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Accumulating evidence across the globe demonstrates that social inequities in health are widespread—in countries of the South as well as the North. The country analyses in this book have provided ample illustrations of this fact. In some cases, the health differences within countries have widened across decades marked out by worsening macroeconomic conditions and increasing socioeconomic crises. At the same time, economic growth in various countries has not necessarily distributed the benefits across all sections of the population. Overall gains in a population’s health frequently mask significant and worsening health outcomes for some population groups.

We believe that addressing health inequities is one of the major challenges for policies that aim to promote and sustain population health. The underlying premise of this chapter is that something can and must be done about inequities in health. The evidence that the choice of development policy, for example, makes a significant difference to the health status of the population as a whole and that differentials in health vary over time and across countries with different policy environments yields the important message that macroeconomic and social policies do matter (Radcliffe 1978; Caldwell 1986; Drèze and Sen 1989; Sen 1995; Dahlgren 1993, 1996; Cornia 1996). In essence, our contention is that it is possible to challenge health inequities with purposeful public policy. Such a challenge is long overdue.

Building a robust and appropriate policy response to health inequities requires action across a broad spectrum of areas: first, establishing values; next, describing and analyzing causes; then, tackling the root causes of inequities; and finally, reducing the negative consequences of being in poor health. This chapter works through these four key elements in turn, drawing lessons from the various analyses presented in this book. A particular effort is made to focus on the practical approaches that address these unacceptable disparities in health. The chapter concludes with some reflections on the opportunities now opening up for a more concerted global response to this major challenge.

Element 1: Establishing Shared Values

Any planned response to the gross and pervasive inequities in health must acknowledge right from the start that action involves ethical and political choices—and therefore has to be based on a firm foundation of shared...
values within a society. Developing value-driven policy action is, however, particularly challenging in the current global context. Economic, social, and health policies have increasingly sacrificed ethical concerns in the race to contain costs and in the pursuit of “efficiency” (Gilson 1998, 2000). Therefore, an essential first step is to demonstrate the injustice and unfairness of present economic and social arrangements while making explicit the values on which proposed action is based. A start can be made by

Setting equity objectives and targets for policy
Subjecting existing and proposed developments to health equity impact assessment

Setting Health Equity Objectives

Establishing a consensus on societal values for policy may seem a daunting task, but it is worth remembering that through international agreements many countries have already committed themselves to health and health care policies with common equity objectives. Several international documents, including the seminal 1948 United Nations Declaration of Human Rights and the 1977 World Health Organization (WHO) Health For All Policy, state that social inequalities should be reduced and that access to good quality health services should be increased and provided according to need. Likewise, the International Conference on Population and Development 1994 in Cairo and the Fourth World Conference on Women 1995 in Beijing catalyzed global solidarity in gender equity in health and other social spheres.

Equity objectives tend to be of two types: symbolic, their main purpose being to inspire and motivate; and practical or action targets, to help monitor progress toward equity and to improve accountability in the use of resources (Whitehead et al. 1998). The two types are mutually supportive in shaping policy action. Such targets are instrumental at global, regional, and national levels.

At a global level, the Organization for Economic Cooperation and Development called upon its Development Assistance Committee to establish International Development Targets (IDTs) that articulate economic and social goals to be achieved by all countries by the year 2015. The economic target aims at reducing the proportion of people living in extreme poverty by 50%. Of concern, the health targets are general and therefore lack an equity focus. As Gwatkin (2000) demonstrates, achieving the overall goal of reducing infant mortality by two-thirds in each developing country can be reached through many different routes. The most likely of these routes will disproportionately improve infant health in the upper and middle income groups, thereby increasing poor-rich gaps in infant mortality. Most concerning is the possibility that the target could be achieved without improving the infant mortality for the poorest quintile of the population. It is argued, therefore, that the IDTs for health should incorporate equity objectives to ensure improving health among the poor (Gwatkin 2000).

The symbolic “Target One” of the WHO European Region’s Health for All strategy (first set in 1985, to which all 50 countries in Europe signed up) has done much to focus attention on the equity issues: “By the year 2000, the differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups” (WHO 1985). Adoption of this symbolic target spurred important developments in the conceptualization, measurement, and articulation of pragmatic equity policies (Dahlgren and Whitehead 1992; Kunst and Mackenbach 1995; Gunning-Schepers 1989).

After years of lobbying from the public health community in the United Kingdom, the latest national health strategy for England has at last acknowledged the centrality of equity for promoting population health and has set one of its two key aims as “to improve the health of the worst off in society and to narrow the health gap” (U.K. Department of Health 1999). In addition, all local statutory agencies are now required to set local targets for reducing health inequalities and to specify plans to meet those targets. Similarly, in January 2000, the U.S. Department of Health and Human Services released national health goals for the decade to 2010, with one of the two overarching goals for the United States being to eliminate health disparities between different segments of the population, including those related to gender, race, education, income, disability, rural location, and sexual orientation (U.S. Department of Health and Human Services 2000).

