
Round Table Discussion

Health inequalities impact assessment

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I have been asked to consider Davidson Gwatkin's article in the light of the Report of the United Kingdom's recent *Independent inquiry into inequalities in health* which I chaired (1). While it is clearly inappropriate to generalize from the experience of one country in terms of particular policies, the weight of scientific evidence suggests, as indeed does Davidson Gwatkin's article, that a socioeconomic explanation of health inequalities is likely to be relevant for all countries rich and poor throughout the world.

The socioeconomic model traces the roots of ill-health far beyond health services to such determinants as income, education and employment as well as to the material environment and lifestyle. This has the practical implication that the necessary policy developments to reduce health inequalities will extend far beyond the remit of departments of health, some of them relating to the government as a whole while others will fall within the terms of reference of a range of other government departments.

As has been the experience elsewhere, the Inquiry found that although health in England (as judged by reductions in mortality rates) had over the past 50 years on average improved greatly, in recent decades inequalities in health had either remained static or widened. These inequalities can be identified at all stages of the life course from pregnancy to old age.

The Report selected the following three of its 37 recommendations as crucial.

- All policies likely to have an influence on health should be evaluated in terms of their impact on health inequalities.
- A high priority should be given to the health of families with children.
- Further steps should be taken to reduce income inequalities and improve the living standards of poor households.

While the reasoning which supports the second and third of these priorities is self-evident, the first, which recommends an important development in health impact assessment, needs further explanation.

Experience shows that a well-intended policy which improves average health in a population may have no effect on inequalities. Indeed it often widens

them by having a greater impact on the better-off. This has happened in some initiatives concerned with immunization and cervical screening, as well as in some campaigns to discourage smoking or promote breastfeeding.

These examples highlight the need for health policies to focus extra attention on the health of the less well-off. This could be done both by policies directed specifically at the less well-off, and by an approach which would require inequalities to be considered wherever universal services are provided (such as publicly funded education or health care) and where other policies are likely to have an impact on health.

The Report identified a wide range of areas for future policy development relevant to the reduction of health inequalities judged on the scale of their potential impact and the weight of the evidence. These policy areas include poverty; tax and benefits; education; employment; housing and environment; mobility; transport and air pollution; and nutrition. In addition, a number of other policies were put forward in relation to stage in life course — for mothers, children and families; young people and adults of working age; and older people — and in relation to ethnic and gender inequalities.

An important aspect of the Inquiry's work was to confirm once again the findings of Black (2) and others that it is an over-simplification to consider socially related ill-health and attenuated life span as restricted to those living in poverty. Poverty is defined here as households in receipt of less than 50% of the average income. It is a rule with few exceptions that whenever it has been possible to relate mortality or morbidity to a graduated social indicator such as income, extent of education, or skill of work task, a gradient has emerged. In England, gradients across the whole social spectrum were found for both men and women. These exist for men in respect of mortality from all causes, coronary heart disease, lung cancer, stroke, accidents and suicide, and for women for all causes of death and for coronary heart disease. Socioeconomic gradients were also shown for longstanding illness in both sexes, and for obesity and high blood pressure in women.

These findings carry an important lesson for policy-makers, namely that measures aimed exclusively at helping those in poverty, or at the bottom of the social hierarchy, will deal with only a small proportion of the burden of socially related ill-health and premature death.

A new direction for public policy which explicitly addresses inequalities is therefore needed. It was the view of the Inquiry that reductions in inequalities in health were most likely to be achieved if *all* relevant policies (and this will include many social policies, far beyond health care) are formulated with the reduction of inequalities in mind.

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Hence the Inquiry's first recommendation: "As part of health impact assessment all policies likely to have direct or indirect effects on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well-off they will, whenever possible, reduce such inequalities."

The transformation of *health impact assessment* to *health inequalities impact assessment* will be a prerequisite for such policies. Their effective formulation and evaluation will be a major challenge for public health workers and should be a priority for research and development. This will be a major step on the path "from analysis to action" suggested by Davidson Gwatkin. ■

1. **Acheson D.** *Independent inquiry into inequalities in health report.* London, The Stationery Office, 1998.
2. **Black D et al.** *Inequalities in health; report of a research working group.* London, Department of Health and Social Services, 1980.

Equality, equity: why bother?

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The excellent papers in this theme section of the *Bulletin* aim mainly at defining the inequalities in health that occur, and Gwatkin presents some interesting aspects of the problem of how to reduce them. It is usually assumed that inequalities in health are undesirable and should be reduced, but the reasons for this are not always made explicit.

The reason most commonly adduced is that it is morally indefensible not to allow all human beings to enjoy what is often posed by Amartya Sen as one of the essential freedoms and the mechanism through which other freedoms can be enjoyed. There is a cap on the level of health that can be attained if one uses commonly accepted measures such as mortality and morbidity indicators. For material goods, however, there is in theory no limit to the potential gap between those who are best and worst off. The case is made that for an essential requirement such as health the gaps that can be reduced should be.

In addition we concern ourselves with inequalities in health because we believe that they may be a cause of social instability. Inequality in health or in access to measures that ensure it can foment

discontent and intergroup enmities that disturb the social order within a country. Likewise the differences between countries contribute significantly to the instability of the world. Unfavourable conditions in human health and the environment in some countries are seen to be threats to the security of the more favoured ones. Men and women do not usually use health as a yardstick of achievement or strive to be healthier than others, but they do regard it almost as a right to be as healthy as others and to have access to the means of being so.

