



The concepts and principles of equity and health

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Target 1

Equity in health

By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups.

Keywords

HEALTH STATUS
SOCIOECONOMIC FACTORS
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DELIVERY OF HEALTH CARE
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^a *Targets for health for all*. Copenhagen, WHO Regional Office for Europe, 1985 (European Health for All Series No. 1).

All the 32 Member States in the World Health Organization European Region adopted a common health policy in 1980, followed by unanimous agreement on 38 regional targets in 1984. The first of these targets is concerned with equity:

By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups (1).

In addition, equity is an underlying concept in many of the other targets. At present, the targets are being reassessed and revised, in particular moving away from a focus on physical health status as measured by mortality to encompass, wherever possible, many other dimensions of health and wellbeing. But still the underlying concept of equity in health has been judged to be just as important for the 1990s as it was when the programme began (2).

However, it has not always been clear what is meant by equity and health, and this paper sets out to clarify the concepts and principles. *This is not meant to be a technical document, but one aimed at raising awareness and stimulating debate in a wide general audience, including all those whose policies have an influence on health, both within and outside the health sector.*

Why is equity in health so important?

To appreciate the importance of striving for equity in relation to health, it is necessary to be aware of just how extensive are the differentials in health found in Europe today. *In every part of the Region, and in every type of political and social system, differences in health have been noted between different social groups in the population and between different geographical areas in the same country* (for reviews see references 3–11).

Firstly, *there is consistent evidence that disadvantaged groups have poorer survival chances*, dying at a younger age than more favoured groups. For example, a child born to professional parents in the United Kingdom, can expect to live over five years more than a child born into an unskilled manual household (12). In France, the life expectancy of a 35-year-old university lecturer is nine years more than that of an unskilled labourer of the same age (13). In Hungary, the Budapest Mortality Study found that males living in the most depressed neighbourhoods had a life expectancy of about four years less than the national average, and of five and a half years less than those living in the most fashionable residential district (14). In Spain, twice as many babies die among families of rural workers than among those of professionals (15).

Large gaps in mortality can also be seen between urban and rural populations and between different regions in the same country. For example, infant mortality rates in the USSR in 1987 were over 21/1000 live births in urban areas, compared with over 31/1000 live births in rural areas (16).

The scale of the differences in mortality is immense. For example, it has been calculated that if manual workers and their families in the United Kingdom had experienced the same death rates as their nonmanual counterparts in 1981, then there would have been 42 000 fewer deaths during that year in the age range 16–74 years (17).

Secondly, ***there are great differences in the experience of illness. Disadvantaged groups not only suffer a heavier burden of illness than others but also experience the onset of chronic illness and disability at younger ages.*** For example, in Finland, 42% of people with lower incomes suffer chronic illness, as opposed to 18% of the high income group (18). In a study carried out in the United Kingdom of people who died prematurely in different neighbourhoods, men and women in poorer areas were likely to have been chronically ill or disabled for longer before death and to have suffered a greater number of distinct health problems than their counterparts in more affluent localities (19).

Other dimensions of health and wellbeing show a similar pattern of blighted quality of life. In many countries unemployed people have poorer mental health and their children are found to be of shorter stature than children of employed fathers (20,21). Differences commonly show up in dental health, too: in Norway, 44% of the lowest income group had their own teeth, compared with 86% of the highest income group (22). In 1986, a major national study carried out in the United Kingdom found similar differences in relation to physiological indicators such as blood pressure and lung function (even when smoking habits were taken into account), as well as for indicators of psychological “malaise” (23,24).

Further examples of differences in accessibility and quality of health services are given below, showing in general that those most in need of medical care, including preventive care, are least likely to receive a high standard of service.

So from the practical point of view of designing effective and efficient health policies, differences on such a large and persistent scale have to be taken seriously and provision made for reducing them.

From an economic standpoint can any country afford to have the talent and performance of sizeable sections of the population stunted to such an extent?

Above all, on humanitarian grounds national health policies designed for an entire population cannot claim to be concerned about the health of all the people if the heavier burden of ill health carried by the most vulnerable sections of society is not addressed. The bias against these social groups in the provision of health care also offends many people’s sense of fairness and justice once they learn of its existence.

However, there is more to the concept of equity than the illustrations so far have brought out, and the meanings of terms need to be made quite clear.

