Critical Reflection

Health inequalities and the health of the poor: What do we know? What can we do?

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The contents of this theme section of the *Bulletin of the World Health Organization* on ''Inequalities in health'' have two objectives: to present the initial findings from a new generation of research that has been undertaken in response to renewed concern for health inequalities; and to stimulate movement for action in order to correct the problems identified by this research.

The research findings are presented in the five articles which follow. This *Critical Reflection* proposes two initial steps for the action needed to alleviate the problem; other suggestions are given by the participants in a *Round Table* discussion which is published after these articles. The theme section concludes with extracts from the classic writings of the nineteenth-century public health pioneer, William Farr, who is widely credited as one of the founders of the scientific study of health inequalities, together with a commentary.

This *Critical Reflection* contributes to the discussion of the action needed by proposing two initial steps for action.

- That professionals who give very high priority to the distinct but related objectives of poverty alleviation, inequality reduction, and equity enhancement recognize that their shared concern for the distributional aspects of health policy is far more important than any differences that may divide them.
- That health policy goals, currently expressed as societal averages, be reformulated so that they point specifically to conditions among the poor and to poor–rich differences. For example, infant mortality rates among the poor or the differences in infant mortality between rich and poor sectors would be more useful indicators than the average infant mortality rates for the whole population.

Keywords: health policy; health services accessibility; health status; policy-making; poverty; social justice; socioeconomic factors.

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Introduction

Objectives and structure of the theme section on health inequalities

Over the past few years, renewed concern for health inequalities and the health of the poor has begun to produce important findings. The first objective of the articles in this theme section on "Inequalities in health" in this issue of the *Bulletin* is to present the initial results of this new generation of studies, which are greatly increasing our understanding of the magnitude and nature of the problems that afflict the underprivileged and separate them from the better-off. But important as this understanding is, it does not by itself save lives or make people healthier. What the research undertaken so far has not yet produced is a strategy for moving beyond understanding and applying this knowledge to the challenges and problems that have been identified. The second objective of this section is therefore to stimulate the necessary movement from analysis to action in order to correct the problems identified by the research.

The first objective is addressed in five technical research papers which illustrate the approaches being taken to deal with two important aspects of the problem. One concerns *the different ways of categorizing or ranking members* of a population in order to examine the inequalities among them; the second deals with the question of how equally or unequally *different aspects of health* are distributed in a population (see Table 1).

The first column in Table 1 shows that members of a population can be ranked by economic status, ethnic affiliation, and health condition. Economic status is the approach used by Wagstaff (*1*), Makinen et al. (*2*), and Castro-Leal et al (*3*), but is by no means the only attribute for investigation. Others include geographical location (e.g. rural–urban differences), occupation (with social class as well as economic connotations), gender and ethnicity, which is of interest to Brockerhoff & Hewett (*4*). Yet another approach is to rank population members in terms of health itself — from least healthy to most healthy, which is what Gakidou et al. (*5*) preferred to do.

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Table 1. **The dimensions of health inequality, as addressed by the technical papers in this theme section of the *Bulletin***

Different ways of categorizing/ranking population members	Different aspects of health	
	Health status	**Health service use and financing**
Economic status	Paper by Wagstaff (*1*)	Papers by Makinen et al. (*2*) and Castro-Leal et al. (*3*)
Ethnic affiliation	Paper by Brockerhoff & Hewett (*4*)	–
Health condition	Paper by Gakidou et al. (*5*)	–

Table 1 also shows that the different aspects of health can be placed under health status and health service use/financing. Three of the above-mentioned papers deal exclusively with health status: Wagstaff (*1*) and Brockerhoff & Hewett (*4*) focus on infant mortality, while Gakidou et al. (*5*) utilize health expectancy, a measure which includes both mortality and morbidity at all ages. The remaining two papers investigate the use and financing of health services: Makinen et al. (*2*) are concerned with the use of and payment for health services by individuals, while Castro-Leal et al. (*3*) examine which economic groups gain the most financially from government curative health service expenditures.

Most of the remaining contents in this theme section issue of the *Bulletin* are oriented towards the second objective: the identification of approaches to reduce the inequalities and problems of the poor which current research is documenting. The following passages of this *Critical Reflection* contain two suggested initial steps for moving from research to action. These suggestions serve as the basis for the *Round Table* discussion which follows the technical research papers. In that discussion, members of a panel composed of international health figures assess and sometimes challenge the two steps and, more importantly, provide suggestions of their own.

To demonstrate how past experience can contribute to such efforts to move ahead, this issue of the *Bulletin* reprints, as a Public Health Classic, extracts from the writings of William Farr, a nineteenth-century British epidemiologist, who is widely credited with having initiated the scientific study of health inequalities (*6*). This material, written over a hundred years ago, stands even today as a model of applied statistical analysis, i.e. the effective application of statistical findings to the advocacy of public policies for poverty alleviation. Farr's model of analytical activism is as relevant today as it was in his own time.

The setting

The renewed concern for health inequalities

The interest of the international community in health inequalities has varied greatly in recent years. It was high from around the mid-1970s to mid-1980s. It was then displaced by greater concern for health system efficiency and sustainability. More recently, the interest in equality, equity, and the health of the poor has begun to rise again.

The earlier ups and downs. For those concerned with health inequalities and related issues, the decade between the mid-1970s and mid-1980s were good years. In the field of economic development, the focus on overall growth was vigorously challenged by advocates of "trickle-up" development with an emphasis on basic human needs. In the health field, this orientation manifested itself in the "Health for All" movement which was greatly accelerated by the 1978 International Conference on Primary Health Care held at Alma-Ata. This led to a strong focus on community orientation, with governments supporting or encouraging the development of free health care services to cover entire populations. Given the epidemiological patterns then prevailing among the poor, inexpensive services provided by village-based paramedical personnel appeared particularly relevant for the achievement of this goal; these and other similar services came to play a central role in what became known as "primary health care" (*7*). Soon after, UNICEF added its enthusiastic advocacy of the "child survival revolution" based on specific primary care measures (*8*).

However, this climate did not last. By the mid-1980s, the situation had changed in three ways. First, the overall development picture was clouded by the severe economic difficulties experienced by many poor countries, which made it clear that the cherished goal of free government health services for all was not going to be realized, at least not soon. Second, the momentous changes in economic philosophy in the socialist countries of Eastern Europe and in China eroded the previous confidence in state-led approaches to development. These changes filtered into the health care field and began raising doubts about the appropriateness of a government's central role in health service provision. Third, reality began to replace the euphoria of the early days of "Health for All", and a closer examination of the primary health care record, rightly or wrongly, led many to question its ability to produce the dramatic benefits initially expected of it.

Thus, the pendulum began to swing away from "Health for All" and towards what became known as "health sector reform". To be sure, poverty, equity, and basic services continued to figure significantly in publications such as the World Bank's *1993 World Development Report* on health (*9*), WHO's first *World health report,* which appeared in 1995 (*10*), and the *1995 Annual report* of the Director of the Pan American Health Organization (*11*). But increasingly,

especially following the appearance of the World Bank's influential *Financing health services in developing countries* (*12*) in 1997, the health of the poor no longer monopolized the attention of those concerned with developing country health problems. Rather, the focus shifted towards sustainability, as reflected in the intensive activity on health financing that took place, and towards efficiency, as seen in the push towards greater cost-effectiveness. In epidemiological terms, the attention moved from the disease burden of the poor to that of the world as a whole, and settled on the demographic-epidemiological transition which was producing new middle and upper classes in the poor countries and whose disease characteristics were more like those of the West than those of the global poor.

