

ASSESSING EQUITY IN HEALTH: CONCEPTUAL CRITERIA

Alexandra Bambas¹ and Juan Antonio Casas¹

INTRODUCTION²

Fifty years ago, the framers of the Universal Declaration of Human Rights (UDHR) established a benchmark of standards against which to assess equity in health, both in terms of equity in health and well-being and in access to medical care. They wrote:

Article 25. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The UDHR also states:

Article 2. Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion,

*national or social origin, property, birth or other status.*³

Unfortunately, those ideals for human health and well-being set forth in that document have not become a reality for every citizen in the world. In fact, given the competition for resources among different aspects of human well-being, attaining these standards is unfeasible for the present. Consequently, we must now attempt to develop a more organic process for assessing fairness in the distribution of resources for health that takes into consideration our organizational and technical abilities, personal autonomy, and reasonable expectations for action.

In recent decades, important authors have devoted themselves to study, define, and interpret the concepts of equity and social justice, as well as that of health equity. The works of John Rawls,⁴ Amartya Sen,⁵ and Margaret Whitehead⁶ stand out. In our Region, several authors and public health leaders have con-

¹ Division of Health and Human Development, Pan American Health Organization.

² This paper is based on a larger work by Alexandra Bambas, entitled "An Interpretation of Equity in Health for Latin America and the Caribbean" (working title), which examines conceptual and programming issues for equity in health in the context of the Region. The paper was also supported by the Division of Health and Human Development's Health Equity Interprogrammatic Group, with inputs from various other PAHO technical units.

³ The full text of the Universal Declaration of Human Rights is available at: <http://www.ifs.univie.ac.at/intlaw/konterm/vrkon-en/html/doku/humright.htm#1.0>.

⁴ Rawls J. A theory of justice. Cambridge: Harvard University Press; 1971.

⁵ Sen A. Inequality reexamined. Cambridge: Harvard University Press; 1992.

⁶ Whitehead, M (1991) The Concepts and Principles of Equity and Health. World Health Organization, Regional Office for Europe. (Who document EUR/ICP/RPD 414. Unpublished.)

tributed to the understanding of health equity as a public health issue,⁷ and since 1995, under the leadership of its Director, Sir George Alleyne, the Pan American Health Organization has identified the reduction of health inequities as the main goal of its technical cooperation.⁸ Other leading development institutions, such as the Rockefeller Foundation⁹ and the World Bank,¹⁰ also have launched important initiatives that consider health equity as a priority issue for human development.

The persistence of infectious diseases among the poor; the growing proportion of the burden of disease that is due to non-infectious, behavior-related causes; and the growing inequalities within and between countries that have accompanied the globalization process and its worldwide expansion of free trade, market economies, and liberal democracy, have added urgency to the need to address the growing health inequalities. As a result, national and international health authorities have increasingly addressed the macrodeterminants of health inequities. The issue of health inequities and their relation to living conditions is now in the mainstream of public health thinking. And yet, although the technical aspects of measuring inequalities in health have evolved, insufficient attention is given to the explanation of why inequalities in health or health resources might be unfair or what the larger implications of labeling them as unfair might be. Moreover, the term “equity” often is used loosely, making it un-

clear as to how the term should be interpreted in a given context.

Many of the discussions about health equity make reasonable claims that there are inequalities in health status and access to care for different categories of people, whether identified by social class (as measured by income, wealth, and/or formal education), spatial distribution, gender, or ethnicity. Those who work in the public policy sector take this a step further, often referring to these inequalities in health as inequities, casually using the term as shorthand for describing differences between better- and worse-off groups. Implicit to these discussions is an assumption that any difference is unacceptable and requires attention and intervention, but such discussions rarely provide an explanation for that value judgment or make distinctions between different kinds and levels of inequalities.

Asserting that these inequalities are inequities makes a forceful claim about justice—the normative implication of the word is useful. Confusing “equity” with “equality,” a common implication of comparisons between the best-off and worst-off, can result in a much higher standard than we might agree to under a more careful examination, however. The failure to distinguish between philosophical and pragmatic decisions regarding equity concerns in health could confuse the assessment of resource allocation or other policy decisions. This, in turn, would undermine the transparency of the process, making it difficult to generate public support.

At least three emerging empirical findings commonly drive the claim that inequalities in health between socioeconomic groups should be a development issue, and specifically a public health concern, particularly in Latin America and the Caribbean.

