



**Global Forum
for Health Research**
HELPING CORRECT THE 10|90 GAP



Health Research for Policy, Action and Practice

Resource Modules

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Module I
**Improving equity and development in
health through research**

Unit 1
**Equity in development: the role of
health research**

**We welcome readers' comments to enable us to
continually update and improve this material.**

THE COLLABORATIVE TRAINING PROGRAMME

Alliance for Health Policy and Systems Research
Council on Health Research for Development
Global Forum for Health Research
INCLEN Trust

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Acronyms

ACHR	WHO Advisory Committee on Health Research
CHRD	Commission on Health Research for Development
ICHRD	International Conference on Health Research for Development, Bangkok, 2000
IDRC	International Development Research Centre, Canada
INCLEN	International Clinical Epidemiology Network

Module I. Improving equity and development in health through research

Unit 1. Equity in development: the role of health research

Introduction

“The obligation to advocate for and act on behalf of the poor rests not only with politicians but also with health professionals. Human development means reducing the burden of human disease. Organizations that represented doctors and other health workers – from the most local of associations to WHO – should be on the frontline of this advocacy work. And yet the societies, centres, colleges, offices, clubs, institutes, and councils of medicine have largely abandoned the poor, preferring instead to advocate for themselves. Where are their arguments supporting the wider responsibilities of medicine to the health and development agenda? Why are they not calling their political leaders to account? The evidence is, after all, now in. In December 2001, the Commission on Macroeconomics and Health described how affordable investments in health care and research could save 8 million lives per year by 2010.” (Horton, 2002)

This unit reviews the decade of the 1990s in relation to:

- discussions and action regarding the role of health research in contributing to improved equity in health
- some of the major research initiatives on inequity in health.

Indeed, the evidence has been in for more than a decade – since the publication of the Commission on Health Research for Development report *Health research: essential link to equity in development* (CHRD, 1990). This unit summarizes the debate about and action on this issue during the 1990s, leading up to the International Conference on Health Research for Development (ICHRD – Bangkok, 2000) (IOC, 2001) and the recent report of the Commission on Macroeconomics and Health (CMH, 2001), entitled *Macroeconomics and health: investing in health for economic development*. The unit highlights some of the recent research about inequities in health. It also identifies advocacy and leadership issues arising in the past decade, which can inform the collaborative actions of the first decade of the new millennium.

The equity focus in health research during the 1990s

The title of the 1990 report of the Commission on Health Research for Development is *Health research: essential link to equity in development*. While there is no special section on the equity issue as such, the first chapter describes health disparities. It includes the question “Why Act?” The answer is threefold. “For people in industrialized countries, there are compelling reasons to care about the health of people in developing countries – the humanitarian need to overcome gross inequities, self-interest for self-protection, and mutual learning for joint action” (CHRD, 1990:9). The report goes on to present its findings, many of which elaborate on the inequity theme, describing great disparities in the way resources are distributed, research priorities are defined and research capacities are strengthened (or neglected). The report makes specific recommendations to address these findings, including calls for a major increase and redistribution of funds for health research.

In the decade following the release of the Commission’s report, two new organizations were created in response to its recommendations – the Council on Health Research for Development (COHRED) and the Global Forum for Health Research (GFHR). Further studies were published, such as the publication by the WHO Ad Hoc Committee on Health Research Relating to Future Intervention Options entitled *Investing in health research and development* (Ad Hoc Committee, 1996). These key events are listed in [Box 1](#). Various agencies and organizations responded in their own way to the issues highlighted in the report. In general, a substantial momentum was created in response to the challenge to health research to contribute to the problem of inequities in health and development. For a more detailed description of activities in the 1990s, see Neufeld and Johnson (2001).

Among the publications produced by these new organizations is a COHRED issues paper entitled *Health research: powerful advocate for health and development based on equity* (COHRED, 2000). This publication, a product of a working group chaired by David Harrison of South Africa, describes three features of effective health research. One of these features is “Work for equity in health” (See [Box 2](#) for a summary of the COHRED argument for working for equity in health.) Some readers may be interested in a further analysis of this theme by Harrison (2001), entitled “Health research: an essential tool for achieving development through equity”. This analysis includes an appendix that attempts to map the relationship between health research and development, with a diagram depicting a series of “possible causal linkages”, along with notes and key references.

