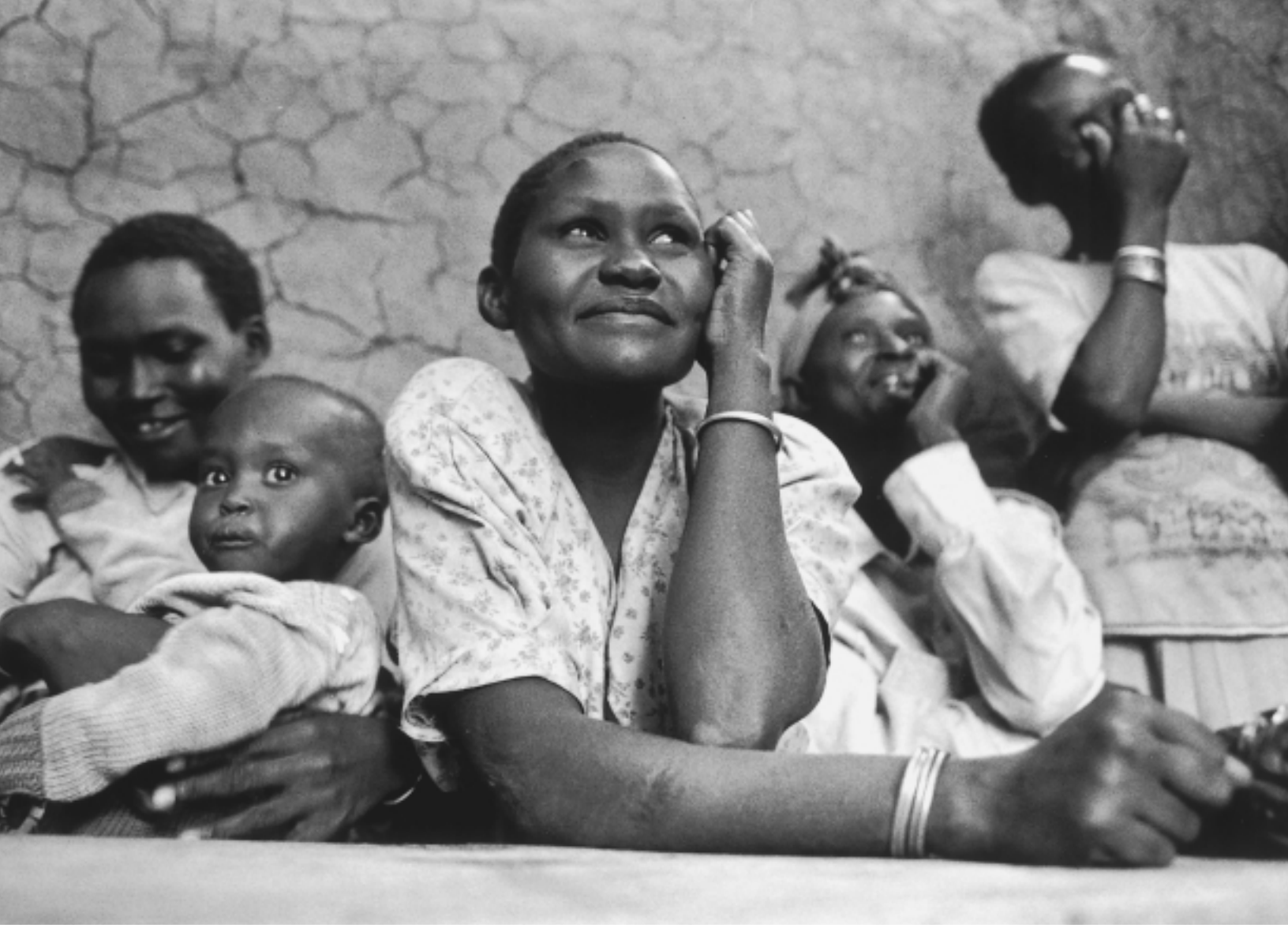


CHALLENGING INEQUITIES IN HEALTH

from ethics to action

summary

The Rockefeller Foundation

Swedish International Development Cooperation Agency

Contents of the Summary

Cover photo by Crispin Hughes/Panos: Kenya

Summary of the book: *Challenging Inequities in Health*

overview

Jésus Quintanar / *La Jornada*: Mexico

THIS VOLUME, *Challenging Inequities in Health*, was conceived as a response to the following:

- Concerns about widening "health gaps" both between and within countries;
- A disproportionate research focus on inequalities in health in the "North" to the relative neglect of the "South"; and
- Inadequate analytic tools and pragmatic policies to redress health inequities.

Through a collective effort of researchers and practitioners called the Global Health Equity Initiative (GHEI), a set of in-depth country studies and conceptual analyses on health equity were undertaken. The main findings of this effort are presented in this book with the central claim that issues of equity, or distributive justice, deserve primary consideration in health and social policy deliberations.

Insights about health equity from the fields of epidemiology, demography, economics and other disciplines are brought to life in case studies from Bangladesh, Chile, China, Japan, Kenya, Mexico, Russia, South Africa, Sweden, Tanzania, the United Kingdom, the United States and Vietnam. The subject matter ranges from adolescent livelihoods in Tanzania to the health burden of peoples living in marginalized counties in Mexico, from the historical antecedents of health equity in Japan to the recent increase in the gender gap in life expectancy in Russia.

As a group, the studies point unambiguously to the existence and multiple dimensions of inequities in health around the globe—in rich and poor countries alike.

- In (previously) centrally planned economies, macroeconomic reforms have been accompanied by new evidence of stark and growing disparities in health. In China, economic liberalization has promoted very uneven development characterized by accelerating urban prosperity and deepening rural poverty. This gaping urban-rural rift has been associated with increased differentials in life expectancy—with the health of urban populations accelerating and rural populations stagnating. Russia's rocky economic adjustments have been paralleled by a health crisis reflected by the enormous growth in the gap between male and female life expectancy. Russian men are dying at younger and younger ages—with the least educated the hardest hit.
- In parts of Africa, a different but related kind of transition is under way. Largely rural cultures are being rapidly urbanized, and people are losing what fragile social safety nets their families and the state once provided. In Tanzania, where education was once free, adolescents who cannot afford to pay newly introduced school fees drop out of school and are put at risk working in dangerous mines, plantations and on the streets—with dire health consequences. In Kenya, an unregulated, profit-driven transport system, open to exploitation of young poor people, has contributed to soaring death rates on the roads.
- In Latin America, shifts in economic policies have in some cases reduced the numbers of people living in poverty, but the circumstances of those left behind have worsened. In Mexico, persistent poverty is increasingly concentrated among indigenous people living in barren, isolated communities. In Chile, despite impressive gains in economic growth and aggregate health,

socioeconomic inequalities are large and widening, with the uneducated suffering the most.

- In the world's rich countries, health inequities are similarly endemic. A chronically ill woman in England has less chance of hanging on to her job than her counterpart in Sweden does. In Japan, the nation with the highest life expectancy, mortality rates for certain occupational groups like male agricultural and service workers are worse than their counterparts in managerial and professional jobs. And young black men in the United States not only have far lower life expectancies than young white men but also lower life expectancies than men in many poorer countries, like Bangladesh.

Beyond the sampling of diverse dimensions of equity in health from 13 countries, the book also covers a spectrum of cross-cutting conceptual themes in equity analysis. These range from fundamental issues such as ethics and measurement, to etiological or causal analyses related to underlying social determinants like gender and globalization, to policy approaches to inequities in health including the financing of health care. It is argued throughout that explicit values related to fairness in the distribution of health outcomes should be front and center in the articulation of policy objectives. Furthermore, policymakers and researchers must be able to draw on appropriate measures of health inequality in pursuit both of a better understanding of their root causes and in tracking the effects of interventions.