The uptake of symbolic targets has not been limited to Northern countries. Triggered by the grossly unjust policies that prevailed under the apartheid regime in South Africa, for example, symbolic equity goals are now at the heart of social policy development in that country. The government’s White Paper, The Transformation of the Health System, states that the overall vision for the health sector includes playing a part in promoting equity within society as a whole by developing a single, unified health system (Republic of South Africa 1997). In addition, the country’s new constitution includes a Bill of Rights that encompasses socio-
economic rights such as to health care. Likewise, the commitment to gender equity enshrined in the Bangladeshi Constitution has legitimized a groundswell of activities advancing the status and well being of women, thereby challenging pervasive cultural norms. Politically, the potential power of such explicit objectives should not be underestimated. These represent useful tools in the attempts to establish the legitimacy of work toward health equity.

More practical, action-oriented targets have recently been announced for Sweden (SOU 1999), focused on tackling the wider determinants of inequities in health, such as income disparities, poverty, marginalization, and poor working environment. For example, for the stated strategy of strengthening the social cohesion and solidarity of Swedish society by the year 2010, the following targets have been set (SOU 1999):

- Income disparities should not increase beyond the present level of a GINI of 0.25.
- Prevalence of poverty (EU definition) should be reduced to less than 4%.
- Long-term dependence on social welfare should be reduced to under 1% and homelessness should be reduced to under 0.05%.
- Political marginalization should be reduced through increasing voting rates in deprived suburban areas.
- Suicide rates should be reduced by 25% from present level of 21 per 100,000.

Setting equity objectives is only the first step in establishing shared values. There is often a gap between stated objectives and how the policies are implemented on the ground. Both the implementation and outcomes of policy therefore need to be monitored and judged against the original equity objectives. At the heart of the monitoring issue is the definition of effectiveness, defined in our analysis as the degree to which the effort expended, or the action taken, achieves the desired result or objective (Slee et al. 1996). In other words, effectiveness must be related to overall objectives. Consequently, if the equity dimension is explicit, then the central focus is on how to achieve this politically determined objective in the most cost-effective way. This contrasts with the more common approach, which sets equity in conflict—or as a trade-off—with efficiency.

Making Health Equity Impact Assessments

The emphasis on underlying values and recognition of the wider determinants of health inequities carries with it an obligation (or the imperative) to undertake health equity impact assessments. Policies and programmes in a wide range of sectors must be subjected to such assessments so that “unhealthy policies” can be identified and “healthier” ones developed. The focus of the assessment process should be the impact of policies on the health and circumstances of the most vulnerable
sections of society relative to other population groups. The field of environmental impact assessment is instructive with regard to its emphasis on prospectively identifying negative impact on ecosystems (Vanclay and Bronstein 1995).

Similarly, the idea of "gender mainstreaming" that emerged from the U.N. World Conferences on Women provides important insights into and experience with sections of society relative to other population groups. It was clear from the analysis, however, that there were practical possibilities for changing the regulations to make the policy more health enhancing (Dahlgren et al. 1997).

In the current context of rapid globalization, with its attendant propensity to generate disparities, there is a rich agenda of issues that urgently need analysis through an equity lens. For example, the effect of global ecological changes on human health (such as climate changes, depletion of resources including food stocks, environmental damage arising from increased economic activity; see chapter 4) are a ripe subject for health equity impact assessment. Furthermore, the World Trade Organization's recent negotiations could have profound implications for the ability of states to maintain equitable health, education, and social services (Price et al. 1999). This development re-emphasizes the need to assess prospectively and retrospectively both the positive and negative effects on health of various policies, interventions, and actions.

This is not an argument for stand-alone health equity impact assessments, but rather a call for an equity-oriented lens—encompassing, among others, health, environment, and gender concerns—for the prospective analysis of economic and development policies.

### Element II: Assessing and Analyzing the Health Divide

#### Describing Inequities in Health

Another key element in any strategy to tackle health inequity is to assess the size and nature of the problem. In this respect we start with the following assertions—first, that health measures based on population averages are not reliable guides to what may be happening to the health of different groups in society; and second, it is always possible (and necessary) to make some assessment of the health divide. What is surprising is that such analysis is still not yet routine practice. Many national databases are analyzed by averages only, undifferentiated by gender, area, ethnicity or socioeconomic characteristics. Differentiation by social groupings should be as natural as the current universal practice of describing the health status of different age groups.

Even if data-poor countries are limited to basic descriptions from the available statistics or from more qualitative assessments, these can still be valuable in providing policy-relevant information on the equity situation in a country (see chapter 12 on Tanzania and chapter 15 on Kenya). Regional differences, for example, may be gleaned from health care statistics and hospital records and backed up by population-based surveys to inform resource allocation (as in Mexico; see chapter 19). In sub-Saharan Africa, where reliable data on health are most scarce, a resourceful group—comprising over 20 computer-connected, district demographic surveillance sites—is compiling the best health data for populations that are otherwise invisible and neglected. Recent analyses have disaggregated Demographic and Health Survey (DHS) data, often the most reliable population health data in data-poor countries, into income quintiles derived from a household asset index. This analysis has highlighted dramatic socioeconomic gradients in health across about 50 of the poorest countries in the world using a data source not originally designed for this purpose (Pande and Gwatkin 1999). Analyses by gender should be possible in nearly all cases and are essential to equity studies. Some countries may be able to go further in analyzing health data by ethnic group or by socioeconomic characteristics, such as education and income, while the data-rich countries will be able to add to these descriptions with more sophisticated measures.