In many discussions on equity, confusion arises because some people are talking about inequities in the level and quality of health of different groups in the population, whilst others are talking about inequities in the provision and distribution of health services, without making a distinction between the two. The next two sections try to clarify concepts first in relation to health, then in relation to health care.

Concepts

The meaning of equity in health^a

The great differences in the health profiles of different nations and different groups within the same country have already been highlighted.

These differences or variations can be measured from standard health statistics. However, not all of these differences can be described as inequities. *The term inequity has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust. So, in order to describe a certain situation as inequitable, the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society.*

Inevitable or unacceptable?

So which health differences are inevitable – unavoidable – and which are unnecessary and unfair? The answer will vary from country to country and from time to time, but in a general sense seven main determinants of health differentials can be identified.

1. Natural, biological variation.
2. Health-damaging behaviour if freely chosen, such as participation in certain sports and pastimes.
3. The transient health advantage of one group over another when that group is first to adopt a health-promoting behaviour (as long as other groups have the means to catch up fairly soon).
4. Health-damaging behaviour where the degree of choice of lifestyles is severely restricted.
5. Exposure to unhealthy, stressful living and working conditions.
6. Inadequate access to essential health and other public services.
7. Natural selection or health-related social mobility involving the tendency for sick people to move down the social scale.

The consensus view from the literature listed in the reference section suggests that health differences determined by factors in categories 1, 2 and 3 above would not normally be classified as inequities in health.

^a Inequality in health is a term commonly used in some countries to indicate systematic, avoidable and important differences. However, there is some ambiguity about the term, as some use it to convey a sense of unfairness while others use it to mean unequal in a purely mathematical sense. Added to this is the problem of translation in some languages, where there is only one word available to cover both inequality and inequity. To avoid confusion, the terms equity and inequity have been chosen by WHO for the European health for all strategy and will be used throughout this paper.

Those arising from categories 4, 5 and 6 would be considered by many to be avoidable and the resultant health differences to be unjust. In the seventh category, involving the tendency for sick people to become poor, the original ill health in question may have been unavoidable but the low income of sick people seems both preventable and unjust.

Further explanation and examples may make these distinctions clearer. Firstly, there is bound to be some natural variation between one individual and another. ***Human beings vary in health as they do in every other attribute.*** We will never be able to achieve a situation where everyone in the population has the same level of health, suffers the same type and degree of illness and dies after exactly the same life-span. This is not an achievable goal, nor even a desirable one. Thus, that portion of the health differential attributable to natural biological variation can be considered inevitable rather than inequitable.

Some of the difference in health between different age groups could be put into this category. For example, the greater prevalence of coronary heart disease in men of 70 years of age compared to men aged 20 would not stir up feelings of injustice, since it could be seen to be due to the natural aging process of human beings.

Some of the differences in health between men and women also fall into the category of biological variation. For example, ill health due to sex-specific problems such as cervical and ovarian cancers and the higher incidence of osteoporosis in elderly women compared with their male counterparts would clearly be attributed to biological differences between men and women, rather than to unjust social or environmental influences.

However, ***much of the differential between different groups in society*** (including that between men and women) ***cannot be accounted for on biological grounds; instead, other factors are implicated. The crucial test of whether the resulting health differences are considered unfair seems to depend to a great extent on whether people chose the situation which caused the ill health or whether it was mainly out of their direct control*** (25). For example, through lack of resources, poorer social groups may have little choice but to live in unsafe and overcrowded housing, to take dangerous and dirty work, or to experience frequent bouts of unemployment. The higher rates of ill health resulting from such environmental factors are clearly inequitable. The sense of injustice is heightened in such cases as ***problems tend to cluster together and reinforce each other, making some groups very vulnerable to ill health.***

Many disabled people appear to suffer a cycle of injustice in this respect. Through circumstances largely outside their control they shoulder a heavy burden of ill health and in addition, their impairment can reduce their employment and earning opportunities. This in turn means that they may have to live in disadvantaged conditions which may endanger their health still further.

Likewise, ***personal health behaviour options may be severely restricted by social and economic considerations.*** For example, a less nutritious diet may be chosen because of restrictions on income or inadequate food distribution networks leading to lack of fresh supplies in the shops. Less physical activity may be undertaken because of lack of leisure facilities or of income or time to make use of them. Promotion of health-damaging products may be targeted at certain groups in society, such as young working-class men and alcohol advertising or young women and tobacco promotion. This puts them under greater pressure than others to consume these products.