Greater equity in the distribution of health within and between countries is a daunting challenge facing health systems and societies globally. This collection of studies, therefore, is intended as a resource for a wide readership including students, policymakers and researchers. It aims to enhance equity assessment and analysis and to spur more effective policies and interventions.

There are several distinctive features of the contributions in the book:

- A conscious effort is made to focus analysis on inequities in health *status*, rather than access to health *care*, and on health inequities *within* countries rather than the more often discussed inequities *between* countries.
- The studies don't stop short at describing health inequities; they examine the determinants of those inequities in their *social context*, as affected by policies both within and beyond the health-care sector.
- The process inherent in each of the country case studies emphasizes *local leadership* and ownership aiming to strengthen capacity for analysis and action on findings—country studies were undertaken by study teams within each country rather than by Northern "experts" parachuted in from outside.
- The book draws on a rich *diversity of disciplines* and research approaches—from demography, epidemiology and economics to historical, policy and other qualitative analyses. This approach makes each case study unique in terms of subject area, but also means that direct, cross-country comparisons are not possible.
- Equal weight is given to work on health equity carried out in the South and the North recognizing that no country is immune to health inequalities and that understanding and policy responses are enhanced by drawing on diverse contexts and experiences.
- Moreover, the analyses undertaken in low-income countries—the first in many cases—demonstrate that available data (however imperfect) can shed light on important insights when viewed through the lens of equity.

Acknowledging health gaps within countries, rich and poor

Crispin Hughes / Panos: Kenya

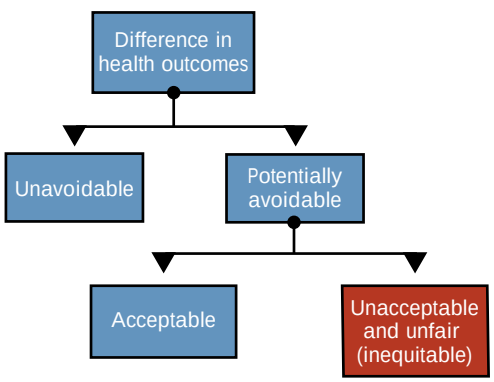
TODAY WE LIVE LONGER, healthier lives on average than at any time in history. Global life expectancy increased faster in the last 40 years than it did in the preceding 4,000—but not all groups benefited equally. Just as there are inequalities in resources in every nation on earth, so too are there striking differentials in health status.

"…a nation's health inequities may be seen as a barometer of its citizens' experiences of social justice and human rights."

Much recent literature highlights disparities in health *between* nations; this volume reveals the tremendous gaps in health status *within* countries. In South Africa, for example, infant mortality is five times higher among blacks than among whites. Men who live in the most affluent U.S. counties can expect to live 16 years longer than men in the poorest counties. Disparities within countries—industrial or developing—can be as great as disparities between the richest and poorest countries on earth. Neither overall increases in economic growth nor gains in aggregate health indicators are reliable proxies for improvements in health equity. Indeed, inequities in health may be *accentuated* in the setting of rapid economic growth and health gains as marginalized groups not only fail to share in the benefits but in too many cases become net losers.

The health of disadvantaged groups is extremely sensitive to economic, social and political trends. Although "snapshots" of health disparities at a particular time are useful, the trends over time are perhaps the most telling. Whether the health of the poor is improving at a faster rate than the rich, at the same or slower rate or actually declining relative to the rich is critical information in judging fairness. This spectrum of possibilities is in evidence among the studies that look at trends in health status. In Bangladesh, strong pro-equity trends show the most disadvantaged group's child mortality rate improving at the fastest rate. In Japan, we see the occupational gap in mortality rates remaining relatively constant as both "advantaged" and "disadvantaged" groups' health improves over a 30-year period. In China, Chile and Russia, gaps in life expectancy are actually widening over time with disturbing evidence of net deterioration in health among certain groups.

Figure 1
Judging the equity of health outcomes



Source: Peter and Evans, Chapter 3

How are health inequities a matter of social justice?

Rhodri Jones / Panos: China

THIS BOOK PLACES HEALTH EQUITY squarely in a larger ethical framework. Inequalities in health exist in every nation on earth. Some variations, including biologically determined differences between men and women, are inevitable. But many inequalities are avoidable. Health inequities exist largely because people have unequal access to society's resources, including education, health care, job security and clean air and water—factors society can do something about. *Inequalities* that are unfair—that arise from social injustices—and *avoidable* are considered *inequities* (see Figure 1).

The studies in this volume provide more than a description of which groups suffer disproportionate ill health and premature mortality. They also point to the unjust social arrangements that underlie these empirical observations. In so many cases where one group is more powerful, or has greater access to resources than another, the less powerful group suffers worse health. In important ways, a nation's health inequities may be seen as a barometer of its citizens' experiences of social justice and human rights. Thus, remedies for

"That few countries track inequalities in health reflects a general neglect of the welfare of the disadvantaged."

health inequities must come not only from the health sector but also from broad social policies, including fair access to education, job training, gender equity, environmental risk reduction and protection from impoverishment. The analysis of health equity must be linked specifically to health *outcomes* and more generally to quality of life and essential freedoms. Health equity is best thought of not as a social goal in and of itself, but as inherently embedded in the pursuit of social justice.

How do we measure health inequalities?

Sean Sprague / Panos: China

THAT FEW COUNTRIES TRACK inequalities in health reflects a general neglect of the welfare of the disadvantaged. Without hard evidence on trends in health equity, we can neither expose current disparities nor measure our success narrowing gaps in health status over time.

Yet measurement is a complex undertaking. Even measuring the state of an individual's health is difficult terrain. An individual may have a different view of the state of their own health than the doctor or epidemiologist; often the disadvantaged and sick rate their own health as satisfactory while the richer and healthier groups rate their own health as poor. Reconciling such differences in perspectives is a critical challenge to further progress on measuring inequities in health. Because of these and other related complexities, the volume puts forth a five-step framework for choosing measures for assessment of health inequalities:

1. Define which aspect(s) of health to measure:
   e.g., death, disability, risk, perceptions, access to care or the social or economic consequences of disease; use multiple measures when possible.

2. Identify the relevant population groupings across which to compare health status:
   e.g., by gender, level of education, income, occupation, ethnicity or other category.

3. Choose a reference group or "norm" against which to compare the health of different groups:
   e.g., within a country the reference group or "norm" might be the mortality rate of the highest income group; between countries a gold standard for life expectancy might be the Japanese life expectancy; when comparing by gender, different norms for males and females may apply.

4. Decide whether to measure inequality using absolute or relative differences in health status between population groups:
   Note: The recognition that patterns of inequality vary by type of measure, absolute (e.g., rate difference) and relative (e.g., rate ratio), argues for inclusion of both approaches when possible.

5. Select among alternative "social weights" for preferences that are built into health measures:
   e.g., in a composite index of health, including different age groups or different types of morbidity, adult morbidity may be "weighted" to be more or less (or equally as) important as child morbidity.

Table 1
Health Equity Measures

Intergroup differentials	Interindividual differentials
Simple Range	Gini coefficient
Odds ratio	Relative mean deviation
Relative risk	Atkinson index
Shortfall	
Rate ratio	Calculating public health impact
Rate difference	Population attributable fraction
	Attributable life lost
Full Gradient	
Slope index of inequality	Assessing causes
Concentration index	Explained fraction
Index of dissimilarity	Synergy index
	Component analysis (*Arriaga* method)

Source: Adapted from Anand et al., Chapter 5

"Without hard evidence on trends in health equity, we can neither expose current disparities nor measure our success in narrowing gaps over time."

