

State of the Art in Research on Equity in Health

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Abstract This essay provided the introduction to a workshop in Bellagio, Italy, on the subject of translating research into policy for equity in health. The essay first defines equity in a way that facilitates its assessment and monitoring and then summarizes evidence from existing research. Directions for developing policy strategies follow from these principles. The role of health services in influencing the distribution of health in populations is discussed in the special context of primary-care-oriented health systems that are, at the same time, more effective, more efficient, and more equity producing than is the case for specialist-dominated health systems.

History of the Concept of Equity in Health

The beginning of interest in equity in health is difficult to pinpoint. Certainly, the issue of social disparities in health has a long history, dating back in modern history at least to the writings of Frederick Engels, who, in 1845 in *The Condition of the Working Class in England*, asked, “How is it possible . . . for the lower class to be healthy and long-lived? What else can be expected than an excessive mortality, an unbroken series of epidemics, a progressive deterioration in the physique of the working population?” (128). Impetus to the policy relevance of social determinants of health was provided by the Black report. This report, titled *Inequalities in Health*,

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was initiated by the Labour government and published in 1980 in the United Kingdom; it described and analyzed the existing social inequalities and proposed government actions to overcome them. Gavin Mooney, in 1983, addressed the ethical dimensions of the inequalities, using the term “equity” in his discussion of implications for health service resource allocation of equal expenditure per capita, equal resources per capita, equal resources for equal needs, equal opportunity of access for equal needs, equal utilization for equal needs, equal extent of meeting priorities, and equal health outcomes.

The World Health Organization (WHO) undertook a global initiative on *Equity in Health and Health Care* in 1995 to focus the attention of governments and international agencies on health equity within countries and between countries (World Health Organization 1996). In 2002, an annotated bibliography provided an overview of the published literature up to that point to show the directions being taken on health equity research, including theories, methods, and interventions to understand the genesis of inequities and their remediation (Macinko and Starfield 2002).

This essay defines equity in health in a manner that facilitates its recognition and monitoring and then summarizes current understanding about its attainment. It then turns to the challenges to policy formulation that are directed at improving equity in health, using the summarized evidence and the case studies presented at the conference on Using International Experiences in Translating Health Equity Research into Policy, held in Bellagio, Italy, in April 2003.

Definition of Equity in Health

The most widely cited definition of equity in health, proposed by Margaret Whitehead (1992: 430) as “differences in health that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust,” assumes that “unfairness” and “unjustness” can be measured. In fact, subsequent work by Norman Daniels and his colleagues (1996) advanced the science and art of assessing unfairness in their development and implementation of measures of the unfairness of health services delivery systems. With an increasing focus on equity in health (rather than on health services), notions of fairness became problematic, as health has no counterpart in anything measurable either in individuals or populations, and fairness in health may differ widely depending on cultural contexts.

As a result, the International Society for Equity in Health, at its inaugural meeting in Havana in June 2000, adopted the following definition:

Equity in health is the absence of systematic and potentially remediable differences in one or more aspects of health across socially, demographically, or geographically defined populations or population subgroups (International Society for Equity in Health 2000). (Conversely, inequity in health is the presence of such differences.)

This definition is both consistent with currently accepted notions of social justice (fairness) and stated in terms that facilitate measurement and, thereby, monitoring. It implicitly incorporates the concept of fairness (by speaking to systematic differences); it meets Amartya Sen's (1999) notions of people's capacity to flourish as human beings (since it addresses "one or more aspects of health"); and it meets John Rawls's (1971) notion that it does not require the sacrifice of the worst-off (by implicitly comparing one population group with another and including potential remediability). It was developed for the purpose of facilitating the planning and conduct of research and analysis directed at informing policy decisions regarding equity in health and goes well beyond conceptualizations that address only particular strategies, such as equity of access to or provision of health services.

