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Social inequalities in health within countries: not only an issue for affluent nations

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Abstract

While interest in social disparities in health within affluent nations has been growing, discussion of equity in health with regard to low- and middle-income countries has generally focused on north–south and *between*-country differences, rather than on gaps between social groups *within* the countries where most of the world's population lives. This paper aims to articulate a rationale for focusing on within- as well as between-country health disparities in nations of all per capita income levels, and to suggest relevant reference material, particularly for developing country researchers. Routine health information can obscure large inter-group disparities within a country. While appropriately disaggregated routine information is lacking, evidence from special studies reveals significant and in many cases widening disparities in health among more and less privileged social groups within low- and middle- as well as high-income countries; avoidable disparities are observed not only across socioeconomic groups but also by gender, ethnicity, and other markers of underlying social disadvantage. Globally, economic inequalities are widening and, where relevant information is available, generally accompanied by widening or stagnant health inequalities. Related global economic trends, including pressures to cut social spending and compete in global markets, are making it especially difficult for lower-income countries to implement and sustain equitable policies. For all of these reasons, explicit concerns about equity in health and its determinants need to be placed higher on the policy and research agendas of both international and national organizations in low-, middle-, and high-income countries. International agencies can strengthen or undermine national efforts to achieve greater equity. The Primary Health Care strategy is at least as relevant today as it was two decades ago; but equity needs to move from being largely implicit to becoming an explicit component of the strategy, and progress toward greater equity must be carefully monitored in countries of all *per capita* income levels. Particularly in the context of an increasingly globalized world, improvements in health for privileged groups should suggest what could, with political will, be possible for all.

Keywords: Equity; Social inequalities in health; Developing countries

Background: wide and widening health inequalities within low- and middle- as well as high-income countries

Over the past decade, there has been a growing body of research and commentary on socioeconomic inequalities in health in western Europe and the United States (Bartley, Blane, & Montgomery, 1997; Braveman, Oliva, Reiter, & Egerter, 1989; Braveman, Egerter, & Marchi, 1999; Gilson, 1998; Kaplan, Pamuk, Lynch, Cohen, & Balfour, 1996; Kennedy, Kawachi, & Prothrow-Stith,

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1996; Krieger, Williams, & Moss, 1996; Kunst & Mackenbach, 1994; Lynch, Everson, Kaplan, Salonen, & Salonen, 1998; Mackenbach & Gunning-Schepers, 1997; Macintyre et al., 1989; Macintyre, 1997; Marmot et al., 1991; Marmot, Ryff, Bumpass, Shipley, & Marks, 1997; Pamuk, Makuc, Heck, Reuban, & Lochner, 1998; Pappas, Queen, Hadden, & Fisher, 1993; Roberts, 1997; Smith, Bartley, & Blane, 1990; Smith, 1997; Townsend, 1990, 1994; Wagstaff, 1992; Wilkinson, 1992a, b; World Health Organization Regional Office for Europe, 1994). Gender disparities also have received increasing consideration in affluent countries (Council on Ethical and Judicial Affairs, 1991; Arber & Cooper, 1999; Dunnell, Fitzpatrick, & Bunting, 1999; Fuhrer, Stansfeld, Chemali, & Shipley, 1999); scholars have pointed out the complexity of interpreting many of the observed gender differences (Macintyre, Hunt, & Sweeting, 1996) and emphasized the importance of examining how socially constructed gender roles and gender inequalities may adversely affect the health of men as well as women (Hunt & Annandale, 1999; Kawachi, Kennedy, Gupta, & Prothrow-Stith, 1999). Racial/ethnic disparities in health and health care in the US have been routinely monitored and discussed for decades (Braveman et al., 1989; Braveman, Egerter, Edmonston, & Verdon, 1994; Breslow & Klein, 1971; Council on Ethical and Judicial Affairs, 1990; Kochanek, Maurer, & Rosenberg, 1994; Maynard, Fisher, Passamani, & Pullum, 1986; Montgomery, Kiely, & Pappas, 1996; Schulman et al., 1999; United States Department of Health and Human Services, 1985; Wenneker & Epstein, 1989; Winkleby, Robinson, Sundquist, & Kraemer, 1999; Yergan, Flood, LoGerfo, & Diehr, 1987). Many scholars have pointed out the need to consider the extent to which the disparities were due to socioeconomic rather than to racial/ethnic factors per se (Bassett & Krieger, 1986; Kaufman, Cooper, & McGee, 1997; Keil, Sutherland, Knapp, & Tyroler, 1992; Muntaner, Nieto, & O'Campo, 1997; Navarro, 1990; Smith et al., 1998a; Terris, 1973; Williams, 1994; Williams, Lavizzo-Mourey, & Warren, 1994), which is made difficult by the lack of information adequately characterizing socioeconomic status/position in most US data sources. By contrast, discourse and documentation on health disparities affecting the populations of low- and middle-income countries, where two-thirds of the world's population resides (World Health Organization, 1998), have most often been limited to north–south and *between*-country differences (World Health Organization, 1995a; World Health Organization, 1998). Relatively little information is routinely available on health status or health care disparities between better- and worse-off groups *within* most countries, and particularly on how within-country social disparities may change over time.

