Bulletin 2000 Feedback

Inequalities in health

In vol.78, issue no.1 of the *Bulletin*, Davidson Gwatkin's critical reflection (*1*) argues that strategies such as primary health care within the health-for-all concept have failed to address inequalities in health, and that new ones are needed to deal more effectively with the problems of poverty and ill-health. In this context, he mentions a new strategy to be developed by a task force established by WHO, involving many international agencies including the World Bank.

However, failures are not usually attributable to faulty strategies, but rather to an inability to implement appropriate programmes. There has been no lack of strategies and policy documents developed by ministries of health and other agencies in most developing countries during the last few decades. The problems arise because of a lack of concerned individuals in charge of implementation and inadequate resources in terms of money, manpower and equipment.

It is important to incorporate research and evaluation into the implementation process, so that new knowledge will be of direct benefit to the programmes. Such research will identify weaknesses as well as strengths and underpin evidence-based changes in activities. In this way, one may avoid the introduction of badly managed "reforms" after adoption of new strategies or policies. The consequences have often been that even the better parts of an old system have been eroded, with no guarantee that a "reform" will work better. Experience from Papua New Guinea recently described by Duke (*2*) illustrates very well how a public health system reaching most of the population before 1990 broke down after reforms were introduced into the country in the mid-1990s.

What is needed, therefore, is that countries examine how their health system can better achieve the targets already set. In the process of evaluating ongoing programmes, redefinition of targets giving priority to the most essential preventive and curative services may be necessary. The next step for improving equity will be to secure the necessary funds; I agree with Dahlgren (*3*) who, in the Round Table Discussion, points to the need for progressive financing of these essential services by direct public funding. Introduction of user fees is currently increasing inequity in many settings.

The Round Table contribution by Éva Orosz (*4*) shows clearly that the political élite in Hungary often has little concern for the poorer part of the population. Her concern is that there is no real will to reduce inequalities, either within politically influential groups or in the health sector itself. This also seems to be the situation in many developing countries today, where lack of political will and capability to tackle observed inequities in health represent greater problems than lack of data on inequalities and new strategies.

I agree with Gwatkin that if people who are really concerned about the appalling health situation among the poor work together, internationally as well as within countries, they will constitute a significant political force which cannot be overlooked. It is encouraging that so many international agencies now are putting poverty and ill-health at the top of their agendas. However, so far this has not had an impact on the policy of the richer countries of the world. Overseas development aid was reduced from an average of 0.33% of GNP in 1992 to 0.24% in 1998, when only Denmark, the Netherlands, Norway and Sweden exceeded 0.7% of GNP — the target set by the United Nations for aid from industrialized countries (*5*). The USA spends only 0.1% of its GNP on development aid, and the cumulative decrease in aid from the USA during 1992–98 amounted to US$ 22 billion.

This trend must be reversed, and the richer part of the world must assist by contributing funding as well as high quality health personnel who are willing to work in partnership with local health workers on different levels. Reduction of inequity in health is of course not only dependent on equity-oriented health programmes, but also on a real commitment to attacking poverty and reducing socioeconomic inequalities. In addition to a necessary reduction in the heavy burden of debt, a well-organized and long-term programme, a "Marshall plan" for the poorest countries, will be necessary in order to achieve the goals of reducing poverty and inequalities in health. These goals have been reiterated by various agencies and individuals over the last 50 years, and actions are long overdue. Though responsibility for action lies with each individual country, the international community must contribute more than before, and the "new" WHO has an important role to play in ensuring that equity-oriented health programmes are introduced in all countries of the world. ■

Gunnar Kvåle, Professor
Centre for International Health
University of Bergen
Armauer Hansen Building
5021 Bergen, Norway
email: gunnar.kvale@cih.uib.no

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2. **Duke T.** Decline in child health in rural Papua New Guinea. *Lancet,* 1999, **354**: 1291–1294.
3. **Dahlgren G.** Efficient equity-oriented strategies for health. *Bulletin of the World Health Organization*, 2000, **78**: 79–81.
4. **Orosz E.** The key to overcoming inequality is political commitment. *Bulletin of the World Health Organization*, 2000, **78**: 83–85.
5. **Development Assistance Committee.** *1999 Development co-operation report.* Paris, OECD, 2000.