Finally there is the prosaic consideration that health is one of the ingredients of human capital that is so essential to other aspects of development. Unequal access to measures that lead to formation of human capital inhibits the reduction or alleviation of poverty. Improvement of health status and the reduction of health inequalities are more and more recognized as essential ingredients for schemes to reduce poverty.

Our concern is not only instrumental. We wish to ground our comment firmly within the historical background of thinking and practice in the World Health Organization over the last two decades. We place the concern for health differentials squarely within the context of the goal of health for all, which has equity as its underlying value and sees inequalities in terms of the social injustice implied by inequity. This framework is in no way inimical to efforts to identify the inequalities that represent inequities and seek measures to reduce them.

The policy issues that these papers raise include the need to establish with more precision some measure of the inequality that exists with regard to health status or outcome. These inequalities can only be deemed inequities if they are unjust and their determinants lend themselves to being manipulated so as to reduce them. Thus, while we acknowledge the need for a measure of the distribution of health status in order to establish the degree of inequality, this can only be a first step if we believe that these differences can be reduced. The real issue is the relation of these differences or inequalities to the distribution of the social determinants of the state of health or the distribution of that state itself.

Gwatkin makes a powerful argument for the significance of the distribution of health outcomes. National averages hide the differences that need to be tackled in order to reduce inequity. But this welcome focus has very practical implications: most of the countries in the Americas do not have the tools to make these determinations, and in many cases they do not see the need for producing the data in a form that shows the relevant distribution and gaps. Only recently has it been possible to organize health data with the degree of geographical disaggregation that will determine the inequalities that exist between the different areas and population groups concerned. The political drive towards decentralization has assisted by making it necessary to have these kinds of data in order to determine resource allocation.

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Apart from the measurement issues, the main concern in public health is whether these inequalities or inequities can be reduced. Some governments are making it national policy to reduce them. Those inequalities in the determinants of health that can be considered unfair, unjust, avoidable and therefore reducible can be divided roughly into three main categories: inadequate access to essential health services, exposure to unfavourable social and living conditions, and health-damaging behaviour that cannot be modified by individual choice alone.

The major thrust of most of the health reform movements in both the industrialized and the developing countries is the equitable provision of services. "Equitable" is assessed in terms of access to and use of services that are no longer segmented in the manner traditional to the Americas. A novel effort of investigation in this area bears some promise. Large segments of our populations are in the informal sector, by definition poor, mainly female and without access to a social security system. The possibility of establishing micro-insurance schemes is being explored, with the thesis that schemes that are grounded in the local environment will be more responsive to the needs of the local population who, partly because they are economically and socially poor, do not or cannot pay the transactional costs involved in obtaining the traditional services.

Another challenge for the services is to ensure the equitable delivery of the health technologies that have been shown to be effective in improving health. Our services have remarkable success with technologies or interventions that are supply-driven, such as immunization, while those that are demand-driven, such as treatment or prophylaxis for chronic diseases, are inequitably delivered, with the distribution favouring the prosperous. We believe that the only feasible approach is to work for a better understanding of the information needs of the different segments of the population, with the clear understanding that special communication techniques have to be developed for the poor. Information will be one of the most powerful tools for ensuring the equitable provision and accessibility of essential health services.

The most important of the social conditions whose distribution makes an impact on health is income. The evidence now clearly shows that not only absolute poverty but also income inequality leads to unequal health outcomes. The solution lies outside the competence of the health sector except insofar as inequality in access to health as a contributor to human capital has an impact on poverty reduction. It has not yet been proved that investment in health affects income distribution. The role of the health sector here is essentially one of advocacy, pointing out that economic measures leading to a more equitable distribution of income and reduction of poverty will result in improved population health. We must also point out that there is evidence that investment in health itself enhances economic growth and therefore reduces poverty.

Changing health-damaging behaviour is doubly difficult when it is not a matter of individual choice. Much of the behaviour of the poor is the result of their social situation and is only to a limited extent within their own volition. Much more attention has to be given to the role of the community and other social groups in the adoption or modification of behaviour. It is of increasing interest whether behaviour such as smoking represents only individual choice when the techniques of advertising are so powerful and so skilfully targeted.

To the extent that most of the health inequalities lie outside the area of individual responsibility, the agent usually held responsible for identifying and rectifying them is the state. In many of the constitutions of our countries and in the international declarations on rights this responsibility is implied or made explicit. However, the nature of political processes is such that the most vocal and privileged groups often influence policy to make equity in the health of population groups a minor issue. We may hope that the currently increasing respectability of welfare economics and awareness of health as a social desideratum will help to make self-evident the need to reduce those inequalities that are unjust and are deemed to represent inequity. ■

Overcoming inequity means finding approaches that work

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For a long time, international health statistics were crudely equated with the disparities in gross domestic product (GDP), and Gwatkin points out the inadequacies of such an approach. A more insightful one is now being devised, which involves analysing the situation of the vulnerable population on the one hand, and social inequalities in access to health care, on the other.