While routine data on within-country health disparities are scarce, special studies have revealed ample evidence that wide gaps in health and health care among different socioeconomic groups within a country are not confined to the affluent nations (Bicego & Boerma, 1993; Breilh, Granda, Campana, & Betancourt, 1987; Cleland & van Ginneken, 1988; Cleland, Bicego, & Fegan, 1992; Evans, Whitehead, Diderichsen, Bhuyia, & Wirth, 2001; Gwatkin, Rutstein, Johnson, Pande, & Wagstaff, 2000; OPS/OMS, 1999; United Nations Development Programme, 1990, 1996a, b; Victora, Barros, Huttly, Teixeira, & Vaughan, 1992; World Bank, 1993; Suarez-Berenguela, 2000). In Venezuela, for example, poorer municipalities have had infant mortality rates three times higher than those in other municipalities (Pan American Sanitary Bureau/United Nations Economic Commission for Latin America and the Caribbean, 1994) and a 1992 study revealed low birthweight rates twice as high in the poorest compared with the most affluent neighborhoods of a city (OPS/OMS, 1999). In a state of Mexico, a 9-year difference in life expectancy was recently observed between people living in a poor county and those in a relatively well-off county (Evans et al., 2001). Marked differentials in child mortality have been demonstrated according to a range of socioeconomic factors in Ghana, Kenya, Lesotho, Liberia, Nigeria, Sierra Leone, Sudan, Indonesia, Nepal, Republic of Korea, Sri Lanka, Thailand, Chile, Jamaica (United Nations, 1985), Costa Rica, Honduras, Paraguay, and Jordan (United Nations, 1991), Peru (OPS/OMS, 1999; Valdivia, 2001), and Brazil (Victora & Barros, 2001; OPS/OMS, 1999). Adults in non-professional jobs in Sao Paulo, Brazil, during the late 1980s had death rates that were two to three times higher than those of professionals (World Bank, 1993). In Bolivia, most public spending on health services has gone toward care for people belonging to the upper 40% of income groups (Unidad de Analises de Politicas Sociales, 1993). In Indonesia during 1990, only 12% of public spending for health care was for services consumed by the poorest 20% of households, who would be expected both to need more health services because of poverty's role in illness and to be less able to pay for health care in the private sector; the wealthiest 20% of households consumed 29% of the government subsidy in the health sector (World Bank, 1993). In the Dominican Republic in 1996, the poorest quintile of the population paid 20% of their income for health care while the richest quintile paid less than 10% (OPS/OMS, 1999). None of these disparities would have been revealed by data routinely collected and analyzed.

Striking gender disparities in health and/or health care have been observed outside the industrialized countries, again generally only as a result of special studies (Standing, 1997). A study in India showed that female infants 1–23 months of age were almost twice as likely to die by the age of two as were males, and concluded that the most likely explanation was different

behavior of families toward male and female children rather than biological differences (Das Gupta, 1987). A United Nations agency report concluded that the death of one out of every 6 female infants in India, Bangladesh, and Pakistan was due to neglect and discrimination (United Nations Population Fund, 1989). Studies in Bangladesh found that boys under 5 years of age were given 16% more food than girls (United Nations, 1993). In some countries, surveys indicate that families are significantly more likely to immunize their male children (Kurz & Johnson-Welch, 1997; Martineau, White, & Bhopal, 1997; Sommerfelt & Piani, 1997). Examples of bias against girls in access to modern health services have been cited from Korea, Togo, Sierra Leone, Nigeria, Jordan, Algeria, Syria, and Egypt (Kutzin, 1993). A recent study in Chile found that women paid more for health care in both the public and private sectors because co-payments/uncovered expenses were greater for many reproductive health services used only by women but affecting the health of the entire society (Vega, Bedregal, & Jadue, 2001).

Racial/ethnic disparities in health and its determinants also have been observed within countries of diverse per capita income levels. In Guatemala, malnutrition rates during the 1980s were 40% higher among indigenous compared with non-indigenous children (Psacharopoulos, Morley, Fiszbein, Haeduck, & Wood, 1993). Studies of child mortality have demonstrated ethnic disparities within Peru, Sri Lanka, Thailand, and many African countries that persist even after control for other factors including some measures of socioeconomic status (United Nations, 1985). Until recently, more than four times as much money was spent on health care for whites as for blacks in South Africa (Yach & Harrison, 1995); reversing the health effects of apartheid is unlikely to be an easy or rapid process (Benatar, 1997). The likelihood of a child dying before reaching age two varied between ethnic groups in Kenya from 7.4% to 19.7%, and in Cameroon from 11.6% to 20.5% (World Bank, 1993).

In contrast with the lack of routine data on socioeconomic, gender, and ethnic disparities in health, urban–rural disparities and disparities between large subnational regions of developing countries are often relatively well documented on a routine basis. In Nigeria, the average life expectancy in the Borno region is only 40 years, 18 years less than in the Bendel region; adult literacy (12%) in Borno is one-quarter of the national average (United Nations Development Programme, 1994). In Peru, the infant mortality rate in some rural areas was recently estimated at 150 per 1000 live births, while in the capital city Lima it was 50 per 1000 (Pan American Sanitary Bureau/United Nations Economic Commission for Latin America and the Caribbean, 1994). Urban–rural gaps may be widening in many nations, along with disparities between different zones within the same city. For example, in Latin America between 1980 and 1994, the proportion of urban dwellers who were poor increased from 25% to 34%; the urban poor are now thought to make up the greatest segment of desperately poor people in the region (OPS/OMS, 1999).