1. The poor use fewer public resources than middle and upper income groups.
2. There are vast and patterned health inequalities between socioeconomic groups, as well as between gender and ethnic origin categories, suggesting links between

⁷ These Latin American public health figures include, but are not limited to, Jaime Breilh, Juan Cesar Garcia, Asa Cristina Laurell, Cristina Possas, Mario Testa, Naomar de Almeida Filho, Pedro Luis Castellanos, Juan Samaja, Carlos Montoya, Jeanette Vega, among others.

⁸ See for example, Pan American Health Organization. *Annual report of the Director, 1995: In search of equity*. Official document No. 277. Washington, DC: 1996; and Alleyne G.A.O. “Equity and Health,” speech presented at the XI World Congress of Psychiatry, Hamburg, Germany, August 1999.

⁹ Rockefeller Foundation. Global health equity initiative report. In press.

¹⁰ The current work by Davidson Gwatkin and Adam Wagstaff in the Poverty and Health Interprogrammatic Group in the World Bank is of particular importance.

health outcomes and a variety of material and social living conditions.

3. Inequalities in the impact of these macro-determinants on health and overall well-being are growing.

These observations are often associated with the effects of globalization, and imply that intervention is required to prevent market distributions of resources from creating large discrepancies in health. These concerns also suggest that past interventions have not sufficiently compensated for these market effects.

DEFINITIONS OF EQUITY

Dictionary definitions of “equity” are fairly consistent. The term is defined as “justice according to natural law or right; specifically, freedom from bias or favoritism,” or “the state, ideal, or quality of being just, impartial, and fair.”¹¹

“Inequity,” then, is the linguistic opposite: the state, ideal, or quality of being unjust, partial, or unfair. Most importantly, notice that not *equality of distributions* but rather *fairness of distributions* is central to the definition. Although “equality” and “equity” are often conflated, the words have two distinct meanings and are conceptually very different. Equality is sameness, and equity is fairness. In any particular situation, equal may not be equitable, or equal may be precisely equitable, but we must present an ethical justification for why a certain distribution constitutes an inequity.

Vertical and Horizontal Equity

In describing an equitable situation, distinctions must be made between the appropriateness of equal and unequal distributions—or horizontal and vertical equity—either of which may constitute “even-handed treat-

ment,” depending on the situation. Equity simultaneously requires that relevantly similar cases be treated in similar ways, and relevantly different cases be treated in different ways. As noted in the *Dictionary of Philosophy*, controversy arises from the delineation of relevant similarity—*horizontal equity* is the allocation of equal or equivalent resources for *equal need*; *vertical equity* is the allocation of different resources for *different levels of need*.

These two conceptions of equity have dramatically different policy implications and cannot be applied randomly to problems. Rather, their application must appeal to some principle or special feature of the problem that justifies the choice of one over the other. For example, a universal health care plan might appeal to horizontal equity on the basis that *everyone* needs health care at some point. On the other hand, targeted programs for the poor would appeal to vertical equity. The distinction between these situations turns on the interpretation of *need*: in the first case, the justification is that everyone needs health care in the biological sense, while the second case appeals to a sense of financial need of the poor which doesn’t apply to the non-poor.

Vertical equity has a higher potential for redistributing resources, and therefore often faces more political obstacles. However, in the current political climate, which challenges the legitimacy of public provision of services in areas thought to have market potential, vertical equity has gained momentum as a mechanism for constraining claims of need to those based on severe financial deprivation. For instance, where market mechanisms have been introduced into national health systems in the process of health sector reform, publicly funded basic packages or focalization strategies were instituted to provide for the needs of the worst-off. This approach has been criticized as having an overly narrow interpretation of need, which left large segments of the population vulnerable once again. On the other hand, some focalized strategies based on vertical equity are seen as quite reasonable and successful, such as in immunization programs.

¹¹ Webster’s New Collegiate Dictionary; American Heritage Dictionary.

EQUITY IN ACCESS TO HEALTH CARE SERVICES

An operational definition of health equity that focuses on need as the appropriate distribution mechanism specifically addresses equity in access to health care services. Aday's definition,¹² which has pervaded thinking in the health field, often is taken for granted and seldom questioned. Aday et al. define an "equitable distribution of health-care services" as "one in which illness (as defined by the patient and his family or by health-care professionals) is the major determinant of the allocation of resources."