The Global Forum on Health Research publishes a periodic report, *The 10/90 report on health research* (GFHR, 1999; 2000; 2002; 2004). These reports provide helpful updates on the “central problem in health research” (to use a term from the reports), which is the “10/90 gap” – the continuing disparity between the areas where resources are allocated and the areas where the problems actually are.

Box 1. Health research for development: key events

1987	First meeting of CHRDR
1990	CHRDR report presented in Stockholm Forty-third World Health Assembly: "The role of health research in the Strategy for Health for All by the Year 2000" International Conference on Essential National Health Research (ENHR), Pattaya, Thailand
1991	Task Force on Health Research for Development begins work
1993	Council on Health Research for Development (COHRED) created World Bank publishes <i>World development report 1993: Investing in health</i> (World Bank, 1993) Ottawa Conference: "Future Partnerships for the Acceleration of Health Development"
1996	WHO publishes <i>Investing in health research and development</i> (Document TDR/Gen/96.1) COHRED interim assessment
1997	ACHR publishes <i>A research policy agenda for science and technology</i> (ACHR, 1997) Global Forum for Health Research established World Bank Group publication <i>Sector strategy: health, nutrition, and population</i>
1999	WHO creates Department of Research Policy and Cooperation
2000	International Conference on Health Research for Development, Bangkok, Thailand

Box 2. Why work for equity in development?

Assumptions of health research for equity

- Every individual is entitled to the opportunity for good health.
- Health for all promotes national development. Countries impede their economic growth and human development by underinvesting in the health of the poor.
- Working for equity also improves efficiency. Countries can make the biggest reduction in the burden of disease if they concentrate on improving the health status of those who carry the heaviest burden of disease – invariably the poor.

Disparities in health research priorities

- Left to market forces and curiosity alone, health research priorities will continue to reflect the health problems and concerns of the rich. Existing disparities between the rich and the poor will widen. Health research should actively work to eradicate such disparities.

What difference can health research for equity make?

- Unlike improvements in the health status of wealthier nations, which will require dramatic technological breakthroughs to make giant leaps forward, relatively small investments in the application of existing knowledge can substantially improve the health of at least some of the poor.
- With local knowledge and customized application, we can squeeze far more benefit out of new or existing interventions.

(Abstracted from: COHRED, 2000)

The International Conference on Health Research for Development, Bangkok, 2000

Ten years after the Commission on Health Research for Development completed its work, the global health research community conducted a review of its achievements and recommendations, while at the same time developing a collaborative agenda for the future. This review had two major components. A series of consultations were conducted in low-income and middle-income countries and regions, along with other consultations (for example, with the donor community). The consultations resulted in a synthesis discussion paper¹ that was used in the second component of the review – the International Conference on Health Research for Development, which was convened in Bangkok in October 2000. Of special interest is the fact that the conference was jointly organized by four major agencies (COHRED, GFHR,

¹ Discussion paper for the International Conference on Health Research for Development, Bangkok, 2000.

WHO and the World Bank) with additional participation by many other organizations and agencies concerned with global health research.

Additional preparations for the Bangkok conference included special articles in professional journals such as the *British Medical Journal* (e.g. Lee & Mills, 2000). Several special studies – such as an analysis of financial flows for health research in selected countries (Alano & Almario, 2000) – took place prior to the conference and informed some of the proceedings.

The report of the conference (released in mid-2001) describes the pre-conference consultation process, summarizes the key points in the conference working paper, and describes the conference process and the action plan (presented at the final session) (IOC, 2001). The appendices include transcripts of plenary addresses, along with other relevant background information. While the challenge of equity in development was discussed as an underlying theme, there were few direct references to the specific role of health research in meeting this challenge. Exceptions were workshops on measuring equity, poverty and health and on resource flows into health research. In addition, the theme of gender inequities pervaded many of the small-group discussions, and was highlighted in several of the plenary addresses.

After the Bangkok conference

Since the landmark Bangkok conference, the various partner organizations have continued with their own mandates, for the most part. Other global level activities (under the heading of “building the coalition for health research”) included the creation of a communication and feedback mechanism for the post-conference period (including a dedicated page on the Conference web site); and planning for the Global Forum’s next international conference on health research, “Forum 8”. This is scheduled for 16-20 November 2004 in Mexico City, on the theme “Health research to achieve the Millennium Development Goals”, and will run alongside the Ministerial Summit on Health Research.