What is equity in health?

Equity is an ethical concept that is as challenging to define precisely as its near-synonym *social justice*, which may mean different things to different people in different societies at different times. *Inequity* refers not to all inequalities, but to those inequalities that are considered unfair and avoidable (Whitehead, 1990). *Equity* implies that need rather than privilege be considered in the allocation of resources; as with *equity* and *fairness,* it is difficult to define *need* in precise terms (Mays, 1995; National Health Service Management Board, 1988). In operational terms, pursuing equity in health can be understood to mean striving to reduce avoidable disparities in physical and psychological well-being—and in the determinants of that well-being—that are systematically observed between groups of people with different levels of underlying social privilege, i.e., wealth, power, or prestige. The fact that an avoidable health disparity adversely affects a group at an underlying social disadvantage makes that disparity unfair, even in the absence of knowledge of the specific proximate causes of the disparity. In virtually every society in the world, social privilege varies among groups of people categorized not only by economic resources but also by gender, by geographic location, by ethnic or religious differences, and by age; other dimensions can be important as well, but these are nearly universal and they often interact with each other to make some groups—e.g., poor women in ethnic minority groups—particularly disadvantaged with respect to opportunities to be healthy.

Assessing health equity within a society requires examining inequalities in health (and in its determinants) between more and less socially advantaged groups within the society, focusing for practical reasons on those inequalities likely to be among the most important causes of ill health and also to be relatively avoidable. Thus, a rational focus on equity would lead one to prioritize the goal of trying to diminish gaps in ill health due to, for example, diarrheal disease, malnutrition, or adverse environmental exposures that disproportionately and significantly affect disadvantaged groups; by contrast, less emphasis would be placed on searching for cures for rare genetic conditions that affect one ethnic group more than another, even though one might believe that ultimately all genetic conditions will be curable or preventable. It would make little sense from

an equity perspective to focus attention on reducing the widespread but genetically based gap in birth weight between male and female newborns, because it is unlikely to be a major source of subsequent health inequality, avoidable, or related to underlying differences in social advantage.

- "Social inequalities in health" or "health inequities" refer to avoidable disparities in health or its key determinants that are systematically observed between groups of people with different levels of underlying social privilege, i.e., wealth, power, or advantage.
- Virtually everywhere, social privilege varies not only by economic resources, but also by gender, racial or ethnic group, geographic location, and other characteristics.
- Equity implies consideration of need rather than social privilege in resource allocation.
- Assessing health equity requires examining avoidable disparities in health (and its determinants) between more and less socially advantaged groups.

For some, a commitment to equity in health means that all social groups should have a basic minimum level of well-being and services, but that at the same time it is acceptable for some social groups to have better health status or health care than others, as long as government does not pay directly or indirectly for the additional benefits. There may be substantial disagreement about what constitutes "minimum" levels of health and health care; implications would be quite different if "minimum" standards meant good, borderline, or poor levels (Jayasinghe, De Silva, Mendis, & Lie, 1998). Because health and health care are not commodities like furniture or automobiles, most people who promote an egalitarian perspective would contend that equity requires the reduction of all avoidable disparities that significantly shape opportunities to be healthy, not only ensuring a minimum standard for all (Gilson, 1998; World Health Organization, 1996).

Why care about equity—in general or in health in particular?

Evidence is accumulating in industrialized countries of a relationship between the magnitude of socioeconomic inequalities and poor health that cannot be explained by differences in absolute levels of income or poverty (Lynch et al., 1998; Kaplan et al., 1996; Kawachi & Kennedy, 1997; Kennedy et al., 1996; Kennedy, Kawachi, Glass, & Prothrow-Stith, 1998; Smith, 1996; Wilkinson, 1992a, b, 1996, 1997). Some researchers have raised methodologic concerns about this observed relationship, however (Deaton, 1999; Fiscella & Franks, 1997; Judge, 1995). Living in an inequitable society could harm health through many economic, social, psychological, and physiological pathways (Adler et al., 1994; Kaplan et al., 1996; Marmot et al., 1997). Income disparities may be linked with deleterious health effects in large part in so far as they reflect varying degrees of investment in human development, e.g., in public education, health care, or other social services (Kaplan et al., 1996; Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997; Kennedy et al., 1996; Lynch & Kaplan, 1997; Smith, 1996), rather than through a direct causal link. Some scholars believe that income disparities may have deleterious effects on health through their association with the degree of social cohesion (Kawachi & Kennedy, 1997; Kawachi et al., 1997; Wilkinson, 1997) and/or through physiologic effects of relative deprivation on those at the bottom of the social hierarchy (Wilkinson, 1997).

Some have argued for greater equity on pragmatic grounds. The United Nations Development Programme's (UNDP) Regional Director for Latin America and the Caribbean recently stated: "In our part of the world there is a consensus that reducing social inequity is not only an ethical, but also a political and economic imperative. Equity is good business." (United Nations Development Programme, 1996a) When he was head of the World Bank, Robert McNamara stated that the "pursuit of growth and financial adjustment without a reasonable concern for equity is ultimately socially destabilizing". (World Health Organization, 1995a) Soaring crime rates in Latin America in recent years have been attributed to failure to consider the effects of uncontrolled free-market reforms on vulnerable social groups, along with the associated dismantling of many state institutions (Anonymous, 1996). A recent article in The Economist (2001) urges governments and the rich to take measures to limit and buffer the effects of economic inequality in order to avoid social conflict.