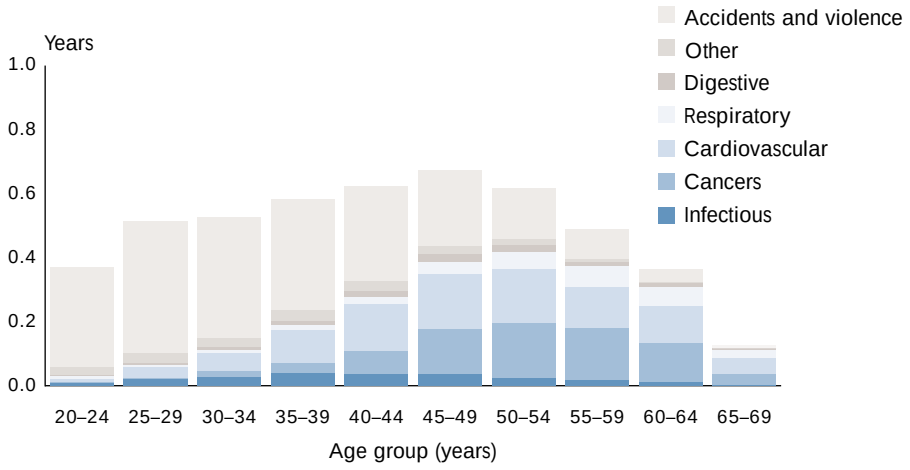
A range of measures, from simple to complex, is available for the measurement of health inequalities (see Table 1). Simple indicators may be sufficient to highlight injustice and spur action. For example, using a rate ratio to demonstrate that ill health in the poorest groups dramatically exceeds that in the richest is a clear mapping of inequity. But in order to disentangle the root causes of inequities in health, more complex measures and techniques are also needed. Several of the case studies in this volume employ a component analysis (the *Arriaga* method) which allows a gap in life expectancy between groups, e.g., educated and non-educated, to be broken down by age and cause of death (see Figure 2). Such sophisticated analyses provide greater insight into the origins of health inequalities and allow greater precision in policy formulation. The sensitivity and technical complexity of measures must be weighed against the availability of reliable data and policymakers' ability to readily interpret the results.

The inequities revealed depend to a great extent upon the measure chosen. Different measures may reveal varying magnitudes of inequities in the same population and may thus affect policy recommendations. The U.S. case study, for example, uses a measure of distribution that takes into account the burden of ill health across the full socioeconomic gradient (slope index of inequality)—not just among the poorest. Such an approach raises the policy challenges of reducing the health burden not only among the poor, but the near poor and middle class. Furthermore, the choice of social stratifier (by education, by income, by gender, by geographic region, etc.) chosen will greatly affect the degree of inequalities revealed.

Though both interindividual and intergroup measures are explored in detail, the overriding emphasis in this volume is on the assessment of inequities between population *groups*. Further priority is placed on the necessity of buttressing policy with the effective monitoring of trends: Is the gap in health status improving or worsening over time? How are policies and interventions working to narrow the gap?

In sum, the complexities inherent in the nature of health and its distribution argue for a plurality of measurement approaches. Whether simple or complex, measurement lies at the heart of our efforts to track progress in redressing health disparities.

Figure 2
Difference in life expectancy among adults age 20 to 69 between men with university education and men with secondary and lower education by age and cause of death in Russia, 1994



Note: Total difference is 4.8 years.

Source: Goskomstat 1997; Shkolnikov, Field, and Andreev, Chapter 11

"In both rich countries and poor, better health is associated with higher social position."

What are the social origins of health inequities?

ITAR-TASS / Sovfoto: Russia

IN BOTH RICH COUNTRIES AND POOR, better health is associated with higher social position. The broad reach of health inequalities across a wide range of risks, diseases and consequences points to their political, economic and cultural antecedents.

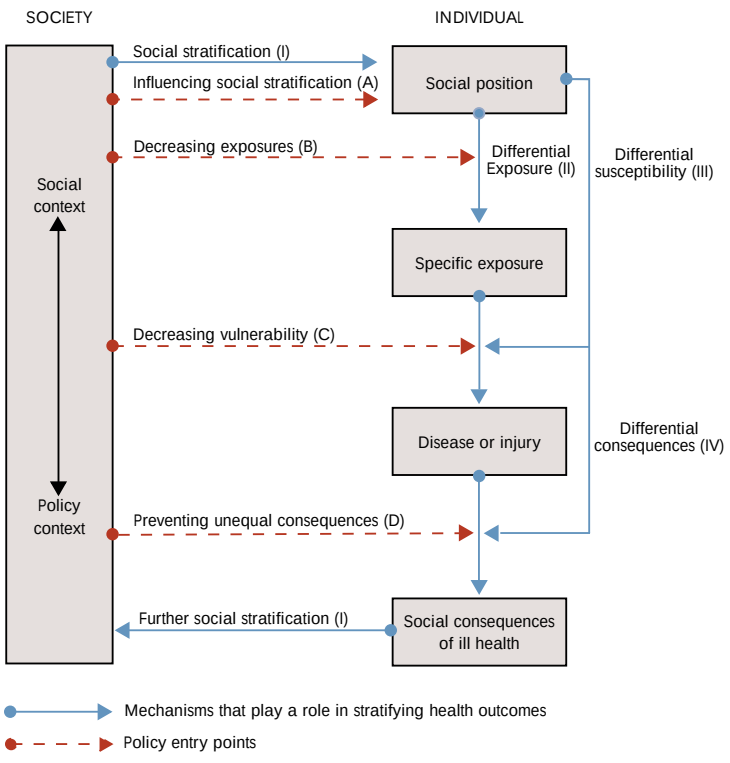
Cultural norms may have a pervasive influence on the nature and magnitude of inequalities and may also dictate the extent to which these are tolerated. Systems characterized by widespread corruption, violence, endemic racism, gender discrimination and the absence of democracy are breeding grounds for inequities in health and other social spheres. Even in more democratic or just nations, however, policies or attitudes toward income distribution, access to education, gender equity, levels of neighborhood violence and stress in the workplace may all serve to widen or diminish differences in health status among social groups. As such, health inequities arise not only from injustices in the health-care sector, but also reflect the unjust nature of arrangements in other sectors, such as labor, finance and education.

Many of the studies in this volume use a "social determinants" framework (Figure 3) that identifies four broad conceptual mechanisms—*social stratification, differential exposure, differential susceptibility and differential consequences*—that play a role in generating health inequities. For each mechanism, the possible policy entry points for interventions are identified.

Systemic forces of *social stratification(I)* lead to a separation of people into different social positions and, crucially, influence how wide the gulf is between these different sections of society. It is possible to influence the process of social stratification through economic, social and education policies that decrease (or increase) the divisions between different groups in society and also influence the ease with which social mobility can take place.

Differential exposure (II) to health-damaging conditions—exposures increasing with decreasing social position—contributes to the observed gradient in health across the social spectrum. Compounding this situation is the fact that there is a tendency for health-damaging exposures to cluster. For example, less advantaged members of a society may be exposed to poorer nutrition than their more affluent counterparts, but they may also face greater environmental hazards, higher tobacco consumption, decreased access to educational

Figure 3
A framework for elucidating the pathways from the social context to health outcomes and for introducing policy interventions



Source: Diderichsen, Chapter 2

"…the combination of poverty and marginalization have cumulative effects across the life course and transcend generations."

opportunity and the higher psychological stresses associated with chronic livelihood insecurity.