The major elements of this definition have been accepted by others (Braveman and Gruskin 2003; Graham 2004); further refinements reflect notions that the most relevant differences are those between better- and worse-off social groups selected a priori based on who historically has been more or less advantaged in a society. Thus, Paula Braveman (2005) narrows the definition to a "particular type of difference in health that can be shaped by policies: . . . a difference in which disadvantaged social groups (such as the poor, racial/ethnic minorities, women, or other groups that have experienced social disadvantage or discrimination in the past) systematically experience worse health or greater health risks than other social groups."

This is in marked contrast to the approach taken in the *World Health Report 2000* (World Health Organization 2000), which used the term *inequities* to refer to the degree of differences across individuals in the population. The latter position has been criticized as not compatible with notions of social justice (Almeida et al. 2001; Landmann-Szwarcwald 2002; Houweling, Kunst, and Mackenbach 2001; Braveman, Starfield, and Geiger 2001; Navarro 2000; among others) because it disregards the ethical concern, such as expressed by Rawls (1971, 1985), that priority should be given to improving the situation of the most socially disadvantaged in a society. From the viewpoint of public policy, it is preferable to have a definition of equity that is compatible with notions of distributive justice.

The remainder of this article proceeds from the notion of equity as systematic differences and draws from the literature on major societal influences on the distribution of health in populations. Using evidence from diverse sources, it examines examples of research cross-nationally and derives principles based on observation and replication of findings in several countries. Because the focus of health equity research and policy worldwide is primarily on social disadvantage, the essay deals primarily with this aspect of inequity.

Because health is a product of many types of previous and current exposures superimposed on genetic predispositions, achieving equity in health is ultimately a political process based on a commitment to social justice rather than to survival of the fittest. It entails an intersectoral approach involving many if not all of a society's policies, including those directed at the physical and social environment, economic policy, and educational policy (Acheson 1998). Clues as to the likely importance of national policy come from evidence of marked variations in levels of health among countries with very similar levels of wealth. For example, Cuba and Mexico have approximately the same gross national product per capita (about \$1,000), but about seventy more children per 1,000 born survive to age five in the former than in the latter (Karolinska Institute n.d.). Similarly, in Sri Lanka, with a gross domestic product (GDP) per capita of about \$500, sixty more children per 1,000 born survive to age five than in Indonesia, with a per capita GDP even higher (about \$1,000/capita) (ibid.).

Current Evidence Regarding Influences on Health Relevant to Equity

Despite the very large research literature on social determinants of health, relatively little has been written that would inform the choice among policy alternatives to address inequities. A few generalizations may help to set the stage for a consideration of promising avenues of approach that could be gleaned from (if not necessarily proved by) recent studies.

There is no basis for expecting a single characteristic or set of characteristics to be most influential in causing inequities in health. Evidence indicates otherwise (Lynch et al. 2004). Whereas most of the research on social determinants uses variables obtained at the level of individuals (fig. 1), equity research requires a model of the influences on the health of populations at various levels (community, local, state, and national; fig. 2). This population model of influences on the distribution of health encourages consideration of the impact of distal factors in the political and