Other pragmatic arguments for equity in health and health care may appeal to the self-interest of privileged groups, for example with respect to avoiding spill-over effects of poor health among the disadvantaged. Given contemporary population density and mobility, neglect of infectious disease control jeopardizes the health of the more affluent as well as that of the poor who provide services for them in their homes, shops, and restaurants. Similarly, spending on public health measures such as immunizations and control of highly infectious diseases among high-risk groups may even yield relatively short-term savings in prevention of epidemics. Failure to address geographic disparities in quality of care can lead to additional costs for the public sector in the short run; for example, when primary care services of adequate quality and convenience are not available near poor neighborhoods, many people will seek primary care at public sector sites such as hospital emergency rooms and

specialty-oriented outpatient clinics where such services are more costly to deliver.

Some pragmatic economic arguments for equity in health and health care are based on achieving greater long-term economic capacity and real productivity, which must be distinguished from short-term efficiencies. The WHO position paper for the 1995 World Summit for Social Development stated that "investment in health is essential for economic growth based on a productive workforce. To achieve this, growth needs to be accompanied by more equitable access to the benefits of development, as inequities have severe health consequences and pose an unacceptable threat to human well-being and security" (World Health Organization, 1995b). For example, malnutrition and poor health decrease worker productivity (Cornia, Jolly, & Stewart, 1987; World Bank, 1993). Similarly, the education of girls and women has been linked with improved child nutrition, decreased infant mortality, and lower pregnancy rates (Bansal, 1999; Cornia et al., 1987), all of which have been associated with economic growth. Poverty and lack of education are associated with high population growth rates which in turn make it far more difficult to alleviate poverty.

However, short-term gains in efficiency are more easily measurable than long-term societal progress; cost-effectiveness estimates are often based on outcomes measurable on a short-term basis. At times, the most rapid way to observe advances in indicators of overall growth may be to give more to those who already have the most and need the least; they are often best equipped to be immediately productive with a given additional input (Wagstaff, 1991). By leaving those in greater need continually further behind, however, this approach limits the capacity for long-term development of the society as a whole. Scientifically sound evidence of the aggregate "utility" of investing in equity may be lacking because the relevant information has not been collected or analyzed or because the impact may not be measurable in terms of the economic indicators being used, at least during the specified time frame. Nobel Prize-winning economist Amartya Sen has pointed out the importance of using health indicators themselves as indicators of development (Sen, 1993). The traditional economic measures of income or commodities need to be seen as instruments toward the end of human well-being itself, rather than as ends in themselves (Sen, 1998).

Global pressures are making it difficult for countries of every income level to achieve greater equity in health

In the face of powerful global economic, social, and political trends, many countries are finding it difficult to implement and sustain equity-promoting policies in sectors with major influences on health. Recent UNDP Human Development Reports have noted widening income inequalities in many countries, including Argentina, Bolivia, Brazil, Peru, Venezuela, Bangladesh, Thailand, Bulgaria, the Czech Republic, the Baltic States, Australia, the United Kingdom, and the United States of America (United Nations Development Programme, 1996b). In Latin America, absolute numbers of people living in poverty have increased markedly since 1980 and the proportion of people living in poverty has been stagnant overall (Anonymous, 1996; OPS/OMS, 1999) and increasing in some countries, such as Mexico (United Nations Development Programme, 1997). A recent Pan American Health Organization report (OPS/OMS, 1999) stated that in 1995, purchasing power parity was 417 times greater among the richest 1% of the population of Latin America than among the poorest 1%, which was the highest ratio in recorded history, and that it probably has worsened since (OPS/OMS, 1999).

While trends over time in disparities in *wealth* are relatively well documented on a routine basis, few countries have routinely collected data that permit examination of time trends in socioeconomic disparities in *health*. However, widening socioeconomic disparities in health status have been demonstrated in a number of industrialized countries. The *Black Report* on social inequalities in health in England showed that disparities in death rates between employed men who worked in the highest and lowest occupational class jobs widened consistently from 1949 to 1970 (Black, Morris, Smith, & Townsend, 1980). In addition to the widening gap between socioeconomic groups as reflected by occupational classes, death rates of unskilled workers in certain age groups rose in absolute terms during the 1960s (Gray, 1982) and 1970s (Marmot & McDowall, 1986; Harding, 1995). These trends accompanied widening income inequalities and occurred despite a serious commitment to equity in health services by the National Health Service (Smith et al., 1990). Since then, the health gap between social classes has persisted (Marmot et al., 1991) or widened (Scott-Samuel, 1997; Smith, 1997; Acheson et al., 1998), while income inequalities are "spiralling out of control" in Britain (Lewis et al., 1998; Townsend, 1994).