A separate mechanism of *differential susceptibility (III)* may sometimes come into play if two or more exposures act synergistically; that is they interact to produce an effect on health that is *greater* than the sum of their separate effects. Such an interaction is one explanation for the observation that Swedish men from lower socioeconomic groups have higher rates of alcohol-related disease and mortality than men from higher groups, even when their levels of alcohol consumption are similar.

Although social disadvantage is likely to lead to ill health, it is also important to point out that ill health through its *differential social consequences (IV)* may accentuate *social stratification*. In societies without social safety nets, adult illness and death are often associated with the loss of household income-generating capacity. Similarly, in systems without insurance or equitable access to it, unreasonably high health-care costs associated with treatment for illness are a primary cause of household asset depletion. These costs of ill health frequently precipitate a downward spiral into poverty and further risks of illness for an entire household.

Importantly, each of these stratifying mechanisms may be countered by specific policies, outlined as policy entry points A to D in Figure 3.

Poverty and marginalization: ill health entrapment

Throughout this volume, poverty and marginalization emerge as underlying or "fundamental" causes of inequities in health. Poverty, defined as an absolute or relative lack of income or wealth, results in certain groups suffering the ill health consequences of being unable to access the basic necessities of life. Marginalization occurs through exclusion based on factors including geography, ethnicity, race or even disability and illness—all factors that put the quality of life, dignity and standards of living enjoyed by other groups in a society out of reach. Not surprisingly the combination of poverty and marginalization have cumulative effects across the life course and transcend generations. Such long-term health effects are evident in the legacy of apartheid, or institutionalized racism, where the disproportionate risk and vulnerability to ill health among the black majority are entrenched despite the encouraging political transformation. Often these two health stratifiers overlap, magnifying risks and heightening susceptibility to ill health as, for example, in the case of women who are poor *and* a member of a racial/ethnic group suffering from discrimination.

Part of the answer to redressing health inequities therefore lies in meeting basic needs, eliminating structural poverty and making the opportunities of society more accessible to the excluded. Sobering, however, is the recognition that even with the advent of a pro-equity social context, progress may only be visible in the long term. Several of the country analyses that tackle these issues are highlighted below.

The widening urban-rural gap in China

Since economic reforms were introduced 20 years ago, *China*'s real output has grown nine percent annually and the economy has quadrupled in size. Real income has increased significantly and poverty rates have declined. But these gains have been accompanied by a rapid rise in economic inequality, with the growing gap in prosperity most evident between urban and rural areas. Life expectancy in wealthy urban areas is 10 years greater than life expectancy in poor rural areas. In 1994, maternal mortality rates in Qinghai province, in China's poor interior, were *10 times* those in Zhejiang, on China's prosperous coast. The resulting urban-rural gap does not simply reflect a slower rate of increase in health improvement in rural areas, but in many cases an actual net decline in the health of the poor. Infant mortality rates in China's poorer counties actually climbed by 25 percent in the 1980s.

An epidemic of road traffic accidents in Kenya

Thousands of *Kenyans* die every year in road traffic accidents. Many of those injured in traffic accidents are injured while riding in *matatus*, small vans used to ferry people around the country. Why does this form of transport prove so dangerous? The Kenya study analyzes the social determinants of road traffic accidents from a broad economic and political perspective. It concludes that the punitive approach of targeting the behavior of individual *matatu* drivers (with proposed

"Part of the answer to redressing health inequities therefore lies in meeting basic needs."

large fines) obscures the roots of the problem, which deeper policy analysis reveals: bribery appears to be commonplace between police and drivers, the *matatu* industry is not regulated, unempowered drivers are poorly paid and the mostly poor passengers have no voice in how the system works. A stakeholder approach to mobilizing action on the part of the public, the police, drivers and health officials is put forth as a way to address this public health threat more equitably.

The health blight on Mexico's marginalized counties

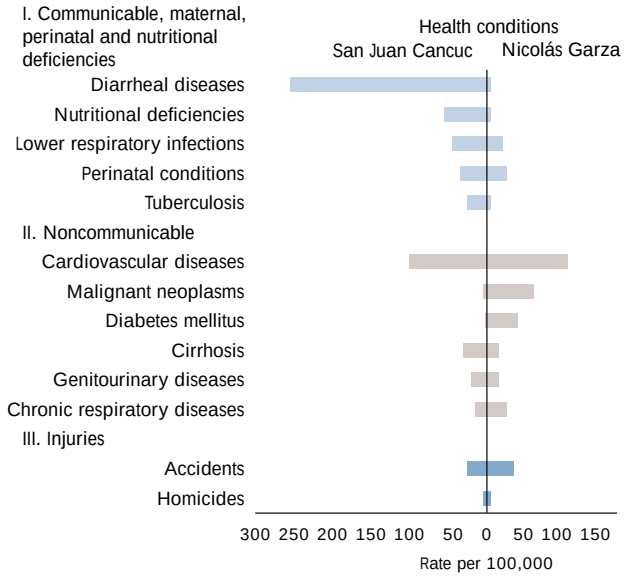
In *Mexico*, enormous differences in health status are evident among counties according to their level of socioeconomic marginalization (see Figure 4). In 1993, average life expectancy in one county in the very marginalized, mountainous state of Puebla was only 58 years; in another wealthy county, life expectancy was 71 years. The most marginalized counties—characterized by overcrowding, a high percentage of indigenous people, low earnings and high rates of illiteracy, and those in which a high proportion of households had no electricity, sanitation or running water—had higher death rates at every stage of life, from infancy to adulthood. Most often those who live in households without such basic services as running water also face discrimination in accessing education and employment. In this way, multiple forms of discrimination magnify the health risks to which marginalized people are exposed.

The legacy of apartheid in rural South Africa

South Africa is considered a middle-income country, a classification that conceals severe inequalities. Using criteria based on consumption, half the population lives in poverty. The overwhelming majority of South Africa's poor are black as reflected in the five-fold differential in average income between whites and blacks. Those most at risk of ill health are those who are unemployed, have little education, reside in former "homeland" areas or live in households headed by women. In 1993, infant mortality was more than five times higher among blacks than whites (see Table 2). The deaths of black infants are overwhelmingly attributable to poverty, malnutrition and preventable or curable infectious diseases—all shockingly common in such a relatively rich country. Although South Africa is on a path toward greater societal justice, the legacy of apartheid continues to differentiate opportunities for health.

Figure 4
Sociodemographic and health conditions in two counties in Mexico, 1990–96

Indicators	San Juan Cancuc (Chiapas)	Nicolás Garza (Nuevo León)
Sociodemographic indicators		
Marginality	Very high	Very low
Population, 1995	27,750	436,603
Indigenous population as percentage of total	100	0.1
Illiteracy rate (percent)	67	2
Average education (years)	4.2	8.2
Households with access to running water (percent)	4	95
Households with access to sewerage (percent)	45	92
Life expectancy (years), 1990–96	62	71
Economic indicators		
GNP per capita (U.S. dollars), 1990	3	43.6
Health expenditures per capita (U.S. dollars), 1995	3	79



Source: Adapted from Zurita et al., Chapter 19

"In case after case…the mapping of inequalities in health is robustly and consistently associated with educational attainment."

Table 2
Infant mortality rate by household income in South Africa, 1993

Income quintile	Infant mortality rate (per 1,000 live births)
Poorest	86
Second	75
Third	60
Fourth	49
Richest	30
Rate ratio: poorest to richest quintile	2.9*

* Significant at the 1 percent level

Note: Households were assigned to quintiles by per capita household income.