Two major earlier efforts have not provided the expected results. In spite of its far-reaching targets and global approach, "health for all by the year 2000" has not durably improved the conditions of the most vulnerable. And the structural approach, although it focused on the necessary reform of health care systems, has not reduced the inequalities between the rich and the poor either in industrialized countries or in developing ones, despite the drastic structural readjustment schemes the latter were forced to carry out.

Other approaches deserve consideration. They are perhaps less bold but could just possibly be more efficient in the long run. These would involve identifying a limited number of priority pathologies within a congruent geographic area. The next step

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would be to reform the organization of health services around the prevention and control of these diseases. In certain areas of the world, the example of acquired immunodeficiency syndrome (AIDS) may serve as a model. In southern countries where programmes for preventing perinatal transmission are being set up, there is a growing realization that the issues at stake call for comprehensive responses whose expected benefits will greatly exceed the AIDS framework. The aim is not to bring back unreplicable microschemes or airtight vertical programmes. It is to learn from the experience and findings of special programmes and use them to spur change throughout the health care system.

These approaches should help overcome the conceptual contradiction between equity and equality in health care. The purpose is to reconcile two priorities: an urgent response to the specific needs of the most vulnerable population (without triggering the perverse effects of excluding people who are not taken into account by these special procedures), and the necessity of working towards more equity in access to health care.

This latter objective must entail empowering people and giving them more freedom of choice. It involves tackling issues that are much broader than health care, such as education and women's status. ■

Combining forces against inequity and poverty rather than splitting hairs

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Davidson Gwatkin's excellent lead article raises many points with important policy implications. I shall comment on just two: equity targets, and health "equity" versus "poverty" approaches.

Equity targets focus attention and increase accountability

Gwatkin aptly points out the need to move from the standard practice of setting population health goals in terms of averages to specifying goals systematically and explicitly in distributional terms. He demonstrates concretely how sizeable improvements can be manifest in an indicator's average level but be concentrated in the better-off groups. In the present global circumstances there is a particular risk of this occurring, since knowledge of preventive practices and ability to apply them, as well as access to

expensive medical technologies, are likely to become increasingly concentrated in the better-off groups in the absence of concerted public policy action.

What stands in the way of countries adopting equity targets? From a research perspective, a lack of reliable data on health indicators disaggregated by social group immediately comes to mind, as does lack of consensus about indicators. Progress towards targets must be measurable in terms of specified indicators; otherwise there is no accountability or way to assess whether policies are likely to be generally on or off track in leading to greater equity. Governments routinely report on scores of health indicators. Should there be an equity target for all of them or only for selected ones, and if the latter, which ones? The literature suggests that disparities in health status associated with socioeconomic differences narrow during adolescence, rise again in young adulthood, then fall again among the elderly (1–3). Should all periods in the life-course be reflected? All health conditions? The literature also indicates that associations between socioeconomic status and health vary with both the health indicator and the socioeconomic measure considered. Should we select the indicators likely to reveal the widest gaps or use other criteria, such as the modifiability of disparities, or the total burden of ill-health (considering both prevalence and severity of health consequences)?

These are difficult questions, but a far more difficult one lies in the political realm: how to build a broad societal consensus. Societies may generally be less tolerant of social inequalities in health than in wealth but they are likely to vary both in the levels of health inequality they will tolerate, and in what the better-off are willing to pay to reduce inequality. Society as a whole — including the better-off, who have greater political power — must feel invested in improving the health of all its members, including those previously left out. Towards that end, equity targets should supplement rather than replace average targets. And there must be adequate public discussion and consensus-building to provide the basis both for setting targets and for formulating actions to achieve them.

Health equity targets may indeed provide a useful mechanism to help build and maintain societal consensus. Both the initial target-setting process and periodic reviews of progress towards achieving targets could provide a focus for public discussion of societal views and policy options; clearly, all social groups — including advocates for the disadvantaged — and all relevant sectors must be included. Gwatkin has rightly noted that effective response to social inequalities in health will often require action outside the health sector. One of the key functions of the health sector should be to provide information on an ongoing basis to reflect the health consequences (overall and for more and less advantaged groups) of actions in all sectors. This role should not depend on whether health services themselves are likely to be of major importance in an effective response to observed health inequalities.

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“Equity” and “poverty” approaches

I also would like to comment on the “poverty” versus “equity” distinction, and to second Gwatkin’s conclusion that the practical differences between these approaches are far smaller than the commonalities. I would like to underscore the wide consensus among those working under the “equity” banner that absolute measures of the health of different social groups, not only relative differences between them, are essential for assessing health equity (4, 5). Correspondingly, in focusing on improving the health of the poor, one is implicitly trying to close a gap, by bringing the poor up to a level of health experienced by better-off groups. The levels achieved by the better-off suggest what is possible and, by extension, what is acceptable.

Among the few differences not discussed explicitly in the lead article is the inherently broader focus of the “equity” criterion, since it concerns social disadvantage not only because of poverty but for any reason, such as ethnicity, gender or location. In practice, disadvantage in other dimensions is often intertwined with socioeconomic disadvantage, and those who focus on “poverty” often address issues such as ethnicity, gender or other factors which make the ill-effects of poverty worse. But in some settings an exclusive focus on poverty will not take adequately into account the health disadvantages suffered by, for instance, ethnic minorities or girls and women. Proponents of the “poverty” focus may well note, however, that from a policy perspective, mixing concern for the health effects of multiple types of social disadvantage can produce a message that is too abstract, complex, and diffuse.

