

10 best resources on . . . health equity

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An astute bureaucratic pundit named Rufus Miles once observed that ‘where you stand depends on where you sit’ (Miles 1978). This ‘Miles Law’ deserves to be kept centrally in mind when considering not only traditional bureaucratic behaviour, but also health equity; for one’s judgment about what’s ‘best’ in the health equity area is unavoidably shaped by his/her institutional experience, background and interests.

Rather than challenge such an unfortunately well-established reality, better for an author to admit at the outset just where (s)he has sat. This author must accordingly confess to having long sat at operationally-oriented external assistance agencies rather than at academic institutions. The consequence has been a preference for pieces that, in the tradition of this journal, can help shape health policy and planning; rather than for the many valuable but more abstract or technical readings on health equity that deal with basic concepts or advanced statistics. It further reflects the technocratic outlook, and orientation toward the economic dimensions of equity that comes from having long been associated with one particular institution, the World Bank; rather than the more explicitly ethical outlook of someone sitting at, say, an activist non-governmental organization more obviously concerned with social justice.

However, not even the most unacademic or technocratic observer of the health equity scene can deny completely the relevance of basic concepts. For instance, one really does need to understand the meaning of the term ‘health equity’ before getting too far into a discussion of it. For this, one obvious source would be the many excellent equity writings of Nobel Laureate economist-philosopher Amartya Sen, such as his recent keynote address to the International Health Economics Association that deals directly with health equity issues (Sen 2002). But for practitioners, there’s another piece that stands out for its unusually accessible explanation. This is **The concepts and principles of equity in health**, by Margaret Whitehead, which appeared in 1992. It is perhaps best known for putting forth and explaining what remains the standard working definition of health equity: ‘differences in health that are not only unnecessary and avoidable, but in addition unfair and unjust.’ Many have since elaborated on this basic theme (Kawachi *et al.* 2002; Braveman 2006; Starfield 2006; Loewenson undated) and Whitehead has herself recently produced an update that well deserves reading (Whitehead and Dahlgren 2006). But such efforts can be more persuasively

described as refinements to rather than as significant departures from the original Whitehead definition.

Another important, conceptually-oriented reading from the 1990s is one that has not yet been written. Rather, it exists as brief sections of several papers and presentations by Timothy Evans and Hilary Brown, usually titled something like **PROGRESS**. This is an acronym, with each letter standing for one of the several dimensions of health inequality that the authors consider important: inequality by **p**lace of residence, by **r**ace, by **o**ccupation, by **g**ender, by religion, by **e**ducation, by **s**ocio-economic status, and by **s**ocial capital. Much further development will be required before this or any other list can be considered definitive. But even in its present, rudimentary form, it has attracted a significant following in organizations like the International Clinical Epidemiology Network (WHO 2004), the Cochrane Collaboration (Tugwell *et al.* 2006; Doull *et al.* 2007a,b) and elsewhere (Chowdhury 2005), whose members regularly cite it as an important reminder that health equity has many significant dimensions beyond the gender and economic ones that have come to dominate the literature.

A further piece from the last century is arguably still the best when it comes to the thorny question of measuring the health inequalities that are centrally important to equity. This is the 1991 article **On the measurement of inequalities in health**, by Adam Wagstaff, Pierella Paci and Eddy van Doorslaer. It is of value particularly for its unusually lucid – so lucid that most of it can be understood even by non-statisticians – discussion of the several statistical measures most commonly used to measure inequalities in health, especially with respect to economic status. At least equally important is its presentation of a measure known as the concentration index, which has risen to prominence over the years since, and to some significant degree because of, the article’s appearance. [For those sceptical of anything so ancient, a solid more recent piece that includes a somewhat larger set of measures is ‘Measuring Disparities in Health’, by Anand *et al.* (2001).]

Measuring inequalities and inequities is one thing; explaining them is another. Those looking for plausible explanations of levels and trends in inequalities will want to consult the well-known 2000 piece by Cesar Victora and his colleagues on **Explaining trends in inequities: evidence from Brazilian child health studies**. In it, the authors develop and illustrate the operation of what they call the ‘inverse equity hypothesis’. According to this thesis, ‘...new interventions will initially reach those of higher socioeconomic status and only later

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affect the poor. This results in an early increase in the inequity ratios for coverage, morbidity and mortality indicators, followed later by a reduction when the poor gain greater access to the interventions and the rich reach minimum achievable levels for morbidity and mortality beyond which there are unlikely to be substantial further improvements.’ This thesis, recognizable as the epidemiological variant of the famous ‘Kuznets hypothesis’ concerning trends in income distribution with economic growth (Kuznets 1955), is presented as an offspring of an earlier, equally important health equity theory known as the ‘inverse care law’, which maintains that ‘the availability of good health care tends to vary inversely with the need for it in the population served’ (Tudor Hart 1971).

Another reading that is valuable in part because of its explanation of the reasons for inequalities is Michael Marmot’s **Health in an unequal world**. A significant portion of Marmot’s wide-ranging presentation is devoted to an articulate presentation of the argument for which he has become well known: that poor health among disadvantaged groups results not just from lack of material resources (food, housing, water, etc.) but also from such psychological factors as lack of empowerment. Earlier, Marmot had identified such psychological factors as a principal source of the surprising class gradient in health he had found among British civil servants, none of whom were lacking in the basic material resources required for good health. Now, he has cautiously extended it to poor countries as well, suggesting the possibility that psychological as well as material factors contribute to the social and economic gradients found there. Aside from the inherent interest of this dual-cause explanatory model, it is also noteworthy as the framework adopted by the World Health Organization (WHO) Commission on the Social Determinants of Health,¹ chaired by Marmot, whose report is due out next year. But this is not all: Marmot’s piece is equally worth reading for the clear and up-to-date review of global- and country-level health inequalities that it contains.