It is also important to analyze the prevalence of not only health and disease in different population groups
but also differentials in exposure to health hazards, in behavioral risk factors, in opportunities and barriers to adopting a healthier lifestyle or to gaining access to essential goods and services, and in the costs and benefits of macroeconomic policies. To do so, monitoring must be improved and socioeconomic variables must be added to health information systems. Conversely, more health information could be added to routine socioeconomic data collection. Chapter 5 on measurement issues outlines a set of principles and indicators that inform the analysis of health differentials within societies.

Analyzing Causes and Understanding Pathways

Many of the causes of inequities in health are social in origin. Considering the magnitude of the problem from a human development and well-being point of view, it is striking how little systematic research has been done on the social causes of ill health. Furthermore, it is equally striking that the now emerging literature on the social determinants of health has been predominantly concentrated in the North. Diderichsen's model (see chapter 2) outlines a valuable framework for understanding how health inequities are generated and maintained in a society. This model provides both a theoretical and a practical tool for analyzing which causes are important for a particular country, at different points in the pathways from social position to disease/disability, and looking both upstream and downstream.

Starting at the “upstream” end of the pathways, with social context and social position and their relationships to health, it is possible to consider the impact of macroeconomic and social policies on life chances and ultimately on health status for different groups in the population. Equally, searching “downstream” is also necessary in order to trace the physiological mechanisms by which specific risk factors or risk conditions actually generate/cause different diseases or poorer health. Not to be forgotten is the imperative of moving back “upstream” to understand how the sick and disabled are dealt with differentially by health and social systems. Above all, the accumulating evidence on the social origins of inequities in health highlights the need to tackle the root causes of poor health, not just the symptoms. In this respect, it should be recognized that

- Determinants of inequities may be different from determinants of aggregate health. For example, in modern-day Sweden, while poor physical working conditions play only a minor role as an influence on the health status of the population as a whole, they explain a large proportion of the differences in health between different occupational groups in the country. Policies specifically designed to reduce inequities in health in Sweden, therefore, may need to focus more strongly on improving the work environment, while a general health promotion policy may focus on other determinants of health (Dahlgren 1997). In Chile, although cardiovascular disease is the leading cause of death, road traffic accidents actually prove to account for much of the disparity in longevity between the least and most educated (see chapter 10).

- The possible synergy between risk factors needs to be considered, in particular when analyzing social inequities in health, as risks to health tend to accumulate in sections of the population already experiencing disadvantage. The effect of a certain risk factor might therefore be different depending on the social position of an individual. The framework presented in chapter 2 provides the methodology for distinguishing empirically between differential exposure and differential vulnerability in particular circumstances. This methodology is employed in the Anglo-Swedish case in chapter 17, in which the two countries provide an illustration of a “natural experiment,” offering the opportunity of carrying out comparative analysis of the different policies in the two countries to help make a more robust health impact assessment.

Element III: Tackling Root Causes

Once the health divide in a country has been described and the causes analyzed, the most critical element of a strategy to promote health equity is to identify points of entry for action on root causes. The main determinants of health in general can be thought of as layers of influence (Fig. 1). Individuals have age, sex, and constitutional characteristics that influence their health (largely fixed), but surrounding them are influences that are modifiable by policy. First, there are personal, behavioral factors such as smoking habits, sexual behavior, and physical activity. Second, individuals interact with peers and their immediate community and come under social and community influences, factors represented in the next layer. The wider influences on a person’s ability to maintain health (in the third layer) include their living and working conditions, food supplies, and access to essential goods and services. Finally, as an overarching mediator of population health, there are the economic, cultural and environmental conditions prevailing in society as a whole. Figure 1 emphasizes interactions: Individual lifestyles are embedded in social and community networks, and in living and working conditions, which in turn are related to the wider cultural and socioeconomic environment.

Drawing on this general model, below we focus on policy options for those determinants that play a par-
particularly major role in generating inequities in health in developing countries, although most are just as relevant to the situation in developed nations. Country-specific analyses are always necessary to take the assessment further, but some general lessons can be gleaned from the Global Health Equity Initiative (GHEI) studies and others about the most effective policy options to tackle root causes (Whitehead 1995; Dahlgren 1997).

Promoting Healthy Macropolicies
The overarching macroeconomic, cultural, and environmental conditions prevailing in a country are of paramount importance in the pathways to inequities in health in developing countries. They are therefore key policy entry points in the promotion of health equity.