An “equity” focus also seems more encompassing in that it is concerned with gaps even when the worse-off are not in absolute poverty. As Gwatkin notes, in most developing countries, such a large proportion of the population lives in absolute poverty, and overall resources are so constrained, that concerns about “equity” and “poverty” are likely to be similar in practice. On the other hand, in most industrialized and some middle-income countries, a large population segment are “near” or “working” poor rather than absolutely poor, making an exclusive focus on the absolutely poor too narrow. However, a “poverty” focus could encompass concern with both relative and absolute poverty or deprivation, and so include the “near poor” or “working poor”.

A concern for health differences across the socioeconomic gradient, rather than only at the poverty line, also distinguishes the “equity” approach from a focus on “poverty”. However, advocates for the “poverty” approach should also find relevant the argument that living in an unequal society may be damaging to the health of everyone in it, not only its most disadvantaged members. Evidence to support this view has been accumulating for some time.

Yet another distinction between a “poverty” and an “equity” focus is that the latter makes explicit that an ethical value, namely social justice, is

involved. By contrast, the need for a healthy workforce and social stability could be reasons for improving the health of the poor without invoking equity. However, in most circumstances (outside of development organizations), appealing to the self-interest of the better-off groups will be more effective in leading to policies which improve the health of the poor than appealing to an abstract notion of equity. Furthermore, despite the theoretical concerns, most individuals focusing on the “health of the poor” do so out of a commitment to equity.

Very much in line with Gwatkin’s conclusions, I believe that in many cases the differences between a “poverty” and an “equity” approach reflect rhetoric more than substance, and tactics rather than long-term strategy or underlying values. Both approaches call for action to improve the health of the disadvantaged. We should combine forces rather than split hairs. ■

1. **Ford G et al.** Patterns of class inequality in health through the lifespan: class gradients at 15, 35 and 55 years in the west of Scotland. *Social Science and Medicine*, 1994, **39**: 1037–1050.
2. **Hart CL, Smith GD, Blane D.** Inequalities in mortality by social class measured at 3 stages of the lifecourse. *American Journal of Public Health*, 1998, **88**: 471–474.
3. **West P.** Health inequalities in the early years: is there equalization in youth? *Social Science and Medicine*, 1997, **44**: 833–858.
4. **Mackenbach JP, Kunst, AE.** Measuring the magnitude of socio-economic inequalities in health: an overview of available measures illustrated with two examples from Europe. *Social Science and Medicine*, 1997, **44**: 757–771.
5. **Wagstaff A, Paci P, Van Doorslaer, E.** On the measurement of inequalities in health. *Social Science and Medicine*, 1991, **33**: 545–557.

Efficient equity-oriented strategies for health

Göran Dahlgren¹

Inspired and provoked by Gwatkin’s interesting article on health inequalities, I am pleased to present the following comments and suggestions.

Define the setting

According to Gwatkin, it is only recently that concern for equality, equity and the health of the poor has begun to creep back into fashion. This may be true for some organizations such as the World Bank where Gwatkin has his office, but is certainly not true for all governments, international organizations and nongovernmental organizations, many of which have had this focus for decades.

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Recognize the ideological environment

Gwatkin provides an excellent summary of some recent more sophisticated methods to measure inequities in health and health care services. Within this context, lack of data on social inequities is seen as a major constraint for initiating equity-oriented actions for health. This is only marginally true. The main determinant for action is of course the political will to tackle observed inequities in health. Even the best epidemiological records on social inequities in the world did not put equity in health on the political agenda in the United Kingdom under the former Conservative government. The same database has now, with a Labour government in power, been instrumental in formulating a comprehensive agenda for actions to combat social inequities in health.

Formulate equity-oriented targets

The importance of equity-oriented targets is also well described by Gwatkin. It must however be recalled that these targets have to be gender-specific, as the causes of social inequities in health and health care, as well as the magnitude and effects of those inequities, differ between males and females.

In addition to equity-oriented health targets, it is also of critical importance to formulate targets related to determinants of poor health in general and of social inequities in health in particular. Targets of particular relevance in this perspective could be specific reductions in terms, for instance, of absolute poverty and income differences, and improved access to clean water and proper sanitation as well as to basic education and health services. There should also be a focus on reducing unemployment and creating healthier work conditions.

The advantage of formulating targets related to the determinants of health is that actions aimed at reducing social inequities in health are related directly to these determinants rather than to poor health and premature deaths in themselves. Furthermore, the focus on both determinants and outcomes often reveals that there is a political consensus to reduce social inequities in health but far from any consensus to tackle the causes of these inequities. Thus this dual approach to target-setting is also useful for testing, to see if the equity targets in health are real or more likely to be window-dressing.

Equity-oriented strategies for health

Gwatkin is very vague about how to achieve equity-oriented targets for health. Instead of trying to suggest equity-oriented strategies for health for the coming decades, he dismisses efforts of the past such as the health-for-all movement and recalls that government-led socioeconomic development strategies are increasingly questioned. A more valid approach would have been to call for a real evidence-based assessment of positive and negative experience to date.

It is then of critical importance to distinguish between healthy and unhealthy economic policies.