On the other hand, some situations are the result of a much greater degree of choice. For example, skiing injuries suffered more frequently by certain groups would not arouse the same sense of injustice, since the cause – skiing – is widely viewed as a voluntary activity chosen by

those who accept and insure against the risks involved.

Similarly, a section of the population may freely choose not to use a particular health service because of religious beliefs, for example, and any resultant excess in sickness in that group would not normally be classed as unfair.

The causes of health differences listed above are not mutually exclusive. They all interact, but the available evidence shows that biological factors and the effects of sick people moving down the social scale play only a small part, the major part being played by socioeconomic and environmental factors, including lifestyles.

Towards a working definition

To sum up, the term inequity as used in WHO documents refers to differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust.

Judgements on which situations are unfair will vary from place to place and from time to time, but one widely used criterion is the degree of choice involved. Where people have little or no choice in living and working conditions, the resulting health differences are more likely to be considered unjust than those resulting from health risks which were chosen voluntarily. The sense of injustice increases for groups where disadvantages cluster together and reinforce each other, making them very vulnerable to ill health. Therefore one working definition would be:

Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided (26).

Based on this definition, *the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level and quality of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair.*

Equity is therefore concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible.

Equity in health care

In the health for all strategy, several targets are concerned with the issue of equity in health care: the question is tackled more explicitly in targets 27 and 28.

Underpinning these targets, and indeed *underpinning most health care systems in Europe, is the belief that there should be a fair and equitable deployment of available resources for the benefit of the whole population, though equity in this context can be interpreted in a variety of ways.*

A number of possible definitions of equity have been put forward for practical purposes (27), but some of them are unlikely to satisfy a common sense of fairness. To take just two of the

examples from this work, health services could be based on equal expenditure per capita. By this definition an equitable allocation would be achieved if the available health service budget were divided equally amongst geographical areas based on the size of population in each area. But even if this were attained, it would make no allowance for the differential needs for care in different age and social groups in each region and so would not be considered equitable by many.

At the other extreme, the most ambitious definition maintains that equity in health care is achieved when equal health status has been attained. In other words, the goal of an equitable health service would be to make the level of health the same in all regions and/or social groups, or at least to narrow the health gap significantly. In practice, this is an unrealistic goal for most services, because health care is only one of many factors which contribute to health differences in a country and acting in isolation would not be able to bring about the required improvement in community health status.

For the purpose of establishing a working definition, the above examples have been rejected in favour of ones which focus on accessibility, quality and acceptability of the care offered to all sections of the population, more in line with targets 27 and 28. Using this approach, *equity in health care is defined as:*

- equal access to available care for equal need
- equal utilization for equal need
- equal quality of care for all (28).

Looking at each of these themes in turn, *equal access to available care for equal need implies equal entitlement to the available services for everyone, a fair distribution throughout the country based on health care needs and ease of access in each geographical area, and the removal of other barriers to access.* An extreme example of unequal access arises when people are turned away from or are unable to use health services because of their lack of income, race, sex, age, religion, or other factors not directly related to the need for care. In most European countries, the spectre of accident victims being left to die because they cannot pay for emergency treatment is thankfully absent, but other inequities of access remain. For example, migrant workers may be excluded from insurance-based services in some countries. Financial, organizational and cultural barriers confront people wanting to use services so that, although they may have a right to health care in theory, their access may be restricted in practice. For example, transport costs fall most heavily on low-income groups, limiting their access to available services. Clinics may have inconvenient opening hours, for instance, so that only limited groups of people can make use of the service. Ethnic minorities may find the language and cultural barriers major obstacles to access (29,30).

Inequities in access also arise when resources and facilities are unevenly distributed around the country, clustered in urban and more prosperous areas and scarce in deprived and rural neighbourhoods. As deprived communities tend to suffer the worst health, such unequal distribution means that medical services are least available where they are most needed — the so-called inverse care law (31).

Access is also restricted unnecessarily if a country's available resources are spent almost exclusively on high technology medical services which cater for a small segment of the population, while little provision is made for balanced health care services of benefit to the majority.