First, in relation to macroeconomic policies, it needs to be acknowledged that absolute poverty is still the major risk factor for poor health and premature death globally. The pathways leading from poverty to poor health include inadequate nutrition and lack of access to other prerequisites for health, such as decent housing, sanitation, and clean water. In addition, the evidence on the psychosocial effects of relative poverty, or social inequality, on ill health is also mounting. Wide income inequalities, for example, are associated with indicators of social breakdown and more threatening, stressful environments. Large and increasing income inequities may have a negative effect on health conditions for the whole population, not just the poorest, as the economic divide promotes social segregation, threatens community values, and thus creates a culture that generates, rather than prevents, violence (Kawachi and Kennedy 1997; Lomas 1998; Kawachi et al. 1999).

Consequently, as discussed above, a health equity impact analysis should inform the articulation of macroeconomic policy. When this is done, it becomes clear that some of the “unhealthy” economic policies are ones based on the widespread view that economic growth should/must occur at any cost, disregarding any adverse impacts on sections of the population. There is now a wealth of experience from around the world on the adverse health effects of macroeconomic policies focused primarily on growth, as eloquently elaborated in the provocatively titled book Dying for Growth (Kim et al. 2000). In this respect, a number of the case studies in this volume—on Russia, Chile, and China—bear witness to these adverse effects.

In Russia, the 1992 liberalization of prices and the termination of state subsidies in many sectors of the economy coincided with an acute crisis in the economy. During this period, liberal monetary and macroeconomic measures were not accompanied by compensatory social policies, with disastrous results for the health and welfare of the population, especially the poorer, less educated groups (see chapter 11). Chile and China are both countries that have gone through major economic, political, and demographic transitions over the past 20 years, and both have experienced sub-
stantial economic growth, but with widening income inequalities and debates, at least in Chile, about the extent to which the poorer sections of the population have benefited from the economic growth. Although population health on average has improved in both countries, the transition has also been accompanied by increasing inequalities in health.

Conversely, the "healthy" economic policies are those that contribute to alleviating poverty and that reduce income inequalities. There is evidence, for example, that it is possible for development strategies to be "pro-growth and pro-poor" by which macroeconomic policies support social policies that deliver services such as primary education and preventive health care, which both have greatest benefit for the poor and high social rates of return (Tanzi 1998). This highlights another important element of macroeconomic policies—their impact on health inequalities through their prescriptions on public sector expenditures. Drèze and Sen (1989) emphasize the real potential for a strategy of "supported security," rooted in direct public support for education, health care, and food, to tackle deprivation even at low levels of income and economic growth.

Second, the overall cultural environment can be improved by pro-equity public policy. The position of women in society or of ethnic minorities, for example, can be greatly influenced by purposeful national action. Countries such as Bangladesh and the Indian State of Kerala, for example, as detailed in chapter 13, have demonstrated this with their dynamic policies of increasing the literacy rate, particularly female literacy, and improving the empowerment and human rights of women, enshrining those rights in the constitution and in law. The role of education in achieving and sustaining greater equity in health is paramount. There are lifelong and intergenerational health benefits arising from the promotion of universal education (Caldwell 1986; see also chapter 8). Furthermore, education may act as a buffer against the adverse health effects associated with increasing economic inequality (see chapters 10 and 11).

Third, hazard control policies in the physical environment are critical at both national and international levels. A poignant example comes from Vietnam, where the country's health system has to deal with the long-term environmental, social, economic, and health problems created by the aftermath of weapons of war, such as Agent Orange. The issue of industrialized countries "exporting" or dumping their toxic waste on the developing world is another example of an environmental cause of injustice. Even within countries, it is noticeable that environmental hazards and degradation are not distributed evenly, but tend to be clustered around where the poorer sections of the population live or work (McLaren et al. 1999). This situation can be a side effect of unhealthy economic policies in which the pursuit of financial profits is given priority over the health of employees and local residents. Recognition of this fact has led in recent years to a growing Environmental Justice movement, advocating policies that redress these excess exposures to environmental hazards.

Improving Living and Working Conditions

The classic public health endeavors to improve living and working conditions and access to essential services, such as education and health care, still have a vital role to play in promoting health equity. Groups experiencing social and material disadvantages are often the ones exposed to the most health-damaging environments. This is painfully obvious in relation to the living conditions experienced in shanty-towns in poor countries, as well as segregated poor urban areas in richer ones. In Mexico, roughly 58% of the indigenous people lack running water and 88% have no sewage facilities. Provision of this basic infrastructure is a prerequisite to reducing the disproportionate burden of diarrheal and other communicable diseases in this group (see chapter 19). Even in a wealthy country like the United States, evidence on the determinants of poor health point to inadequate access of substantial sections of the population to healthy living and working conditions and to essential services, such as an adequate social security system and health care coverage (see chapter 9).

One of the starkest illustrations of the pathways leading from inequitable housing and work policies to disadvantages in many spheres of life, including health, is given in chapter 14, where the apartheid system in South Africa had severe consequences for the nonwhite majority. This resulted in large sections of the population living in poverty, in squalor, and without the basic prerequisites for good health. South Africa is now trying to deal with this legacy of apartheid by implementing policies with explicit equity objectives.