The crux of the argument is that health resources are special goods that should not be distributed strictly as normal market commodities according to economic resources, because their social worth is significant. But this service-oriented approach has been found to be insufficient in reducing inequalities in health status and access to health between socioeconomic groups, a finding cited by the widely influential Black and Acheson Reports of the United Kingdom. These reports examined the British National Health System, a prime example of universal coverage in health, and concluded that the effect of approaching health using a medical services strategy did not address concerns of reducing health inequalities and achieving fairness.

"Access to medical services" historically has been used as a measure of fair distribution, partly because it is easier to measure and to improve access to services than to achieve more ambitious goals—say, securing a certain level of well-being in a population—and because of the historical compartmentalization of the social sectors within government, which provide focal advantages, but may at times limit the activities seen as appropriate for any one sector.

Additionally, there is an implicit assumption that services are a means to improve the

population's health, an assumption that has not been sufficiently confirmed.¹³ Recent attention to inequalities in health status, especially with regard to socioeconomic categories, underlies a certain dissatisfaction with approaches strictly focused on access to services. This is due in part to the recognition that medical services may not be the most important determinant of health status and certainly are not the only means to improving health status. Insofar as access to services is supposed to be a means to higher level goals, such as better health, or even more opportunities in life, it is a limited measure of health equity. Various other sectors and aspects of life affect one's health status, including living conditions, working conditions, environmental issues such as air quality, education level, and access to cultural, social, and political participation.

By limiting our evaluation of health equity to "access to medical services," we ignore the importance of other sectors in determining health, and effectively exclude their incorporation into an equity strategy. Such an approach tends to value these services for their own sake, rather than emphasizing the role of medical services as *one of many means* to attain health.

If our consideration of health equity is widened to include inequalities in health outcomes, it becomes necessary to measure health status directly (rather than using only access to services) and to incorporate the analysis of access to other basic services and the level of satisfaction of other basic needs into the assessment of equity in health. The shift from a medical services approach to a health outcomes approach involves the recognition that people do not get sick randomly, but in relation to their living, working, environmental, social, and political contexts, as well as with regard to biological and environmental factors that are unevenly distributed in the popula-

¹² Aday LA and Andersen RM (1981). Equity of access to medical care: a conceptual and empirical review. *Med Care* 19(12), Suppl. pp. 4-27.

¹³ McKeon T. The role of medicine: dream, miracle or nemesis? Nuffield Provincial Trust; 1976 (also available in Spanish, under the title, "El papel de la medicina: sueño, espejismo o nemesis." México: Siglo XXI; 1982).

tion. This broader concept is also much more conducive to considering the improvement of health status as part of the larger work of human development.

EQUITY IN HEALTH OUTCOMES

Based on the broad concept of health equity, as developed by Margaret Whitehead and adopted by EURO/WHO, the government of the United Kingdom has taken the policy position that all health differences between the best-off and worst-off in different socioeconomic groups constitute inequities in health. Whitehead defines health inequities as “differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust.”¹⁴

If this were the complete definition, people with different life perspectives and even different political ideologies might be able to agree to it in principle, which would make it useful in the larger political forum to generate a working consensus on the matter. However, it entails reaching agreement on two potentially controversial parameters, i.e., determining what is unnecessary and unfair *vis-à-vis* what is inevitable and unavoidable.

Whitehead goes on to specify seven determinants of health inequalities that can be identified:

1. Natural, biological variation.
2. Health damaging behavior that is 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 behavior (as long as other groups have the means to catch up fairly soon).

4. Health damaging behavior in which 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 basic services.
7. Natural selection or health-related social mobility involving the tendency for sick people to move down the social scale.

Health inequalities determined by the first three categories would not be considered unfair nor unjust, while the last four would be “considered by many to be avoidable and the resultant health differences to be unjust.”¹⁵

Although Whitehead’s definition includes adequate access to health services as a condition of justice, it extends far beyond that—and beyond the more procedural standard related to access to services—to a much broader set of conditions that can affect health and establish a health advantage of one group over another. It’s a robust concept of equity, encompassing a range of situations including outcomes, exposures, risks, living conditions, and social mobility.

CRITERIA FOR ASSESSING HEALTH EQUITY

The burden of proof lies in demonstrating that a situation is inequitable (rather than equitable), because making a social argument to change the present order requires justifying the allocation of public resources for interventions to redress the inequality. But to make this claim, we must give contextual and concrete meaning to the operational definitions of equity to determine when the judgment would apply. These meanings are reflected in the criteria that are repeatedly referred to in discussions regarding fair distributions of goods.