The incipient renewal of concern. As the third millennium begins, there is an incipient renewal of concern for poverty and equity in health. One sign is the emergence of over a dozen inter-country research projects on health, poverty, and equity, supported by a wide range of donors and covering over a hundred countries (*13*). Another indicator is the importance given to improving the health of the poor in the World Bank's current strategy for work on health, nutrition and population (HNP), adopted in 1997. According to this strategy, the Bank's first HNP priority is "to work with countries to improve the health, nutrition, and population outcomes of the world's poor" (*14*). Further impetus was provided in recent statements by WHO's Director-General, Dr Gro Harlem Brundtland. For example, in her introductory message in WHO's 1999 *World health report*, Dr Brundtland opened her review of challenges to be addressed in order to improve the world's health by indicating that, "first and foremost, *there is a need to reduce greatly the burden of excess mortality and morbidity suffered by the poor*" (*15*).

During at least the next year or two, such renewed concern seems likely to continue. This is partly because of increased attention being given to poverty and inequality in the field of overall development, and partly as a result of developments within the international health community. One reason for anticipating increased attention on poverty and inequality is the focus on poverty in the World Bank's next annual *World development report* (*WDR*). The *WDR* team's initial consultations with the development community have already resulted in a noticeable amount of attention on poverty; and, if past experience is any guide, this attention can be expected to increase over the remaining months prior to the *WDR*'s appearance and for at least a year or two afterwards, when the WDR findings become widely known. This emphasis on poverty will reinforce the analyses and publications of the United Nations Development Programme (UNDP), which devoted its *Human development report* (*HDR*) *1997* to poverty (*16*), and which has paid central attention to questions of poverty and inequality in subsequent issues on other topics. The HDR's poverty-oriented "human development index" has drawn increasing notice; and there is every reason to believe that the *HDR* will continue to call attention to it and related poverty questions. It will be aided in this by its continuing association with Professor Amartya Sen, whose receipt in 1998 of the Nobel Prize for Economics has given prestige and visibility to work on poverty by economists.

Within the health sector, findings from the technical research articles presented in this theme section, along with several other publications due to appear in the coming months, can be expected to increase awareness about the health of the poor and about poor–rich health inequalities. And the greater the amount of available knowledge, the easier it will be to call attention to issues covered by that knowledge — and, even more importantly, the easier it will be to develop strategies for correcting the problems that are revealed.

Further stimulation can be expected from organizations like the Rockefeller Foundation, whose Global Health Equity Initiative has already made a significant contribution, and which has recently selected health equity as a priority issue for attention and funding; the United Kingdom Department for International Development, which is currently in the process of thinking through the implications for health of a recent White Paper which gave highest priority to poverty alleviation; the European Union, which is beginning a similar exercise of examining the implications of its health activities for the poor; and poverty-oriented aid agencies such as those of the Netherlands and the Nordic countries, whose efforts are continuing. Even greater interest appears likely to be generated by WHO and the World Bank. WHO has recently established an agency-wide task force to develop a strategy for dealing with poverty. The World Bank, along with the International Monetary Fund (IMF), is planning a major initiative to encourage developing nations to increase their commitments to health and education for the disadvantaged in connection with the provision of debt relief for heavily-indebted poor countries.

Implications for the longer term. While all this is encouraging for those concerned with health equity and the health of the poor, it remains far from enough to guarantee significant improvements in the current situation. The serious problems presented by inadequate health among the neediest require far more than a few policy pronouncements, statistical studies, and international meetings to combat successfully. Significant progress will clearly require a deep, long-term commitment and a willingness to make major changes in health and development strategies. This means building on and going far beyond the promising developments described above in order to create an effective momentum and force for reform. Determining how this can best be done presents one of the leading challenges facing those concerned with health inequalities.

Any strategy to overcome these inequalities will undoubtedly want to accord highest priority to overall poverty alleviation through broad-based

social and economic development. It will also, no doubt, require an impressive degree of political will, including a firm determination on the part of national and international leaders to stand up to the interests of the "haves" in order to advance the cause of the "have-nots". Such considerations argue for health professionals being prepared to enter the political forum on behalf of social and economic equity, rather than limiting themselves simply to work within the health sector.

At the same time, it must also be recognized that, although the health sector is not necessarily the most important channel for dealing with inequalities, it is the field in which health professionals have the greatest expertise and thus a comparative advantage. This provides a rationale for health professionals to devote at least some of their time and energy to the health sector, to see what they can do within it to support the struggle for a more equal society. The remaining parts of this paper therefore concentrate on the health sector, and suggest two initial steps which health professionals might take, as part of the far broader effort that will be required in this direction — that is, towards increasing the degree and the effectiveness of the health sector's concern for health inequalities.

Establishing objectives

Coming to terms with the poverty–equality–equity distinction.

The first step is to think more clearly about objectives. This means, in the first instance, coming to terms with three streams of thought existing within the international community concerning the most appropriate objective when dealing with the health of disadvantaged population groups. These streams focus on: 1) improving the health of the poor; 2) reducing poor–rich health inequalities; and 3) redressing health inequities.

- *What are the similarities and differences among these three streams?* Those concerned with poverty and those more interested in reducing inequality or inequity all share a recognition that in health, as in many other fields, societal averages typically disguise as much as they reveal. Their interest is thus not in health conditions that prevail in society as a whole, but in the condition of different socioeconomic groups within society — especially in that of the lowest or most disadvantaged groups. But within this shared concern lie a number of distinctions. Those who approach health from a poverty perspective are typically concerned primarily with improving the health of the poor alone, rather than with reducing differences between poor and rich. For those oriented towards equality, the principal objective is the reduction of poor–rich health differences. Those concerned with health inequities are concerned with righting the injustice represented by inequalities or poor health conditions among the disadvantaged.
- *What are the practical implications of these similarities and differences?* The distinction between poverty, equality, and equity is often of limited practical importance. However, there are situations in which the distinction becomes significant.
- *What is a sensible position to take concerning poverty–equality–equity?* This question is both the most difficult and most important. The propositions to be advanced here are that what adherents to the different perspectives have in common is much more important than what separates them; and that achievement of consensus in favour of any one perspective alone is much less important for progress than is mutual tolerance.

But before presenting these propositions in any detail, it is useful to pause for a fuller explanation of just what poverty- and equality-oriented approaches to health involve, of how each is related to health equity, and of what the implications are of adopting one approach or the other.

Poverty and health. Poverty, the focus of the first school of thought mentioned above, has occupied a central role in established thinking about overall development for over two decades. It emerged in the late 1960s and early 1970s in reaction to the then-dominant emphasis on countries' overall per capita income growth rates. At the time, a concern for distribution was thought likely to detract from the overall economic growth that was considered a necessary condition for the long-term alleviation of poverty. Concentrate first on overall growth, was the prevailing view. The result might be a rise in inequality over the short term. But eventually, the benefits would trickle down to the poor and, over the long run, the poor would end up better off than under a development strategy oriented towards their immediate needs.

The "trickle-up" and "basic human needs" schools of thought, which emerged to counter the view just presented, advocated dealing directly with the poor as the best means of producing sustainable growth. The many discussions about how best to define the poor population groups of concern produced two approaches.

