Priorities for research to take forward the health equity policy agenda

WHO Task Force on Research Priorities for Equity in Health,[1] & the WHO Equity Team[2]

Abstract Despite impressive improvements in aggregate indicators of health globally over the past few decades, health inequities between and within countries have persisted, and in many regions and countries are widening. Our recommendations regarding research priorities for health equity are based on an assessment of what information is required to gain an understanding of how to make substantial reductions in health inequities. We recommend that highest priority be given to research in five general areas: (1) global factors and processes that affect health equity and/or constrain what countries can do to address health inequities within their own borders; (2) societal and political structures and relationships that differentially affect people's chances of being healthy within a given society; (3) interrelationships between factors at the individual level and within the social context that increase or decrease the likelihood of achieving and maintaining good health; (4) characteristics of the health care system that influence health equity and (5) effective policy interventions to reduce health inequity in the first four areas.

Keywords Research; Health services research; Social justice; Health priorities; Health services accessibility; Delivery of health care; Socioeconomic factors; Politics; Public policy (*source: MeSH, NLM*).

Mots clés Recherche; Recherche en santé publique; Justice sociale; Priorités en santé; Accessibilité service santé; Délivrance soins; Facteur socioéconomique; Politique; Politique gouvernementale (*source: MeSH, INSERM*).

Palabras clave Investigación; Investigación sobre servicios de salud; Justicia social; Accesibilidad a los servicios de salud; Prestación de atención de salud; Factores socioeconómicos; Política; Política social (*fuente: DeCS, BIREME*).

الكلمات المفتاحية: البحوث، بحوث الخدمات الصحية، العدالة الاجتماعية، الأولويات الصحية، إتاحة الخدمات الصحية، إيتاء الرعاية الصحية، العوامل الاقتصادية والاجتماعية، السياسة، السياسة العامة. (المصدر: رؤوس الموضوعات الطبية، المكتب الإقليمي لشرق الأوسط)

Bulletin of the World Health Organization 2005;83:948-953.

Voir page 952 le résumé en français. En la página 952 figura un resumen en español. يمكن الاطلاع على الملخص بالعربية في صفحة 952.

Background

Equity has been a stated or implied goal of health policy in many countries and international health organizations for decades. At Alma-Ata in 1978, a global health strategy was launched by the World Health Organization's (WHO's) World Health Assembly with the goal of Health for All by the Year 2000 (HFA) (1). Health equity is an implicit priority in HFA, and was particularly prominent in WHO's HFA strategy for Europe (2). The European HFA strategy for the twenty-first century identified promotion of equity and improvement of health as guiding principles (3). WHO in Geneva launched a global initiative on Equity in Health and Health Care from 1995–1998 (4). Equity concerns were also prominent in parts of the 2000 Millennium Declaration, which gave rise to the Millennium Development Goals (5). Although impressive overall gains were achieved in life expectancy and child survival during the second half of the twentieth century, inequities in health status and in health systems between more and less privileged groups within and between countries have persisted, and in many regions and countries are widening (6, 7).

Health equity has also emerged as an important theme in research and advocacy (8, 9). Pursuing equity in health "reflects a concern to reduce unequal opportunities to be healthy associated with membership in less privileged social groups, such as poor people; disenfranchised racial, ethnic or religious groups; women; and rural residents. In operational terms, pursuing equity in health means eliminating health disparities that are systematically associated with underlying social disadvantage or marginalization" (10). The unequal distribution of the social and economic determinants of health, such as income, employment, education, housing and healthy environments remains the primary policy problem for reducing health inequities (11). Striving for equity in health *care* is one aspect of the wider concept of equity in health *status*, and implies that health

[1] **Members of the WHO Task Force:** Piroska Östlin, Karolinska Institutet, Sweden; Paula Braveman, University of California, USA; J. Norberto Dachs, Universidade Estadual de Campinas, Brazil; Göran Dahlgren, University of Liverpool, England; Finn Diderichsen, University of Copenhagen, Denmark; Elisabeth Harris, Centre for Health Equity Training Research and Evaluation, Australia; Philippa Howden-Chapman, University of Otago, Wellington School of Medicine, New Zealand; Ronald Labonte, University of Saskatchewan, Canada; Rene Loewenson, Training and Research Support Centre, Southern Africa; Di McIntyre, University of Cape Town, South Africa; Supasit Pannarunothai, Centre for Health Equity Monitoring, Naresuang, Naresuan University, Thailand; Gita Sen, Indian Institute of Management, India; Margaret Whitehead, University of Liverpool, England. Correspondence should be sent to Piroska Östlin, Karolinska Institute, Department of Public Health Sciences, 171 77 Stockholm, Sweden (email: piroska.ostlin@phs.ki.se).