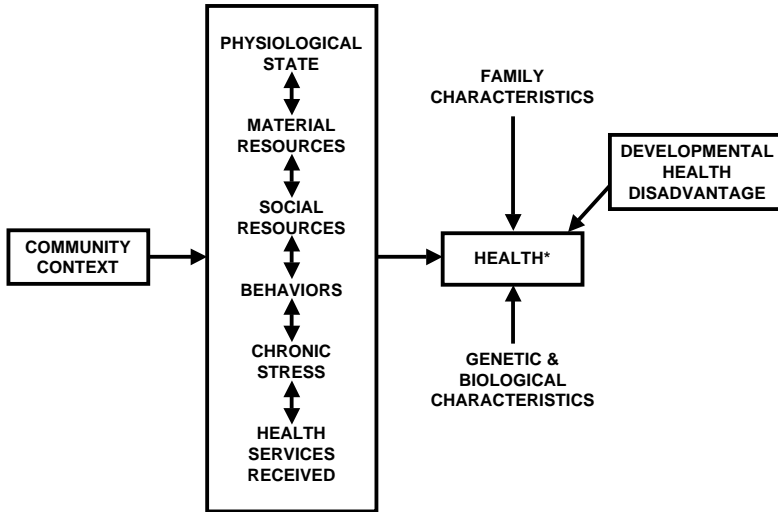


Figure 1 Social Influences on Individual's Health

*"Health" has two aspects: occurrence (incidence) and intensity (severity).

policy realms on more proximal factors at the community level that, in turn, influence the constellation of characteristics at the individual level. As equity research matures to specifically address the implications for policy, it would be expected that more influences of the more distal kind would emerge.

Influences on Health Related to Causal Pathways

Pathways influencing health depend on the particular type of health measure. Figures 1 and 2 indicate that the relative impact of various types of influences will depend on whether the health measure concerns the occurrence (incidence) of illness (individual discomfort and disease) or on the prevalence of manifestations of progression (including disability and death). Jo Phelan et al. (2004) hypothesized and demonstrated that, for more preventable causes of death (i.e., those about which more is known regarding prevention and treatment), socioeconomic status (SES) is more strongly associated with mortality than for less preventable causes, because what is known about cause can more easily be manipulated by the more socially advantaged by virtue of their greater exposure to resources.

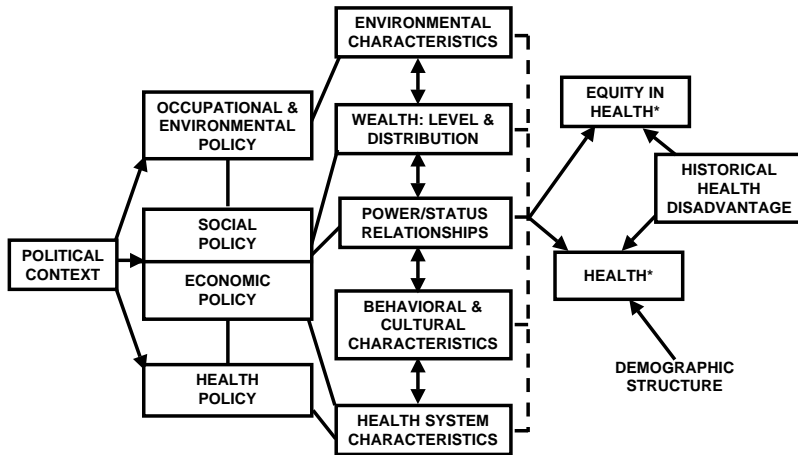


Figure 2 Societal Influences on Population Health

Note: Dashed lines indicate the existence of pathways through individual-level characteristics that most proximately influence health.

*"Health" has two aspects: occurrence (incidence) and intensity (severity).

The choice of particular health outcomes to be addressed in research needs to be taken into account in interpretation of the findings. Although narrowing the field of inquiry to specific diseases may help in specifying pathways of effect, the reality is that ill health in populations is more than specific diseases. People at lower levels of income not only have more illnesses, but they also have more comorbidity (O'Donnell and Propper 1991; van Doorslaer, Wagstaff, and Rutten 1993). Differences in health between poor and less poor populations are greater for severity than for incidence, at least in some countries (Gwatkin 2003; Starfield 1992). This has important implications for strategies to reduce inequity. Health services preferentially affect severity (including mortality) from ill health. From the viewpoint of equity, effective health services directed at early detection and prevention of progression are likely to have a considerable impact in reducing disparities in severity of illness, whereas interventions outside the health sector are likely to have relatively greater impact on the occurrence (incidence or prevalence) of illness.