Examples of countries with unhealthy economic policies may be the Russian Federation, where male life expectancy declined from 64 years in 1990 to 58 years in 1994, and the United States, where black Americans as a group have a smaller chance of reaching advanced ages than people born in countries such as Sri Lanka and Costa Rica with a much lower per capita income.

The key indications of a healthy economic strategy are, as also recalled by Amartya Sen in his keynote address at the World Health Assembly in 1999 (1), the extent to which increased economic resources improve the incomes of the poor and are invested in public systems for health services and education. These findings also provide an important starting-point for understanding why, for example, the remarkable health achievements in China have been replaced by stagnation and even higher mortality rates among the rural poor during recent periods of unprecedented economic growth.

In a historical perspective, it thus seems as if the Alma-Ata Declaration and the health-for-all strategy provided not only a positive vision but, to a large extent, evidence-based equity-oriented strategies for health. It thus seems wiser to update and further develop these strategies in the context of the economic and social realities of today — as WHO's Regional Office for Europe has recently done (2, 3) — than to dismiss them as unrealistic.

Health care reforms benefiting the poor

The market-oriented health sector reforms introduced during the 1990s in high-income as well as low-income countries have often been driven more by ideology than by evidence. They have been seen as tools for cost containment and privatization rather than for improved health and access to health services. Considering the important role played by the World Bank in promoting such reforms, it is regrettable that Gwatkin is so vague about present and future World Bank policies for the provision and financing of health services for economically less privileged groups.

Awaiting clarification on this, I would like to suggest some points for consideration.

- Measurements of efficiency should always be related to overall objectives, such as improved economic access to good health care. The key issue is thus not, as suggested by Gwatkin, how to make a trade-off between efficiency and equity, but how to find the most efficient way to achieve the equity-oriented targets. To do the wrong things more efficiently can hardly be considered a positive achievement.
- Financial strategies for health must be progressive. Progressive financing can be achieved by direct public funding (with revenue from taxes) to providers of health services or by social health insurance schemes covering the whole population, or by a combination of these two. Direct user fees constitute the most regressive approach to health

care financing. Experience indicates that high user fees can be a major poverty trap as people have to sell land or cattle or take a loan to pay their medical bills. In rural China, this is true for 40% of all patients. It means that private costs of medical services are a leading cause of impoverishment.

- Access to and use of health care services must be according to need rather than according to purchasing power. This can be gradually achieved by increasing government funding either by direct payments to providers of health services or by subsidizing social health insurance schemes.

High user fees and health insurance schemes which only cover better-off groups usually increase both economic and geographical inequities in access to care. Systems for waiving and reallocating fees may at best only marginally reduce these negative effects. The magnitude of this problem can be illustrated by an example from rural China, where 40% of those reporting seriously ill said that they had not sought medical assistance because it cost too much, and nearly 60% of those for whom hospitalization was recommended did not apply for admission because they said they could not afford it.

China is not unique. The same problems are experienced in most — if not all — poor countries employing high user fees without securing public or community-based financing for all those who cannot pay.

In view of all this, an international organization such as WHO has an important role to play in promoting evidence-based strategies for efficient equity-oriented health sector reforms. ■

1. **Sen A.** Health in development. *Bulletin of the World Health Organization*, 1999, **77**(8): 619–623.
2. *Health 21. An introduction to the health for all policy framework for the WHO European Region.* Copenhagen, WHO Regional Office for Europe, 1998 (WHO European Health for All Series, No. 5).
3. *Health 21. The health for all policy framework for the WHO European Region.* Copenhagen, WHO Regional Office for Europe, 1999 (WHO European Health for All Series, No. 6).

Equity and gender

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Gwatkin's paper provides an excellent historical review of the developments in thinking and research with regard to health inequalities and the health of the poor. More importantly, the paper provides a thought-provoking analysis of the impact of those developments on policy and its implications for health inequalities and the health of the poor. I agree entirely with Gwatkin's conclusion that there has

been a puzzling disconnection between policy discourse and the setting of health policy objectives and that this disconnection has severely limited the impact of health policies and programmes in reducing health inequalities or solving the health problems of the poor.

The central thesis of Gwatkin's paper is that health goals based on societal averages without an effort to incorporate distributional differences in health conditions across the socioeconomic classes do very little to meet the needs of the poor. I would like to add that the setting of health targets based on societal averages also masks gender differentials and thereby fails to deal with the gender-based health inequities that take a great toll on the health of women. In India, for example, using under-five-year-old mortality rates in aggregate form as an indicator of health status would mask the fact that the deaths of girls in this age group exceed those of boys by nearly 330 000 annually (1). Although Gwatkin acknowledges gender inequalities in health status when discussing the dimensions of inequality that matter most, he restricts his recommendation for disaggregated goals to the socioeconomic dimension.

It could be argued that because women constitute about 70% of the world's poorest people, disaggregation by socioeconomic status and the pursuit of health goals that specifically target the poor would automatically include the needs of women. But just as Gwatkin argues that using a pro-poor target, such as reducing under-five-year-old mortality by one-third, may not result in any appreciable improvements in the conditions of the poorest, it could be argued that a target to improve the health status of the poor without explicit goals to improve women's health may likewise run the risk of completely missing the health needs of the most vulnerable and the poorest of the poor — women. Poor women suffer the interactive consequences of two of society's most persistent and damaging inequities, poverty and gender. If the goal of health policy is to reduce health inequalities, it is imperative to set explicit goals for improvements in women's health.