Building Social Cohesion and Mutual Support

Some commentators believe that the most health-damaging effects of social inequality are those that exclude people from taking part in society, denying them self-respect and dignity (Wilkinson 1996; Sen 1999). The negative health effects of social exclusion are increasingly recognized—the exclusion and powerlessness that comes with lack of money, lack of education, and lack of influence.
CONCLUSION

The challenge is to open up opportunities for everyone in the population, not just for the people who have the loudest voice, at the same time building up conditions in society that offer greater mutual support (Drèze and Sen 1989; Gilson 2000). Policy options at this level include building inclusive social welfare systems (in which everyone contributes and everyone benefits); implementing initiatives to strengthen, and to make it easier for people to participate in, the democratic process; designing facilities to encourage meeting and social interaction in communities; and promoting schemes that enable people to work collectively on their identified priorities for health. These options must give explicit weight to the most disenfranchised, including ethnic and racial minorities, women, and the poor.

The Bangladesh country analysis in chapter 16 provides an example of action on several levels, including strengthening mutual support in communities to promote the rights and status of the poorest women in that society. Development policies in one region in particular, Matlab, have emphasized complementary improvements in access to health care, combined with strategies to reduce poverty and increase the status of women. Among these strategies, participatory microcredit schemes linked to employment for women have been vigorously promoted, together with the provision of more places in schools for the daughters of poor families. The microcredit schemes involve groups of women in poor rural villages meeting together to pool funds. These funds are then used to provide loans at affordable interest rates to members of their group to set up small businesses and stimulate employment opportunities in the community. The scheme is controlled and run by the women themselves—an important aspect of the strategy for improving not only the women’s economic position but also their status within the prevailing culture. The chapter provides compelling evidence of a health equity dividend.

Creating Supportive Environments for Behavioral Changes

The pathways linking socioeconomic position to health-damaging behavior highlight the need to take into account the structural barriers to healthier lifestyles and the creation of supportive environments. The research evidence clearly indicates the importance of structurally determined lifestyles, rather than freely chosen lifestyles, among less privileged socioeconomic groups. In short, the evidence reinforces the need for combining structural changes related to economic, living, and working conditions with health education efforts when trying to influence lifestyle factors such as smoking, use of violence, alcohol intake, diet, and sexual behaviors. Furthermore, general policies for health promotion and disease prevention need to be based on the reality ex-
experienced by socioeconomically less privileged groups rather than on that of the middle classes (Townsend 1987; Townsend et al. 1993). Tobacco control policies will be of the utmost importance for population health in many developing countries in the coming decade, as the growing opportunities to market tobacco products are aggressively exploited by the major producers in industrialized countries. Once again, it is the poorest countries, and the health of the poor within those countries, that will suffer the most from this trade. Policies will be needed at all levels—from global to local, and from legal and fiscal to community development and individual support—to regulate this threat to health equity.

Another example of the type of policy action relevant to this discussion of behavioral factors is provided by the Kenyan analysis of road traffic accidents in chapter 15. The study demonstrates that taking a broad perspective in developing policy action is important even when the determinants appear to be behavioral. Seeing the reckless behavior of the drivers of matatus (i.e., minibuses) as the major determinant of road traffic accidents previously led policy proposals to a narrow focus on modifying the individual behavior of drivers. The current study, however, revealed the complex linkages between driver behavior and the way the transport industry is organized, the long hours and employment conditions of drivers, the lack of safer alternatives for low-income passengers, and the role of bribery in the feeble enforcement of road safety laws. The study points to the futility of exacting massive fines on individual drivers. Such action is likely only to exacerbate the problem in the absence of a more comprehensive attempt to address the social and economic context underlying poor driver behavior and traffic accidents.

The Tanzanian country analysis in chapter 12 also illustrates insights from taking into account the lives and livelihoods of vulnerable adolescents rather than the standard approach of scrutinizing their sexual behavior in isolation. It reveals that those who are not in school may face immediate physical health hazards, such as dangerous work environments, unsanitary living conditions, and poor access to food and essential health care. For many there are additional emotional and social health hazards as they attempt to survive in lonely and unprotected circumstances, separated from their families. Their sexual behavior (and related morbidity and mortality), the study argues, has to be seen in the light of these interwoven economic, social, and cultural factors if effective policy responses are to be formulated.
Element IV: Building Equitable Health Care Systems

A critical dimension of social and economic policies for health equity (not mentioned thus far) is, of course, the health care system. There are important welfare issues concerned with improving the quality of life of people who are already sick. The issue of how to ameliorate their ill health and reduce the socioeconomic consequences of illness is a concern in all societies. The fourth element of a policy response is therefore concerned with building more equitable health systems, with the dual purpose of removing barriers to access to good quality health care while at the same time preventing the health care system itself from contributing to poverty and other adverse consequences.