[2] **Members of the WHO Equity Team:** Jeanette Vega, Alexander Irwin, Ulysses Panisset, Nicole Valentine, Evidence and Information for Policy Cluster, World Health Organization, Geneva, Switzerland.

Ref. No. **04-020610**

(*Submitted: 22 December 2004 – Final revised version received: 28 March 2005 – Accepted: 09 May 2005*)

care resources are allocated and received according to need, and financing is according to ability to pay (4, 12). Adequate progress in narrowing gaps, particularly where resources are limited, requires frameworks that will ensure attention to the needs of those with the greatest health needs and the least resources.

Over the last few decades WHO has considered health and health services in their social, cultural and economic context. WHO defines health systems as "all the activities whose primary purpose is to promote, restore or maintain health" (13). Health systems are not only producers of health and health care, but also "purveyors of a wider set of societal norms and values" (14).

Health systems in many countries, however, have been unable to introduce or sustain improvements in health equity. One obvious reason — as a recent synthesis of research on vulnerability to human immunodeficiency virus (HIV), tuberculosis and malaria infection has noted — is that health systems, and the people who use them, exist within social contexts that exert a powerful influence on people's chances to be healthy (15, 16). Social values and political processes determine the allocation of resources (wealth, power and opportunities to acquire them) for health. This makes it unlikely that equity will be achieved without confronting the entrenched interests and political and economic processes that give rise to inequalities in the distribution of health determinants. One measure of equity, therefore, is the extent to which public policy and authority are structured to serve public interests and justice, as reflected in part by the degree to which non-élite groups can influence the allocation of resources for health (7).

Research and interventions that focus only on the technical, clinical or financial dimensions of health interventions and systems generally lose sight of these structural (political and economic) and social dimensions. Promoting health equity requires:

- integrated action to develop healthier social, economic, political and physical environments;
- improved access to appropriate universal health systems; and
- priority interventions and programmes within health systems (e.g. scaling up antiretroviral therapy for HIV/acquired immunodeficiency syndrome (AIDS) in sub-Saharan Africa) where the burden of disease is greatest and resources to address it are least.

How can the research community support these three levels of intervention and policy? Biomedical research, while making a significant contribution to curative services, often ignores the social etiology of disease — the causes behind the causes. Similarly, research on individual risk factors often neglects the social context that frames their distribution and modifies their effects (17).

We need to improve our understanding of the effects of social context and position on health outcomes for individuals and populations. Studies are needed on how macroeconomic and social policies have affected the life chances and health of different population subgroups, defined by socioeconomic position, gender, race/ethnicity, religion or geography (18). Research must go beyond the behavioural and other individual determinants of illness, to examine the links between proximal and structural (distal) determinants of ill-health and study the institutions and processes leading to health inequities.

It should be acknowledged that there has already been considerable research in the above-mentioned areas. However, as addressing the social and environmental determinants of health invariably raises policy questions that are highly political, research must be conducted continuously to keep the policy and political discourse on these issues current. Addressing the main determinants of population health usually requires actions from many sectors, not only the health sector, and new forms of multidisciplinary research focusing on equity are needed to guide multisectoral policy (19, 20).

Research, whether biomedical or social, is invariably informed by value judgements, even if these are not explicit. The equity-oriented research discussed here is primarily defined by a desire for social justice, specifically to reduce modifiable inequalities that are particularly unfair. Our concepts of "unfairness" influence both the research questions and the methods used to address them.