Moreover, the salience of particular interactions among types of influences in pathways differs from one population to another. For example,

neighborhood poverty rates and housing inadequacy increase the rates of very preterm births for African Americans, whereas the fraction of female-headed households is influential for Hispanics, and the low fraction of people employed in professional occupations is influential in white subpopulations (Reagan and Salsberry 2005). Thus, in analyses directed at influencing policy, it is important to stratify populations into relevant subgroups as well as to consider the particular health outcomes that are the target for change.

The basis for many types of inequities in health lies in early life (Galobardes, Lynch, and Davey-Smith 2004). The two main areas of influence involve poorer maternal health prior to pregnancy (and hence influences on fetal growth) and infant/child infections, both of which are more common in socially disadvantaged populations. These early childhood manifestations of poor health have correlates in health at older ages (Davey-Smith and Lynch 2004).

Across the age span, the weakest association between income and health is in old age (Judge and Paterson 2001). Social disadvantage is damaging at any stage in life but is especially harmful when experienced early in life (Benzeval, Dilnot, and Judge 2000). Thus, other things being equal, priority should be given to effective interventions at younger ages.

Although it might be expected that racial and socioeconomic disadvantage would reinforce each other in producing health inequities, there is evidence that racial differences in health outcomes are stronger among higher SES strata than among lower ones, at least with regard to birth weight. Consistent with other information, this is likely to be, in part, a result of prior racial discrimination and poorer health care experienced by pregnant women long prior to their pregnancies (Williams 1999).

Educational attainment influences primarily those aspects of health that require knowledge (Winkleby et al. 1992; Oliver 2001). That is, policies to provide better educational programs in areas with lower educational achievement will decrease inequity primarily in those aspects of health that are particularly related to preventive activities of individuals. Moreover, interventions that rely on structural changes to improve health tend to be more effective than interventions targeted at individual behavior, because they are more effective for individuals with limited social resources (O'Campo et al. 1997; Arblaster et al. 1996). Thus, structural changes at the population level that do not require changes in initiatives taken by individuals are more effective where improvement is warranted.

Populations of lower social class are subjected to the inverse care law. Enunciated by Julian Tudor Hart in the early 1970s, this law asserts that populations most in need of health services are the least likely to receive them (Hart 1971). Equity of access to primary care (family medicine) services has been achieved in some countries (as demonstrated for Canada, the Netherlands, and Scandinavian countries as well as for the elderly population in the United States as a result of Medicare), but inequity of access to specialty services is prevalent everywhere it has been studied, even in countries with guaranteed financial access (van Doorslaer, Koolman, and Jones 2004). The impact of these differences on health is not yet clear; in the few places it has been examined with regard to mortality (both in total as well as for specific conditions), a larger supply of specialists is associated with more frequent use of medical procedures, but also a higher rate of age- and cause-specific mortality (i.e., greater age- and cause-specific mortality with higher specialist to population ratios; Fisher et al. 2003a, 2003b; Bongers et al. 1997; Dunlop, Coyte, and McIsaac 2000; Frohlich, Fransoo, and Roos 2002; Veugelers and Yip 2003; Starfield et al. 2005), but the literature on health gains from specialty care for nonlethal health conditions is sparse. There is evidence, however, that preventive care delivered in specialty practice is inequitable in that it is available preferentially to the more socioeconomically advantaged, at least in Belgium, where the study was conducted (Lorant et al. 2002). Because of the likelihood that unregulated distribution of health services will lead to preferential use of these services by the more socially disadvantaged, programs specifically designed and targeted to the disadvantaged are required to improve equity (Wagstaff 2002b).