- The first, based on what is often called "absolute poverty", takes a universal perspective and defines poverty in terms of a given level of income or consumption which is equally relevant for people wherever they may be. This is usually done by defining a "poverty line" as the lowest amount of money sufficient to purchase the amount of food necessary for a minimally adequate diet (with enough left over to buy other essentials). A well-known practitioner of this approach is the World Bank, which has devoted a great deal of time and effort to defining a suitable international poverty line and estimating the number of people living below it. The current international poverty line stands at an average per capita consumption of US$ 1.00 per day (in 1985 dollars), as adjusted for purchasing power differences between countries.

The consumption level of around 1300 million people of the world's population lies below this line. Almost all these people — who constitute just under one-quarter of the world's total population — live in South Asia, sub-Saharan Africa, and China (*17*).

- The second approach, more country-specific, deals with what is frequently referred to as "relative poverty". The practice here is to define the poverty line in terms of relevance for a specific society. This is typically done in one of two ways. One way, analogous to the international approach just described, is to determine how much income one needs to live decently according to some locally established definition of decency. Poverty lines of this sort are used in the developed as well as in the developing world. In the USA, for example, the Census Bureau estimates that a family of four requires US$16 000 annually to purchase a minimally adequate diet and meet other basic needs, and that 12.7% of the population falls below this level (*18*). The second approach is simply to define the national poverty line as some proportion — often arbitrarily determined — of a society's average per capita income or expenditure. In the United Kingdom, a statistic frequently cited to document the prevalence of poverty refers to the proportion of the population (currently just under one-quarter) living at less than one-half the country's average per capita income (*19*).

As suggested by the frequent above references to income and expenditure, poverty has traditionally been defined in economic terms under both of these two approaches. By and large, health status has not been an element in the definition. Rather, health has entered into thinking about poverty primarily as a service to be delivered to those who are found to be poor on the basis of income/expenditure criteria. Thus, for example, the World Bank's *World development report 1990,* on poverty, defined the poor in economic terms, and included health programmes among the social services recommended for helping the poor (*20*).

However, this appears likely to change significantly over the years immediately ahead. The primacy in the income/expenditure definition of poverty has been actively challenged by such leading thinkers as Amartya Sen, who has advocated instead a definition of poverty based on the capacity of the poor to improve their condition, and who considers health (and education) status as important for this as income (*21, 22*). He has been joined by institutions like the United Nations Development Programme, which assesses poverty in terms of a human development index which includes health and education status alongside income (*22*). As of this writing, it appears highly likely that the World Bank, too, will move towards some sort of wider basis for defining poverty in the course of preparing its forthcoming, year 2000/2001 *World development report* on that topic. Because of developments like these, health appears poised for a significant move towards the centre of thinking about poverty, as a component rather than simply as a determinant of it.

Inequality in health. While a concern for lessening poverty and improving the health of the poor is widespread, it is by no means the approach preferred by everybody. Many focus more on inequalities, both in general and with respect to health in particular.

Such a focus has long occupied a particularly important place in thinking about international health issues. To say that the focus has been exclusively on inequality would be to overstate the case; for it is possible to cite expressions of concern for poverty in prominent international health documents from at least the time of the 1978 Declaration of Alma-Ata onwards. But it is rare for a prominent international health statement not to give at least equal, if not more, weight to inequality reduction. For example, at the same time as the Declaration of Alma-Ata professed its concern for the unacceptable health conditions found among the hundreds of millions among the world's poor, it also advocated primary health care because of its potential "to close the gap between the 'haves' and the 'have-nots' (*7*)", i.e. to lessen health inequalities. The previously cited *World health report 1995* (*10*), which had a great deal to say about the health of the poor, was subtitled "*Bridging the gaps*", referring to inequalities between poor and rich. A major WHO document in this area emphasized the importance of being concerned with poor–rich health inequalities, rather than simply focusing on the health of the poor alone (*23*).

Similarly, health inequalities have played a much more central role than the health of the poor alone in a long European tradition of concern. Thus, for instance, the widely heralded 1980 Black Report in the United Kingdom was titled "*Inequalities in health*" (*24*), as was the exercise that produced its successor, the 1998 Acheson Report (*25*). In the same vein, the 1984 targets of the WHO Regional Office for Europe (EURO) were expressed in terms of reducing poor–rich disparities. "By the year 2000," said the WHO document in which these targets were presented, "the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the health of disadvantaged nations and groups" (*26*).

However, just as there are different approaches to poverty alleviation, so too are there various views about the most appropriate strategies for the reduction of inequalities. Illustrative of the issues that arise in discussing the reduction of health inequalities are questions on the following.

- *The dimensions of inequality that matter most.* The most traditional approach has been to think of differences in health status according to an individual's income or economic standing; and, in line with this tradition, it is the perspective taken by most of the articles in this theme section.

However, the economic dimension is by no means the only one that matters, and some would consider other dimensions even more important. Gender inequalities in health status have received a great deal of attention in recent years. Ethnic inequalities in health, the topic of the paper by Brockerhoff & Hewett (*4*), have been of particular concern in many areas, such as South Africa and the USA. Education and occupation have also been widely used as a basis for dividing populations in assessing inter-group health differentials, although often more as a proxy for economic status than as indicators of interest in their own right. Yet another approach, advocated in the paper by Gakidou et al. (*5*), might be called "pure" health inequality — that is, the ordering of people on the basis of their health status, from most to least healthy regardless of income or any other attribute, for the purpose of measuring health diversity in a society. In so doing, people applying this approach are drawing on a long tradition of studies with respect to income distribution.

- *How inequality is to be measured.* As can be seen in the paper by Gakidou et al. (*5*), there are almost as many statistical definitions of inequality as there are statisticians; and the different definitions can produce very different interpretations of the same situation or trend. Until recently, one particular measure — the Gini coefficient — has been dominant, at least in economic thinking, supplemented by comparisons between the poorest and richest population quintiles (or between people above and below the poverty line) when the data available were insufficient for the calculation of the Gini coefficient. While the Gini coefficient probably remains the most frequently used indicator even now, its position is slipping, with no clear consensus about a preferred alternative
- *What aspects of inequality are most important.* As can be seen from the technical articles in this section, there are many different views. Some would argue for looking at inequalities in health status as the outcome that counts; others favour focusing on health services, as the determinant of health status which health professionals can most easily influence. Within each of these two streams of thought are further distinctions. Health status, for example, can be determined either through a physical examination or through self-assessment. (The two approaches can produce quite different results, in that people found to be relatively unhealthy through a physical examination do not always consider themselves to be less healthy than people whose health was determined by examination to be considerably better.) With respect to health services, there are distinctions between use and financing; among public, private non-profit, and private for-profit services; and between preventive and curative services. People who come out ahead in one of these respects may lag from another perspective.
- *Whether the focus should be local or global.* The technical articles, like most other elements in this section, deal primarily with inequalities within countries. But there are also obviously very large differences between countries and regions of the world; and many observers would give at least equal, and in some cases higher, priority to the inequalities presented by intercountry/regional differences.

Health equity. Poverty and inequality, as described above, are both primarily empirical concepts. Equity, by contrast, is a normative one — a question of values, and closely associated with the concept of social justice. When applied to health, equity has traditionally been most often linked to the reduction of inequalities. Thus, one of the most widely cited definitions of health inequity is that it "refers to differences in health which ... are considered unfair and unjust." In a similar vein, the above-cited WHO/EURO document on health equity indicated that "equity requires reducing unfair disparities ..." and that "pursuing equity in health and health care development means trying to reduce unfair and unnecessary social gaps in health and health care ..." (*26*).