Meeting gender-based health goals, however, will only be possible with an approach that addresses the gender-specific sociocultural and economic factors that increase women's vulnerability to illness and infection and restrict their access to health care information and services. For example, women's use of health services has been found to be impeded by sociocultural norms that restrict their mobility or limit their participation in household decision-making (2). Research on human immunodeficiency virus/acquired immunodeficiency syndrome has also shown that economic dependence and income insecurity act as significant constraints for women who want to adopt preventive practices such as the use of a condom, if these go against the wishes of their male partners (3).

Likewise, gender-based violence against women, the most pervasive form of human rights abuse, is increasingly recognized as a profound health

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problem that needs policy attention because it is a significant cause of morbidity and mortality among women (4). Thus, ensuring that gender-based health goals are translated into action will require an approach that recognizes the importance of assuring women's health and well-being, and the only way to do that is by strengthening their economic and social capabilities.

In his recent book, *Development as freedom* (5), Amartya Sen argues that it is only by strengthening women's agency and voice, through measures such as increasing their earning power and assuring their literacy, that we can begin to remove the inequities that compromise women's well-being. He points out that the benefits of investing in women's agency accrue not only to women but to their children and their families, through improvements in child survival rates and a reduction in fertility.

Despite these proven benefits and the undeniable gender disparities that persist in indicators of health and well-being, it has been difficult to convince policy-makers that they should give high priority to the health of women. The persistence of an unacceptably high maternal mortality rate (more than half a million deaths a year from preventable causes) is vivid proof of this. The setting of gender and socioeconomic health goals is only one component of an approach that seeks to tackle health inequalities. What is required, as Gwatkin rightly points out, is "an impressive degree of political will," which can only come about if health professionals make clear the need for gender-based and economic equity in order to obtain positive and sustainable health outcomes. ■

1. **Chatterjee M.** Indian women: their health and productivity. Washington, DC, The World Bank, 1991 (World Bank discussion paper 109).
2. **Timyan J et al.** Access to care: more than a problem of distance. In: Koblinsky M, Timyan J, Gay J, eds. *The health of women: a global perspective*. Boulder, Colorado, Westview Press, 1993: 217–234.
3. **Weiss E, Gupta GR.** *Bridging the gap: addressing gender and sexuality in HIV prevention*. Washington, DC, International Center for Research on Women, 1998.
4. **Heise L.** Violence against women: the missing agenda. In: Koblinsky M, Timyan J, Gay J, eds. *The health of women: a global perspective*. Boulder, Colorado, Westview Press, 1993: 171–196.
5. **Sen A.** *Development as freedom*. New York, Alfred A. Knopf, 1999.

Understanding and setting up the process for health equity

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Simply put, one of the central questions raised by Gwatkin's lead article is: why do we keep on "talking

the talk" but not "walking the walk", when it comes to achieving health equity goals? Recent years have seen a renewed interest in health equity, as reflected in part by a significant increase in the number of international initiatives and published studies (1, 2). While different views have been expressed regarding how to define and measure health equity, a conviction shared by many is that expressed by Gwatkin, that "what matters are not societal averages with respect to health, but rather the health conditions that prevail among different groups within society, particularly among disadvantaged groups". But why has this conviction not been translated into policies in any noticeable way? There might be two basic reasons for lack of action on the health equity front. First, societies may not be highly motivated to take action. Second, they may want to take action but not know what exactly that action should be. I would argue that to help move from analysis to action, we need to fill two important knowledge gaps: an understanding of the political process for setting health equity goals, and empirical evidence on how practically to achieve those goals.

Understanding the process

There usually seems to be an implicit assumption embedded in health equity studies that epidemiological evidence on determinants of health and health equity will inevitably lead to the development of more equitable policies. That may help to explain why the majority of these studies tend to focus on finding a clinical explanation for the link between low social status and ill-health. As pointed out by Rich & Goldsmith, however, epidemiological information is but one input into the political decision-making process, and often a minimal one at that (3). Social, economic, and political forces that produce and sustain inequities in the first place might be more important (4). Compared to the abundant measurement studies and prescriptive policy analyses that come out, there is a serious lack of positive enquiry into the political process of generating health equity goals in different societies. At present we do not know why health equity is defined differently in different societies, or what makes policy-makers care about health equity, or why specific health equity goals have been put on the political agenda in some countries but not in others.

As any equity-oriented health policy changes seek to expand benefits for relatively powerless population groups and promise to impose new costs on relatively powerful groups, the resulting political challenges are significant. The demise of the Clinton health reform in 1994 vividly illustrated for the world the importance of politics: politics affects the definition and explanation of a policy problem, the way it is formulated, its recognition or denial, and the implementation of public policy aimed at solving it (5, 6). For industrialized as well as developing countries, therefore, the success of health reforms aimed at increasing health equity requires in-depth political analysis and astute political management.

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Would-be reformers have to find out who the movers and shakers are in formulating health equity policies. Then they need support in assessing the political feasibility of a policy, managing the process of policy design and acceptance, and thinking up strategies that improve the prospects of implementation. For this, applied political analysis provides a relevant assessment procedure to probe the political dimensions of policy-making in ways that increase effective interaction and enhance the quality of the reform process. Some tools such as PolicyMaker, a computer software program for political mapping, can be readily applied for this purpose (7).