Methods

In May 2004, the WHO Evidence and Information for Policy Cluster convened a Taskforce on Research Priorities for Equity and Health to provide expert advice for a report to be presented to the World Ministerial Summit on Health Research held in Mexico, 16–20 November 2004. Taskforce members were selected purposively from around the world for their dual expertise in both health equity research or development and in advising national and international policy-makers on the implications of research relating to equity-oriented policy.

Priorities were identified by two main processes. Firstly, a consultation paper containing open-ended questions was drawn up by the taskforce convenor, Dr Östlin, and the WHO Equity Team and presented to a public meeting at the biannual conference of the International Society for Equity in Health, held in Durban, South Africa, in June 2004. The meeting was advertised as open to all conference participants and was designed to elicit views from the wider health equity research community on major gaps in existing research and research priorities to address health equity. Suggestions from the meeting were recorded and reviewed by Dr Östlin and the WHO Equity Team.

Secondly, taskforce members were requested to respond electronically to the same questions, after considering a summary of the input from the Durban meeting and following discussion among members of the taskforce. From the first round of taskforce responses, the convenor identified five overarching areas of priority, and taskforce members were asked for their comments and to elaborate on key research questions within each area. This iterative process continued with taskforce members being asked to prioritize items from a full list of suggestions circulated during successive rounds. The final draft of the paper was also informed by suggestions received from participants attending a working session at the World Ministerial Summit on Health Research in Mexico. This paper presents the considered reflections and opinion expressed during this iterative process.

A growing evidence base, but a lack of policy-relevant synthesis

To support improvements in health equity, gaps need to be filled in five distinct but interrelated research areas.

1. Global factors and processes affecting health equity.
2. The societal and political structures and relationships that differentially affect people's chances to be healthy within a given society.

3. The interrelationships between individual factors and social context that increase or decrease the likelihood of achieving and maintaining good health.
4. Factors within the health care system that influence health equity.
5. How to influence factors 1–4 effectively, i.e. identification of policy interventions with the potential to reduce inequities in the determinants of health and health care. In each of these areas, much remains to be understood.

Global factors and processes affecting health equity

In theory, the diffusion of new knowledge and technology through global trade and investment should improve the surveillance, treatment and prevention of disease. Economic growth, necessary for sustaining public goods such as health care, should improve the supply of and access to essential health-promoting services, while also reducing poverty, both of which would lead to better health (21). However, there is now considerable evidence to suggest that the prevailing globalization policies, emphasizing trade and investment liberalization, privatization of state assets and global market integration, have not reduced health inequities (22, 23). Rather, they have contributed to the rapid spread of infectious diseases and high-risk lifestyles (24), systematically undermined the public provision of essential services and food self-sufficiency, and reduced the authority and capacity of states to protect public health (25).

Other problematic consequences of contemporary globalization include trade in health-damaging products, such as military weapons and tobacco, migration of people displaced by conflict and/or poverty; new environmental threats including depletion of resources and climate change; and increased commercialization and privatization of essential services associated with segmentation of health systems and diminished access to services in poor communities.

Research aimed at maximizing or protecting health and access to health care must take into account these features of globalization, and cannot be confined to the national and subnational levels. The economic and political drivers of harm to health include policies and trends that transcend national borders and are at least in part beyond the policy "reach" of national governments acting in isolation (26–28).

Research relevant to these challenges would need, for example, to examine the impact of debt payments, movement of capital from one country to another and tax avoidance on public revenue, health and social spending; the effects of macroeconomic conditions found in Poverty Reduction Strategy Programmes, International Monetary Fund (IMF)/bank loans, World Trade Organization (WTO) agreements and development assistance; and the impact of General Agreement on Trade in Services (GATS), Trade-Related Aspects of Intellectual Property Rights (TRIPS); and other WTO and bilateral "free trade" agreements on health and health services. Policy research is needed on possible conflicts between multilateral environmental agreements (which have health impacts), human rights (notably the right to health) and trade/finance liberalization agreements and various aid, debt relief and bank/IMF loan conditions and on the possible solutions for such conflicts.

Research on these issues requires not simply comparative cross-national studies, but detailed national case-studies that extend from the household level to national policy sectors, and carefully assess the impacts of specific globalization "drivers" on national policy capacity e.g. related to revenue-generating capacity and trade agreement restrictions on national policy-making. Related and overarching research objectives should include the answer to the question: What a priori global, international and national economic, governance and policy conditions produce economic growth in ways that reduce poverty and disparity and promote health?