Source: 1993 South African Living Standards and Development Survey; Gilson and McIntyre, Chapter 14

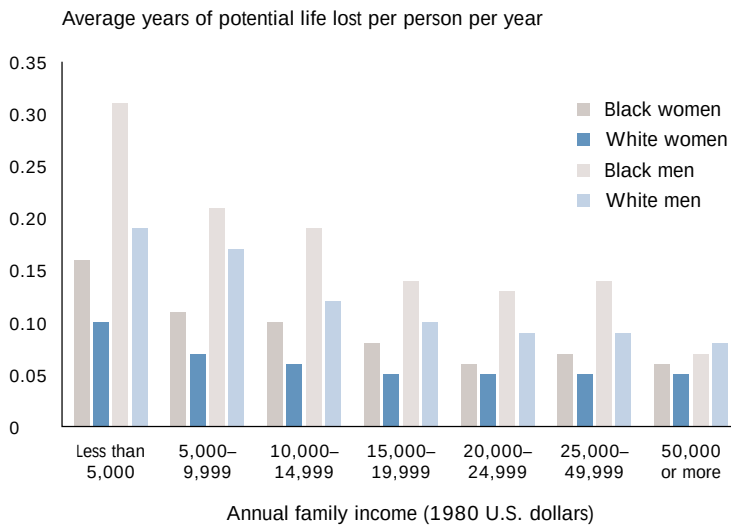
Income and race affect life chances in the United States

In the *United States*, lower income significantly increases the risk of disability and premature mortality. The lower a person's income, the more likely the person is to be disabled or die at an earlier age than someone with more wealth. Importantly, the effects of income on premature mortality and disability vary by age group, race/ethnicity and gender (see Figure 5). Blacks generally lose more years of life than whites, and black men in the lowest income stratum fare worse than any other group. In contrast, middle-aged blacks and whites do not differ significantly in levels of disability within each income group. Among the elderly, however, within each income group, black women generally reported the highest levels of disability while white women reported the lowest levels.

Educational opportunity determines health chances

In case after case, in this volume and elsewhere, the mapping of inequalities in health is robustly and consistently associated with educational attainment. Those with higher levels of education enjoy greater life expectancy, and in many cases lower levels of ill health or disability, than those with less education. Education is highlighted here because it is arguably one of the most modifiable social determinants of health. Furthermore, the health benefits of education are not specific to age—they occur across the lifespan and spill over into future generations, as seen in the association between maternal education and improved child health. Moreover, educational attainment (often determined at an early stage in life) exerts a strong influence on

Figure 5
Premature mortality by race/ethnicity, gender and income level in the United States, 1979–89



Source: Based on data from the National Longitudinal Mortality Study; Kubzansky et al., Chapter 9

"…those who remain in school are 'on the road to health,' a path that leads to a life of greater opportunity."

income earning potential and livelihoods, which themselves are important determinants of health. As stated in the Tanzanian study, those who remain in school are "on the road to health," a path that leads to a life of greater opportunity. A few salient examples from the book are noted below.

Health vulnerability of out-of-school adolescents in Tanzania

Adolescence is a critical formative period when educational opportunities determine livelihoods and life prospects. However, despite its disproportionately large size, this age group in *Tanzania* faces bleak prospects. As part of a larger process of structural adjustment, in recent years, school fees have been introduced leading to declining primary and secondary school enrollment. Increasing numbers of out-of-school children from poor households are forced by economic necessity into poorly paid, dangerous work situations in plantations, mines or on the city streets. As one adolescent respondent in the group discussions states, "We cannot be employed because we are under age, and yet we need to provide for our own survival the hard way." The resulting health risks from injuries, substance abuse and HIV and AIDS go undetected and untreated in a health system that has no effective monitoring, or accessible health care, for this population. To remedy this situation, a "lives and livelihoods approach" to adolescent well-being, focusing on the social and economic antecedents of their marginalization, is needed.

Dramatic health losses for those with lower education in Russia

The deteriorating health of *Russian* men and women is closely linked to dramatic social and economic changes arising from the dissolution of the Soviet Union in 1989. Market-oriented socioeconomic policies introduced shortly thereafter brought explosive rises in consumer prices and abrupt changes in the labor market. Real income was cut by half, savings disappeared and poverty and inequality increased. Psychological stress, greater intake of alcohol and the social dislocation associated with increased unemployment and Russia's abrupt economic transition caused the death rate for men to skyrocket in the early 1990s. Notably, higher educational attainment, particularly for women, appears to have acted as a relative buffer to this health crisis that was disproportionately concentrated in the unemployed and those with lower levels of education.

Educational level predicts longevity in Chile

Chile has undergone a less severe neoliberal transition than Russia, but has also seen large increases in income inequality during the past three decades. However, during the period of structural adjustment and rapid economic growth, Chile doubled its investment in education. Both individual and ecological analyses point to the association between greater levels of education and increased longevity—across all disease groups. In Chile, those with lower educational levels have lower average life expectancy, and differences in life expectancy between educational groups have been increasing over time. Adult male life expectancy among people with no education has declined two years since the 1980s, for example; during the same period, life expectancy for the well-educated males increased 0.4 years (see Table 3). Importantly, the study suggests that without the investment in education during the period of economic reforms, the group of those suffering

Table 3
Life expectancy among adults age 20 to 69 by education level in Chile, selected years, 1985–96
(years)

Years of schooling	1985–87	1994–96	Change 1985–96
Men			
0	41.5	39.5	–2.0
1–8	44.8	44.7	–0.1
9–12	45.1	45.6	0.5
13 or more	47.7	48.1	0.4
Total	45.1	45.6	0.5
Gap between groups with most and least education	6.3	8.7	2.4
Women			
0	44.9	44.6	–0.3
1–8	47.3	47.6	0.3
9–12	47.9	47.9	0.0
13 or more	48.5	49.1	0.6
Total	47.4	47.8	0.4
Gap between groups with most and least education	3.6	4.5	0.9

Source: Vega et al., Chapter 10

"Gender is a key social stratifier that is distinct from but interactive with other social features like social class or race/ethnicity."

increased premature mortality may have been much greater. The "protective" role played by education in mediating vulnerability to premature mortality makes universal access to education a key policy entry point for health equity.

Women's education paying long-lasting health dividends in Japan

A historical analysis of the antecedents to *Japan*'s remarkable health achievements highlights a strong social commitment to universal access to education and gender equity in educational attendance beginning at the end of the nineteenth century. Subsequent progressive social movements and public health efforts are hypothesized to have been well-received and, in part, fueled by this newly educated cohort of women. In turn, these social movements laid a firm foundation for the rapid advances in health status that occurred across the population in the middle of the twentieth century—despite significant income inequality. The effect of education on health continues in modern Japan despite very high overall levels of both education *and* health. An ecological analysis reveals differentials at the prefectural level with higher female life expectancy strongly associated with higher educational levels even in 1990.

Gender acts as a key social determinant of health

Gender is a key social stratifier that is distinct from but interactive with other social features like social class or race/ethnicity.

Broad social and economic determinants of health affect men and women differently, depending on their relative social positions, the occupational roles to which they are "assigned" and the various social and cultural expectations and constraints that shape their lives. All of these social factors combine to determine power relations in society that lead not only to inequalities *between* women and men, but also to inequalities *within* different groups of women and different groups of men.

The gender, health and inequity interface can initially be broken down into two conceptually distinct dimensions: (1) biologically specific health needs of men and women that are not fairly accommodated; and (2) inequities in health and health care arising from unfair gender relations and not from biological differences between the sexes.

