission on the Future of Health Care in Canada, was that medicare has served Canadians well and that while improvements can certainly be made, medicare has "consistently delivered affordable, timely, accessible and high quality care to the majority of Canadians on the basis of need, not income".

This conference has allowed for both a discussion of the barriers to action and the various approaches for achieving equity and it was very clear that all agencies were happy to be a partner in it. This is important not just for people in the various policy branches but something we should all bring back to our colleagues who actually implement the policies through programs in our bilateral branches.

THANK YOU TO OUR SPONSORS

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Majestic Travel
Days Inn

REGIONAL CONSULTATION ON POLICY TOOLS:
EQUITY IN POPULATION HEALTH EVALUATION FORM

Please complete this evaluation and return to Bev Shea.

1. What was your overall level of satisfaction with the aspects of the workshop?

Excellent Very Good Good Poor Very Poor

2. What was your overall level of satisfaction of the workshop format including the breakout sessions?

Excellent Very Good Good Poor Very Poor

3. What did you like best about the workshop?

_____
_____
_____

4. What did you like least about the workshop?

_____
_____
_____

5. Please offer your comments and suggestions for how this workshop should be improved in the future.

_____
_____
_____

6. Please comment on how useful you think this workshop has been for you and your daily work.

_____
_____
_____

7. If you would like other workshops related to equity and policy tools, please suggest specific topics for future programs.

i. _____
ii. _____
iii. _____

FUTURE RESEARCH QUESTIONS

1. What are the key factors that lead to failure (some successes) of previous initiatives?
2. What are the real determinants of equity and its impact (not just health) and how do we measure them?
3. What are the barriers to achieve equity (within and outside the health sector)?
4. Need cost effectiveness of interventions to reduce inequities
5. How do we manage competing agendas? What are the impacts of competing agendas?
6. Who are the key decision-makers and how do they, or will they use evidence? What is the impact of such a process?
7. What is the impact of a policy on a widening or narrowing equity gap?
8. How has the health reform impact on Human Resources?
9. Have existing policies been implemented?
10. Explore the determinants of inequity with a policy-oriented approach.
11. Will use of decision support tools help women make cost-effective decisions?
12. Is targeting the poor an effective strategy to improve equity at the national level?
13. As a social experiment, what would happen if women were allowed to pool resources? Would they invest in determinants of health?
14. How many resources would be necessary for implementing and sustaining health care models?
15. Who are vulnerable and how do we deal with it?
16. How to promote a shift to a needs-based system with strong accountability to ensure efficiency?
17. How to include other voices (community based)?
18. How to promote sustainability and ongoing review of the programs
19. How can we use technology (e.g., Telehealth) and efficiently link it to the system?
20. How can we promote collaboration and mutual learning?
21. What additional resources would be necessary for achieving such a goal and what would their main sources of financing be?
22. Conduct studies comparing the performance of universal health systems versus targeted programs in terms of equity, cost, as well as health and social impact.
23. Is it possible to use the tool analyzed in a complementary way and subordinate to a policy of equity in health?
24. What is it the risk that this type of tools overrides the policy key questions of health resource allocation for the achievement of equity?
25. Even though the macro level discussion on resource allocation such as the cases of Argentina and Venezuela: Is it possible to use a tool like the one described at local level for available resource allocation for health equity purposes?
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28. What are the effects or impacts of the economic, fiscal and political crisis on the financing and provision of health, and how they affect equity in health?
29. Comparisons between and within countries
30. Impact of resource allocation decisions
31. Interaction between descriptive and normative judgments in interventions – trade-offs
32. Policy-based research costs of doing and **not** doing various policies, and on economic incentives (positive and perverse)
33. Monitoring natural experiments
34. The impact of political systems on welfare, health systems
35. Area-based deprivation measures to explore resource allocation

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