Setting up the process

Whenever and wherever political will is in place, the next question naturally arises: what are the most feasible and effective strategies for reducing inequities in health and health care? The basic source of information for policy-makers in their search for viable options is domestic and international experience of what has worked and what has failed. Intervention studies aimed at achieving specific equity goals represent a cost-effective way of providing policy-makers with the most relevant information. Some policy changes may work on paper but not in practice. Before applying a new policy nationwide, a country might want to try it out in some representative local communities. In this way even failed pilot projects can provide valuable lessons and yield the benefit of avoiding high costs associated with setting up an unproven scheme on a national scale. To illustrate this point, I shall draw on experience from an on-going project in China, in which I had the privilege to be closely involved (8).

In 1993, UNICEF launched the Basic Health Care for China's Rural Poor project. Initially, this project focused on building up a thorough understanding of the health and poverty problems of 114 poor counties in China, especially among minority ethnic groups. Drawing heavily on the research findings of the first phase of this project, the Chinese government decided at the first National Conference on Health Policy in December 1996 that a viable system for financing and delivering basic health care to China's rural poor was a top priority. In the light of the large variations in socioeconomic and cultural backgrounds across rural China, operational field research was needed for the successful implementation of this policy.

The second phase of the project has been under way since 1997 to field test an entirely new system for financing and organizing health care in 10 pilot counties. Key elements of the pilot project include:

- provision of basic medical equipment and essential drugs to needy villages;
- creation of a revolving fund to make sure clinics can afford to replenish drug supplies;
- establishment of a two-tiered health protection system.

The first tier of this system is a community-level Cooperative Medical Fund to pay for basic preventive and curative services. Each of these funds is financed by the farmers and rural industries and managed by local people. The second tier is a Hospital Insurance Fund to cover catastrophic medical expenses for the poor. The fund is organized at the county level, with seed money from donors and matching funds from government sources. Encouraging results from the pilot interventions have prompted the Chinese Ministry of Health to work with the World Bank (the World Bank Health Loan VIII to China) to expand these models to other poor regions in China. At the international level, governments and health planners in countries such as Viet Nam and Bangladesh are keeping a close eye on the project's progress. It is viewed as one of the viable models for combining external assistance with local community participation to enhance health equity.

Needless to say, the limited experience of some local communities cannot and should not be seen as a recipe for a whole nation, and one country's successful models cannot and should not be blindly transplanted into another country. Nonetheless, such evidence does raise a question: do we learn more powerful lessons from "talking" or from "walking"? ■

1. **Van Doorslaer E, Wagstaff A, Rutten F.** *Equity in the finance and delivery of health care.* Oxford and New York, Oxford University Press, 1993.
2. *Equity in health and health care: a WHO/SIDA initiative.* Geneva, World Health Organization, 1996 (unpublished document WHO/ARA/96.1).
3. **Rich RF, Goldsmith NM.** The utilization of policy research. In: Nagel S, ed. *Encyclopedia of policy studies.* New York, Marcel Dekker, 1983.
4. **Navarro V.** The political economy of the welfare state in developed capitalist countries. *International Journal of Health Services*, 1999, **29**(1): 1–50.
5. **Rochefort DA, Cobb RW,** eds. *The politics of problem definition: shaping the policy agenda.* Lawrence, KS, Kansas University Press, 1994.
6. **Sabatier PA.** Public policy: toward better theories of the policy process. In: Crotty E, ed. *Political science: looking to the future, volume two: comparative politics, policy, and international relations.* Evanston, Northwestern University Press, 1991.
7. **Reich MR, Cooper DM.** *PolicyMaker: computer-assisted political analysis* (Software and manual). Newton Center, MA, PoliMap, 1996.
8. **Liu Y et al.** Is community financing necessary and feasible for rural China? *Health Policy*, 1996, **38**(3): 155–171.

The key to overcoming inequality is political commitment

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One of the main conclusions of Gwatkin's article was the need "to rethink the way in which health goals are

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established, and recast them in terms more relevant for inequality reduction”. His recommendations and most of his article itself focus on the content of health policy and do not deal with the political processes and factors that shape health policy, such as competing interests.

The need for more reliable information on health inequalities (and the role of the international organizations in providing it) cannot be doubted. Its absence is a reflection of the lack not only of knowledge but of political commitment. The reverse is not true: if the health policy of a given country includes the reduction of inequalities, we cannot conclude that the political commitment to implement such objectives exists.

Why does the political commitment not exist? What factors prevent the reduction of inequities from being given priority in health policy? What could change the existing situation? Answers to such questions naturally vary from place to place. What I discuss here refers to the post-socialist countries, especially Hungary, but I believe that parts of it are valid elsewhere too.