Effects of societal and political structures and relationships on chances to be healthy

The social environment, or social context, in which we live leads to unequal distributions of power, wealth and risks to health. The way in which societies and communities are organized has a major impact on determinants of population health and health inequalities. Areas of concern include policies on the labour market and income maintenance; gender norms; influence of land-use planning (e.g. on rural production and household food security, or urban demand for motor transport and the associated air pollution); access to social services, health care and education; housing; environmental protection; water and sanitation; transport; and security. A given policy — for example, the introduction of school fees — can have differential effects on the chances of different groups to be healthy.

Indicators and methods are required urgently for systematic assessments of the impact of policy on health equity at an aggregate level, and also to determine whether the impact differs for different population groups in a given society. The assessment must cover not only health systems policy, but also policy in other sectors (29, 30). The creation of such indicators and methods is not just a technical exercise. It should incorporate an understanding of the social values and political choices that strengthen fair process and outcomes in decisions related to policy-making.

The interrelationships between individual factors and social context

Numerous studies intended to lead to an understanding of inequalities in health have focused on exploring the individual characteristics that differentiate health risk, such as smoking, alcohol consumption, eating patterns and blood pressure. The burgeoning literature on the social determinants of health emphasizes that many of these risk factors are corollaries of, or are strongly influenced by, an individual's social position as reflected, for example, by income, accumulated wealth, economic (in)security, location of residence, gender, ethnicity, educational attainment or work. The limitations of focusing on individual risk factors have been examined as "public health behaviourism" (31) in the literature on HIV/AIDS. It is not enough to study the impact of a given proximate risk factor in isolation from the influences of other risk factors on health and social inequities in health. The "risk-factor" approach fails to uncover multi-causal mechanisms and root causes behind health inequities and ignores the accumulation of influences over the life course (32). More generally, social context and social position may play an important role in predisposing some population groups to heavy social consequences from disease or injury, or in buffering them against such consequences (18). Despite considerable knowledge of the social determinants of health and health equity, the evidence base exhibits major gaps (6, 33, 34). For example, information is lacking on the specific pathways by which disadvantaged social positions translate into ill-health in specific country contexts. Relevant areas of research would include: how socioeconomic factors interact with other

factors in contributing to health inequities in middle-income and low-income countries; how socioeconomic factors contribute to ill-health at the household level; and what strategies best mitigate these risks in ways that cover both coping (short-term) and socially transformative (long-term) cases?

Health care system factors influencing health equity

Although the antecedents of health inequities often need to be tackled within the broader social and economic arena, the role of health care in reducing ill-health and suffering, redressing inequities and preventing future inequities remains critical. In the short term, the health sector may be a promising entry point for equity-oriented policies and interventions (6) for preventing impoverishment due to health care expenses, and preventing declines in social position due to chronic diseases (35).

In the past two decades, major changes in the health sector have occurred worldwide. These reforms, often market-oriented, have introduced structural changes, including privatization, commercialization and segmented financing, that have led to a fundamental reorganization of the principles driving health systems. Other changes have included performance-based funding or private-sector management contracts. Specific approaches vary between countries and regions (36), but the main motivation for reform appears to have been economic efficiency rather than health equity (37).

Research suggests that many health sector reforms have raised barriers to access to essential care for the less well off. Despite acknowledgement that public expenditure cuts and user fees have impeded access to health care, little has been done to remove these harmful effects or protect the most vulnerable population segments (38). Direct effects include decreased access to health care and delays in health-seeking behaviour leading to worse health outcomes (39). This may affect women disproportionately as they have less access to household resources, a higher risk of poverty and require more reproductive health services (40, 41). Promotion of user fees was based on promises of increased budgetary allocations to improve the quality of services, but this did not happen (42). Out-of pocket expenditure for public and private health care services has driven many families into poverty, especially in developing countries (43–45) — a phenomenon termed the "medical poverty trap" (46).