Although there are few studies of impacts on health that are in the political or policy realms, those analyses that exist suggest the likely importance of such distal factors on population health. The few existing analyses address the impact of political regimes, political and economic participation of population subgroups, social transfers and social welfare policies, female representation in political and economic affairs, and racism. Vicente Navarro and Leiyu Shi (2001) examined the relationship between the overall distribution of income derived from capital versus labor, wage dispersion in the labor force, the redistributive effects of social policies, levels and types of employment, levels of public expenditures and health benefits, and public support of family services and infant mortality in advanced Organisation for Economic Co-operation and Development countries and found that social democratic regimes generally had lower infant mortality rates. Carles Muntaner et al. (2002) found that five char-

acteristics of welfare states and low economic inequality were associated with better life expectancy, self-rated health, birth weight distributions, and age- and cause-specific mortality in sixteen wealthy countries. Ichiro Kawachi et al. (1999) found that indices of women's political and economic status were associated with lower female and male mortality rates as well as activity limitations in the fifty states.

As most interventions initially reach those of higher socioeconomic status and only later affect the poorer segments of society, there are early increases in inequity for morbidity and mortality indicators that must be considered in monitoring changes in equity (Victora et al. 2000; McKee 2002). Consequently, one needs to assess the impact of interventions on equity by understanding where in the life cycle of the intervention each country is. For each new policy intervention or technology, changes that initially do not seem to increase equity may do so in the longer run. This can be identified by focusing on countries and localities that are furthest along the diffusion curve.

Influences on Health Related to Place (Geography)

The magnitude of inequities in health not only varies within each society over time but also varies between societies. For example, socioeconomic differences in mortality appear to be larger in northern than in southern European countries. This might be due to a varying socioeconomic gradient in ischemic heart disease (Kunst et al. 1998). Thus, the existence of disease-specific disparities, along with the prevalence of the disease (and, hence, its importance in the population), provides important clues about the genesis of disease and its distribution in the population.

At least in some countries, for example, Canada, the health of socially disadvantaged people who live in generally wealthier areas is better than the health of the similarly disadvantaged who live in poor areas (Statistics Canada 2004). There is mixed evidence, however, of how the health of advantaged populations is affected by the local presence of disadvantaged groups (Weich, Lewis, and Jenkins 2001; Subramanian, Kawachi, and Kennedy 2001). The extent to which the health of the more advantaged is influenced is likely to determine the strength of the consensus for or against policy changes to decrease inequity.

Variability in health across geographic areas (within countries) is greater among the lower socioeconomic classes (Regidor et al. 1997). This suggests that there are likely to be differences in social, environmental,

and health policies that, themselves, have an impact on more proximal influences on health.

The influence of income inequality in particular areas is widely debated, but consensus is emerging that it is place specific (Craig 2005) and more salient as an influence on health in the United States than in most other industrialized countries (Macinko et al. 2003; Beckfield 2004). The salient effect in the United States is most likely a consequence of racial composition of the U.S. population and the historical impact of racial discrimination in the country (McLeod, Nonnemaker, and Call 2004).

Methodologic Considerations in Equity Research

Interpretation of research findings requires consideration of the variables and methods employed in the analysis. Improving average health is not necessarily associated with better distribution of health, that is, increased equity (Wagstaff 2002a; Acheson 1998; Gwatkin 2002). As a result, policy decisions to improve average levels of health (as, for example, to improve international rankings) will not necessarily improve equity in health and may even decrease it. Improvement in equity in health, as measured by decreased absolute differences, may appear as increases in relative differences (Wagstaff 2002a). Thus, the extent to which goals are met depends on how they are stated—as percentages or absolute reductions.

As the level of geographic aggregation influences the extent to which income inequalities exist (Soobader and LeClere 1999), the choice of the level of analysis (country, state, county, urban versus rural, census tract, block level) will influence the conclusions about the distribution of ill health.

Moreover, policy to increase equity in health and resulting in both relative and absolute changes may have little practical impact because the frequency of the problem addressed is rare in the population (Oliver, Healey, and Le Grand 2002). Thus, specific targets for rare problems, even if achieved, will not affect overall differences in equity in health in the population.