Impoverishment and Barriers to Access

The fact that ill health often leads to impoverishment is of major concern. Moreover, the very fact that people experiencing social and economic disadvantage tend to be sicker raises fundamental issues for the organization of health systems. It means, for example, that their need for health care services is greater and would require more resources per capita to meet that need. Despite overwhelming evidence of greater need, a common finding is that health services are sparser and of poorer quality in areas serving populations experiencing disadvantage and access is more difficult—the so-called inverse care law (Tudor Hart 1971). A wide literature proves the tenaciousness of this maxim, showing repeatedly that the lower the level of income, the larger the gap between health needs and utilization of health services (Makin et al. 2000; Castor-Leal et al. 1999). There are several dimensions of access to which the inverse care law can be seen to apply:

- **Financial access**: User charges are often prohibitive. High user fees not only reduce access and utilization of health services but also force people to bypass medical personnel when in need of drugs. Furthermore, economic growth is not enough to increase access to health services. In fact, recent experience in Asia indicates the opposite trend, that is, rapid economic growth tends to generate or spur increasing inequities in access.

- **Geographical or physical access**: There may be uneven distribution between urban and rural areas, most acute in a predominantly agrarian society, or concentration of the system on providing tertiary services that reach relatively few while primary care services that would benefit many are neglected.

- **Cultural access**: Negative attitudes of health workers to poor people often discourage poor people from using the services. Discrimination against girls and women for health care when resources are scarce (see chapter 13) and against ethnic minorities is also an important issue. Amartya Sen has highlighted a further issue related to "cultural access" concerned with differing perceptions of ill health, an acceptance of one’s lot among people experiencing disadvantage, when there is no scientific reason for accepting such poor health from conditions that could be prevented or at least ameliorated by good quality health care (Sen 1999).

All three aspects are vividly illustrated in relation to gender inequities in access to care in the developing world, where women use health services less than men (WHO 1995). Due to a deadly combination of financial, geographical, and cultural barriers, women’s access to high quality health care is compromised, often costing them their lives, particularly around the time of labor and delivery (WHO 1998a; Thaddeus and Maine 1994; see also chapter 13).

Building an Equity-Oriented Health System

To address issues of access and impoverishment, there are many factors to consider, including:

- How to mobilize financial resources in order to improve access
- How to allocate those resources equitably in relation to need
- How to monitor the use of available resources to ensure that they are being deployed to meet the stated equity objectives

Mobilizing financial resources

The costs of health care services are paid for by the citizens of a country via taxes, social health insurance, community-based insurance schemes, private health insurance, and/or direct user fees. Foreign aid can also provide health care financing in low-income countries. The mix of these different sources determines to a great extent how the financial burden for health care costs is shared between different age and social groups, as well as how available resources can be utilized. The choice of financing options should be guided by the following equity principles:

- The mobilization of financial resources should be based on contributions from the population as a whole and should be progressive, that is, according to ability to pay
- Financial protection should be optimized by pooling risks among the largest number of people to avoid impoverishment due to high medical expenses

Despite these clear principles there is no global blueprint for an equitable and sustainable financial system. This is due in part to the multiple stakeholders involved in health care financing, the dynamics of the public-
private mix characterized primarily by increased private sector and reduced public sector presence, and the pervasive trends toward decentralization of health systems. Nonetheless, using the principles outlined above, a set of policy lessons can be drawn from experiences gained in high- as well as in low-income countries:

- Taxes, including payroll taxes and subsidized community health insurance schemes, constitute the fundamental basis of an equitable financial system for health.
- Any shift, at a given level of services, from tax to, for example, direct user fees increases the burden of payment on economically less privileged groups, reduces access, and may generate a serious poverty trap.
- Private, for-profit health insurance schemes, direct user fees for public health services, and direct fees to private for-profit schemes produce substantial, and over time usually increasing, inequities in terms of financing, access, and financial security.

The Vietnamese case study in chapter 20 illustrates how one country has been struggling with such major financing issues and the complexities behind some of the decisions that have to be made when there is so little room for maneuvering. In such circumstances, however, the importance of analyzing the health sector reforms from an equity perspective is greater than ever. Allocating financial resources according to need A key equity principle is that resources should be allocated according to need, regardless of ability to pay. In practice, this can be promoted by devising more equitable resource allocation mechanisms for commissioning health care, with need for care assessed not only based on size and age structure of the population but also according to disease burden and socioeconomic characteristics.

- The allocation of available resources between different areas should be based on an assessment of need for health services, for example, related to the age, disease burden, and socioeconomic structure of the population.
- The allocation of available resources for health within a specific area should be determined by perceived as well as by professionally defined need for health services, regardless of age, sex, ethnic background, and ability to pay.

Above all, this requires taking into account the identified social gradients in mortality and morbidity that exist and that indicate differential levels of need in different places and for different groups of people. In Britain and Sweden, for example, funds from general taxation are allocated on a geographic basis to official health authorities to cover the health care needs of the residents in each administrative area. Both countries have selected lack of employment and living alone as important indicators of increased need for health care resources. Sweden has added indicators of housing tenure (Diderichsen et al. 1997), while Britain has taken into account the proportion of households with single parents, as well as direct health indicators (Carr-Hill et al. 1994).