Turning from the general to the specific, one quickly comes to the dimension of health inequity that has perhaps attracted the most attention: namely, gender. At the top of the mountain of available readings on this topic is the overview piece **Gender, inequity, and health: the intersections**, by Piroška Östlin, Asha George and Gita Sen. It is in two parts: the first articulately summarizing the evidence on gender inequities in health; the second discussing the policies available to reduce those inequities. Of particular interest, at least to empirically-oriented readers, is the former, which deals with a range of fascinating as well as important issues, such as the conundrum of women’s simultaneously greater longevity and poorer health. (An added plus: the reading constitutes part of an important volume on health equity that contains other chapters of interest, such as the Anand *et al.* reading referred to above.)

If gender is losing its lead as the most frequently studied dimension of health inequity, it is in no small part because of the methodological finding reported in **Estimating wealth effects without expenditure data – or tears: an application to educational enrollments in States of India**, by economists Deon Filmer and Lant Pritchett. Simply stated,

the finding is that household assets are closely enough related to household consumption/expenditures for the former to serve as a reasonable proxy for the latter. This had two important consequences. The first is that it has allowed distributional analyses of many important household data sets, such as those described in the next section, which contain information about assets but not consumption or expenditures. Second, since information about household assets is far simpler to collect than data on consumption/expenditures, the finding has made it feasible to add an economic equity dimension to future health surveys. In brief, the seemingly daunting task of measuring household economic status has suddenly become manageable; and the result has been a sharp rise in the number of studies reporting on health inequities across economic classes.

Among the extant household health data sets that have been analyzed using techniques based on the Filmer-Pritchett approach are ones collected by the USAID-supported Demographic and Health Survey (DHS) programme, the UNICEF multiple indicator cluster surveys (MICS), and the WHO World Health Surveys (WHO/WHS). Which of these should be considered ‘best’ is probably a matter of taste and the type of health issue in which one is interested (since the three data sets cover somewhat different issues). The most fully documented of the three is a set of 56 country studies, covering 100+ health indicators in each, based on DHS data, and undertaken cooperatively by the World Bank and the DHS secretariat. These have appeared under the title of **Socio-economic differences in health, nutrition, and population** by Davidson R Gwatkin and colleagues, and are available in electronic form from the World Bank poverty/health website² or (while supplies last) as hard copies upon request via that site. Tables containing economic and other equity-relevant breakdowns from the other two data sets are also available electronically, at the UNICEF/MICS site³ and WHO/WHS site.⁴

While analyses based on data sets like these can be quite useful for identifying previously unrecognized health inequities, they are of only limited help in finding remedies to them. Perhaps the most ambitious attempt to move beyond identification to remedy, at least in the hopeful eyes of its organizers, is a recent project titled **Reaching the poor with health, nutrition, and population services: what works, what doesn’t and why**, coordinated by Davidson R Gwatkin, Adam Wagstaff and Abdo S Yazbeck. The project constitutes an effort to apply to health a modified version of an assessment technique called benefit-incidence analysis. This technique, originally developed by public finance economists, is the equity analogue of cost-effective analysis for efficiency. (For example, cost-effectiveness analysis is oriented toward determining, say, how many immunizations one can get for a given amount of money; benefit-incidence analysis is concerned with measuring how a given number of immunizations is distributed across groups in society.) At the project’s core is a large number of case studies presented at the project’s 2004 conference, published in the volume that constitutes the project’s principal report, and/or available on the project website. Among the project’s limitations, at least in the eyes of some, must be counted its narrow, technocratic focus on specific health projects/policy measures, and corresponding

lack of concern with such larger issues of political economy that are arguably more important for dealing with health inequities.

While the Reaching the Poor studies point to ways of lessening health inequalities by helping the poor achieve better health, they and the other readings thus far cited largely ignore another important equity need: preventing the increased poverty to which poor health can lead through high household health expenditures for catastrophic illness. The nature and magnitude of the challenge is well outlined in **What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts?** by Diane McIntyre and colleagues. They deal with issues that have recently risen to the fore with increasing awareness of the prominence of regressive out-of-pocket payments for health in many poor countries; and with the highly controversial advocacy of such payments (especially user fees at government facilities) by external assistance agencies like the World Bank. Of particular interest are the readings' central sections that explain the approaches taken by researchers in this area, summarize their findings thus far, and carefully note the several important limitations in the approaches taken and the resulting need for care in interpreting the findings.

Happy reading!

Resources

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8. Gwatkin DR, Rutstein S, Johnson K *et al.* 2007. *Socio-economic differences in health, nutrition, and population*. Washington, DC: The World Bank.

9. Gwatkin DR, Wagstaff A, Yazbeck A (eds). 2005. *Reaching the poor with health, nutrition, and population services: what works, what doesn't, and why*. Washington, DC: The World Bank.
10. McIntyre D, Thiede M, Dahlgren G, Whitehead M. 2006. What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts? *Social Science and Medicine* **62**: 858–65.

Endnotes

- ¹ Website: http://www.who.int/social_determinants/en/, accessed 5 March 2007.
- ² Website: <http://www.worldbank.org/povertyandhealth>, accessed 7 March 2007.
- ³ Website: <http://www.childinfo.org/MICS2/natlMICSrepz/MICSnatrep.htm>, accessed 7 March 2007.
- ⁴ Website: <http://www.who.int/healthinfo/survey/en/index.html>, accessed 7 March 2007.

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