Markedly widening inequalities in income in the United States (Pamuk et al., 1998; United States Bureau of the Census, 1996) also have been accompanied by increases in socioeconomic disparities in various health measures. Socioeconomic disparities in US infant mortality rates widened significantly from 1964 to 1987–1988 (Singh & Yu, 1995). The association between poverty and fair or poor child health status also appeared to increase between around 1980 and around 1990 (Montgomery et al., 1996). Increases have been observed over time in the proportion of all adult deaths in the US that are likely to be due to poverty; some

studies have concluded that the relationship between mortality and socioeconomic status in the US has become stronger over time (Hahn et al., 1995; Pappas et al., 1993; Yeracaris & Kim, 1978), although apparently contradictory results also have been reported (Hahn et al., 1996). Comparable observations have been made in France and Hungary (Pappas et al., 1993) and in New South Wales, Australia (Burnley, 1998). While temporal association does not establish a causal relationship, it can suggest the need for further study and/or help confirm or disconfirm other evidence.

Even without data disaggregated by socioeconomic group, deteriorations in health measured at the aggregate level have been observed recently in some countries where income inequalities have widened and public service safety nets have been markedly reduced. Political and economic changes in Russia and throughout Eastern Europe have been accompanied by striking trends in health that are evident even in national averages. Between 1990 and 1994, life expectancy in Russia fell from 63.8 to 57.6 years among men and from 74.4 to 71.0 years among women (Leon et al., 1997). "According to the preliminary 1993 data available for several…Newly Independent States…, life expectancy dropped to the lowest levels seen for decades" (World Health Organization Regional Office for Europe, 1994). The specific direct or indirect role of income inequalities (exerting an effect through, for example, decreased social safety nets and/or decreased social cohesion), in contrast to heightened violence and alcoholism that could be related to social and political instability rather than to economic inequalities (Kaasik, Andersson, & Horte, 1998; Leon et al., 1997; Notzon et al., 1998; Walberg, McKee, Shkolnikov, Chenet, & Leon, 1998) cannot be confirmed. It appears likely that alcoholism played an important role; abandonment of a Gorbachev-era anti-alcohol campaign may have been key (Leon et al., 1997; Shkolnikov & Nemtsov, 1997). Some observers have thought that economic inequalities were likely to have had a substantial influence (Walberg et al., 1998). Similarly alarming trends are occurring in countries that historically placed a high priority on equity. For example, "as an unfortunate consequence of China's liberalization program of the past decade, government funding for public health has declined and the rural insurance system has now largely disintegrated. A recent study suggests that these new health policies have made the distribution of government spending for health in China more unequal and may be contributing to an increased incidence of easily treatable diseases such as tuberculosis" (Birdsall & Hecht, 1995).

The costs of foreign debt repayment and economic structural adjustment programs have resulted in cuts in social spending in many developing countries (Kanji, Kanji, & Manji, 1991; Lown, Bukachi, & Xavier, 1998; United Nations Children's Fund, 1991). These cuts have been widely associated with deteriorating conditions or a halting of previous trends toward improvements for vulnerable groups (Cornia et al., 1987; Jolly & Cornia, 1984; Kanji et al., 1991; Morales, 1993), although some have questioned whether that connection is causal or inevitable (Weil, Alicbusan, Wilson, Reich, & Bradley, 1990). In Zambia from 1980 to 1984, when implementation of that country's structural adjustment program was at its height, the proportion of hospital deaths attributed to malnutrition rose approximately 1.5- to 2-fold among children under age five (Kanji et al., 1991). Similarly, low birth weight rates in Nigeria almost doubled (from 7% to 13%) at a major hospital from 1984 to 1989 (Ibe, 1993). Women may suffer more than men from structural adjustment programs (Kanji et al., 1991; Jazairy, Alamir, & Panuccio, 1993).

The effects of structural adjustment programs may be difficult to distinguish from the effects of the economic crises that precipitated the imposition of structural changes in national economies. For example, during the early 1980s many countries experienced severe economic recessions that in themselves appeared to have demonstrable adverse effects on vulnerable populations, particularly children (Cornia et al., 1987; Jolly & Cornia, 1984). UNICEF (Jolly & Cornia, 1984) conducted a literature review and 11 case studies to study the effects of economic recession during the late 1970s and early 1980s in Italy, the US, and selected countries of Latin America, sub-Saharan Africa, and South Asia. The conclusion was that, in the face of global recession, "only in South Korea and Cuba—countries that have deliberately implemented policies to protect children and the poor even in times of relative economic adversity—have the broad trends towards improvement in child welfare continued almost unaffected" (Jolly & Cornia, 1984).

Regardless of the role of structural adjustment, real per capita public expenditures on health began to decrease in many countries during the late 1970s and that decline has continued. Accompanying the diminished investment,

> …the quality and quantity of public subsidized health services has fallen correspondingly. Utilization levels, particularly at rural health facilities, have declined. Outreach services no longer function, drugs are often unavailable, and health staff are unsupervised and sometimes unpaid for long periods of time. Rural populations have faced higher costs for health care in terms of transport and time to get to hospitals in larger towns, or by payments to private providers of treatment and medication. "Free" care has come to mean unacceptably poor care. (Creese & Kutzin, 1995)

In Sri Lanka, for example, "there are data which indicate that despite the state sector providing a health service at zero user charges, 40–50% of the health care costs are borne by the household". (Jayasinghe et al., 1998).