Turning to the concept of equal utilization for equal need, great care needs to be taken in interpreting this goal. ***If differences are found in the rates of utilization of certain services by different social groups, this does not automatically mean that the differences are inequitable. Rather it is an indication that further study is needed to ascertain why the utilization rates are different.***

In some instances, a small proportion of the difference will be due to some people exercising their right not to use health services if they so wish, perhaps for religious or ethical reasons. Likewise, there is concern that increasing activity in some services may lead to unnecessary treatment. For example, some countries may be worrying about the already high hysterectomy or tonsillectomy rates in higher income groups and would not want to aim for higher surgery rates for other income groups in such circumstances.

However, ***where use of services is restricted by social or economic disadvantage, there is a case for aiming for equal utilization rates for equal need.*** For instance, in relation to immunization and other preventive services, positive discrimination may be justified in providing outreach and other imaginative schemes to make it easier for people to use services in low take-up areas (32).

With regard to the concept of equal quality of care, it is very important in many societies that every person has an equal opportunity of being selected for attention through a fair procedure based on need rather than social influence. This issue arises most critically when resources are scarce or are being cut back. In such a climate it would seem unfair to many if one social group consistently obtained preferential service over less favoured groups, or conversely, if other groups, because of race or ethnic origin for example, were consistently pushed to the back of the queue for treatment.

This type of inequity was highlighted in Norway when it was found that women from different parts of the country had different chances of being selected for an abortion, based on an arbitrary interpretation of the regulations by regional committees. The sense of injustice that this situation induced among women themselves led to successful public pressure for a change in the law, with the government eventually granting abortion on demand together with contraceptive services (33).

Rehabilitation services are also scarce in many countries; they often concentrate on getting people back to work and so are biased in favour of people with jobs and against the selection of the unemployed, retired people and housewives. Yet rehabilitation in the widest sense of the word can have an immense impact on a person's quality of life (34).

In Poland, at a time when hospital services were in short supply, one study found that the higher the occupational class of the patients, the higher the proportion of those who personally knew medical staff and the more likely they had been to use this acquaintance to gain entry to the hospital (35). A similar situation has been noted in the Netherlands when, during a shortage of hospital beds due to financial cuts, the higher social classes had a disproportionate number of admissions; the reverse was true when there was surplus capacity (36). It seems that when efficiency measures cause shortages, then there is a danger of a direct increase in inequity.

Equal quality of care for everyone, also implies that providers will strive to put the same commitment into the services they deliver for all sections of the community, so ***that everyone can expect the same high standard of professional care.*** Inequities arise in this case when professionals do not put the same effort into their work with some social groups as with others, offering them less of their time or professional expertise. For example, there is evidence from the

United Kingdom of doctors giving shorter consultations to lower-class patients and referring them less frequently to specialist services (37,38). There is also evidence of quality of care being compromised by poor quality of premises in disadvantaged areas and reluctance of more experienced staff to work in such conditions.

Acceptability is another important component of the quality of care. It may be that some services are inequitable in the way they are organized, making them unacceptable to some sections of the community that they are intended to serve. Only by monitoring acceptability with the users of services will defects of this nature be revealed. Steps can then be taken to make such services more user-friendly.

Principles for action

Several principles stem from the concepts of equity outlined above. These are listed here as general points to be borne in mind when designing or implementing policies, so that greater equity in health and health care is promoted. More specific suggestions for strategies are the subject of a separate paper.

Equity policies should be concerned with improving living and working conditions.

Because most of the present inequities in health are determined by living and working conditions, attempts to reduce them need to focus on these root causes, with the aim of preventing problems developing. This is potentially a more efficient approach than relying solely on the health care sector to patch up the ill health and disability such inequities create (5,20,39).

Several public policies, although designed to benefit the population as a whole, can have the most dramatic impact on people living in the worst conditions, by helping to raise the standards of their physical and social environment to a level closer to that of a more fortunate group. In doing so, such policies encourage equity in health. Examples include those policies designed to provide adequate and safe housing; to ensure the provision and accessibility of high quality food together with nutritional information; to raise the standard of occupational health and safety practice; to control pollution, and to ensure clean water supplies.

More specific preventive policies related to equity would include such measures as the maintenance of full employment and the raising of income of poorer socioeconomic groups, reducing the gap between rich and poor (5,17,40).

Equity policies should be directed towards enabling people to adopt healthier lifestyles.