Gender differences in health outcomes that arise partly from sociocultural beliefs and behaviors may be sustained and accentuated by policies that are insensitive to gender bias in its many manifestations. After tracing evidence of the intersections between health, equity and gender, three broad policy options are framed to redress health inequities:

- Promoting gender-sensitive health and macroeconomic policies;
- Ensuring gender equity in access to essential goods and services; and
- Empowering women and reducing gender bias at the community level.

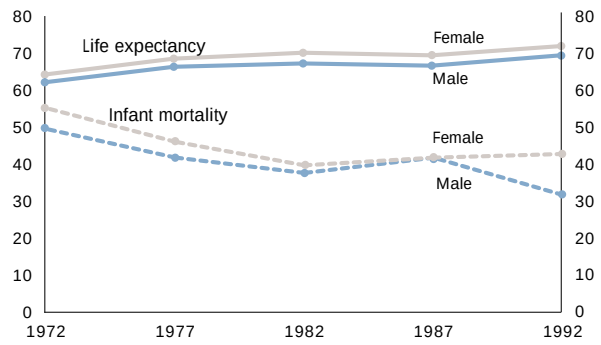
Many of the case studies in this volume provide clear evidence of the distinct patterns of health inequities among men and women, emphasizing the imperative for age group, sex and specific health outcome disaggregation of empirical data. Because of the strong role of gender bias in the patterning of morbidity and mortality, the studies point to the need to compare women's experiences to appropriate global norms for women, and men's experiences to equivalent global norms for men.

Persisting gender inequity in China

Gender equality is a prominent policy issue in *China* that has been addressed in successive governments since the founding of the People's Republic of China in 1949. Despite China's broad commitment to gender equity, there is evidence of persistent health discrimination against women and girls. Chinese women live longer than men on average, but mortality rates among Chinese women are still higher than would be expected based on international standards. Most alarming, since 1987, infant mortality for girls has increased slightly, so that in 1995 it surpassed that of boys by more than 25 percent (see Figure 6). Of further concern is the remarkably high disability rate among girls in the age

"The case studies provide clear evidence of distinct patterns of health inequities among men and women."

Figure 6
Life expectancy and infant mortality rate by sex in China, selected years, 1972–92



Source: Huang and Liu 1995; Liu et al., Chapter 7

group of birth to four years. Across the lifespan, the female morbidity rate tends to be higher than that of males for all age groups except for children under 10 years of age. China is also one of very few countries in which the suicide rate among females exceeds that for males (it is a dramatic 30 percent higher for women in China).

Male disadvantage in the widening gender gap in Russian life expectancy

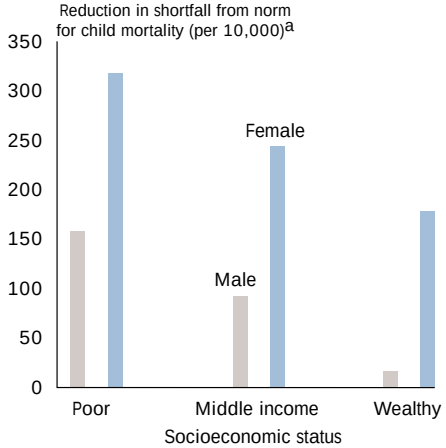
Russian women now outlive men by 13 years on average, a gender gap in life expectancy that is twice as wide as in other developed countries. Male death rates soared during Russia's harsh neoliberal transition, a time of high labor turnover, rising unemployment and steep reductions in the value of the *ruble*. Deaths from accidents and violence—strongly associated with alcoholism—and from cardiovascular disease account for most of the excess loss of life among Russian males. Though women are faring much better than men in Russia, their life chances are clearly compromised as well—female life expectancy falls far short of international norms. Importantly, the gender gap in mortality persists in all socioeconomic and sociodemographic groups, but the gap is always smaller for men and women in higher social positions than in lower ones.

Dramatic equity gains for girls in Bangladesh

Since 1981, child mortality in the Matlab region of *Bangladesh* has dropped 65 percent, from 20 per 1000 to 7 per 1000. These overall gains have been accompanied by marked improvements in gender equity: girls living in the poorest households have experienced the greatest reductions in mortality (see Figure 7). Today, girls are as likely to survive to age five as boys, in stark contrast with their historical survival disadvantage. How have these gains come about—and how might other countries learn from Bangladesh's example?

Two interventions in the Matlab area were studied to determine their joint and independent effects on health equity. One project focuses on maternal and child health and family planning. It provides contraceptives for women, safe childbirth services and treatment of illness and referrals for women and children. The other, run by a rural development nongovernmental organization, Bangladesh Rural Advancement Committee (BRAC), focuses on

Figure 7
Gains in gender equity in child mortality rate by socioeconomic status in Matlab, Bangladesh, 1982–96



Note: Socioeconomic status is based on square meters of dwelling area.

a. The norm for 1982 is the 1982 Japanese child mortality rate (63 for males, 49 for females), and that for 1996 is the 1994 Japanese rate (44 for males, 35 for females).

Source: International Centre for Diarrhoeal Disease Research, Bangladesh, Demographic Surveillance System data; Bhuiya et al., Chapter 16

"…globalization is likely to enhance health opportunities for the fortunate…and impose further obstacles to health among the poor and excluded."

empowering women by strengthening their economic opportunities through the promotion of mutual support organizations in villages, through which women can learn new skills and gain collateral-free loans to set up small businesses.

Both interventions seem to confer significant health advantages. Poor children whose mothers have access to the maternal and child health program are more likely to survive than poor children whose mothers did not. Similarly, the poor children of mothers who are members of BRAC's mutual support initiative achieve the same survival advantages as the children of rich nonmembers.

Globalization provides both challenges and opportunities

The globalization of trade and finance are giving rise to ever greater economic and social disparities between those with money—plus access to information, education and the power to act on what they know—and those without. As such, globalization is likely to enhance health opportunities for the fortunate and empowered while imposing further obstacles to health among the poor and excluded.

In addition to heightened social polarization, at least two further equity challenges are associated with rapid global change. The first relates to an emerging global pattern of health marked by the permeability of borders to old and new infectious threats, epidemic sociobehavioral pathologies, such as violence or substance abuse, the growing prominence of chronic diseases and the noncontainment of environmental hazards. A new global health order that values each person's life equally would invest now to secure health benefits for all, recognizing that past responses aimed at protecting the rich are both ineffective and inequitable. Such a response, however, is limited by the state of flux of health-care systems globally. This second global challenge arises in part due to a retrenchment of the public sector, and the concomitant growth of the private sector, in the provision of health care. Medical innovations could vastly improve the length and quality of human life for all, but not if they are available only to the rich. Similarly a wave of health-care reform based on increased privatization and reduced spending on public health will push new life-saving technologies even further out of reach of the poor.

Despite these threats, globalization holds some promise. More equitable production and dissemination of health knowledge, effective use of new information technology and strong leadership by global institutions could be harnessed to pave the way toward "universal health democracy." This vision of global health equity places a premium on people being informed, their voices heard and their participation in health and development decisions guaranteed.

How does access to health care fit into health equity?

Liba Taylor / Panos: India

THOUGH FACTORS OUTSIDE the health sector are increasingly recognized as determinants of health inequities, the health sector itself plays a pivotal role in health equity. By tailoring programs to meet the needs of marginalized groups, promoting good health and preventive care, as well as providing curative care, health systems can remove barriers to good health care, prevent illness and improve the quality of life of people who are *already* sick. Conversely, without a focus on equity, health systems have the potential to exacerbate or create health disparities by neglecting special needs of vulnerable populations and ignoring cultural, financial or geographic barriers to accessing health services. All too often, public health spending ends up disproportionately benefiting richer groups (see Table 4).

"…without a focus on equity, health systems have the potential to exacerbate or create health disparities."