¹⁴ Whitehead M (1991) The Concepts and Principles of Equity and Health. World Health Organization, Regional Office for Europe (WHO document EUR/ICP/RPD 414. Unpublished); p. 5.

¹⁵ Whitehead M (1991) The Concepts and Principles of Equity and Health. World Health Organization, Regional Office for Europe (WHO document EUR/ICP/RPD 414. Unpublished); p. 6.

To establish a situation as inequitable, differences in distributions of a good, such as health resources or even the larger determinants of health status, must satisfy each of the criteria:

- The differences in distribution must be *avoidable*,
- must *not reflect free choice*, and
- the claim must link the distribution to a *responsible agent*.

As the claimants, we must be able to argue how these criteria relate to particular claims of inequity.

Although these criteria might be applied to either individual distributions or to social distributions, their implications will take on somewhat different tones with each. For the purposes of policy development, we are concerned with social distributions, and therefore the interpretation of each of these criteria will relate not to equity judgments of any particular person's situation, but to trends in the health of the population and its subgroups. Some might argue that distributions are *politically necessary*—that sufficient support cannot be generated to support redistribution. But political will should be driven by justice; it should not constrain justice. If political will is lacking but equity criteria are present, mobilizing civil society to create political pressure becomes a technical issue.

Avoidability

“Avoidability” is a key criterion for equity, because if a distribution is not avoidable, it cannot be interpreted to be unfair in a social sense. While we emotionally respond by feeling that the universe or life is not just—and we may even have a will to intervene to change such distributions—to make a social claim based on equity is quite a different matter in that it *requires* action.

A proposal for redistribution, whether it be of health services or of macro-determinants of health, must show the current distribution to be avoidable in several senses.

It must be *technically avoidable* because current scientific and organizational knowledge provides a solution for successful intervention.

It must be *financially avoidable* because sufficient resources exist either within the public sector or more generally to satisfy fair conditions.

And it must be *morally avoidable* because the proposed redistribution would not violate some other, greater, sense of justice.

The subcategories of avoidability are highly relevant to claims of socioeconomic health inequities. Certainly there are individual cases of “technically unavoidable” health differences, such as in the case of health harms linked to naturally occurring genetic variations. But unless given reason to believe the contrary, we would not expect such occurrences to be patterned according to socioeconomic groups, thereby eliminating one source of “technically unavoidable” health inequalities and strengthening claims that patterned distributions of health may constitute inequities. Assuming that genetically related differences in health are not used to define our groups, the health standard of best-off groups demonstrates that those health indicators are indeed technically feasible. That is, in *technical terms* there is no reason why all groups could not achieve health levels similar to those of best-off groups.

However, the setting of standards according to best-off groups may be prohibitively expensive, at least above a certain level of health. Diminishing margins of utility certainly do not argue against *any* redistribution or investment, but may place a limit on what might be financially possible in reducing health inequalities given resource constraints. Therefore, such studies contribute significantly to our understanding of financial avoidability, and therefore to reasonable and fair differences, even if absolute equality proves unfeasible. Finally, the evaluation of financial feasibility and the effect of re-distributions cannot be restricted to current public spending levels, but must necessarily include an economic evaluation of the availability of external resources based on

the potential to increase fiscal base, since the question at issue is whether the financial resources exist at a macroeconomic level, not only within the institutional confines of the health sector.

At some point, we may determine that a certain redistribution level is technically and financially feasible, but impinges on other social values to the extent that the redistribution itself becomes unjust, either by severely restricting civil liberties or by prioritizing health to the unjustifiable detriment of other social goods. Analyses must therefore include not only studies of diminishing margins of utility, but also the larger social effect of such redistributions. Hypothetically, if, for a given country, we found that we could bring inequalities of infant mortality rates, maternal mortality rates, and communicable diseases within “an acceptable range” only by instituting tax rates of 90% of income, we may decide that personal freedoms would be compromised to an extent that the social injustices created are greater than those that existed under conditions of larger health inequalities. If we accomplished the task by directing public spending for health activities by virtually eliminating other important national programs, not only might we find greater injustices than health inequalities, but also the actions might prove counter-productive if certain other programs (such as education or environmental protection) were to be affected.