Several specific developments relate to the theme of this unit.

- The Global Forum for Health Research published an important study, *Monitoring financial flows for health research* (GFHR, 2001). This document provides an analysis (updated to 1998) of the state of global health funding for research and development. The main findings are that, although the total amount of funding has increased substantially (to US\$ 73.5 billion), the pattern of distribution of these funds has essentially remained unchanged since 1990. Some information was available concerning the level of research funding by low-income and middle-income countries (primarily the latter). Overall, this component has increased gradually during the 1990s, with a small number of countries (such as Brazil and Cuba) approaching the recommended 2% of national health expenditure to be invested in health research (CHRD, 1990). Research funding from private foundations increased in the late 1990s.
- The challenge of equity-oriented health research has recently been addressed by the International Clinical Epidemiology Network (INCLEN). A more

detailed account of this development can be found in the case-study section of this unit.

Research on health inequities

Over the last decade, there have been several important initiatives concerning research and health inequities. Two illustrative programmes are described below, together with a brief note on the Commission on Macroeconomics and Health, which addressed the issue of these health inequalities in its 2001 report. Additional examples can be found in the [Recommended Reading](#) section at the end of this unit.

EQUINET: a regional network for equity in health in southern Africa

Established in 1997, EQUINET is a network of institutions working on equity issues in southern Africa. Its aims are:

- to further the conceptual framework and policy issues in relation to equity in health in southern Africa
- to gather and analyse information to support scientific debate and decisions on equity in health in southern Africa
- to engage stakeholders and, in particular, those social groups whose interests would be better served by more effective pursuit of equity measures in health
- to use all of the above to provide input into policies affecting health at the national level and the regional level of the Southern African Development Community.

The network is supported financially by the International Development Research Centre, Canada (IDRC), and coordinated by Dr Rene Loewenson, Director of the Training and Research Support Centre in Harare, Zimbabwe. An international steering committee, consisting mostly of members from southern Africa, guides the work of EQUINET. Among other activities, the network has published a series of policy papers. These are listed in [Box 3](#).

Global Health Equity Initiative (GHEI)

This initiative began in late 1995 during a meeting of Swedish and American researchers and policy analysts, convened to examine Sweden's experience in reducing inequity. Participants in this meeting recognized the challenge of increasing awareness of health inequities globally, and in particular, the need to develop capacity in low-income and middle-income countries to identify and describe inequity problems, analyse the underlying causes, and test interventions to produce change. This in turn led to the creation of the Initiative in 1996, with funding from the Rockefeller Foundation and the Swedish International Development Agency (SIDA). The Initiative had five objectives:

- to articulate the concepts and values underlying equity in health
- to develop measures and tools for health research and policy to help analyse equity and inequity in health

Box 3. Equinet Policy Series

During the period 1998-2000, the Regional Network for Equity in Southern Africa (Equinet) published a series of policy papers. Some of these were co-published with other regional partners. Below is a listing of the titles.

1. Can research fill the equity gap in southern Africa? By Rene Loewenson. Co-publisher: Training and Research Support Centre (TARSC).
2. Equity in health in southern Africa: overview and issues from an annotated bibliography. By the EQUINET Steering Committee.
3. A review of experience concerning household ability to cope with the resource demands of ill health and health care utilisation. By Jane Goudge and Veloshnee Govender.
4. World Trade Organization agreements: implications for equity and health in southern Africa. Working draft by G. Munot, edited by V. Tyson. Co-publisher: Southern African Development Community (SADC) Health Sector Coordinating Unit.
5. Health and human rights in Southern Africa? By Barbara Klugman and Nana Kgosidintsi. Co-publisher: Women's Health Project.
6. Public participation in health systems. By Rene Loewenson. Co-publisher: Training and Research Support Center (TARSC).
7. Equity in health in southern Africa: turning values into practice. By the Equinet Steering Committee.
8. Public sector subsidies to the private health sector in Zimbabwe. By Oliver Mudyarabikwa. Co-publisher: University of Zimbabwe Medical School.