Table 4
Share of public health spending benefit received by poorest and richest quintiles in selected countries, various years, 1979–95
(percent)

Country	Year	Poorest quintile	Richest quintile
Sri Lanka	1979	30	9
Jamaica	1989	30	9
Malaysia	1989	29	11
Brazil	1985	17	42
Egypt	1995	16	24
Kenya	1993	14	24
Vietnam	1992	12	29
Indonesia	1989	12	29
Ghana	1992	11	34

Source: Alailima and Mohideen 1983; Demery et al. 1995; Grosh 1995; Hsiao and Liu, Chapter 18

Access to care and the relative financial burden shouldered by different groups in a society are strongly influenced by financing approaches used in the health-care system. In general, tax based and social insurance systems tend to be fairer and more progressive compared to those based on user fees or private insurance, often designated as regressive. Whether there are safety nets for the poor or user fees imposed on all are policy decisions that have profound consequences for health equity. Despite these generalizations, the actual equity implications of alternative financing systems are largely influenced by the underlying strength of institutions both public and private to deliver and implement. In many developing countries where institutional capacities are weak, equitable financing becomes an even greater challenge. Hence, a combination of sufficient institutional capacity and a progressive approach to financing can enhance equitable access to care and prevent the health-care system from contributing to the impoverishment of those seeking care.

Vietnam strives toward universal health care

Vietnam was once held up as a health-care model, in part due to its success in fostering a basic rural health-care network. The centrally planned economy provided equitable access to health care despite the overall economic constraints faced by the country. However, a shift to a more market-oriented economy and the introduction of hospital user fees has resulted in growing inequities in access to hospital services. This study provides an analysis of the challenges of creating an efficient, equitable health-sector reform in a low-income country during economic transition. Vietnam is currently exploring three long-term strategies:

- Increasing overall public funding for health-care services from US$5 per capita to US$8;
- Expanding social health insurance schemes to rural areas through subsidized health insurance cards and community-based health insurance schemes; and
- Reducing high hospital user fees while public prepayment schemes for health-care utilization are developed.

Policy distortions neglect the most vulnerable in Tanzania

In *Tanzania*, donor-driven health policies promote a narrow focus on issues of sexuality in girls attending school—systematically neglecting many at great risk. These distorted health policies ignore younger adolescents, the needs of adolescent boys and the entire population of out-of-school adolescents. This study points out the gaps and contradictions plaguing the emergence of an equitable health policy for adolescents in Tanzania. Of importance, the focus on health services for a narrow segment of the population ignores the importance of social and economic antecedents that fundamentally shape and differentiate opportunities for the health of adolescents.

"…it is possible to challenge health inequities with purposeful public policy. And such a challenge is long overdue."

Building a policy response: What can be done?

Ron Huibers / Panos: Haiti

DISPARITIES IN HEALTH between social groups exist in all societies, but are not inevitable—it is possible to challenge health inequities with purposeful public policy. And such a challenge is long overdue. We need not and must not tolerate such inequities.

Building a robust and appropriate policy response to health inequities requires action across a broad spectrum of areas. This response requires four major efforts:

1. Establishing strong values. Set equity objectives and policy targets and assess the impact of existing and proposed developments on health equity.

2. Assessing the nature and size of the problem. In analyzing the causes and measuring the extent of health inequities, start with two assumptions: first, that health measures based on population averages are not reliable guides to what may be happening to the health of different groups in society; and second, it is always possible (and essential) to make some assessment of the health divide(s).

3. Tackling the root causes of health inequities. The conditions that shape an individual's health status—and contribute to, or ameliorate, health inequities—may be viewed as layers of the person's health environment (see Figure 8). As the figure suggests, individual lifestyles are embedded in social and community networks and in living and working conditions, which in turn are affected by a society's broad cultural and socioeconomic environment. All of these factors are amenable to purposeful action:

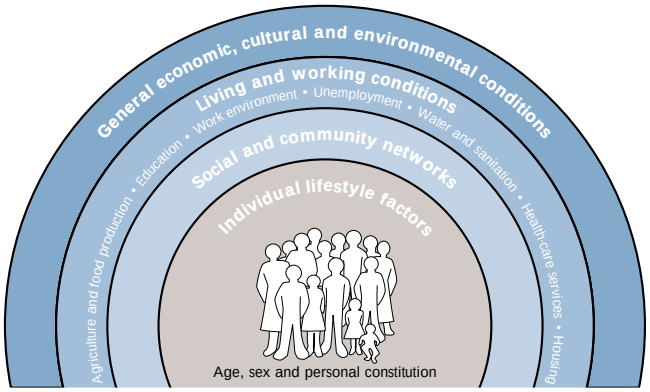
   - The overarching macroeconomic, cultural and environmental conditions prevailing in a country are of paramount importance in the pathways to inequities in health, and are therefore key policy entry points in the promotion of health equity.
   - The classic public health endeavors to improve living and working conditions and access to essential services, such as education and health care, still have a vital role to play in promoting health equity provided they are accessible to the poor and excluded.
   - Some commentators believe that the most health-damaging effects of social inequality are those that exclude people from taking part in society, denying them self-respect and dignity. The negative health effects of social exclusion are increasingly recognized—the exclusion and powerlessness that comes with lack of money, lack of education and lack of influence. The challenge is to open up opportunities for everyone in the population, not just for the people who have the loudest voice, at the same time building up conditions in society that offer greater mutual support.
   - The pathways linking socioeconomic position to health-damaging behavior highlight the need to take account of structural barriers to healthier lifestyles and to create supportive environments, sensitive to the harsh conditions in which many people live.

4. Reducing the negative consequences of being in poor health. In addressing issues of impoverishment and equitable access to health care, policymakers must consider such factors as these:

   - How to mobilize the financial resources needed to improve access to health care;
   - How to allocate those resources equitably relative to need; and
   - How to monitor the use of available resources to ensure that they are being deployed to meet the stated objectives of equity.

A key principle of health equity is that resources should be allocated according to need, regardless of ability to pay. In practice, this can be promoted by devising more equitable resource allocation mechanisms for commissioning health care, with need for

Figure 8
Layers of influence on an individual's health



Source: Adapted from Dahlgren and Whitehead 1991; Whitehead et al., Chapter 21

care assessed not only by the population's size and age-structure but also according to its disease burden and socioeconomic characteristics.

The body of evidence set forth in this volume emphasizes that in addition to a person's inborn biological characteristics, socioeconomic, cultural and environmental conditions are immensely important for an individual's health. Policymakers must recognize that aggregate health indicators such as average life expectancy or average infant mortality provide too little information about the health of different groups within their societies. Health policy and research should also assess the distribution of health status among different groups in a society, because it reflects the degree to which social injustices prevail in that society. More importantly, it reveals unfair and avoidable suffering.

Healthy social policy: a comparison between Britain and Sweden

Being poor in *Britain* appears to be more damaging to health than being poor in *Sweden*, at least for women. This was one finding in the Anglo-Swedish study of the health effects of joblessness or living in poverty. Is there something about living in Britain that exacerbates the health effect of poverty? Is there something about the social context in Sweden that might protect people experiencing poverty from ill health?

It was also evident that the social and economic consequences of chronic illness varied for different social groups and for the two countries. For example, the chance of a chronically ill person holding a job was much lower in Britain than in Sweden. There was a steep social gradient in Britain: chronically ill British men who performed manual labor were far more likely to be unemployed than white-collar workers, for example, which appeared not to be true of their Swedish counterparts.

Part of the answer to the questions posed by these findings appears to lie in the very different social, economic and labor-market policies that have prevailed in the two countries. In Britain, the policies are much less supportive for people who lose their jobs or fall on hard times. Such policies, however, are not fixed but are amenable to change, as illustrated by Sweden where the social protections for the unemployed are more progressive.