Policy Implications

The knowledge provided by the summary of research on equity suggests several directions for policy strategies. Several countries make explicit attempts to regulate the distribution of health practitioners so that resources are distributed more equitably. For example, some northern

European countries and some provinces in Canada do not reimburse or otherwise pay physicians who settle in areas that already have enough physicians. In Australia and in Canada, non–primary care specialists receive lower reimbursements if they see patients who are not referred by primary care physicians. Such a solution is technically feasible in the United States, particularly in the case of the Medicare program, although it will undoubtedly be politically difficult given the power of medical academia and specialist physicians. One alternative is for federal and state leadership to expand the network of community health centers. There is considerable evidence that health policies that strengthen primary care are associated with better levels of health and with better preventive care (Pan American Health Organization 2005). The evidence for the benefit of community health centers in deprived areas of the United States is strong and extends to lower rates of low birth weight, better quality of care, and higher levels of preventive services (Starfield, Shi, and Macinko 2005).

Goals and objectives should be explicitly linked with specific interventions. As noted above, different aspects of health respond preferentially to some types of interventions. For example, health-promoting behaviors are heavily influenced by educational levels, whereas prevention and management of some illnesses are more sensitive to the level of material resources. The U.S. health objectives (U.S. Department of Health and Human Services 2000) do not specify alternative health policy interventions that might be expected to influence the attainment of the objectives. Doing so would help to identify those objectives that are influenced by the same type of intervention, thus enabling more efficient targeting of resources to deal with them. For example, those aspects of health that are common and particularly amenable to primary care services (as distinguished from other types of services) are known (table 1); policies aimed at strengthening primary care could be expected to improve health levels for these particular health problems.

Policies directed at improving physical and social environments for populations will result in greater equity because they do not require behavior change that is particularly influenced by material wealth, education, or social connectedness of individuals. For example, mandated desegregation following a 1963 U.S. Appeals Court decision as well as invalidation of the separate but equal clause in funding for hospital construction were followed by large improvements in the health of African Americans in the South (Mechanic 2002). Another example is provided by experience in Spain, which enacted a law in the mid-1980s to develop primary care health centers throughout the country. An evaluation showed that impact

Table 1 Consensus Indicators for Evaluating Outcomes of Primary Care at Population Levels

Hospitalizations for ambulatory care-sensitive conditions
Accomplishments in prevention not related to specific diseases: immunization status, personal behaviors (breast feeding, not smoking, avoidance of obesity, use of seat belts, use of smoke detectors, physical activity, good diet)
Reduced frequency of conditions related to prevention: stroke, amputations resulting from diabetes complications, surgery for preventable eye conditions, incidence of sexually transmitted diseases and AIDS
Unwanted pregnancies
Low incidence of vaccine-preventable diseases
Low incidence of child abuse
Low incidence of attempted suicide
Low incidence of accidental poisoning
Low incidence of adverse effects of medications
Low postneonatal mortality rates
Improved quality of life, including decreased disability from
Asthma
Osteoarthritis
Postmyocardial infarct
Shortened duration of symptoms associated with peptic ulcers
Reduced use of unnecessary resources, including
Laboratory tests and procedures
Unjustified medication (such as antibiotics for influenza, growth hormone treatment for short children)
Improved quality of dying/terminal care
Rates of death due to
Asthma
Hypertensive and cardiovascular disease
For all health indicators—reductions in disparities across population subgroups

Source: Starfield 1998; Kunitz and Pesis-Katz 2005.

resulted in the form of reduced death rates from conditions expected to be amenable to primary care, and it did so preferentially in those areas that were reformed first because they were the most socially deprived (Villalbi et al. 1999). However, policy changes that are not specifically intended to reduce inequities may have no or opposite effects. A prime example is legislation directed at the de-leading of gasoline, which was very effective in reducing blood lead levels among children overall (Cummins and Jackson 2001) but did not reduce the existing disparities in blood lead levels between disadvantaged and more advantaged populations. In this case, the

major contributor to raised lead levels in the disadvantaged segments of the population—lead exposure from residing in old housing stock—was not addressed by the legislation.