These negative consequences of health sector reforms are seldom recognized in policy-making and implementation. Research should assess not only the social and health costs, benefits and trade-offs of policy shifts, but also the values and assumptions behind national policy shifts. Research on the effects of introducing a competitive health systems market on equity in provision of and access to health care should provide clear information for planning short- and long-term costs and benefits, and particularly the quantity, relevance, distribution and quality of health services within countries. A greater understanding is needed of existing demand-side constraints that need to be overcome to address the social consequences of different policy options (47).

Research and policy need to focus on the human component of development of health systems. The quality, commitment and dedication of health care providers are critical to equitable health systems, health and development. Numerous recent assessments indicate that the "brain drain" of health care providers from developing countries, especially from southern Africa, threatens to precipitate the collapse of health systems already stretched to breaking point by financial constraints and the impacts of HIV and AIDS (48).

Effective policy interventions to reduce health inequity

The research agenda must also identify and analyse effective policy approaches and interventions that could be implemented within countries (6, 9, 49).

Until recently, research on health equity has described inequalities more than it has explained or proposed interventions to address them. It is now timely to invest in research evaluating the health effects of policies and interventions among different population segments; framing the health consequences of alternative options for enhancing equity; and guiding policy-making. Research must be oriented toward policy solutions that can effectively link priority health programmes; strengthen the broader health system; and act on the social determinants of health. The health sector should play an advocacy role in catalysing and guiding multisectoral action to address the social determinants of health. A key task for research on equity-oriented health systems is to identify strategies, policy interests and "pressure points" for this process.

This can be done at various levels. At the international level it is important, for example, to develop methods to distinguish ex ante between healthy and unhealthy economic growth policies. At the local level, research in cold countries might include assessments of the health impact of improved heating systems in old, cold and damp homes, which are disproportionately occupied by people with low incomes (50).

Establishing what constitutes adequate evidence on successful interventions, and the value of evidence from different stakeholders, i.e. international and national scientific groups, communities and nongovernmental organizations, are also important research issues. Understanding the process of implementing successful interventions may be as important as the outcomes. Policy changes provide opportunities for natural experiments to increase understanding of the relationships between policies and health outcomes. There is no universal blueprint: solutions must be devised that suit each country's specific context. This calls for an international reporting system to collect information on current and completed evaluation studies to increase the accessibility of policy-makers to relevant information.

Conclusion

This paper notes that inequalities in health arise at a number of levels: in the economic, social and environmental determinants of health, in the policies that influence the distribution of these determinants and in the political and economic interests that shape these policies. It argues that these conditions are being powerfully transformed by a process of globalization in which the interests of transnational capital dominate public health and national authority. Any research process that seeks to explain and understand the sources and drivers of this inequality would need to take account of these determinants, and of the policies, interests and imperatives that influence them. More importantly, a research process driven by values of equity and goals of justice, would need to generate knowledge that can be used to confront these trends and promote public, population health interests in a way that preferentially benefits the worst off members of society.

This has implications for both the type of research questions we ask, and the way we seek to address them. In this paper we propose some research priorities and also discuss the need for such questions to be addressed in ways that strengthen social action for health equity and reinforce policy actors promoting health equity.

The global community has set itself targets such as the achievement of the Millennium Development Goals. In the coming year we may see a great deal of research that describes the gap between these targets and the current lives of many people in the world. This is necessary but not sufficient in the face of a growing unmet demand for health equity and justice. We need to do more with our research. We need to choose the questions and generate the knowledge and analysis that explains the drivers of unacceptable gaps between our social aspirations and our economic and social practice. More importantly, we need to generate the knowledge and analysis that informs public policy-making and the economic and social processes that influence it. ■

Acknowledgements

We thank Ted Schrecker, University of Saskatchewan, Canada, and David McCoy and Amit Sengupta, Peoples Health Movement, for their valuable comments.

Competing interests: none declared.