However, equity need not be exclusively a matter of reducing inequalities. It can also be associated with poverty, since one could argue that it is unjust to allow people to continue living in poverty when adequate resources are available within the society at large to lift them out of it. Such a link figures prominently in general thinking about social justice; and it also appears in writings on health equity.

A particularly well-known example of poverty-oriented general thought about equity is the "maximin" principle of distributive justice posited by John Rawls. That principle and others like it call for resources to be distributed in a way that the worst-off people in society (i.e. those occupying the "minimum" position) get the maximum possible amount of gain. What happens to the better-off through such a pattern of resource distribution is extraneous to the maximin principle (*27*). A variation on this theme, as applied to health, would consider any health gains among the rich in the course of implementing efforts to improve the health of the poor as welcome side-benefits, rather than regrettable, because of the dilution in inequality reduction which they represent (*28*).

While not many equality-oriented advocates of health equity seem prepared to go this far, almost all incorporate at least traces of such a poverty-oriented equity definition in their statements. The traces are to be seen most clearly in the tendency of equality-oriented discussions to disavow interest in one of the arguably more effective potential ways of reducing poor–rich health inequalities: assassination of the rich. Rather, the focus of all known inequality-oriented health equity proposals is on lessening poor–rich differences through special efforts to improve the health of the poor — a focus which makes the proposals sound suspiciously similar to

what one might wish to do under a poverty-oriented health equity approach.

Thus, for instance, the previously-cited inequality-oriented definition of health equity (*24*), referring to the inequalities of health that are unjust and unfair, was developed in conjunction with the WHO/EURO health equity objective which called for a reduction in health disparities by improving the health of the disadvantaged (*26*). And WHO's 1996 health equity document, while giving primacy to poor–rich health differences, also called for ensuring an adequate standard for the entire population, noting that, "for some, 'equity' means that all social groups should have a basic minimum level of well-being and services" (*23*).

However, regardless of whether one considers health equity to be related more to equality or poverty, the introduction of normative or social justice considerations also raises questions. For example:

- *When is an inequality unfair?* Not always, certainly. It is quite possible to imagine a situation marked by health inequalities that are not necessarily inequitable. One example is an inequality that is irremediable (*26*). Another might be two population groups with similar incomes but marked differences in life expectancy attributable to different lifestyles. If the less healthy group adopts its lifestyle in full awareness of the risks involved, the resulting differences in life expectancy might be said to be simply a reflection of differences in the social preferences of the two groups, rather than any fundamental inequity. Or, to illustrate the same point by a more general example: if two individuals are in fact unequal in capacity, equal treatment would be unfair to the more capable of the two. In such a case, equity might well call for unequal treatment. In other words, equity and equality are by no means synonymous and need to be carefully distinguished from one another.
- *On what basis can one decide when the resources in a society are adequate to alleviate poverty?* "Adequacy" is not a binary concept, such that there is one level of resource availability above which availability is totally adequate, and below which it is completely inadequate. Rather, there is a spectrum running from a total lack to infinite availability of resources, often with no obvious cut-off point along the way. Also, perceptions can differ: resources that seem adequate to one person may not be so to another.

Significance of the poverty–equality–equity distinction. The distinctions described in the preceding sections on poverty, inequality, and equity have been vigorously debated over the past several years. But the fact that such debates have taken place does not necessarily mean that they have been worth while. To have been worth while, the issues debated must have significant practical implications.

What has been said thus far provides a basis for suspecting that, in general, the practical implications are likely to be limited. As has been noted, even those who seem furthest apart — those giving highest priority to reductions in poor–rich health inequalities in the name of equity, and those concerned with improving the health of the poor — end up sounding rather similar, once one realizes that the approach preferred by advocates of inequality reduction looks primarily to improvements in the health of the disadvantaged.

A more careful look reinforces this view that the poverty–equality–equity distinction is often largely academic. The most obvious situation is in a low-income country where the most cost-effective measures available for the improvement of health in the society as a whole are also those that are especially beneficial to the poor. As pointed out in the 1993 *World development report*, the contents of minimum service packages that feature such measures — management of the sick child, prenatal and delivery care, family planning, etc. — are especially relevant for low-income groups (*9*). Where this is the case, adoption of the approach that is most sensible for the poor is also more beneficial for the poor than for the rich, and can thus be expected to produce a reduction in poor–rich differences.

However, the record would not be complete without noting that there are at least some other circumstances where an interest in poverty can imply a different approach from that resulting from a concern for inequality reduction. One obvious example concerns interregional resource allocations by international agencies. Three cases can illustrate the implications of the different approaches.

- *An absolute poverty approach.* According to the World Bank figures cited earlier, some 90% of the world's 1300 million people living below the poverty line live in Asia and Africa. This being the case, an international agency guided by an absolute poverty objective would wish to put virtually all of its health resources into those regions; there would be much less justification for working in Latin America; and practically none at all for health activity in the Middle East or in Eastern Europe, where hardly anyone is so poor as to lie below the international poverty line.
- *A relative poverty approach.* Relative poverty exists in every country. From this perspective, there could thus be as strong a justification for supporting pro-poor health activities in one region of the world as in any other.
- *An equality approach.* Assuming that most of the existing health inequalities observed in the developing world are also inequitable and that inequality reduction interventions are equally effective, an equity approach would imply a particularly high priority to countries where health inequalities are greatest. Recent research, such as that reported by Wagstaff in this section (*1*), points to the existence of large country-to-country differences in the degree of health inequality, which in turn suggests that some countries deserve much more attention than others from an equity perspective. According

to Wagstaff's findings, Brazil, Nepal, Nicaragua, and South Africa have large health status inequalities and would thus be of high priority, while health status inequalities are quite low in Ghana, Pakistan, and Viet Nam which would accordingly merit a low priority.

Other instances of differences implied by a poverty and equality orientation can be drawn from epidemiology. The available information does not permit citation of "real world" experiences, but the basic point can be illustrated through two schematic examples concerning disease priorities, one from a global and one from a national perspective.

- *Global disease priorities*. A global institution focusing on absolute poverty would logically devote primary attention and resources to communicable diseases, since they are the dominant causes of deaths and disability among the global poor (*29*). In an institution concerned with relative poverty, there would be a case for a much broader concern. Such an institution would be involved not only with the poor in Africa and Asia, but also with the disadvantaged populations in Eastern European countries, among whom noncommunicable diseases may well be the dominant problem.
- *Disease priorities within advanced developing and transition countries*. While communicable diseases are dominant among the global poor, chronic diseases in advanced developing and transition countries are likely to be responsible for a majority of deaths and disability among the poor — but, in all likelihood, for a smaller percentage among the poor than among the rich. The implications of such a situation can be illustrated by reference to a country where noncommunicable diseases cause 60% of deaths among the poor, 90% of deaths among the rich. From a burden of disease perspective, such figures point to noncommunicable diseases as a natural focus for a programme concerned with poverty alleviation, since such diseases cause a majority of deaths. But such a focus, if introduced on a societywide basis, could well lead to an increase in inequality. This is because noncommunicable diseases are even more important for the rich than for the poor, so that the benefit to the rich of any general, evenly distributed decline in noncommunicable diseases would be correspondingly greater. Thus, in a situation like this, burden of disease considerations would argue for the highest priority to be given to one type of disease (i.e. noncommunicable diseases) from a poverty perspective, and to a different type of disease (i.e. communicable diseases) from an inequality-reduction perspective.