Policies directed at infants and children will have much greater long-term effect than will policies directed at older individuals or populations. This is not only because children have a longer time to live, but primarily because of the influence of early health on later health (Davey-Smith and Lynch 2004).

These observations indicate that the choice of policy alternatives should be informed by evidence as to what types of policy change are likely to lead to what types of effects. Choice depends upon whether the goals are improved overall health or better distributions of health within the population, whether the potential for indirect effects is possible, and the relative costs in the long and short term. The possibility for indirect effects should not be neglected; as noted above, even though the influence of political context is distal, studies have shown a relationship between the type of government and at least certain aspects of the health of populations.

The likely possibility that national health goals to improve overall health may lead to greater inequities unless special efforts are made to have a preferential effect on the disadvantaged has profound policy implications. On the whole, the areas in which inequities in health primarily exist are in common manifestations of ill health and in the severity and progression of common illnesses. Second, interventions that are directed at societal and policy changes are likely to have more of an impact than interventions directed at individuals (Mackenbach and Stronks 2002). Third, there is a clear role for appropriate health services in reducing inequities in health, for example, by attacking severity of illness and preventing comorbidity.

Special Challenges for Policy Concerning Primary Care

Because morbidity clusters in particularly vulnerable subgroups rather than being randomly distributed (Starfield 2001; Starfield et al. 2003; van den Akker et al. 1998), overall improvements in equity in health are likely to require generic interventions rather than ones directed at specific manifestations of ill health (such as diseases). This logic provides the basis for hypothesizing that health services interventions that are directed at people (i.e., primary care) have more of a likelihood of improving overall equity in health than those directed at specific diseases. An additional rationale for this hypothesis is that primary care is more accessible to people than

is specialty care; also, primary care is less costly, thus making it possible to share resources more equitably across the population.

From the vantage of developing countries, investments in primary care produce more equity than investments in the health system in general. For example, Castro-Leal and colleagues (2000) have shown that the highest 20 percent of the population receives well over twice as much benefit from overall health services investment than the lowest 20 percent (30 percent versus 12 percent). For primary care investments, however, the rich-poor benefit ratio is much lower (23 percent versus 15 percent).

The equity-enhancing effect of a stronger primary care orientation is also evident from recent studies in several countries, including at least one that is highly inequitable and highly specialized (the United States). This evidence documents the importance of a strong primary care infrastructure to a health system, both for effectiveness (Starfield and Shi 2002; Starfield 2003; Starfield, Shi, and Macinko 2005) and for equity (Starfield 1998; Shi et al. 2005; Politzer et al. 2001; Shi, Starfield, et al. 2003; Shi et al. 2001; Starfield, 2002; Shi, Macinko, et al. 2003; Diez-Roux, Link, and Northridge 2000; Kahn et al. 1998; Mackenbach 2003).

The United States has a particularly poor primary care infrastructure, which is at least partly responsible for its relatively poor standing on health measures among its peer industrialized countries (Starfield and Shi 2002). Based on the evidence summarized above, it appears that any health care reforms, including ones focused on increasing or universalizing coverage, will have to deal with the issue of strengthening primary care and placing specialty services within a framework that recognizes the key role of primary care services in their use. From the viewpoint of evidence of equity, it is instructive that the health policies that created and support community health centers have been followed by clear evidence of fewer inequities in several aspects of health between population groups characterized by socioeconomic disadvantage, minority race, or different ethnicity as compared with the general population, including populations covered by Medicaid as the source of financial access (Starfield 2003, 2004a, 2004b). More than one policy strategy is needed; the possibilities range from changing aspects of the delivery system, to alterations in financing mechanisms, to improving medical education, to increasing the attractiveness of primary care to medical trainees (Starfield and Simpson 1993).