The principle of enabling people to adopt healthier lifestyles acknowledges that some groups in society face greater restrictions than others in their choice of lifestyle due, for example, to inadequate income, which limits where and how people live.

Local and national agencies therefore need to make healthier lifestyles as easy to adopt as possible. This means, for instance, looking at:

- whether leisure and exercise facilities in the community are accessible and reasonably priced;

- whether food distribution networks are adequate to ensure supplies of cheap and nutritious food in local shops;
- whether advertising and promotion of health-damaging products is controlled and restricted;
- whether products are clearly labelled so that people have adequate information on which to base their choice, and so on.

The process of enabling people to adopt healthier lifestyles also involves the recognition that some social groups may come under greater pressure to adopt health-damaging behaviour (41), and sensitive policy-making is needed to deal with this issue. In particular, health education and disease prevention policies need reorientation, bearing in mind the fact that traditional health education programmes have generally been less successful at reaching the vulnerable groups in greatest need. They may even have been counter-productive if they stimulated defensive reactions in certain social groups by blaming them for their own ill health. “Blaming the victim” can cause people to reject the advice offered and to refuse to take part in any improvement programmes.

New educational programmes are needed based on giving support to and encouragement for lifestyle changes and helping to develop the skills required to maintain those changes against negative social pressures (1,42).

Equity policies require a genuine commitment to decentralizing power and decision-making, encouraging people to participate in every stage of the policy-making process.

This is too often interpreted in a very restricted sense by professional planners, who acknowledge little more than that they need the public to cooperate willingly in order for official plans to work. The principle, however, goes beyond this to the acceptance that *plans and actions should be based on what people feel are their own needs, not on solutions imposed from the outside.*

The point is that projects and plans to reduce inequities are things done not to people but with them. Plans should be as much those of the public as of the planners (33,40,43,44).

This holds true for the health for all policy as a whole, but it is seen particularly acutely in relation to disadvantaged and vulnerable groups who tend to have the least say and the lowest participation rates in key decisions affecting their health and wellbeing. The more articulate members of the population and those with the most powerful representation tend to have more influence than others in a weaker position. This situation can also arise with residents of outlying regions of a country, distant from the centre of decision-making, who may feel that their views and needs have been ignored.

This means that administrators and *professionals need to make a determined effort to provide administrative systems and information to make it easier for lay people to participate.* They need to find ways in which people can express their needs, particularly vulnerable groups who may not have the skill or confidence to use existing arrangements without positive encouragement. An awareness of equity issues at every level is essential for these policies to work, and this in turn requires an educational input for professionals and non-professionals at each level.

Health impact assessment together with intersectoral action.

Having accepted that the determinants of inequities lie in many different sectors, there is obviously a ***need to look at policies in all sectors, assessing their likely impact on health, and especially on the health of the most vulnerable groups in society, and to coordinate policies accordingly.***

The aim of this type of assessment is to get health taken into consideration when plans are formed. At the very least, this implies that when health goals are in conflict with goals in other sectors, efforts will be made to find a solution which does not have an adverse effect on health and that possible adverse effects are made explicit. At best, this approach leads to the acceptance of health as a major goal of development in its own right and to its being made part of national social and economic development plans (44).

Collaboration and coordination on such a scale does not happen of its own accord.

There are many obstacles in the way. Sometimes policy-makers are just not aware of the health implications of their plans or perceive health as being mainly concerned with medical services and therefore of little relevance to their responsibilities. Often there is competition and rivalry for resources between ministries, which inhibits rather than encourages cooperation. Competing claims can override the goal of equity in health, which can be considered of low priority, especially in times of economic recession when economic growth can seem all-important. Then there are obstacles of a practical nature — lack of expertise and training in collaborative work, for instance.

To overcome such obstacles requires, first of all, ***an awareness-raising exercise on the part of the health sector***, to explain the true extent of the problem and increase understanding of the effects of diverse policies on health, especially that of vulnerable groups. This is a two-way process, because the health sector also needs to make itself aware of the many initiatives already happening in other sectors which have a positive effect on health.

In addition, to facilitate the development of equity policy, governments ***need to establish administrative arrangements at national, local and regional level to encourage intersectoral action*** (33).

Mutual concern and control at the international level.

Target 1 also refers to improving the level of health of disadvantaged nations, and several equity issues stems from that concept.