This example is obviously oversimplified, ignoring cost–effectiveness and targeting considerations that may well be more important than disease burden factors in the establishment of health service priorities. But the oversimplification is intentional, designed to illustrate a point that remains valid despite it: there is not an inevitable congruity between national-level policy prescriptions that are optimal for improving the health of the poor and those that are best for reducing health inequalities.

Policy implications. While illustrations just presented show that the distinctions among approaches to the health of the poor, the reduction of health inequalities, and health equity can be significant, the illustrations should not be taken as an indication that the distinctions are necessarily more important than the common outlook shared by those supporting the different approaches. Although the advocates of the approaches described above differ among themselves in some respects, they are united in the more important conviction noted briefly at the outset: that what matters are not societal averages with respect to health, but rather the health conditions that prevail among different groups within society, particularly among disadvantaged groups.

This concern for the distribution of health benefits places advocates of all the approaches described here squarely at odds with the currently predominant school of international thought about health systems, as presented in the preceding section. Members of this school are concerned primarily with the efficiency of health systems in bringing about improvements in health conditions prevailing in society at large, and with the reforms required to achieve this objective. Proponents of the alternative, poverty/equality/equity viewpoint, just described, are no less convinced of the need for health system reforms. But the reforms they consider necessary would have a very different objective — to see that the systems are more equitable and reach the poor more effectively, rather than that the systems are more efficient in serving society at large.

Compared with the distinction between overall efficiency on the one hand and poverty–equality–equity on the other, the differences between the poverty-, equality-, and equity-oriented health policy advocates approach insignificance. This implies that the advocates of poverty/equality/equity-oriented health systems reform can most productively focus on what unites them rather than on the distinctions between them. These distinctions can be handled through mutual tolerance and a policy of informed choice: i.e., a focus not on seeking the dominance of one particular approach, but rather of ensuring that those needing to choose are as knowledgeable as possible about the different approaches available to them. If this is done, it is difficult to imagine anyone going terribly wrong, whichever choice is made.

Taking the next step

Formulating health policy goals in distributional terms

With the conceptual underbrush cleared away, the next step is to begin thinking operationally. This means, in the first instance, formulating health policy goals with greater attention to specific health

problems of the poor, which distinguish them from the rich. Surprisingly, this has rarely been done.

In the light of the intense concern for the health of the poor during the 1970s and 1980s, one might reasonably have expected the setting of health sector goals in terms specific to the health of the disadvantaged, and the development of data specific to the poor and rich for monitoring progress towards these goals. Such an expectation would seem all the more reasonable because of what happened in the field of economic development, which saw attention turning towards the conditions of the poor during the 1970s at the same time as the international health community was developing a similar concern.

In economic development, the evolution of the "basic human needs" school of thought gave rise to a tradition of expressing general development goals, not in terms of a society's average per capita income growth, which was the earlier tradition, but in terms of what was happening to the incomes of people in poverty. It also led to the establishment of data collection systems specific to the poor.

But nothing similar happened in health. Those concerned with poverty tended to rely primarily on general humanitarian appeals, which proved quite effective in mobilizing support, without employing the rigorous epidemiological tools to the measurement of poor–rich differentials and of conditions prevailing among the poor. To the extent that rigorous tools were employed, they were applied to the development of overall goals for societies as a whole. The result is a deficiency that has two aspects: a lack of health goals that are relevant for the poor; and a lack of the information needed to track progress towards such goals.

The need for more relevant goals. Only rarely have health goals been expressed in terms relevant for equity enhancement or poverty reduction. In fact, the 1984 WHO/EURO objective, which called for a 25% reduction of disparities, is the only clear illustration of an equity-oriented health objective which has so far been identified. Almost inevitably, health goals are stated in terms of some societal average: say, a decline of x% in a country's infant or maternal mortality rate, or an increase of y years in its life expectancy.

A recent, prominent example illustrating this point, and the difference in contemporary thinking about economic and about health goals, is the set of year 2015 targets developed from the 1995 Copenhagen Social Summit by the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD). These goals are reproduced in the Annex at the end of this paper. In line with the Copenhagen Summit's orientation, the economic target is stated in terms that are exclusively distributional. That is, the economic target contains no reference to an increase of average per capita incomes, as was the earlier tradition in development thinking. Rather, in accord with current economic approaches to poverty lessening, the target is to reduce by at least one-half the proportion of people living in extreme poverty in developing countries.

In contrast, the principal health target makes no reference to the health of those living in poverty. It is stated, rather, in the health equivalent of the earlier tradition of expressing economic goals in terms of raising average per capita income growth. That is, the principal health indicators used are the national infant and child mortality rates, which are societal averages, and which are to be reduced by two-thirds in each developing country.

To be sure, infant and child mortality rates are considerably more relevant for the poor than are some other societywide indicators — such as life expectancy — which might have been selected, because of the tendency for mortality among the poor to be concentrated in the younger age groups. But even infant and child mortality rates are far from exactly related to poverty: in the world as a whole, for example, over one-half of all under-five deaths occur among people who are not poor (people in poverty being defined as those 20% living in countries with the world's lowest per capita incomes) (*30*). As a result, while achievement of the OECD goals might benefit the poor, it would also be possible to achieve this goal by reducing deaths with significantly larger declines among the non-poor.

The existing range of possibilities can be illustrated by considering two very different scenarios by which the OECD target of a two-thirds reduction in infant mortality might be reached.

- A "top-down" strategy, under which reductions in the upper classes come first, followed by reductions in the middle classes, and only later by improvements in conditions among the poor.
- A "bottom-up" strategy which, as its name suggests, is the converse of the top-down strategy described. Infant mortality reductions start in the poorest segment of the population, then spread to the next-poorest, and continue up the economic class scale until the OECD target is achieved.

Thanks to recent tabulations of household data from a well-known set of demographic and health surveys, prepared for the World Bank and described below, it is possible to demonstrate the implications of these two strategies for different socioeconomic classes of the population. These tabulations, which are more fully presented elsewhere (*31*), provide data for infant mortality for each economically defined population quintile in each of 48 developing countries. The tabulations can be used to demonstrate the impact of a reduction of infant mortality in any given population group on a country's overall average infant mortality rate; or conversely, to indicate the different patterns of infant mortality across population quintiles that are consistent with any particular country's average rate.

For the present purposes, data from three countries — Bolivia, Côte d'Ivoire, and India — are used to show the range of possibilities that exist. The possibilities are illustrated through a pair of estimates

for each country. One estimate shows the results of following an extreme form of the top-down approach just described. The first step in preparing this estimate is reduction of the infant mortality rate in the richest 20% of the population to the lowest level commonly found in the industrialized world (set at 7 deaths per 1000 live births for the purpose of this exercise). Then, infant mortality among the second-richest 20% is reduced to that same, industrialized-country level. The process is continued until the country's overall average infant mortality rate equals one-third of its initial level. (Linear interpolation of infant mortality rates among quintile means is used to permit rough estimates to the nearest centile.) The second estimate permits identification of the impact of following the most extreme form of a bottom-up approach. The estimation procedure is analogous to that used for the top-down estimate, with infant mortality being reduced first in the poorest rather than the richest quintile, and subsequent reductions moving up rather than down the economic ladder.