All eight policy papers can be downloaded in PDF format at: <http://www.equinet africa.org>.

- to encourage empirical research on health inequities within countries in the developing world
- to establish a scientific foundation for proactive advocacy, policies and programmes
- to stimulate action to reduce inequities in health at all levels of society, by providing decision-makers with knowledge and concrete suggestions for change.

During the first phase of the Initiative (1996-2000) six working groups conducted a series of seminars on key conceptual issues. These included ethics, social determinants, gender, measurement, health care financing, globalization and policy. As a complement to this conceptual analytical work, 12 research teams conducted country studies. In an introduction to a recent publication which presents much of the first-phase work, *Challenging inequities in health: from ethics to action* (Evans et al.,

2001), the leaders of the Initiative identify three features that, in their view, make it distinctive.

- “The participants in the Initiative share common values and concerns about equity, an interest that drew many to the Initiative in the first place.”
- “The country studies have been undertaken by study teams within each of the countries rather than by Northern “experts” parachuted in from outside. This is important in terms of generating ownership and ensuring relevance of the results as well as nurturing interest and capacity in health equity analysis.”
- “The participants in the Initiative, through a mutually supportive network, were able to engage in an ongoing dialogue on the multiple complex dimensions of health equity analysis. The meetings that facilitated these exchanges – held in various locations around the world – provided extraordinary opportunities for the diverse group to challenge their own and each other’s thinking about equity in health.
- Although all participants benefited from such an exchange, it was particularly important for those working in countries where there is little or no experience with health equity analysis.”

Exercise 1

You are a senior national health research manager who is planning a national workshop on “equity-oriented health research”. As a starting point, ask yourself the following questions.

- What is known about health inequity in my country? Where would I find useful information about this? (See Tool No. 2.)
- Are there any externally-funded studies concerning health inequities currently being conducted in my country? (See Tool No. 1.)

Exercise 2

You are a trauma surgeon with a research interest in road traffic injuries. Ask yourself the following question.

- When considering the burden of illness due to motor vehicle accidents in my region, what are the causal factors that relate to inequity of access to appropriate health care? How would I investigate these further?

Commission on Macroeconomics and Health

Two of the working groups of the Commission on Macroeconomics and Health (CMH) were concerned with aspects of health inequities – Working Group 1 on health, economic growth and poverty reduction and Working Group 5 on improving health outcomes of the poor.

An adaptation of a Commission working paper by Adam Wagstaff of the World Bank appeared in a recent issue of the *Bulletin of the World Health Organization* (Wagstaff, 2002: see also [Recommended Reading](#) section). In his conclusions, Wagstaff highlights three points.

- There is a considerable knowledge base on the extent of health inequalities between poor and non-poor in developing countries, including a “reasonable amount” about inequalities in health determinants.
- Too little is known about the relative importance of inequalities in the determinants of health and health service utilization.
- Too little is known about the impact of programmes and policies on health sector inequalities.

Conclusions

In summary, the last five years have seen a considerable increase in the amount of research being done about the problem of health inequities. Two particular points can be noted.

- Unfair differences between groups can be better understood when the focus (or “variable”) of the difference is clarified. Examples are: socioeconomic differences; geographical differences (e.g. rural versus periurban, or differences among populations living in defined geographical areas, such as districts or provinces); gender; race.
- A useful distinction can be made between health *status* inequities and health *system* inequities. Health system inequities can include differences in the actual provision of health care or in the costs (and funding) of care – both direct and indirect – and in the accessibility of use of care.

While more is known, there still are major gaps (as noted in Wagstaff's paper above), in both the production and the use of knowledge about health inequities. The [Recommended Reading](#) list below provides more detail about the current state of research into health inequities.

This summary of the current state of health inequities research raises some advocacy and leadership challenges for the health research community to consider.

Tools and resources

Listed below are some examples of available tools related to the issue of health inequities.

1. **Compendium of multicountry studies on equity, poverty and health**

This document was prepared in 1999 by Dana Carr, Davidson Gwatkin and Dianna Fragueiro of the World Bank's Population, Health and Nutrition (PHN) department. The compendium introduces 14 multicountry programmes, and provides summary and contact information for each of them. In a second section, tables display country-by-country lists of studies produced and in progress under the auspices of each programme. For further information, contact Dana Carr at dcarr@worldbank.org.