Firstly, it needs to be recognized ***that an improvement in health or a reduction in inequities in one country can inadvertently cause a deterioration in health or an increase in inequity in other countries.*** For example, countries in Europe may improve their level of nutrition by stimulating less developed countries to change to a different agricultural base which is less suited to the nutritional needs of the indigenous population. Conversely, health-damaging products or production processes may be prohibited for reasons of health in one country but allowed to be exported to another without restriction. Within Europe itself, pharmaceuticals which have been restricted or banned in western countries have been tested and marketed in eastern Europe. Agricultural and import/export policies need to be designed to guard against such eventualities.

Secondly, ***in times of economic crisis and mounting debt problems, governments and international bankers from developed countries come up with economic solutions for***

countries in crisis. These can have disastrous effects in those countries if, for example, they put a strain on the agricultural system threatening the nutrition of children and other vulnerable groups in those societies. In addition, proposed solutions often involve restricting demand and government spending at home, while allocating more resources to export sectors. Government expenditure in the social sector is often the first casualty of these policies, and the disadvantaged are again hardest hit as a result.

This situation has led to recommendations from the World Health Assembly in 1986 (43) that:

... international financial agencies, in the design and implementation of adjustment policies, should recognise the health and nutritional status of the population as an important factor and should ensure the protection of minimum levels of health and nutrition of vulnerable groups ... Donor agencies should support countries undergoing severe adjustment to their economies in order to avoid adverse impact on the health conditions of the population.

This principle has underpinned the work of the WHO Regional Office for the Americas, which carried out an analysis of the health impact of the International Monetary Fund's economic adjustment policies for the Region, and provided a powerful tool for a dialogue with bankers on health matters. Clearly WHO can do much to further encourage such international cooperation.

International cooperation is also crucial following the waves of migration which have taken place from less to more economically developed countries in Europe over the past three decades. Further population flows are expected as a result of developments in the European Community and the rapid changes taking place in central and eastern Europe. ***Migration on this scale has equity and health implications for the host country in terms of coverage and availability of health services, for instance. It also has equity implications for the country from which the migrants have departed,*** in terms of support for families with children left behind with inadequate income, for example (30). ***Migration of health professionals, made possible by relaxation of former regulations, poses potential problems for many countries trying to maintain the staffing of health services on an equitable basis.***

In other respects, the European Community's harmonization programme is a good example of the potential of international equity policy if standards relating to health in each country are brought up to the level of the best.

Pollution control is perhaps the prime example of the need for international cooperation to be based on equity principles, with more prosperous countries helping disadvantaged nations to improve their health protection measures. In the long run, such activities lead to benefits for all countries involved, rich and poor alike, since pollution does not respect national boundaries. It can even be the most cost-effective option for a developed country. For example, if a country wanted to clean up the sea water around its shores it may be more efficient to give aid to a less developed country on the opposite shore to tackle the problem at the source of the pollution rather than working in isolation.

Equity in health care is based on the principle of making high quality health care accessible to all
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This means actively promoting policies in the health sector to enhance access to and control quality of care, rather than assuming that a universal service provided by law is equitable in practice (45,46). This involves checking:

- resource allocation in relation to social and health needs;
- geographical distribution of services linked to measures of need and access in each area;
- the experience of different social groups in their attempts to gain access to facilities, using consumer surveys where appropriate;
- quality of care, including its acceptability; and
- reasons for low uptake of essential services.

Rehabilitation services can also be expanded to play a valuable part in alleviating the suffering caused by poverty or disability and promoting a more equal chance for self-realization.

The attainment of equity in health care faces many additional obstacles at the present time, with the introduction of cost-containment programmes in many European countries as the costs of medical care have escalated. ***It is particularly important at this time for health personnel to assess proposed policies and monitor their effects on access, utilization and quality of care for disadvantaged groups*** (8).

Of course efficiency measures, if implemented with care, can have the added effect of reducing inequities in access to services, but all too often the reverse is true in practice. There is a need for vigilance on this issue, together with the setting of explicit priorities.

Equity policies should be based on appropriate research, monitoring and evaluation.

Action to reduce inequities calls for an active search for information about the real extent of the problem. This includes the systematic identification of vulnerable groups in society through the collection of appropriate health and social statistics and analysis of the social processes leading to their poorer health. ***In many countries, traditional statistical systems do not record such information on a routine basis and adjustments to data collection may be necessary.***

It also calls for closer links at national level, to coordinate the diverse work being carried out in different fields into a coherent research policy, together with international cooperation to enable cross-country analyses to be made (8,47).