Table 2 presents the infant mortality level that would prevail in each population quintile after achieving the OECD objective through a top-down and a bottom-up strategy. For comparative purposes, information about the infant mortality level currently prevailing in each quintile is also provided. The data in Table 3 summarize the distributions in Table 2 using two indicators of inequality: the ratio of infant mortality between the top and the bottom population quintile; and the concentration index, a summary measure that is analogous to the Gini coefficient for income distribution.

Even a cursory glance at Table 3 suffices to show that the distributional situations produced by following a top-down and a bottom-up strategy differ greatly from one another:

- At present, the infant mortality rate in the bottom population quintile is roughly two to four times higher than it is in the top population quintile. Under the top-down strategy, that ratio would have increased greatly by the time the OECD goal is reached. Specifically, infant mortality would be in the order of eleven to sixteen times higher in the bottom than in the top quintile. Were the bottom-up strategy followed instead, the ratio would be reversed. That is, at the time of reaching the OECD goal, the infant mortality rate would be around four to nine times higher in the top than in the bottom quintile.
- The concentration index of infant mortality currently has a value of approximately –0.1 to –0.2 in the three countries covered, indicating a modest-to-moderate inequality. Were one to achieve the OECD goal through a top-down strategy, the value of the concentration index would fall to around –0.5 or –0.6, which represents an extremely regressive situation — and a change of nearly half the distance from an equal distribution (concentration index value of 0.0) to the most unequal distribution attainable (concentration index value of –1.0). Attainment of the OECD goal through a bottom-up strategy would produce the opposite result: the concentration index value would rise out of negative territory to somewhere in the order of +0.25 to +0.50, indicating a situation that is quite progressive.

To be sure, such large differences result from producing estimates of situations that lie at the two extremes of the range of theoretically attainable possibilities. In the "real world", the differences resulting from a determined effort to implement one strategy rather than the other, i.e. a top-down or a bottom-up strategy, would no doubt be much smaller than those indicated in Table 3. The Table 3 results are nonetheless of interest for two reasons.

Table 2. **Infant mortality rates,[a] by wealth quintile, before and after achieving the OECD goal[b]**

	Bolivia			Côte d'Ivoire			India		
	Current level	Level after attaining OECD goal		Current level	Level after attaining OECD goal		Current level	Level after attaining OECD goal	
		Through "top-down" strategy	Through "bottom-up" strategy		Through "top-down" strategy	Through "bottom-up" strategy		Through "top-down" strategy	Through "bottom-up" strategy
Top 20% of the population	25.5	7.0	25.5	63.3	7.0	63.3	44.0	7.0	44.0
Next-highest 20%	38.6	7.0	38.6	78.8	7.0	78.8	65.6	7.0	65.6
Middle 20%	75.5	7.0	52.7	86.9	7.0	10.8	89.7	7.0	31.1
Next-lowest 20%	85.0	7.0	7.0	97.3	7.0	7.0	106.3	7.0	7.0
Bottom 20% of the population	106.5	74.4	7.0	117.2	110.3	7.0	109.2	101.5	7.0
Population average[c]	**73.5**	**24.5**	**24.5**	**90.9**	**30.3**	**30.3**	**86.3**	**28.8**	**28.8**

[a] Deaths under one year of age per 1000 live births.

[b] From: Reference *36*.

[c] Population averages are based on population quintile figures, weighted by the number of births in each quintile.

Table 3. **Poor–rich disparities in infant mortality, before and after achieving the OECD infant mortality rate (IMR) goal**[a]

Country	Disparity indicator					
	Ratio of IMR in the top 20% of the population to IMR in the bottom 20%			Concentration index		
	Initial	After "top-down" strategy	After "bottom-up" strategy	Initial	After "top-down" strategy	After "bottom-up" strategy
Bolivia	4.2 : 1	10.6 : 1	1 : 3.6	– 0.21	– 0.53	+ 0.29
Côte d'Ivoire	1.9 : 1	15.8 : 1	1 : 9.0	– 0.11	– 0.60	+ 0.47
India	2.5 : 1	14.5 : 1	1 : 6.3	– 0.15	– 0.58	+ 0.26

[a] From: Reference *36*.

- First, the breadth of the range, even though theoretical, is instructive as an indication of just how wide an array of distributional patterns the attainment of the OECD goal can accommodate. The fact that the framers of this goal, whose commitment to poverty reduction is not to be doubted, did not think of expressing the goal in distributional terms suggests that the existence of such a wide range of possible outcomes is not intuitively obvious.
- Second, the range can serve as the starting point for speculation about the likely distributional consequences of an effort to reach the OECD goal through initiatives that focus only on the population average infant mortality rate, a focus which the goal's current formulation encourages. Such speculation leads to the suspicion that an outcome closer to that produced in the top-down illustration is at least more likely than that resulting from a bottom-up one. Admittedly, an extreme version of the top-down outcome may well seem improbable. But given the political realities of today's world and the role of political considerations in health policy formulation, some variant of it appears considerably less implausible than a bottom-up scenario which would see most of the gains going to the poorest.

To the extent that the suspicion just presented is correct, one would be ill-advised to look to attainment of the OECD or other health goals stated in terms of population averages, to bring major improvements to the health of the poor, and even less to the reduction of poor–rich health inequalities. For the poor to benefit, it will be necessary to work towards goals that are stated in terms much more directly relevant to the disadvantaged. For instance, instead of adopting a goal to reduce infant mortality by two-thirds in the entire population, those concerned with poverty alleviation would be much better advised to select, say, a "one-third, two-thirds" goal, as an expression of determination to reduce infant mortality in the bottom third of the population by two-thirds. Those more interested in reducing inequality might advocate a "one-third, one-third, one-third" goal, indicating an aspiration to reduce by one-third the gap separating the top and bottom thirds of the population.

The need for more relevant information. If correctly stated goals are to be meaningful, information to track progress towards achieving them must be readily available. Here, too, the health field has until recently been weak. This weakness can most readily be demonstrated by contrasting information on the health situation with the available economic data on the conditions among the poor and poor–rich economic differentials.

In economic development, the concern for poverty that emerged in the 1970s gave rise to a determined effort to produce basic information, led by a group of economists, especially in the World Bank, for whom poverty became a principal concern. Prominent in this effort was the establishment of the previously noted international poverty line, and a vigorous programme of household data analysis to produce estimates of the number of people in each country and region whose consumption placed them below that line. A second, related activity was the compilation of periodic information about intra-country income inequalities, as measured by the Gini coefficient.

As a result, the World Bank now publishes an annual set of estimates about levels and trends of poverty in the world; and also sets of data about intra-country income inequality which permits an assessment of the differences and trends. The most recent of these, published in the *1998 World development indicators*, consists of a three-page table indicating for nearly 100 countries the Gini coefficient and the percentage of national income going to each economically defined quintile of the population. Another three-page table indicates the percentage of the population below the poverty line in nearly 50 countries (*32*).

The situation with respect to health is very different. To be sure, certain non-economic aspects of health inequalities have received considerable attention. In particular, gender-specific mortality estimates have long figured prominently in collections of demographic data; and these have played an

important role in documenting and calling attention to gender inequalities. Also, the USAID-sponsored Demographic and Health Survey (DHS) Program has published tables of infant and child care and illness treatment by mother's education, father's occupation, and place of residence (rural or urban), based on comparable household surveys in a number of developing countries (*33, 34*). These data too have proved to be useful, even if they are often hard to interpret because of large intercountry and intertemporal differences in the number of people in each category.