2. **Country profiles on “socio-economic differences in health, nutrition and population”**

The HNP/Poverty Thematic Group of the World Bank has produced a series of short publications on the health, nutrition and population status and access to related services of most low-income countries, by quintile. These data are displayed by total population, gender and place of residence (rural/urban). The information is available through the World Bank's web site: <http://www.worldbank.org/hnp> (accessed August 2004).

3. **Equity gauge**

This is a tool for tracking gaps in health status at national or subnational levels, first developed and tested in South Africa. Several different versions of this tool are now being used in an increasing number of countries. Along with technical quality, important features of the use of equity gauges include involvement of key health system stakeholders, community ownership and adaptation to ensure that decision-making is facilitated. Experience using equity gauges was shared at a meeting in South Africa in August 2000. The papers and proceedings of the meeting can be found at the following web site: <http://www.hst.org.za>.

4. **Benchmarks of fairness for health care reform**

Led by Normal Daniels, a professor of philosophy at Tufts University, United States of America, this “policy tool” has been applied to aspects of the health care reform process in several developing countries. There are nine benchmarks. For example, Benchmarks 2-4 address different aspects of access to medical services. Benchmark 5 concerns equity in financing. For more information, the following publications are recommended:

Caplan RL, Light DW, Daniels N (1999). Benchmarks of fairness: a moral framework for assessing equity. International Journal of Health Services, 29:853-869.

Daniels N, Light DW, Caplan R (1996). Benchmarks of fairness for health care reform. New York, Oxford University Press.

5. **World Bank Poverty Reduction Group. User’s guide to poverty and social impact analysis of policy reform (draft for comments). Available at <http://www.worldbank.org/poverty>.**

This draft User's Guide is intended to help policy-makers and analysts in developing countries, as well as representatives of donor agencies and civil society organizations, in undertaking poverty and social impact analyses of policy reforms.

6. Kawachi I et al., eds (1999). *Income inequality and health: the society and population health reader*, Vol. 1. New York, The New Press.

This useful volume has some excellent contributions from a wide range of authors on key issues relating to socioeconomic health inequalities.

Case-studies

1. **INCLLEN and equity: a story in the making**

The International Clinical Epidemiology Network (INCLLEN) was initiated in 1982 by the Rockefeller Foundation. The goal was to provide training in epidemiological research for academic clinicians from developing country institutions. Over the years, it has evolved into a “matrix network” that uses diverse disciplinary resources and collaborative arrangements to address health care problems. Currently, it has a membership of over 700 graduates in clinical epidemiology, biostatistics, clinical economics and health social sciences; they are based in 44 clinical epidemiology units and 19 clinical research and training centres in 26 countries.

In October 2000, the network became the INCLLEN Trust, registered as an international nongovernmental organization based in the Philippines. One of its strategic directions involves more emphasis on semiautonomous regional research and training networks. The leaders of these networks sit on a Board of Trustees. The executive office moved from the United States of America to Manila, under the leadership of Dr Mary Ann Lansang, the Executive Director. The organization's revised mission statement now includes an emphasis on equity, reading, in its short form: “research and training for improving equity, efficiency and quality in health care”.

The process of introducing an equity focus into the work of INCLLEN has been most interesting. The challenge was (and is) to help INCLLEN members, most of whom are academic clinicians, to understand the concept of equity and, even more importantly, to incorporate an equity-oriented emphasis into their research and training. The main strategies to date have included the following.

- A paper in the INCLLEN newsletter (July 2001) on the topic of “Equity and INCLLEN”, written by Dr. Tessa Tan-Torres Edejer, an INCLLEN “fellow”. This article can be downloaded from the INCLLEN Trust web site: <http://www.inclentrust.org>.
- The theme of INCLLEN's global meeting in February 2002 was “Equity-Oriented Research: Leadership Challenges in the 21st Century”. The programme included several presentations on this theme. One of the plenary presentations (by Marian Jacobs) was reproduced in the June 2002 *INCLLEN News*. The title is: “Reducing health inequities – the impact of health and

healthcare research on reducing inequities: challenges for the 21st century". (This newsletter and other summaries from the February meeting can also be accessed through the INCLEN web site.)