In the 1990s in the post-socialist countries, the emergence of a group of wealthy people has coincided with a decline in economic performance, as reflected by a shrinking gross domestic product (GDP). Obviously, if some people are getting richer it can only be at the expense of the other social strata, partly the middle class and mainly the poor, who get poorer and poorer. In Hungary, for example, the gap in income between the lower and the upper decile from 1990 to 1997 increased from 4.5 to almost 9. The majority of the political elite, irrespective of their political allegiances, have tried to get into the richest part of society in the course of this social realignment. The political elite is much more sensitive about the inequalities between countries (which are to their disadvantage) than to the inequalities within their own country (which are to their advantage). The challenge felt most keenly by the political and economic elite, not only for their countries but for themselves, is to catch up with the West. Questions of internal inequality are much less compelling. A good example of this is health. In non-Western countries a major objective in health policies is to narrow the gap between their own and Western life expectancy, while unequal life expectancies within the country get no attention.

Miklós Tamás-Gáspár, a philosopher who was a key figure of the liberal intellectual resistance in the socialist period, describes the new political elite in harsh but accurate terms:

The ideas of welfare, public interest and good governance are meaningless to them. They do not want power because they want to save the world or make improvements or promote social justice, ... though they might sometimes inadvertently use such phrases. The new elite are as indifferent to the fate of the poor as their communist predecessors were (7).

The apparent contradiction between the new political elite's lack of interest in social justice and the priority given to poverty alleviation as a social policy objective is deceptive. This policy can also be interpreted as the desire to increase GDP while remaining firmly on the development track that increases inequalities.

In the last decade not only socioeconomic factors but elements of the health care system itself have worked against the development of an equity-oriented health policy. The basic economic and budgetary interest was to reduce spending on welfare and health in order to reduce state redistribution. The concern of the physicians was quite contrary to this: it was to increase their own income and to reduce the gap between their own technology and that of the West. The effect of these factors on health policy was to make its share of the national resources the main concern, with little interest in increasing efficiency, and none at all in equity. The allocation of resources in the health sector was strongly influenced by the “background industry” of pharmaceuticals and health care equipment, and the emergence of market conditions in this sector. Another fundamental interest influencing health policy objectives is that of the high-income stratum of society in having better health care services for themselves.

As a result of these developments the Ministry of Finance gained a much bigger role in shaping health policy than the public health experts. The keywords for health policy were cost-containment, improved efficiency, competition, and the facilitation of market conditions. The improvement of the health status of the population was mentioned among the general objectives for decency's sake, and the reduction of inequalities was not mentioned at all.

The role of physicians is of fundamental importance in shaping health policy. During the last decade the attitudes and behaviour of physicians and other health workers have been fundamentally influenced by the fact that they are relative losers in the economic transformation: their social and financial status has gone down. The official income of health workers lagged behind that of business people and of other public sector workers. Gratitude money compensated only a minority of the physicians. This situation strongly influenced the views of physicians on health policy: their first priority was the improvement not of the population's health status but of their own income status. The situation was made worse by the fact that the prestige of public health experts, who “ex officio” dealt with the health status of the population, and health promotion was already declining in the 1980s and continued to do so in the 1990s.

Does all this mean that the situation is completely hopeless? I think not. The experts, politicians and co-workers in international organizations committed to the reduction of health inequalities have several tasks they can carry out.

Of course, neither the political elite nor the physicians form a homogeneous group: even in the circumstances outlined above there are politicians,

bureaucrats and physicians who are committed to the reduction of inequalities in the context of their own scheme of values and political beliefs. But for the time being neither within the health sector nor outside it can a politically influential group be found that is willing to strive to reduce inequalities. The current situation will not go on for ever. A positive change could occur if more and more people in the political elite and in the bureaucracy recognized that the social costs incurred by increasing inequalities are too high. This recognition can be promoted by experts, academics and members of associations, as well as people in international organizations, who work to reveal the inequities and analyse their causes and consequences.

As to the relation between income and health, Wilkinson says that "evidence strongly suggests that as social differences in a society increase, the quality of social relations deteriorates". He adds: "The hypothesis is that the most important psychosocial determinants of population health are the levels of the various forms of social anxiety in the population, and these in turn are determined by income distribution, early childhood and social networks" (2). If the reduction of income inequalities and the improvement of social cohesion are not priorities in government policy, the mitigation of health status inequalities is unlikely to occur. Therefore a fundamental health policy question is: what are the conditions necessary for promoting an economic and social policy that decreases income inequalities?

Success in carrying out any given health policy objectives is affected by the following factors: the

amount of power shared by the groups concerned; the resources available (in the absence of which even the most beautiful objective remains a dead letter); and the technical, professional and theoretical tools available. Power by itself, without an appropriate concept, is not sufficient to bring about a successful change, just as the appropriate concept remains useless without power. This is the framework within which to assess the chances of success for policies aimed at reducing inequalities.

As to technical and professional means, a small step forward could be to set up a unit within the public administration that has the specific task of investigating and monitoring health inequalities and evaluating the impact of government policy on reducing them. The establishment of such a unit would at least make it possible to detect and define these problems as part of the procedures of public administration.

To sum up, confronting politicians, physicians and society with the social costs of the currently increasing inequalities, and generating political commitment to reducing them by developing new approaches within public administration, could turn health policy into an equity-oriented direction. Such a policy should in fact reconcile the values of equity and efficiency. ■

1. **Tamás Gáspár M.** Paradoxes of 1989. *East European Politics and Societies*, 1992, **2**.
2. **Wilkinson RG.** Health, hierarchy and social anxiety. In: *Proceedings of the New York Academy of Sciences Conference on Socioeconomic Status and Health in Industrial Nations*, New York, 1999 (unpublished document).