South Africa provides an example of the potential for and problems associated with trying to develop allocation formulas adjusted for need in a data-scarce system (Doherty and van Den Heever 1998). Similar issues arise for other countries introducing reforms in which the function of commissioning services is separated from the provision of care or in which there is decentralization of budgets and control to local areas. The Chinese country analysis in chapter 7, for example, highlights a particular problem of resource allocation in this respect. Administrative areas that were relatively well-off used to be able to subsidize more disadvantaged areas, but this is no longer the case following health sector reform in the country because of decentralization. In the poorer regions, where the tax base is smaller, there is now less money for health services and these services are at risk of serious decline, while the services in the more affluent areas are in a position to expand and improve. Unless mechanisms can be devised to cross-subsidize, the inequities are bound to increase still further. Similar problems arise under user-fee systems where revenues collected at the point of provision cannot be used to improve services elsewhere (Russell and Gilson 1997).

Vigilance in Monitoring and Protecting Equity

The need to maintain equitable health systems has become more pressing since the early 1980s, as many countries have had to face both economic recession and rising unemployment, pushing more people into poverty and ill health (Whitehead 1992). This situation is made worse by cost-containment measures (or budget cuts) in health systems in response to the economic climate and the introduction of market-oriented health sector reforms (Gilson 1998; Whitehead 1994; Dahlgren 1994b). For many countries, though, the pressing task is to maintain the access that has been achieved in the face of mounting forces working against this aim (Dahlgren 1994a; Gilson et al. 1995). It is particularly important to develop tools and approaches for monitoring and protecting equity in such circumstances.

One equity-monitoring approach is provided by the "benchmarks of fairness" concept. This originated in the context of the U.S. health care reform efforts of 1993 as a means of making explicit in a systematic way
the ethical dimensions and trade-offs inherent in the health care system (Daniels et al. 1996). In the U.S. context, benchmarks queried the following equity dimensions of health care reform proposals: the provision of universal access to services; the comprehensiveness of services; uniformity of benefits; equitable financing by ability to pay; value for money (clinical and financial efficiency); public accountability; and degree of consumer choice. Interestingly, efficiency was one of the criteria under a broad enquiry into equity. Since this application in the U.S. context, the “benchmarks of fairness” idea has been initiated in several developing countries, including Thailand, Pakistan, Mexico, and Colombia.

In such settings, new benchmarks have been added as different social determinants of health are highlighted in these diverse contexts. The range of benchmarks discussed in Pakistan, for example, includes benchmarks for intersectoral public health; financial barriers to equitable access; nonfinancial barriers to access (including gender); comprehensiveness of benefits and tiering; equitable financing; effectiveness, efficiency, and quality of health care; administrative efficiency; democratic accountability; and, finally, patient and provider autonomy (Khan 1999). In addition to provoking debate about health care systems within particular countries, the benchmarks have potential to be developed into a useful mechanism for comparing the relative equity of different countries’ health systems (Daniels et al. 1996; Khan 1999).

South Africa provides a further example of an explicit equity-monitoring approach. As detailed in chapter 14, the paucity and nature of the available data must be addressed within efforts to allow the impact of new programs on the apartheid legacy of inequity to be monitored (Bloom and McIntyre 1998). One monitoring system that is being developed within South Africa is the “equity gauge.” This approach engages legislators at national and subnational levels in monitoring the impact of government policy actions on the health system (Ntuli et al. 1999). The “gauge” monitors equity in health and health care and feeds this information into parliamentary and legislative processes related to health policy and resource allocation.

**Strategies for a Global Response**

Over and above specific policy actions, what could and should a more concerted global effort to redress inequities in health entail in the immediate future? A number of strategies have been effective at creating a climate for policy change, and some new approaches hold promise for the future. It is important to recognize the two-way traffic in ideas and strategies: from global to local and from local to global. On the one hand, policy developments in other countries or agencies can be valuable in raising awareness and stirring political response closer to home. On the other hand, greater understanding of how inequities in health come about, gleaned from experiences gained locally, can provide some of the most powerful ammunition for global advocacy. Most importantly, perhaps, is the recognition that equity in health is a common challenge to all societies and thus requires an integrated global response.

**Taking Advantage of Current Experience and Opportunities in Developing Policy Action**

Knowledge about research and policy gained from developments around the world could be used much more systematically to gain entry into national debates, although there is always a need to be sensitive to time and context in a particular country when drawing lessons from elsewhere. First, much more could be made of the power of comparison in spurring national action. For example, researchers and public health advocates in Europe have been successful in raising and maintaining awareness of health equity issues among national policy makers through a diversity of approaches—ranging from a careful consensus building approach in the Netherlands, to a more confrontational strategy in the United Kingdom, and to a stance built on arguments of social justice in Sweden (Whitehead 1998). Despite this diversity, what has been most striking about the European developments is the reinforcing effect of events in one country on the situation in others. Progress in one country has been used to stimulate or legitimize work toward health equity in others. The fact that the Dutch government set up a prestigious national program of research on inequities in health, for example, helped to persuade other governments to follow suit. The Dutch initiative itself had in part been triggered by the interest stimulated by the British Black Report, which also set off a spate of investigations around the world, with countries producing their own “Black Reports” on the extent of inequities in health in their society.