If an argument that inequities exist is able to respond to each of these issues, it has succeeded in establishing that such inequalities are in fact avoidable, perhaps the most difficult of the criteria to secure.

Choice

Choice is particularly relevant to interpreting justice in health in terms of the protection of individual autonomy. Therefore, *health behaviors* are better at indicating possible choice issues than are health outcomes. The application of choice as a criterion might range from an individual electing to (1) engage in an ac-

tivity, to (2) buy a product, and to (3) prioritize needs. We hope that given sufficient information and opportunity, people will opt for activities and behaviors that enhance their health. Even when such activities and behaviors may not always be chosen, justifying health-enhancing interventions may be limited by concerns for autonomy and the preservation of civil liberties.

Free choices may, in fact, create acceptable differences between *individuals'* health, as some persons may choose behavior that leads to worse health outcomes. But if the choice was in fact made under perfect, or even reasonably high conditions of choice, including adequate information and free will, claims of an injustice would be more difficult to sustain.

Particularly in the context of population-based analyses, however, protecting autonomy and promoting health often are more complimentary goals rather than competing interests. While individuals might make free choices based on their own particular wants or needs, we would not expect to see strong patterns of such behavior stratified in socioeconomic groups, unless an additional correlation that explains the concentration of risky behavior were presented.

A case for socioeconomic inequities in health must be built on the presumption that population *groups* would not freely choose lesser levels of health. In fact, some studies have shown that health behaviors do not differ significantly between population groups, and when they do, such as in the case of high fat diets among some minority groups in the United States or the urban poor in Latin America and the Caribbean, culture and lack of health information can be seen to clearly diminish the role of free choice. Further, when health behaviors are controlled for income, differences between groups dissolve, and income is not usually considered a “chosen” socioeconomic category. Consequently, choice as a justification for health differences tends to fall away in population studies. Therefore, when we do see such patterns, there is reason to believe that low levels of choice, or a thin sense of choice, might better

describe those behaviors or decisions. Investigation into causality, whether through physical or social science, can bolster the argument that choice is limited.

Opponents of redistribution sometimes try to limit the scope of challenges to choice by depending on claims of economic choices in prioritizing goods or procedural interpretations of legal entitlement (in the case of public programs) as sufficient conditions for establishing free choice. Such conclusions generally rely on assumptions of equal opportunity for individuals within a society, at least at some level, although little attention is given to elaborating on the conditions of equal opportunity or a practical demonstration that such opportunity exists. Failure of the poor to “protect their health,” for instance, is seen as due to their own negligence or to the life situation that they have put themselves in (e.g. “choosing” to work in a dangerous factory), rather than any larger social, economic, or political disadvantages over which they had little control.

Some might argue that the poor or other vulnerable groups “choose” poor health, particularly when they fail to seek care when they are ill. However, the priorities that intervene to prevent such utilization of care are often not only equally basic and necessary for survival, but also often contribute to the family’s health in some other way, as when financial resources are used to purchase food or support the survival of the family business. Such arguments gain by conflating “decision making,” which can include prioritizing certain needs over other needs, with a richer meaning of “free choice.” Further, if we can demonstrate that health is strongly linked to other social sectors, the argument that the poor can “choose” to invest in health by financially prioritizing health care services over, say, housing or nutrition, loses its weight, since the areas are interrelated, and that “choice” simply becomes a decision, with little real meaning in terms of improving one’s well-being.

Insofar as access to health services is concerned, proponents of resource redistribution

have succeeded in expanding the narrow, but commonly used interpretation of “choice”—the *legal right to utilize resources*. They include more socially embedded issues that are needed to access health resources, such as support services, including transportation. Recognizing the social context of a situation demonstrates how real “choices” can be thwarted by the reality of people’s daily lives. Removal of those barriers, then, actually enhances individual autonomy in a meaningful sense, rather than detracting from it.

Transportation is only one of many barriers to free choice. While individuals often do make choices about their own health, decisions also are made by groups at the national, community, and family levels. Such situations can be used against the politically disenfranchised in a democracy, if the assertion is made that all citizens have agreed to certain conditions, and therefore have “chosen” those conditions. The recognition of macrodeterminants of health, including social and economic factors that influence health status, has greatly broadened the social meaning of health resources, and consequently has expanded the list of relevant resources involved in the choice claim. Lack of access to education and access to information, for instance, can ground a health inequity claim related to choice. Though more difficult to empirically demonstrate, psychological issues also are basic to a conception of choice. Elements of social control and influence, actual and perceived locus of control, and the larger implications of certain health-related choices on one’s life become very important to identify in order to establish that choice is more limited than it might appear.