One characteristic is, however, certain: government policy can encourage improvements in health services. The international comparative study of health services and health outcomes (Starfield and Shi 2002) showed

clearly that countries with health policies more conducive to primary care practice achieve better quality of practice and better outcomes. The relationship between policy and practice is strong and consistent in that all countries with better primary care make attempts to distribute resources equitably throughout the population (at least with regard to horizontal equity, which is based on equal resources for equal need), to provide publicly accountable financial access to services, and to minimize co-payments for services to a low or nonexistent level. When ranking countries according to characteristics of policies conducive to good primary care, there was an almost perfect straight-line relationship between these rankings and the strength of the primary care orientation of practices in the individual countries, suggesting that improvements in the organization and delivery of clinical practices require support in conducive health policies. This relationship was shown in two successive studies, a decade apart, indicating that it is robust over time (Starfield and Shi 2002; Starfield 1994).

Implications of the Bellagio Case Studies for U.S. Policy

The case studies presented at the Bellagio meeting are instructive with regard to their relevance for U.S. health policy. All of the case studies explicitly or implicitly recognized that addressing inequities in health requires

- the problem to be recognized and documented,
- existing principles of justice and explicit goals for attaining it,
- specification of alternative policy strategies,
- widespread involvement (including those who are especially affected), and
- support at high levels of government and/or strong and dynamic leadership.

In Chile, the effort has been directed at developing goals and objectives very similar to those in the United States and developing plans for monitoring their attainment. However, the engagement of the population and of high officials in the government has been much greater, particularly in the implementation phase, than appears to be the case in the United States.

In South Africa, recognition of the problem of HIV/AIDS was followed by an inadequate specification of policy alternatives. The particular lesson for the United States is that addressing the challenges of a particular

disease (e.g., HIV/AIDS) may be better approached through a strategy of providing widespread basic (primary care) services, which would have been more acceptable to the affected population and its representatives.

The experience in the United Kingdom, particularly as represented by the government-commissioned Acheson report, is also instructive. In that report, alternative strategies were delineated: addressing poverty, medical care for the “major killers,” improving transport to public services, making environments safer, and dealing with the effects of social exclusion. However, it was criticized for lacking a coherent ethical framework and for focusing on improving overall health rather than its distribution. Although priorities were not set and no relative costs and benefits of the individual alternatives were provided, at least the range of interventions with likely positive effects on equity in health were specified. The contrast with the approach in the United States is striking; a comprehensive report commissioned by a concerned government led to a range of governmental policies directed at various aspects of the recommendations in the United Kingdom, whereas the major effort in the United States was to set goals without a specific set of governmental strategies.

The experience in the Netherlands was based on a long history of research concerning influences on health and on a long tradition of social solidarity that made inequities unacceptable. Several policy strategies were chosen, the most prominent of which was to change individual behaviors that were risks for poor health. Other strategies were reducing physical workloads; increasing the provision of primary care in geographic areas with poor access; improving local networks particularly to address social problems among the mentally ill; maintaining existing pro-equity education policies, redistributive income policies, and work disability payments; and encouraging pro-equity health services financing.

China was faced with large proportions of the population having no financial access to health services. Once it was shown that health problems in rural areas were themselves generating poverty, individuals at the highest levels of government realized the political advantages of taking steps to reduce poverty by providing financial access to health services in the form of medical care insurance to this population group. The United States had already adopted that type of strategy in the form of the Medicaid program directed at its poor population; its lack of success in eliminating disparities in health insurance and in receipt of adequate services may well provide a lesson for China as it implements its policy.

Conclusions

Efforts to mount interventions to improve equity in the distribution of health can be made more effective and efficient when informed by well-conceptualized and well-conducted evidence-based frameworks of policy-relevant influences on health. There is considerable evidence, for example, that the organization of health services, particularly when built on a strong primary care base, improves effectiveness, efficiency, and equity in health. Alternative and complementary strategies, based on knowledge in other areas of influences on health, are also warranted. An informed and committed national policy toward equity in health depends on actions based on such evidence.

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