During the final decade of the 20th century most developing country governments implemented cost-sharing mechanisms such as user fees to help finance health services (Collins, Quick, Musau, Kraushaar, & Hussein, 1996), often with the expectation that this would result in improved quality as well as sustainability of public services (Adeyi, Lovelace, & Ringold, 1998; Creese & Kutzin, 1995). Despite acknowledging that "there clearly are inequitable consequences in many cases…", some maintain that "user fees and co-payments are not necessarily at odds with equity". (Adeyi et al., 1998) However, some economists who have reviewed the experience in many countries have concluded that overall, compared with obtaining revenues for health services from general progressive taxation, cost recovery in the health sector appears to be inherently inequitable as well as inefficient (Creese, 1990; Creese, 1997). Outside of very protected circumstances, user fees and exemption mechanisms have generally proven to be difficult to implement without letting the most vulnerable people suffer; furthermore, re-investing user fees in improved quality of local services has proven an elusive goal (Creese, 1990; Creese, 1997; McPake, 1993). The costs of determining eligibility for fee waivers often exceed the returns in fees collected. When user fees were increased in Swaziland, there was a marked decline at government facilities in use of basic health services by patients previously exempted for poverty, including services for diarrheal disease, sexually transmitted disease, and infant immunizations; utilization remained diminished one year later, and increases in utilization of non-governmental facilities did not compensate for the decline (Yoder, 1989). A study in Ghana's Volta region, where user fees were markedly increased around 1985, determined that during 1995, exemptions for inability to pay were granted in fewer than 1 in 1000 patient encounters, while 15–30% of the population were estimated to be poor; the authors concluded that fees "are preventing access… or are posing significant financial hardships…" on the most vulnerable segment of the population (Nyonator & Kutzin, 1998).

The World Health Organization's 1978 Alma Ata declaration on Primary Health Care voiced a global commitment to attaining health for all; however, that commitment to equity crystallized during a period of widespread economic growth. During the 1980s and since, economic recession has been experienced at some time virtually worldwide, along with the economic and political effects of globalization of the world's economy. Measures taken in industrialized and non-industrialized countries to increase competitiveness in the global economy, along with structural adjustment programs in developing countries, have led to diminished *per capita* social spending in most countries. Globally, there has been a down-sizing of government and a marked trend toward privatization of many functions formerly within the public domain. To varying degrees, many countries have experienced a shift from centrally planned and regulated to market-dominated economies. In addition, in many nations, military spending has increasingly devoured scarce resources that potentially would be available for social development.

Worldwide, including in lower-income countries, economic globalization appears to be yielding unprecedented increases in wealth for those individuals and population groups who are socially positioned to profit most and most rapidly from the economic opportunities presenting under competitive conditions (Greider, 1997; Kanji et al., 1991; Mander & Goldsmith, 1996). The justification for not interfering with this markedly accelerated "the rich-get-richer" tendency in lower-income countries is the belief that societies can break out of the vicious cycle of poverty and underdevelopment only by placing the highest priority on short-term efficiency and overall economic growth, at the expense of social spending. The reasoning is that when adequate rates of growth are achieved the benefits will "trickle down" to all; according to this perspective, too much emphasis on equity now will jeopardize economic growth and perpetuate poverty and deprivation.

However, considerable evidence has accumulated to discredit the hypothesis that economic growth is automatically accompanied by benefits for all (United Nations Children's Fund, 1991; United Nations Development Programme, 1996b). The United Nations Development Programme's 1996 Human Development Report noted that "Widening disparities in economic performance are creating two worlds—ever more polarized…. The poorest 20% of the world's people saw their share of global income decline from 2.3% to 1.4% in the past 30 years. Meanwhile, the share of the richest 20% rose from 70% to 85%. That doubled the ratio of the shares of the richest and the poorest—from 30:1 to 61:1; furthermore, during 1970–1985 global GNP increased by 40%, yet the number of poor increased by 17%" (United Nations Development Programme, 1996b). The same report also commented that "Policy-makers are often mesmerized by the quantity of growth. They need to be more concerned with its structure and quality. Unless governments take timely corrective action, economic growth can become lopsided and flawed. Determined efforts are needed to avoid growth that is jobless, ruthless, voiceless, rootless and futureless"—in other words, growth *without* equitable, sustainable human development (United Nations Development Programme, 1996b). Kanji et al. (1991)

have described the emergence and consolidation of a new class of entrepreneurs within many developing countries, among whom gains in total national wealth are increasingly concentrated. Anand and Ravallion (1993) have argued that differences in social spending, i.e., public investment in expanding human capabilities, may have a more profound effect on health and overall human development in developing countries than differences in average income, and perhaps even more profound than direct poverty reduction when the latter is confined primarily to changes in income.

It is difficult to obtain timely evidence of the effects of economic and political changes on equity in health and health care. In the first place, it is always challenging to establish the causality of any observed pattern or trend in health, given the complex and multifactorial pathways almost invariably involved. Second, reliable information to document patterns and trends in social inequalities in health is often lacking or, when available, not presented in a manner likely to highlight the policy implications. Traditional methods for routine monitoring of health and health care often obscure large or growing disparities between groups. In most nations, routinely collected data on health and health care are rarely disaggregated meaningfully according to socioeconomic factors or other markers of social advantage such as gender and ethnicity. While poor countries often have limited data, even in higher-income countries routine methods of analyzing and presenting data as nationwide, provincial, or city-wide averages obscure large disparities between diverse groups within territories. In addition, there is lack of consensus on the best technical methods for measuring the magnitude of social inequalities in health (Mackenbach & Kunst, 1997; Wagstaff, Paci, & Van Doorslaer, 1991).