Challenging Inequities in Health highlights how policies outside the health sector can have profound and independent effects on the health of the disadvantaged, both by thwarting sound health policies and by making social inequalities more pronounced. By keeping track of health inequities, policymakers may become more sensitive to the ways in which their actions—in the health sector as well as in other sectors—may lead to a reduction in the health gap.

NOTES ON FIGURES AND TABLES

Figure 2 Goskomstat. 1997. *Rossiyskiy statisticheskiy yejegodnik 1996* [*Russian Statistical Annual 1996*]. Moscow: Goskomstat.

Figure 4 Zurita, B., Colín, R., Villoro, R., Gamble, A., and Cruz, C. 1995. Situación actual de las necesidades y la oferta de servicios de salud: 227 municipios de extrema pobreza (mimeo). Mexico City, México, D.F.: PASSPA-SSA / Banco Mundial.

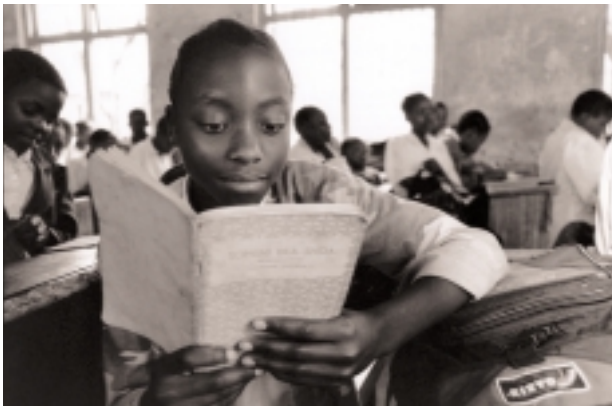
Figure 6 Huang, Y., and Liu, Y. 1995. *Mortality Data of the Chinese Population*. Beijing, PRC: The Chinese Population Press.

Figure 8 Dahlgren, G., and Whitehead, M. 1991. *Policies and strategies to promote social equity in health*. Stockholm: Institute for Futures Studies.

Table 3 Instituto Nacional de Estadísticas (INE). 1998a. *Compendio Estadístico*. Santiago, Chile: INE; Instituto Nacional de Estadísticas (INE). 1998b. *Anuario de Demografía y Causas de Muerte*. Santiago, Chile: INE.

Table 4 Alailima, P., and Mohideen, F. 1983. Health sector expenditure flows in Sri Lanka. *World Health Statistical Quarterly*. 37(4): 403-420; Demery, L., Chao, S., Bernier, R., and Mehera, K. 1995. *The incidence of social spending in Ghana, 1989-92*. Draft unpublished report, Ghana Extended Poverty Study. Washington, D.C.: The World Bank; Grosh, M. 1995. Toward quantifying the trade-off: administrative costs and incidence of targeted programs in Latin America. In: van de Walle, D., and Nead, K. (eds), *Public spending and the poor. Theory and evidence*. Baltimore: The Johns Hopkins University Press for the World Bank.

A global agenda



Crispin Hughes / Panos: Tanzania

IN A TIME OF GROWTH AND PROMISE, yawning health divides must not be tolerated. But tackling health inequities requires taking action on several frontiers. To stem the tide of health inequities, dynamic and respected international leaders must launch a more concerted effort to develop advocacy for improved health status, with equity as a guiding principle. Such an effort can be accelerated by encouraging global advocacy, enlarging the health equity policy community—to include governments, ministries of health, regional organizations, nongovernmental organizations, researchers, advocacy groups and individuals—and building greater capacity to monitor and analyze policies from an equity perspective.

A global response will require the public health and development communities to refocus our efforts by:

- Becoming more sensitive to our propensity to generate disparities through the health and social sectors;
- Recognizing that health inequities signal social injustice;
- Promoting "health equity" and the "distribution of health status across social groups" as a legitimate focus of health policy and health research; and
- Generating evidence-based "best practices" to monitor and redress inequities.

The challenge before us, therefore, is not merely the promotion of health, but a fair chance for all to achieve it.

"In a time of growth and promise, yawning health divides must not be tolerated."

The global health equity initiative

THE VOLUME, *Challenging Inequities in Health*, presents the results of an international initiative called the Global Health Equity Initiative (GHEI). Drawing on the Rockefeller Foundation's 80 years of commitment to international health, together with a contribution from the Swedish International Development Cooperation Agency (SIDA), the GHEI represents a major investment in charting the extent and causes of inequities in health around the globe.

The five aims of the GHEI are:

- To articulate the concepts and values underlying equity in health;
- To develop measures and tools for health equity research;
- To encourage empirical research on health inequities in developing countries;
- To establish a scientific foundation for advocacy, policies and programs;
- To provide policymakers with knowledge and concrete suggestions for change, so they will act to reduce health inequities.

The GHEI draws on the work of over 100 researchers from more than 15 developing and industrialized countries, working in a range of disciplines, including medicine, public health, economics, demography, sociology, political science and anthropology. As part of the Initiative, researchers, government officials and representatives of nongovernmental organizations have worked together to draw attention to the causes and consequences of unacceptable health inequities.

Their work reflects a shift in focus toward the widening health gap within many countries around the world. The World Health Organization, the World Bank, the Pan American Health Organization and the United Nations Children's Fund (UNICEF) have declared the reduction of health inequities an important target. In 1999, the British government released the "Acheson Report" on Inequalities in Health and implemented new policies based on its findings; in the United States, the National Institutes of Health and the Surgeon General recently declared equity in health a central priority; in Vietnam, equity and efficiency are dual goals of the health sector. Finally, the International Society for Equity in Health was launched in Cuba in the summer of 2000.

It is hoped that this volume, the culmination of the GHEI, will spur further efforts to identify and redress inequities in health in developed and developing countries alike.

A key international GHEI meeting, Rajendrapur, Bangladesh, 1998

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Critical Acclaim for *Challenging Inequities in Health*

"This is a powerhouse of a book. It succeeds in covering the wide range of issues involved in striving towards equity in health in a very inequitable world."

—Barbara Starfield, M.D., M.P.H., President, International Society for Equity in Health and Distinguished University Professor, Johns Hopkins Medical Institutions

"*Challenging Inequities in Health* is far and above the most comprehensive book on this subject to date. This book is global and local at once, providing specific examples from a dozen or so countries, from the poorest to the richest, while taking on the bigger issues. I have no doubt that this book will become a classic, and will not stray far from your desk."

—George Kaplan, M.D., Professor and Chair, Department of Epidemiology, University of Michigan

"In a world that seems almost dizzy with the heady prospect of rapid economic growth and the benefits of globalization, *Challenging Inequities in Health* serves as a much needed antidote. With great clarity of concept and analytical rigor, the contributing authors of this edited volume highlight the global patterns of health inequity that are caused by the 'fault lines' that lie between different social, political, ethnic, sex and occupational groups, and they recommend ways to shape policy and direct resources to ensure that these fault lines are not further deepened."

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"It was truly a delight to read and it is the kind of book that will serve as a reference for many years to come."

—Sir George Alleyne, M.D., Director, Pan American Health Organization

"Although there is a broad consensus that equity in health is a good thing, there is much debate and discussion on how to achieve it in real life. The authors have taken the bull by the horns in this excellent book which contains a deep analysis of inequalities in health and how to correct them. Outstanding expert contributions make this book a real classic and a valuable reference work."

—Adetokunbo O. Lucas, M.D., Visiting Professor, London School of Hygiene & Tropical Medicine, University of London

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