Until very recently, however, there has been no significant effort to develop data oriented to the distribution of health conditions and health service use across economic classes, comparable to what economists have been routinely producing for income and poverty. As a result, the data needed to measure progress towards poverty-oriented objectives of the sort advocated in the preceding section are not available.

Thus, for example, there were no distributional data on health to report in the *1998 World development indicators* (*32*); and it remains silent about intracountry differences in health conditions. Rather, all health information relates to conditions in countries as a whole. There is information about infant mortality in entire country populations, but not about infant mortality among the poorest 20% of the opulation. Data are presented on the percentage of births attended by trained health staff; but not about the percentage of births among the poor who receive this service, or about how big the poor–rich difference is in this regard. Figures are provided for overall government health expenditures, but not for how the beneficiaries of these expenditures are distributed across economic classes.

Only now, well over a decade after poverty-oriented economists began collecting the data needed for equitable development, are there signs that this situation is about to change; and that health statisticians may soon begin to catch up in providing the data that policy planners need for poverty- and equality-oriented programmes. At present, at least three exercises are under way to begin systematically providing information.

- The first has been undertaken by a WHO group. It applied sophisticated statistical techniques to national-level data to produce figures on several health indicators for the poor and non-poor in 46 developing countries, which were published in the *World health report* (*35*).
- The initial findings from the second initiative are presented in the article by Wagstaff in this issue of the *Bulletin* (*1*). His very different approach employed household survey data generated through comparable country exercises undertaken (primarily) under the World Bank's Living Standards Measurement Survey (LSMS) programme. It employed and extended to the developing world an approach which Wagstaff & van Doorslaer had previously developed and successfully applied in the OECD countries.
- The third exercise is also based on household data, but from a different source — comparable household studies in 48 countries produced under a DHS programme. The exercise is providing information on 30 indicators in each country covered, for each economic quintile defined on the basis of household assets. An example of the information they produced (infant mortality data for Bolivia, Côte d'Ivoire, and India) is presented in Table 2. The full results of this exercise will be included in the next issue of the World Bank's *World development indicators*, which will help to fill the gap referred to above.

Just how far these three exercises will go towards meeting the pressing need for comprehensive and reliable information on health disparities remains an open question. As is to be expected in a new field, there are a number of issues still to be resolved. For one thing, the important differences in approach and data sources used by the three studies make it unclear whether they will produce results that are mutually consistent. Another question is whether any one of the approaches will prove suitable for tracking changes over time, as would be required for the monitoring of progress. The limited sizes of the household data sets used in the second and third exercises described above, for example, have frequently resulted in large confidence intervals, so that only very large changes from one period to the next would be statistically significant.

Because of considerations like these, it would clearly be premature to declare with confidence that the information needed by planners will soon be available. But neither can one rule out that possibility; even under a worst-case scenario, the badly needed drive to provide systematic distributional data about health has at last begun and is off to an encouraging start. As a result, the effort to generate the information needed to assess progress towards health goals for improving conditions among the poor or reducing poor–rich differences is well under way and ahead of the establishment of such goals. This strengthens the case for increased attention to the formulation of suitable goals.

Conclusion

From research to action

As noted at the outset, global opinion has begun to shift towards an increased concern for the health of the poor and for a reduction in health inequalities. This interest now provides a better opportunity for movement towards action than has existed for the past decade or more.

The contents of the technical papers in this theme section of the *Bulletin* show that a promising start has been made to understanding the extent and nature of the problem. While more knowledge about

many issues remains vitally important, the recent progress means that a lack of information about prevailing conditions can no longer be said to be the principal barrier to further progress. The priority need at present is to begin applying what is already known in order to obtain a political commitment and develop effective intervention strategies.

This paper proposes two initial actions that professionals can take to begin meeting the need.

- The first is that those concerned with health inequalities and the health of the poor should look beyond the issues that divide them and focus on the much more important beliefs which they share.
- The second is that they work towards the redefinition of health goals, now expressed primarily in terms of population averages, so that the goals refer directly to improving the conditions among the poorer groups and to reducing the differences between those groups and others in society.

These proposals are put forward in full recognition that they are of only limited value in themselves, and that interest in them results from their potential contributions as precursors or facilitators of further action. But seen from this perspective, they can be significant. Agreement on conceptual issues, for example, may be of little inherent interest from an immediate policy perspective, but it can play an important role in forging unity among people of different viewpoints which will be necessary for the creation of a significant political force. Similarly, appropriate health goals do not in themselves save lives. But they can be valuable as a way of directing the attention of policy-makers towards health inequalities and the health of the poor, thereby preparing the way for the development of effective interventions to deal with these issues.

Even if their full potential is realized, the proposed actions remain very modest relative to the total need. They cannot legitimately claim to represent anything more than two early steps in the long journey to be covered if the health of the poor is to be improved and health inequalities lessened. Even small steps can be valuable, however; and if the two proposals submitted here can stimulate thoughts about further, more important steps from participants in the Round Table discussion in this issue of the *Bulletin* (pp. 75–85), they will have fully achieved their objectives. ■

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Résumé

Inégalités de santé et santé des pauvres — Que sait-on ? Que peut-on faire ?

Les articles de ce dossier du *Bulletin de l'Organisation mondiale de la Santé* sur les inégalités de santé ont un objectif double :

– présenter les résultats d'une nouvelle série de travaux de recherche sur les inégalités de santé, question à laquelle on recommence à s'intéresser de près ;
– inciter à prendre des mesures pour résoudre les problèmes mis en lumière par ces travaux.

Depuis deux ou trois ans, les inégalités de santé et la santé des pauvres suscitent un regain d'intérêt qui se traduit par des travaux de recherche importants dont les résultats font l'objet de cinq articles techniques publiés dans ce numéro du *Bulletin*. Dans cette Réflexion critique, il est suggéré de prendre deux mesures initiales pour s'attaquer au problème. Figurent également dans ce numéro une Table ronde où l'on trouvera d'autres suggestions, ainsi que des extraits commentés des écrits de William Farr, grande figure de la santé publique au XIX^{e} siècle et généralement considéré comme l'un des premiers à avoir étudié les inégalités de santé de manière scientifique.

L'intérêt pour les inégalités de santé et la santé des pauvres n'a pas toujours été constant. Entre le milieu des années 70 et le milieu des années 80, alors que l'OMS plaidait en faveur de « la santé pour tous » et des initiatives de soins de santé primaires et que l'UNICEF appelait à une révolution en matière de survie de l'enfant, ces deux questions furent au cœur des préoccupations. Par la suite, l'attention s'est portée sur la réforme des systèmes de santé en vue de les rendre plus efficients. Aujourd'hui, par un mouvement de balancier, on recommence à s'intéresser aux inégalités de santé et à la santé des pauvres, thème qui devrait continuer à retenir l'attention dans un proche avenir ; mais on ignore quelle sera l'importance accordée à ces questions à long terme : cela dépendra de la mesure dans laquelle on est parvenu à répartir plus équitablement les fruits du développement socio-économique, y compris des acquis sanitaires. Même si le secteur de la santé ne prend qu'une part limitée à ce développement, c'est là que les professionnels de la santé ont le plus à apporter, argument suffisant pour qu'ils œuvrent énergiquement à l'intérieur comme à l'extérieur de leur secteur. Deux formes d'action intrasectorielle sont suggérées :

- Les professionnels qui accordent une très grande importance au recul de la pauvreté, à la réduction des inégalités et à une plus grande équité — objectifs distincts, quoique liés — devraient prendre conscience que leur souci commun d'axer la politique de santé sur la répartition l'emporte sur les différences qui les séparent. Dans certains cas, l'action sanitaire en faveur des démunis et les efforts de réduction des inégalités de santé entre riches et pauvres peuvent prendre des formes différentes. Mais étant donné que les partisans de la réduction des inégalités de santé font généralement en sorte d'améliorer l'état de santé

des pauvres (et non d'abaisser le niveau de santé des riches), les différences qui les séparent de ceux qui ne s'attachent qu'à l'amélioration de la santé des pauvres sont en fait limitées.

