

Practical dimensions of health equity

An economist's point of view

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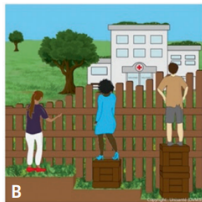


Dimensions of Equity

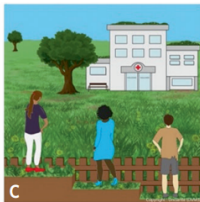
Bodenman, Vu Morisod, Jackson (2023)



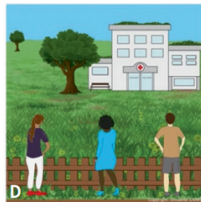
Égalité



Équité clinique



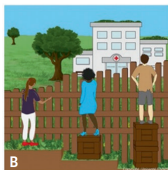
Équité institutionnelle



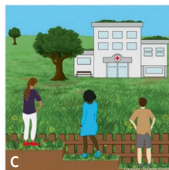
Équité structurelle

Source: Bodenman, Vu Morisod, Jackson (2023)

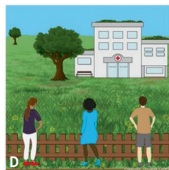
Which dimensions?



Équité clinique



Équité institutionnelle



Équité structurelle

- **Clinical equity:** The doctor pays more attention to the patient on the right than to the other two; (s)he tailors care to each patient, considering the socioeconomic, environmental and cultural differences that influence health and disease
- **Institutional equity:** The care organisation adapts to the specific needs, skills and competences of patients.
- **Structural equity:** Society is ready to evolve to reduce the impact of socioeconomic, environmental and cultural inequalities on health.

Drivers of Racial Differences in C-Sections

Adriana Corredor-Waldron, Janet Currie & Molly Schnell

WORKING PAPER 32891

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- What? Delivery type, (c-section vs. vaginal)
- Where and when? Non-planned deliveries in New Jersey, from 2008 to 2017
- Result? Black American women have 25% higher probability of c-section, compared to white non-Hispanic
- Why? The most plausible mechanism is healthcare providers' discretionary choices; a clear signal of this is that when c-section is more expensive for hospitals, the gap vanishes
- Implication: systematically offering more c-section to Black American women, even when that is not clinically appropriate, generates extra risks for mothers and children

Example of institutional inequity

Hill, Jones & Woodworth, JHE (2023)



Physician-patient race-match reduces patient mortality



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- What? Re-attendances and hospital mortality in emergency care
- Where and when? “Florida”, 2011-2014
- Results? Black American patients randomly assigned to a Black American physician benefit from lower mortality (0.28 percentage points, or -27%)
- Why? Better patient-provider relationship and communication
- Implication: ethnic diversity of ED staff is important for patients' health

Socioeconomic position and the COVID-19 care cascade from testing to mortality in Switzerland: a population-based analysis



Julien Riou*, Radoslaw Panczak*, Christian L Althaus, Christoph Junker, Damir Perisa, Katrin Schneider, Nicola G Criscuolo, Nicola Low, Matthias Egger



- What? Care and mortality following a COVID-19 test
- Where and when? Switzerland between March 2020 and April 2021
- Results? Individuals living in low socioeconomic status neighbourhoods had lower probability of being tested but higher probability of having a positive results, being admitted to the hospital and higher mortality compared to patients living in high SES areas.
- Why? *Inverse care law*
- Implication: testing and vaccination campaigns were not tailored to the structural barriers of individuals living in poorer areas

Wrapping up: conditions for equity

Lessons from the 3 examples

- **Clinical equity:** Provider discretion creates room for discrimination
→ Condition: Reduce/limit/bound provider discretion (e.g. guidelines)?
- **Institutional equity:** Concordance in ethnic group between patient and provider has a positive impact on patients' health
→ Condition: Equal ethnic representation of staff in relation to the population they serve
- **Structural equity:** During the COVID-19 pandemic, testing and vaccination in Switzerland were not tailored to the structural barriers faced by individuals living in poor neighbourhoods
→ Condition: Implement public health campaigns with the goal of levelling structural societal differences rather than replicate (or worse increase) them