Agency

The third criterion for establishing that an inequity exists is that the claim be linked to a *responsible agent*. To make this determination, either of two meanings of “responsible” may be used. We may establish that there is a *culpable* entity who caused direct or indirect

harm, as we might apply in cases of damage to health due to environmental degradation or occupational hazards. One of the difficulties in identifying and establishing the culpable agent is that culpability can be masked. The externalization of health harms in industry or manufacturing, for instance, would first have to be recognized, then traced. In the absence of empirical studies linking problems to their sources, our ability to perceive the culpability of a particular agent will be impaired, even if there is a very direct cause/effect relationship. Further, for the purposes of socioeconomic differences in health, discrete instances of culpability are less relevant than larger systematic patterns of harms that would be generated through responses to policy, or its absence.

Alternatively, we might make a claim that there is an *accountable* entity, one who is responsible for rectifying the unfair distribution. In the case of health equity, claims often center on the responsibility of the government to ensure certain rights or provide a certain amount of protection to all citizens, which justifies state intervention. A claim of lax or unenforced government regulations, or governmental assistance in externalizing health harms, makes a particularly strong claim. Although a government might not be responsible for creating a health-harming situation, once an issue has been publicly discussed, lack of response by government must be interpreted as a decision affecting the public to which it, as a presumably just institution, must be held accountable. The level of governance then, will also affect perceptions of the responsibility (and the ability to respond) of the government.

The Spectrum of Inequalities

If any one of these criteria is absent, or is present only weakly, the argument that a difference is an inequity begins to lose power. In addition to the empirical verification that inequalities in health status or access to resources exist, scientific research can assist in

demonstrating that these criteria apply, thereby greatly strengthening the political claim that inequities also exist. Because scientific knowledge is constantly growing, our interpretation of whether criteria apply to specific issues also changes over time. For instance, in relation to “free choice,” alcoholism and smoking are not seen as much as lifestyle *choices* as they once were, because of increasing evidence on the biological basis of addiction. Social science research also contributes to our interpretations, as when we attend to the effect of targeted advertising on alcohol consumption and smoking rates.

When we make the claim that differences in health are inequitable, the strength of the evidence or the argument, according to the above criteria, will determine the level of inequity. We might think of this as a spectrum, with each of the criteria moving our assessment of the situation either closer to “misfortune” or to “inequity.”

Misfortune	Inequities
(Fair differences)	(Unfair differences)
Avoidable Differences	
Chosen Differences	
Responsible Agent	

To be sure, we must be willing to recognize some differences as “fair” differences; otherwise, the criteria would not be meaningful. Genetic birth defects and deaths due to “old age” may be very unfortunate but not necessarily unfair if little could have been done to prevent them; that is, they were not avoidable. Therefore, it will also be important for a clear analysis to identify those differences that do not fit into the criteria.

CONCLUSION

The framework presented here must now be supplemented with quantitative and qualitative information that applies each of these criteria to the health conditions and broader societal abilities and resources in order to set

priorities and targets for equity in health. Research must be supported not only by traditional epidemiological studies but also by social health research, including methodologies that are continuing to be developed. The particular resources and challenges will differ among countries, and the quest for health equity should be recognized as a development process, and one that must alter its goals on occasion to adjust to the changing environment.

An equity-driven approach in health policy requires a broad vision of the determinants of population health and an understanding of how both health policy and wider social policy will affect those determinants. To the extent that health and other socioeconomic factors are interdependent, health policy must consider how other sectoral policies and actions, as well as societal trends, can be directed to promote health equity. Similarly, health policy must take into consideration how health

policy can contribute to broader equity goals in health development.

Finally, the pursuit of equity is necessarily linked to issues of governance, which include accountability, transparency, decision-making procedures, and the ability of the political arena to allow for broad representation and the effective exercise of choice by all social groups and members of society.¹⁶ Leadership in health equity requires both a high capability for managing resources and developing policy and a strong political society. Once a society embraces a political foundation of egalitarianism, whereby all citizens of a country are due equal regard under the law and have equal political voices, societies themselves become the ultimate arbitrators of equity, in health or any other sphere.

¹⁶ Gilson L. In defence and pursuit of equity. *Soc Sci Med* 1998; 47: 1891–1896.