- A concept paper is being written to stimulate further discussion about INCLEN's distinctive contribution to equity-oriented research.
- The Leadership and Management Program (LAMP) working group has begun to prepare a training module on "Equity-oriented health research", geared to the needs and interests of INCLEN members. An initial workshop on this theme was planned in conjunction with the IndiaCLEN meeting in Trivandrum in September 2002.

This is an ongoing story about how the equity theme can be incorporated into the training, research, practice and advocacy activities of INCLEN members, most of whom are busy academic clinicians.

2. Adapting to economic transition in China

The Chinese health system heavily influenced international policy during the 1970s, when it became apparent that the provision of simple, cost-effective interventions had contributed to dramatic improvements in health. Since the end of that decade, China has been in transition to a market economy. It has experienced sustained economic growth, associated with a dramatic fall in the number of people living below the poverty line. However, changes in the economic and institutional environment have created serious problems for the health sector [Hu and Hu 2002; Gao J *et al*, 2002]. The Chinese experience offers insights into how research can help policy-makers cope with rapid change.

During the early years of economic transition, researchers documented changes in urban and rural health services. A number of studies reported the growing proportion of health expenditure derived from user charges [Zhao, 1999]. They also showed that government health expenditure was much higher in the rapidly growing cities and surrounding areas. Other studies showed how the pricing system encouraged a costly, hospital-based style of medical care [Meng *et al*, 1998]. These findings were published in scientific journals and presented at meetings for policy-makers. As a result, researchers and many government officials share an understanding of the basic concepts of health economics and of the problems that have emerged with the transition to a market economy.

By the mid-1990s there was increasing public concern about problems in the health sector. Public opinion surveys found that the high cost of medical care was one of the greatest concerns of urban residents [Dong, 2003]. There were also mounting concerns amongst rural people. In 1996 the Government organized a national conference to discuss health policy options and since then it has undertaken a series of policy initiatives.

Several features of China's management of transition have influenced the kinds of research undertaken. One is the rapidity of change. As China radically changes its economic system it is simultaneously urbanizing, industrializing and undergoing a demographic and epidemiological transition. The political leadership has coped with these multiple challenges by defining broad objectives for sector development, whilst giving localities considerable freedom of manoeuvre [Liu and Bloom, 2002]. This approach attaches great importance to local innovation. Researchers have played an important role in alerting government to emerging problems and assessing the performance of innovative approaches.

The example of health finance can be used to illustrate the evolution of health systems research. In urban areas, the pre-existing system has come under increasing pressure due to ageing of the insured population, rising costs of medical care and the financial pressures on the many state-owned enterprises through which health and social care is still commonly provided. The central government encouraged city governments to test new models of health insurance. Towards the end of the 1990s it decided to shift responsibility for urban health insurance to the Ministry of Labour and Social Security. Studies have documented the increasing difficulties experienced by people on lower incomes in paying for health care [Liu *et al*, 2002; Dong, 2003; Chen *et al*, 2004]. The research also documents the unsustainably high costs generated by a combination of a rapidly ageing population and the dependence on hospital-based care for the elderly. These findings have stimulated efforts to make services more cost-effective and provide a safety net for the poor.

A number of studies have documented the dependence of rural health facilities on user charges. They have shown how health workers give increasing priority to curative care and the sale of drugs [Zhan *et al*, 1997; Dong *et al*, 1999]. During the period of the command economy the communes had organized the so-called collective medical system, which reimbursed a proportion of the costs of hospital care and other services. By the mid-1980s, studies had documented the collapse of most of these schemes. The Government has encouraged localities to test alternative financial models.

During the 1990s there were several experiments with rural health insurance. The early focus was on the design of benefit packages. There was extensive discussion of the advantages and disadvantages of covering routine care and major illness. It turned out to be unexpectedly difficult to establish new schemes, for a number of reasons. Some local government units diverted resources for other purposes. Some overstuffed health facilities sold more drugs or acquired new equipment to generate more revenue. Many schemes eventually lost public support and recent studies have highlighted the importance of public trust in insurance schemes and the health facilities that provide services [Wang *et al*, 2001; WHO, 2003]. They emphasize the need to make schemes more accountable to the population.