- Les planificateurs sanitaires devraient suivre l'exemple des planificateurs économiques et commencer à énoncer leurs objectifs en termes de répartition. Les planificateurs économiques qui entendent lutter contre la pauvreté ont depuis longtemps renoncé à accroître le revenu moyen par habitant pour s'efforcer de réduire le nombre de personnes vivant en-dessous du seuil de pauvreté ou de réduire les écarts de revenu. Les planificateurs sanitaires, en revanche, continuent de tendre à un accroissement de l'espérance de vie moyenne ou à une réduction des taux moyens de mortalité infanto-juvénile dans l'ensemble de la population. Les objectifs courants concernant la mortalité infantile, tel celui de l'OCDE qui consiste à réduire des deux tiers la mortalité infanto-juvénile dans tous les pays en développement d'ici 2015, seront plus facilement atteints si le recul est plus rapide chez les riches que chez les pauvres, ce qui creuse encore les inégalités. Il faut se fixer un objectif plus précis, par exemple réduire des deux tiers la mortalité infantile dans le tiers le plus pauvre de la population, ou réduire d'un tiers la différence de mortalité infantile entre le tiers le plus pauvre et le tiers le plus riche de la population.

Resumen

Desigualdades sanitarias y salud de los pobres — ¿Qué sabemos al respecto? ¿Qué podemos hacer?

Los artículos presentados en esta sección temática del *Boletín* dedicada a las desigualdades sanitarias tienen una doble finalidad:

– presentar los resultados de una nueva generación de investigaciones iniciadas en respuesta a un renovado interés por las desigualdades en materia de salud; y
– estimular la adopción de medidas orientadas a corregir los problemas identificados en esas investigaciones.

A lo largo de los últimos dos o tres años, un renovado interés por las desigualdades sanitarias y la salud de los pobres ha propiciado varios hallazgos importantes, que se describen en cinco artículos técnicos de este número del *Boletín*. En la presente Reflexión Crítica se proponen dos primeras medidas para mitigar el problema; otras sugerencias en este sentido son las formuladas por quienes participan en el debate de la Mesa Redonda que también se publica en este número del *Boletín*. Aparecen aquí asimismo, junto con un comentario al respecto, fragmentos de los escritos de una autoridad del siglo XIX en salud pública, William Farr, ampliamente reconocido como pionero del estudio científico de las desigualdades en salud.

El interés suscitado por las desigualdades sanitarias y la salud de los pobres ha venido oscilando. Entre mediados de los años setenta y mediados de los ochenta esos temas fueron objeto prioritario de atención, coincidiendo con la promoción que hizo la OMS de la «Salud para todos» y las iniciativas de atención primaria, así como con la «revolución para la supervivencia infantil» que entonces propugnaba el UNICEF. A continuación se pasó a hacer hincapié en las reformas sanitarias orientadas a la eficiencia. Actualmente el péndulo ha empezado a desplazarse de nuevo hacia las desigualdades sanitarias y la salud de los pobres, y ese interés seguirá siendo alto probablemente en un futuro próximo. Sin embargo las perspectivas a largo plazo siguen siendo inciertas, pues todo dependerá del ritmo de avance hacia una distribución equitativa del desarrollo social y económico, incluidas las mejoras de salud. Aunque el papel del sector de la salud en tal desarrollo sea reducido, es en ese terreno donde mayor puede ser la contribución de los profesionales de la salud, lo cual justifica que trabajen activamente tanto dentro como fuera de ese sector. Se presentan seguidamente dos propuestas de acción intrasectorial.

- El reconocimiento, por parte de los profesionales de la salud que conceden alta prioridad a los objetivos — distintos pero relacionados — de mitigación de la pobreza, reducción de las desigualdades y fomento de la equidad, de que su común preocupación por los aspectos distributivos de las políticas de salud es mucho más importante que cualquiera de las diferencias que puedan separarles. En determinadas circunstancias, la opción de interesarse exclusivamente por la salud de los pobres y la opción de intentar reducir las desigualdades en salud entre pobres y ricos podrían dar lugar a distintas líneas de acción. Sin embargo, en general, el hecho de que los interesados en reducir las mencionadas desigualdades procedan a ese efecto a mejorar la salud de los pobres (no a reducir la salud de los ricos) significa que las diferencias entre ellos y quienes se preocupan exclusivamente de la salud de los pobres no pueden ser importantes.
- La segunda propuesta es que los planificadores de la salud sigan el ejemplo brindado por los planificadores de la economía y empiecen a definir sus objetivos en términos distributivos. Los planificadores económicos orientados a los sectores pobres han abandonado hace tiempo la idea de aumentar el promedio de los ingresos por habitante de los países y se dedican a intentar reducir el número de personas situadas por debajo del umbral de pobreza en los países o a reducir las diferencias de ingresos. Los planificadores de la salud, sin embargo, siguen cifrando sus objetivos en aumentar la esperanza de vida promedio o reducir la tasa promedio de mortalidad infantil en el conjunto de la población. Las metas más corrientes en cuanto a la mortalidad de lactantes, como las de la OCDE, que propugna una reducción de dos tercios de la mortalidad de lactantes y niños en cada uno de los países en desarrollo para 2015, pueden alcanzarse más fácilmente persiguiendo reducciones más rápidas

entre los ricos que entre los pobres, con el consiguiente agravamiento de las desigualdades entre unos y otros. Es necesario reemplazar esa meta por otra más específica, como es la de lograr una reducción de dos tercios de la mortalidad de lactantes en el tercio más pobre de la población, o una reducción de un tercio en la diferencia de mortalidad de lactantes entre los tercios más pobre y más rico de la población.

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Annex
OECD development targets for the twenty-first century[a]

Economic wellbeing

- The proportion of people living in extreme poverty in developing countries should be reduced by at least one-half by 2015.

Social development

- There should be universal primary school enrolment in all countries by 2015.
- Progress towards gender equality and the empowerment of women should be demonstrated by eliminating gender disparity in primary and secondary education by 2005.
- The death rate for infants and children under the age of five years should be reduced in each developing country by two-thirds of the 1990 level by 2015. The rate of maternal mortality should be reduced by three-quarters during the same period.
- Access should be available through the primary health care system to reproductive health services for all individuals of appropriate ages, including safe and reliable family planning methods, as soon as possible and no later than the year 2015.

Environmental sustainability and regeneration

- There should be a current national strategy for sustainable development, in the process of implementation, in every country by 2005 so as to ensure that current trends in the loss of environmental resources are effectively reversed at both global and national levels by 2015.

[a] Source: **Development Assistance Committee of the Organisation for Economic Co-operation and Development.** *Shaping the 21st century: the contribution of development co-operation*. Paris, Organisation for Economic Co-operation and Development, 1996.