Résumé

Promotion de politiques d'équité en santé : priorités de la recherche

Malgré l'amélioration considérable des indicateurs composites de la santé au niveau mondial depuis quelques dizaines d'années, les inégalités en matière de santé à l'intérieur des pays et entre eux persistent, quand elles ne s'aggravent pas dans de nombreux pays ou régions. Nos recommandations concernant les priorités de la recherche sur l'équité en santé reposent sur une évaluation des informations jugées nécessaires pour mieux comprendre comment réduire sensiblement les inégalités en matière de santé. Nous recommandons d'accorder le rang le plus élevé de priorité à la recherche dans cinq domaines généraux : 1) les facteurs et processus mondiaux qui ont une incidence sur l'équité en santé et/ou limitent ce que peuvent faire les pays pour redresser les inégalités à l'intérieur de leurs frontières ; 2) les structures et les relations politiques et sociales qui influent différemment sur les chances des individus d'être en bonne santé dans une société donnée ; 3) les interrelations entre les facteurs au niveau individuel et à l'intérieur du contexte social qui accroissent ou décroissent la probabilité d'être en bonne santé et de le rester ; 4) les caractéristiques du système de soins de santé qui ont une incidence sur l'équité en santé et 5) les interventions efficaces au niveau des politiques pour réduire les inégalités en santé dans les quatre premiers domaines.

Resumen

Prioridades de investigación para impulsar la agenda de políticas de equidad sanitaria

Pese a las notables mejoras experimentadas por los indicadores globales de salud a nivel mundial durante los últimos decenios, las desigualdades sanitarias entre y en los países no han desaparecido, y en muchas regiones y países están incluso aumentando. Nuestras recomendaciones respecto a las prioridades de investigación en pro de la equidad sanitaria están basadas en una evaluación del tipo de información requerida para comprender mejor las posibilidades de reducir de forma sustancial las desigualdades en salud. Recomendamos que se otorgue la máxima prioridad a las investigaciones centradas en cinco áreas generales: (1) los factores y procesos mundiales que afectan a la equidad sanitaria y/o limitan las posibilidades de los países para corregir las desigualdades en salud dentro de su territorio; (2) las estructuras y las relaciones sociales y políticas que afectan diferencialmente a las oportunidades de la gente de conservar la salud en una sociedad determinada; (3) las interrelaciones entre factores a nivel individual y social que aumentan o disminuyen la probabilidad de lograr y mantener una buena salud; (4) las características del sistema de atención de salud que influyen en la equidad sanitaria, y (5) las intervenciones normativas que reduzcan eficazmente las desigualdades en salud en las cuatro primeras áreas.

ملخص

الأولويات البحثية لدفع مخطط العمل في سياسات العدالة الصحية إلى الأمام

فريق عمل منظمة الصحة العالمية المعني بتحديد الأولويات البحثية بشأن العدالة في الصحة وفريق المنظمة المعني بتحقيق العدالة

على الرغم من التحسُّن الباهر في المؤشرات الصحية الإجمالية على مستوى العالم على مدى العقود القليلة الماضية، فلازال عبء الجور الصحي فيما بين البلدان وداخلها مستمراً، بل يزداد اتساعاً في العديد من الأقاليم والبلدان. وإن توصياتنا فيما يتعلق بالأولويات البحثية الخاصة بالإنصاف والعدالة الصحية ترتكز على تقييم المعلومات المطلوبة للحصول على فهم لكيفية خفض حالات الجور وعدم الإنصاف الصحي بشكل كبير. ونحن نوصي بإعطاء الأولوية القصوى للأبحاث في خمسة مجالات رئيسية هي:

1. العوامل والعمليات العالمية التي تؤثر على العدالة الصحية أو تعرقل الجهود التي تستطيع الدول عملها لمعالجة الجور الصحي داخل حدودها.
2. البنى والعلاقات الاجتماعية والسياسية التي تؤثر تأثيراً متفاوتاً على فرص الأفراد في أن يتمتعوا بصحة جيدة.
3. العلاقات المتبادلة بين العوامل المؤثرة على مستوى الأفراد وضمن السياق الاجتماعي لزيادة أو نقص احتمال تحقيق الصحة الجيدة والمحافظة عليها.
4. صفات نظام الرعاية الصحية الذي يؤثر على العدالة الصحية.
5. تدخلات سياسات فعَّالة لتخفيف وطأة الجور الصحي في المجالات الأربعة الأولى.