Monitoring and evaluation are also essential in any interventions to reduce inequities, in order to refine policies and make sure that they do no harm.

This may seem startlingly obvious, but ***all too often it is assumed that because a policy is based on the best of intentions, it can do nothing but good.*** However, there are plenty of examples from many fields of apparently desirable policies which have proved counter-productive in the end, producing unintended negative effects. For example, some positive discrimination policies for ethnic minorities living in poor conditions run the risk of stirring up anger and feelings of injustice from members of the majority population living in the same conditions (30). Programmes targeted at high-risk groups, if introduced insensitively, can be stigmatizing and thus be avoided by the very people the programme was designed to help. For example, poor parents may fail to claim tickets for free school meals for their children because they would highlight the family's poverty when presented at school.

Equity policies must therefore be monitored for effectiveness as a matter of principle and unintended side effects taken into consideration in the evaluation.

Conclusion

The concept of equity in relation to health and health care can mean different things to different people. What this discussion paper has tried to do is to pin down some of the essential elements by pointing out not only what we are aiming for, but also what we are not aiming for. Equity does not mean that everyone should have the same health status, for example, or consume the same amount of health service resources irrespective of need. Some people may dismiss the goal of equity altogether if they interpret it along such lines.

When the meaning of equity is defined more precisely, a start can be made on developing practical policies, keeping in mind some of the basic principles outlined above. Accepting target 1 as a goal serves a valuable purpose if it puts the issue on the agenda and provides a stimulus to countries to recognize and challenge the causes of inequities.

Above all, it should be stressed that solving problems of inequity cannot be achieved by one level of organization or one sector but has to take place at all levels and involve everyone as partners in health to meet the challenges of the future.

Preparation of this discussion paper

The programme on Equity in Health in the WHO Regional Office for Europe was originally established in the late 1970s to examine issues of unemployment, poverty and health. Gradually the scope of the programme was expanded to cover a wide variety of vulnerable groups. Over the years, a strong network of experts was built up in Member States throughout the Region. Despite the difficulties involved in dealing with what was sometimes considered a sensitive issue, these specialists put equity firmly on the political agenda, providing a wealth of information and insights into the complexity of the problem.

In 1989, the Regional Office decided to take the next step, to move from research to action. The equity programme was therefore integrated with the programme for Health Policies and Planning, and the main focus became that of utilizing for decision-making purposes the valuable work done in universities and research centres.

A practical tool was needed to bring to the policy-makers the collective wisdom gathered in the many publications issued in the Equity in Health programme. Margaret Whitehead was therefore asked to examine this rich documentation and to distil from it a definition of equity in health as it is understood in the context of the WHO health for all policy.

The first draft of her paper was presented at an advisory group meeting in March 1990. This was an interdisciplinary group drawn from different parts of the Region. The participants at this meeting were:

Dr J.M. Freire, Regional Minister of Health for the Basque government
 Professor Maria do Rosario Giraldes, National School of Public Health, Lisbon, Portugal
 Dr V.I. Grabauskas, Director of the Central Research Laboratory, Kaunas, USSR
 Dr Louise Gunning, Ministry of Welfare, Health and Cultural Affairs, Netherlands

Dr Alex Scott-Samuel, Liverpool Health Authority, United Kingdom
Margaret Whitehead, Consultant, United Kingdom

Representing the WHO Regional Office for Europe:

Dr A. Nossikov, Technical Officer for Epidemiology, Statistics and Research
Dr A. Ritsatakis, Regional Officer for Health Policies and Planning
Dr Mildred Blaxter, United Kingdom, and Dr Per-Gunnar Svensson, Sweden, were unable to attend the meeting but gave written comments.

The present document incorporates the advice given by the above group and others. Whilst the form and readability of the present document are due to the skill and competence of Margaret Whitehead and the above advisory group, it is in fact a culmination of the work of many experts who offered their time and experience to WHO over a number of years.

This document is the first in a series of three such practical tools for decision-making. Subsequent papers will deal with policies and strategies for equity in health, and measuring equity in health.

For further information regarding the Equity programme, please contact the Health Policies and Planning unit, WHO Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark.

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