Conclusion: the need for international and national organizations to focus explicitly on equity in health and its basic determinants, within as well as between countries

International agencies could play an important role in supporting research and action on social inequalities in health that is relevant to the needs of low- and middle-income countries. For example, international agencies can encourage and support national researchers from low- and middle-income countries to apply their talents to work in this area, and can support exchange among researchers from different countries as well as efforts to translate research into policy. Research methods and suitable data sources need to be developed not only for one-time special studies but also for ongoing routine monitoring over time (Braveman, 1998). The Rockefeller Foundation's recently launched Equity Gauge initiative is focusing on these concerns, and particularly on ensuring close links between monitoring and systematic efforts for advocacy and to increase public participation in decision-making that shapes health (see www.rockfound.org). Globally, more knowledge is needed about the mechanisms through which economic inequalities damage health, apart from the obvious effects of extreme material deprivation. However, concern about the pathways through which relative social inequalities affect health in the absence of absolute material deprivation is unlikely to be perceived as a major research priority in lower income countries, where large proportions of the population continue to suffer extreme material deprivation measured in absolute terms. On the other hand, research on the mechanisms explaining the health effects of relative economic disparities could contribute to better understanding of effective approaches to mitigate poverty's health-damaging effects; such approaches should be undertaken simultaneously with efforts to attack poverty itself at its root causes, and are likely to require action by a range of social sectors, minimally including education, housing, labour, and finance, not only health services. Research is also needed to compare the costs of different approaches to reducing health inequalities while achieving improvements for all. While the fundamental reasons for pursuing equity are ethical, evidence of economic gains associated with social investment targeting health inequalities should be documented and disseminated; as noted earlier, an appropriate range of outcome measures that reflect progress in human development should be considered, including but not limited to traditional economic measures such as income, and the time frame for outcome measurement must be long enough.

While the technical challenges in describing equity and assessing the equity impact of policies are considerable, the most daunting challenges to achieving greater equity are of course political. Better information alone will not produce more equity. In general, for both national and international agencies and in countries of all average income levels, it is far more politically sensitive to talk about inequities *within* rather than *between* countries. In trying to promote greater equity, international organizations must respect national sovereignty and cultural differences, while recognizing that "cultural differences" can be invoked by privileged groups to justify the maintenance of inequities in settings where disadvantaged groups within a society are voiceless. International organizations can support efforts by national groups committed to achieving greater equity, by creating forums for exchange of ideas and experience within and between countries. In itself, the articulation of an explicit commitment to equity by other countries and international organizations can boost the morale of domestic movements for greater social justice. International agencies also can create forums for international exchange about equity goals

and about policy options for achieving greater equity, recognizing that notions of what is fair or just, as well as preferred approaches to achieving greater fairness or social justice, vary among different societies. As much as one may like to prescribe what is right and wrong for others, for practical reasons each society needs to achieve a sufficient level of consensus about what equity goals it will adopt, in order to move toward effective, sustainable actions to reduce inequities; on the other hand, it is important to note that a national consensus may be affected by participation in international discussions.

International agencies can undermine or strengthen national efforts to achieve greater equity. Multilateral lending agencies in particular must consider the short- and long-term effects on equity of the conditions imposed on debtor nations (e.g., dismantling public service safety nets and privatizing previously government functions), and develop approaches and criteria that are likely to distribute the burden of belt-tightening in a more equitable fashion than has often been the case (United Nations Children's Fund, 1991). Over the past decade UNICEF and advocacy groups called upon creditor and debtor nations to consider "debt swaps for investment in social development programmes" (United Nations Children's Fund, 1991). In response to these efforts and evidence of the impossibility of debt repayment by many countries, the World Bank and International Monetary Fund recently launched the Highly Indebted Poor Countries (HIPC) initiative; in 70 poor countries, debt forgiveness is being made conditional on detailed plans for poverty reduction. The obstacles are daunting and it remains to be seen whether the initiative will result in significant social investment effectively reaching disadvantaged groups. Domestic as well as international development agencies need to consider whether their actions adequately encourage and strengthen efforts to improve equity; despite the best intentions, development aid can be channeled in ways that bring relatively little benefit to disenfranchised groups (United Nations Children's Fund, 1991). The World Bank has recently produced fact sheets for many developing countries, showing a range of health and health care indicators disaggregated by an indicator of household wealth (Gwatkin et al., 2000); such information should be used routinely to assess who is—and who is not—benefitting from development aid as well as domestic policies. Failure to disaggregate health data according to socioeconomic levels could result in policy recommendations that neglect the top causes of ill health among the world's poorest and hence most needy populations, for whom the communicable diseases and perinatal conditions remain the major causes of suffering, disability, and premature death (Gwatkin, Guillot, & Heuveline, 1999). An increase in the overall amount of funds for non-military international assistance from the affluent nations (and particularly from those, notably the United States, who until recently have not fulfilled even their basic commitments (Wegman, 1999) could contribute to increased equity between countries as reflected by aggregate statistics; however, such an increase might not necessarily improve inequities within countries without systematic effort focused on that goal.