The time has come to marshal these experiences, learning from the mistakes as well as the successes, to strengthen the impact of existing efforts. A more critical challenge, however, in keeping with the themes of
this volume, is to extend the burgeoning interest in health inequities to developing countries. Encouraging in this regard are the emergence of global efforts aimed at the reduction of poverty broadly defined. The World Bank’s explicit focus on the poor—as exemplified in their World Development Report 2000/2001—the G-8-supported Highly Indebted Poor Country (HIPC) initiative for debt relief, and the civil society-led protests for greater transparency of global trade and economic policies are enhancing prospects for concerted action toward distributive justice.

Second, collective setting of international standards, targets, and resolutions can improve the political climate within countries providing impetus to local advocacy efforts or even helping to shape national public health strategies. In this respect, the setting of equity targets in the WHO (1998b) renewal of Health For All in 1998 should not be underestimated as a future lever for change. The UN Conference on Population and Development, Cairo, 1994, continues to aid the recasting of population policies in terms of health, empowerment, and rights of women in many developing countries (Sen et al. 1994). As mentioned earlier, it is particularly important to place equity- or distribution-sensitive targets on the international agenda (Gwatkin 2000).

Third, much can be achieved by taking advantage of windows of opportunity that unexpectedly arise. The global wave of democratization represents one such phenomenon. As Amartya Sen points out, “the absence of democracy is in itself an inequality—in this case of political rights and powers.” The strengths of democracy—participation, civil rights, and liberties—are tied to a society’s ability to stem inequality, provide security and protection for all citizens, and prevent major catastrophes such as famine (Sen 1999: 187). Despite formidable obstacles in the aftermath of apartheid in South Africa, the advent of democratic elections has resulted in an upsurge of political and popular will to build a fairer society. Similarly, transitions from states of conflict and insecurity to peace and responsible governance provide a solid foundation and fresh hope for redressing long-standing inequities.

Developing the Capacity for Monitoring and Advocacy

Awareness of health equity as an international issue has reached the point where sufficient momentum has built up to stimulate the types of collaborative action that are necessary to monitor and advocate for health equity worldwide. The types of practical initiatives that need to be taken include

- **Enlarging the health equity policy community.** This can be achieved by building or strengthening networks of researchers and advocates. Examples of existing networks that could be expanded, apart from the Global Health Equity Initiative, include Southern Africa’s Equinet and the International Society for Equity in Health, as well as the various human rights networks. Sharpening the equity focus of existing research networks such as the Global Forum for Health Research would be valuable, as would building supportive links between established networks, such as the EU Network of Researchers Evaluating Policies and Interventions to Reduce Inequalities in Health (Mackenbach and Droomers 1999) and emerging networks in the South.

- **Building greater capacity to monitor and analyze policies from an equity perspective.** More collaborative work should be encouraged to focus minds on refining methods and tools for monitoring and analysis, particularly for use in low-income and data-poor settings. The South African Equity Gauge, for example, is being adapted to monitor health system changes in other countries. Research and professional training must be supported to develop the new skills and perspectives required. Innovative thinking and pump-priming support is required to investigate the pressing issues surrounding the effects of globalization on the determinants of health and inequalities. Beaglehole and Bonita (2000) have gone a step further and proposed a worldwide cooperative research program that would be the public health equivalent of the human genome project.

- **Encouraging global advocacy.** There are multiple opportunities for synergistic action by statutory organizations, multilateral funders, and charitable foundations. Following the example of the World Health Organization’s World Health Report 1999, international reports on health and development issues could be identified while still in preparation and encouraged to have a substantive focus on health equity. Strong efforts should be made to inject a consideration for equity into current policy debates, a prominent instance being health sector reform proposals in low-income countries (Gilson 1998; Whitehead and Dahlgren 1991). Other pressing global developments requiring an equity lens include the effects of moving toward ever more deregulated market economies and the World Trade Organization agreements that recently triggered such a violent reaction in Seattle and Washington (Price et al. 1999).

Taking action on all these frontiers requires respected international leadership, as Chen and Berlinger emphasize in chapter 4. They call for the World Health Organization to assume that role once more, becoming “the world conscience of health.” Certainly, we must launch a more concerted effort—beyond the well-meaning, but thus far largely haphaz-
ard, development of advocacy in this field. In a time of growth and promise, yawning health divides must not be tolerated. With a “world conscience” playing a leadership role, it is up to a constellation of governments, ministries of health, regional organizations, non-governmental organizations, researchers, advocacy groups, and individuals to stem the tide of widening inequities in health. We must collectively seize this unprecedented opportunity for global equity in health.

References


