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Health Economics View is an initiative started by the department of Health Economics to sensitise health related issues as defined in academia and practice. The essays included in this academic forum can be event-based, action-oriented, experiential, expository, descriptive, processual, or discursive. This academic forum is open for the students, faculty and researchers of PIDE.

The topic of first Health Economics View is **Health Equity** authored by Zeynab Ameer.

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## HEALTH EQUITY

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Pakistan is a resource constraint country where the access and affordability of health care is not accessible to all but only to the affluent. The matter that makes the access and affordability to health more perplexing is that the constitution of Pakistan only provides the right to access to health care while Pakistan is the signatory of the Almaty declaration where it has been stated that:

“Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organisations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice” (Hixon et al., 2008). The policies that have been so far approved to be the part of the constitution concerning health care system has been forty two but only three have been approved which clearly shows that policies that are made for health care systems lack “Expediency”. If “Expediency” is the major clarity point for the policy making then the only double burden of disease that Pakistan is experiencing can be curtailed and overcome. Expediency includes five dimensions that should be made obligatory inbuilt part of Health policies. These dimensions are Advantages, Convenient, Profitability, Effectiveness and Utility which present a useful conglomerate to study health equity.

Health equity means that everyone has a fair opportunity to live a long, healthy life. It implies that health should not be compromised or disadvantaged because of an individual's or population group's race, ethnicity, gender, income, sexual orientation, neighborhood or other social condition. Achieving health equity requires creating fair opportunities for health and eliminating gaps in health outcomes between different social groups. It also requires that public health professionals look for solutions outside of the health care system, such as in the transportation or housing sectors, to improve the opportunities for health in communities. Health equity is about everyone in the community having the necessary knowledge, skills and resources to achieve and maintain good health and wellbeing. It is also about having the right services provided in the right ways and in the right places to support health and wellbeing. Health equity is concerned with ensuring the social determinants of health. Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential if it can be avoided (Chang, 2002). Health plays an important role in shaping the human capital. Good health enhances the productivity and efficacy of the labour force which leads to the economic growth and human welfare. World Health Organisation (WHO) has defined health system as “all organisations, people and actions whose primary intent is to promote, restore or maintain health”.

Health disparities do not mean the same thing as health inequalities. There exist differences in the presence of disease, health outcomes, or access to health care between population groups. Health inequities, on the other hand, are differences in health that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust. Health inequities are rooted in social injustices that make some population groups more vulnerable to poor health than other groups. Research also consistently shows people living in poverty receive less than a proportional share of public health funding relative to those who are better off. Discrimination based on gender, sexuality, race and ethnicity contribute significantly to inequities in health and in access to health care services. Health equity is not the same as health equality, but it looks and sounds similar so it is easy to get confused. Health equality, or sameness, does not exist; we do not and cannot have exactly the same experience of health and wellbeing. This is because we are subject to vast individual differences, including biological factors such as genetics, sex and age. Health inequities are avoidable. They result from decisions made by society such as policy or legislative measures on tax, welfare, healthcare funding and the creation of supportive environments.

Health equity is achieved by removing unfair and avoidable barriers that compromise health and wellbeing. The practice of health equity is focused on supporting fair access, fair chances and fair resource distribution to alleviate any disadvantage experienced by at-risk or vulnerable groups. Health equity could exist but often does not. The goal of health equity for communities, service systems and practitioners in their work is to make sure no one experiences poor health and wellbeing because of such unfair and avoidable disadvantage.

#### **References**

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