References

1. Global Strategy for Health for All by the Year 2000. Geneva: World Health Organization; 1981.
2. Targets for health for all. Copenhagen: World Health Organization Regional Office for Europe; 1985.
3. Health21 – Health for All in the 21st Century. Copenhagen: World Health Organization Regional Office for Europe; 1998.
4. Braveman P, Tarimo E, Creese A. Equity in health and health care: a WHO initiative. Geneva: World Health Organization; 1996. (WHO document WHO/ARA/96.1.)
5. The General Assembly. United Nations Millenium Declaration. (A/RES/55/2). New York; United Nations; 2000.
6. Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, editors. Challenging inequities in health: from ethics to action. New York: Oxford University Press; 2001.
7. EQUINET steering committee. Turning values into practice: Equity in Health in Southern Africa. Harare: Benaby Printers; 2000. (EQUINET Policy Series No.7.)
8. Braveman P, Gruskin S. Defining equity in health. J Epidemiol Community Health 2003 Apr;57(4):254-8.
9. McIntyre D, Gilson L. Putting equity in health back onto the social policy agenda: Experience from South Africa. Soc Sci Med 2002 Jun;54(11):1637-56.
10. Braveman P. Monitoring equity in health and health care: a conceptual framework. J Health Popul Nutr 2003 Sept;21(3):181-92.
11. Graham H, editor. Understanding health inequalities. Buckingham: Open University Press; 2000.
12. Starfield B. Basic concepts in population health and health care. J Epidemiol Community Health 2001 Jul; 55(7):452-4.
13. World health report. Geneva: World Health Organization; 2001.
14. Gilson L. Trust and development of health care as a social institution. Soc Sci Med 2003 Apr;56(7):1453-68.
15. Bates I, Fenton C, Gruber J, Lalloo D, Medina Lara A, Squire SB et al. Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease, part 1: determinants operating at individual and household level. Lancet Infect Dis 2004;4(5):267-77.
16. Bates I, Fenton C, Gruber J, Lalloo D, Medina Lara A, Squire SB et al. Vulnerability to malaria, tuberculosis, and HIV/AIDS infection and disease, part 2: determinants operating at environmental and institutional level. Lancet Infect Dis 2004;4(6):368-75.
17. Saracci R, Olsen J, McMichael A. Europe's health research: getting the right balance. BMJ 1998;316:795.
18. Diderichsen F, Evans T, Whitehead M. The social basis of disparities in health. In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, editors. Challenging inequities in health: from ethics to action. New York: Oxford University Press; 2001.
19. Benzeval M, Judge K, Whitehead M, editors. Tackling inequalities in health: an agenda of action. London: King's Fund; 1995.
20. Östlin P, Sen G, George A. 2004. Paying attention to gender and poverty in health research: content and process issues. Bull World Health Organ 2004;82(10);740-5.
21. Dollar D, Kraay A. Growth is good for the poor. Washington, DC: World Bank; 2000.
22. Wade RH. Globalisation, poverty and income distribution: does the liberal argument hold? In Gruen D, O'Brien T, Lawson J, editors. Globalisation, living standards and inequality: Recent Progress and Continuing Challenges. Camberra: Reserve Bank of Australia; 2000:37-65.
23. Deaton A. Health in an age of globalization. Washington, DC: Brookings Institution; 2004.
24. Cornia GA. Globalization and health: results and options. Bull World Health Organ 2001;79(9):834-41.
25. Muroyi R, Tayob R, Loewenson R. Trade protocols and health: issues for health equity in Southern Africa. EQUINET/GEGA/SADC Parliamentary Forum Regional Meeting on Parliamentary Alliances for Equity in Health South Africa, August 2003 EQUINET Discussion Paper 17, 2003. Available from: URL: www.EQUINETafrica.org
26. Labonte R, Schrecker T, Sanders D, Meeus W. Fatal indifference: The G8, Africa and global health. Cape Town: University of Cape Town Press; 2004.
27. Padrath A, Chamberlain C, McCoy D, Ntuli A, Rowson M, Loewenson R. Equity in health personnel distribution in Southern Africa. Harare: Benaby Printers; 2003. (EQUINET discussion document 4.)