A parallel set of studies looked specifically at the needs of the poor. This began in the context of a large rural health project, which tested a targeted benefit for the poor. Studies demonstrated that the funds are reaching poor people, but that there are problems in the selection of beneficiaries and the use of funds to purchase cost-effective services. The Government has announced that it will establish a nationwide programme of health benefits for the rural poor. Research will be needed on, among other things, targeting, selecting appropriate benefit packages and control of hospital performance.

The recent SARS outbreak has brought the importance of a coherent and effective health system to the attention of senior policy-makers in China. This has created an important window of opportunity for change. Researchers will play an important role in assessing the impact of new policy measures in different regions and contributing to the refinement of health system strategies on the basis of experience.

Recommended reading

Bulletin of the World Health Organization (2000), Vol. 78, No. 1.

Most of this issue of the Bulletin is on the theme of "Inequalities in health". Following an editorial introduction by Richard Feachem, there is a paper by Davidson Gwatkin on "Health inequalities and the health of the poor". This paper includes a commentary (and a framework) for the five articles that follow. These represent specific studies on health inequities. An interesting and helpful "Round table discussion" comments on both Gwatkin's reflection and the five papers. As a reminder that research about health inequities is not new, a "public health classic" by William Farr is reprinted; it was first published in 1885.

Evans T et al., eds. (2001). Challenging inequities in health: from ethics to action. Oxford/New York, Oxford University Press.

This multiauthor book presents the work of the Global Health Equity Initiative (GHEI) described above. There are four main sections: "Establishing values"; "Assessing and analyzing the health divide"; "Tackling root causes"; and "Building efficient, equitable health care systems". A concluding chapter presents ideas about "Developing the policy response to inequities in health: a global perspective." This helpful chapter includes ideas for international health organizations to consider in a section titled: "Strategies for a global response." Included as chapters in the book are 12 country-based studies from both high-income and low-income countries.

Leon D, Walt G, eds. (2001). Poverty, inequality and health: an international perspective. Oxford/New York, Oxford University Press.

Another multiauthor publication, this book is the product of a three-day meeting held at the London School of Hygiene and Tropical Medicine in April 1999. It contains 17 chapters, roughly half of which are case-studies from low-income countries. Of particular interest to researchers is a chapter by representatives of WHO on "Measuring health inequality". The final chapter is by Amartya Sen on "Economic progress and health".

Sen A (1992). Inequality reexamined. New York, Russell Sage Foundation.

Sen A (1999). Development as freedom. New York, Alfred A. Knopf.

Wagstaff A. (2002). Poverty and health sector inequalities. Bulletin of the World Health Organization, 80:97-105. (Note: this paper is based on the paper "Poverty and health" [Commission on Macroeconomics and Health Working Paper No. WG1:5, available at: http://www2.cid.harvard.edu/cidcmh/wg1_paper5.pdf]).

Poverty and ill-health are intertwined. Poor countries tend to have worse health outcomes than better-off countries. Within poor countries, poor people have worse health outcomes than better-off people. This association reflects causality running in both directions: poverty breeds ill-health, and ill-health keeps poor people poor. The evidence for inequalities in health between the poor and non-poor and the consequences for impoverishment and income inequality associated with health care expenses is discussed in this article. It gives an outline of what is known about the

causes of inequalities and about the effectiveness of policies intended to combat them. It is argued that too little is known about the impacts of such policies, notwithstanding a wealth of measurement techniques and considerable evidence about the extent and causes of inequalities.

Walt G (1994). Health policy: an introduction to process and power. Johannesburg, Witwatersrand University Press.

The book discusses how politics affect decision-making and health policies. Of particular interest is the chapter on how interest groups try to influence government policy on particular issues at various stages of the policy process. There is also a description of how different groups may form alliances to propose or resist policies.

WHO (World Health Organization) (1998). Health for all in the twenty-first century (World Health Assembly document A51/5). Geneva.

This document discusses the new threats and opportunities in the 21st century for health for all. Globalization, new technologies and stronger partnerships between private and public sectors and civil society are mentioned as the key influences that health systems need to recognize in the 21st century.

World Bank Group (1997). Sector strategy: health, nutrition, and population. Washington, DC, World Bank.

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