International and domestic governmental and non-governmental agencies also can provide support for bold experiments with policies and programmes. While rigorous evaluation of the costs and outcomes of different specific strategies to achieve greater health equity is scarce (Gepkens & Gunning-Schepers, 1996; Mackenbach & Gunning-Schepers, 1997), enough is known to suggest that action will be needed in certain general areas (Arblaster et al., 1996; Bansal, 1999; Bartley et al., 1997; Mills, 1998). Strategies that target childhood well-being and development seem particularly promising as a way to achieve greater equity in health across the life cycle. Consideration of the available evidence suggests that particularly under conditions of severe resource constraints, it is likely that the following will be needed: giving the highest priority to eliminating absolute material deprivation; ensuring universal, compulsory and free education at least up to the level required to understand and apply a health message and to function in the national economy; ensuring safe drinking water and sanitation for all; providing free basic health services, including maternal and child health services with family planning; promoting rural development; providing micro-credit to small businesses; favoring full employment; and generally improving the status of women (United Nations Development Programme, 1990, 1991, 1992, 1994, 1996a, b, 1997).

Any successful strategy to address socioeconomic disparities in health will need to be based on a recognition that the biggest threat to health equity is overall socioeconomic inequity. The powerful relationships between socioeconomic position and health have been demonstrated repeatedly (Bicego & Boerma, 1993; Breilh et al., 1987; United Nations Development Programme, 1996a, b; Victora et al., 1992; World Bank, 1993; World Health Organization, 1995a, b), even in affluent countries (Adler, 1993; Adler et al., 1994; Evans, Barer, & Marmor, 1994; Feinstein, 1993; Kaplan, 1996; Kaplan et al., 1996; Kaplan & Keil, 1993; Kunst et al., 1998; Lynch, Kaplan, & Salonen, 1997; Macintyre, 1986; McKeown & Lowe, 1974; Pappas et al., 1993; Smith & Egger, 1992; Smith et al., 1998a) and even in affluent countries with relatively equitable health care provision (Black et al., 1980; Blane, Smith, & Bartley, 1990; Eachus et al., 1996; Mackenbach, Kunst, & Cavelaars et al., 1997; Marmot et al., 1991; Townsend, 1990; Smith, Hart, Watt, Hole, & Hawthorne, 1998b). Widening social inequalities in health should raise concerns about the consequences of macroeconomic or

social policy, not only about inequalities in health services; while the health sector can play an important role in documenting and disseminating evidence, action by the health care sector alone may not be effective or efficient. Equity in health care must be addressed, because, while not the only determinant of health status, health services are an important and often more easily modifiable factor than some others (Egbuono & Starfield, 1982). However, advocates for equitable access to health services must also be vocal advocates for equitable distribution of other key determinants of health, such as education, safe water and sanitation, housing, and food security. Advocates for investment in health care services may unwittingly play a destructive role in the health outcomes of their societies, when such investment competes with investment in other potentially more powerful determinants of health; this tension is likely to be greatest in countries with the most limited overall resources.

When developing strategies to increase equity, particularly in low- and middle-income countries, it must be made clear that the goal is an equitable sharing of progress in improving health, and not an equal distribution of the health consequences of lack of development; Whitehead has articulated the need to "level up" rather than to "level down" (Whitehead, 1994). The Primary Health Care strategy to achieve Health for All, articulated and promoted by WHO from the late 1970s on, was specifically designed to achieve greater equity and overall progress in settings with severe resource constraints. It entails a commitment to universal coverage with (at least) the most effective health services that will disproportionately benefit disadvantaged populations; reliance on low-technology, community-based solutions; emphasis on education, clean water, sanitation, and other living conditions fundamental to health; as well as a commitment to empowerment of those who have historically been marginalized. This strategy is at least as relevant today as it was two decades ago, when there was an expectation of growing rather than shrinking resources for social investment. There has been a notable silence at WHO recently about Health for All and Primary Health Care; this is unfortunate, creating the impression of stepping back from a commitment to equity, and should be addressed by member countries. As part of reaffirming the Health for All commitment, equity needs to move from being largely implicit to becoming an explicit component of the strategy, and progress toward greater equity in health needs to be monitored systematically to provide guidance for policy and programs at all levels.

Concerns about health equity in developing countries cannot be adequately addressed with an exclusive focus on closing north–south and between-country gaps. Globally, with increasing market orientation on all continents and in all political systems, there is a real risk that concerns about equity will be forgotten—or paid only token attention—on the policy agenda in the pursuit of short-term gains reflected in average statistics. It is of great importance to focus on equity in health, not only because health status should be a key indicator of human development, but also because in most societies, there is less tolerance for avoidable disparities in health than in wealth. Addressing health equity both requires and provides an opening for addressing equity in the determinants of health. At the beginning of the 21st century, large segments of the population within nations of very diverse per capita income levels remain on the other side of a deep divide, enjoying little or no benefit of the economic growth reflected in average national economic indicators or even average health statistics. Particularly in the context of an increasingly globalized world, improvements in health for privileged groups should suggest what could, with political will, be possible for all.

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