28. Chen CL, Berlinguer G. health equity in a globalizing world. In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, editors. Challenging inequities in health : from ethics to action. New York: Oxford University Press; 2001.
29. Lehto J, Ritsatakis A. Health impact assessment as a tool for intersectoral health policy. Brussels: European Centre for Health Policy/WHO Regional Office for Europe; 1999.
30. Whitehead M, Burström B, Diderichsen F. Social policies and the pathways to inequalities in health. A comparative analysis of lone mothers in Britain and Sweden. Soc Sci Med 2000;50(2):255-70.
31. Basu S. Aids, empire, and public health behaviourism. Equinet-newsletter, August 2003 Harare: EQUINET.
32. Dean K. Integrating theory and methods in population health research. In: Dean K, editor. Population health research: linking theory and methods. Thousands Oaks, California: Sage; 1993.
33. Waitzkin H, Iriart C, Estrada A, Lamadrid S. Social medicine in Latin America: productivity and dangers facing the major national groups. Lancet 2001;358(9278):315-23.
34. Almeida-Filho N, Kawachi I, Filho AP, Dachs N. Research on health inequalities in Latin America and the Caribbean: Bibliometric analysis (1971-2000) and descriptive content analysis (1971-1995). American J Publ Health 2003 Dec 93(12):2037-43.
35. Mackenbach, J, Bakker MJ, Kunst AE, Diderichson F. Socioeconomic inequalities in health in Europe: an overview. In: Mackenbach JP, Bakker MJ, editors. Reducing inequalities in health: a European perspective. London: Routledge; 2002.
36. Standing H. Frameworks for understanding health sector reform. In: Sen G, George A, Östlin P, editors. Engendering international health: the challenge of equity. Cambridge MA: MIT Press; 2002.
37. Gilson L . In defence and pursuit of equity. Soc Sci Med 1998;47(12): 1891-6.
38. Bangser M. Policy environments: macroeconomics, programming, and participation. In: Sen G, George A, Östlin P, editors. Engendering international health: the challenge of equity. Cambridge, MA: MIT Press; 2002.
39. Kutzin J. Experience with organizational and financing reform of the health sector. Geneva: World Health Organization; 1995. (Current concerns SHS paper 8, SHS/CC/94.3.)
40. Gijsbers Van Wijk CMT, Kolk AM, van den Bosch WJ, van den Hoogen HJ. Male and female health problems in general practice: The differential impact of social position and social roles. Soc Sci Med 1995;40(5):597-611.
41. Hanson K. Measuring up: gender, burden of disease, and priority setting. In: Sen G, George A, Östlin P, editors. Engendering international health: the challenge of equity. Cambridge, MA: MIT Press; 2002.
42. Griffin DC. Welfare gains from user charges for government health services. Health Policy Plan 1992 Jun;7(2):177-180.
43. Russell S, Gilson L. User fee policies to promote health service access for the poor: a wolf in sheep's clothing? Int J Health Serv 1997;27(2):359-79.
44. Pannarunothai S, Mills A. The poor pay more: health-related inequality in Thailand. Soc Sci Med 1997;44(12):1781-90.
45. Sen G, Iyer A, George A. Class, gender, and health equity: lessons from liberalizing India. In: Sen G, George A, Östlin P, editors. Engendering international health: the challenge of equity. Cambridge: MIT Press; 2002.
46. Whitehead M, Dahlgren G, Evans T. Equity and health sector reforms: can low-income countries escape the medical poverty trap? Lancet 2001;358(9284);833-6.
47. Standing H. Understanding the 'demand side' in service delivery. Definition, frameworks and tools. London: UK Department of International Development; 2004.
48. Aitken JM, Kemp J. HIV/AIDS, equity and health sector personnel in Southern Africa. In: Loewenson R, Thompson C, editors. EQUINET Discussion Paper Number 12. Harare: EQUINET and Oxfam GB; 2003.
49. Petticrew M, Whitehead M, Macintyre S, Graham H, Egan M. Evidence for public health policy on inequalities. 1: the reality according to policymakers. J Epidemiol Community Health 2004;58(10):811-6.
50. Howden-Chapman P. Housing standards: a glossary of housing and health. J Epidemiol Community Health, 2004;58(3):162-8.