

The many dimensions of health equity

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The articles featured in this issue of the *Revista Panamericana de Salud Pública/Pan American Journal of Public Health* illustrate well the many dimensions of health equity. The contents of the issue constitute a unique review of the current debates concerning conceptual and methodological issues and empirical evidence regarding the determinants of health equity. The pieces begin with the cogent argument put forward by Amartya Sen calling for considering health inequity not just a discrete phenomenon but rather a manifestation of broader social inequities. That piece is followed by a summary of the findings of various ongoing multicountry research projects sponsored by the Pan American Health Organization (PAHO) on the determinants and dimensions of health inequities in the Americas. A series of essays explores a wide range of issues related to equity, including gender, ethnicity, age, poverty, income distribution and economic growth, governance, globalization, legislation, ethics, and the role of access to information and to financing. The essays also consider new approaches to assessing the health impact of public policies intended to promote health equity as well as new ways to better transfer information and knowledge from researchers to decisionmakers. Another important contribution is the presentation of a growing cadre of Web-based information sources developed by PAHO and by other organizations. These new materials are leading to the development of a global virtual library on health equity that will increasingly link academia, government, and civil society, which all have a shared interest in and a commitment to creating a world with more equity and more fairness in health.

What are the most important of the various themes in these pieces? Each reader will no doubt have his or her own answer to this question, but most of the responses are likely to include at least some of the following:

- *Economic disparities, important as they are, constitute just one of the many important causes of inequitable intergroup health differences.* The importance of economic disparities is obvious from the article by Dachs and colleagues on self-assessed health status and health-seeking behavior. But for anyone thinking that economic differences are all that matter or that they are the ones that matter the most, other papers are required reading: the piece by Gómez on gender disparities, the discussion by Larrea and Freire of ethnic differences with respect to malnutrition, and the presentation by Soares et al. on urban-rural differences in access to drinking water. Differences along gender, ethnic, and geographic lines clearly matter as much as economic disparities do.
- *Measuring inequalities in terms of standard measures such as mortality rates and health-service use capture only a small part of the total picture of health inequality.* Health inequalities cannot be seen in isolation from other social inequalities. This message, which Sen appropriately emphasizes, also comes through in other articles. As Soares and colleagues point out, the water supply lies at the fringe of the traditional definition of the health sector, but it is no less important. Similarly, the focus of the Larrea and Freire paper on child malnutrition is a welcome reminder of the importance of looking beyond standard measures of health conditions and including such other dimensions as nutritional status. Introducing equity-based epidemiological and self-perceived health situation monitoring and analysis that utilizes population-based information sources such as household surveys, as described by Dachs, is another important measure. It will greatly enhance the health sector's ability to introduce more effective, focused interventions as well as to advocate for interventions that lead to greater equity.
- *Not all health disparities are inequitable.* The classic definition of a health inequity is a disparity or inequality that is unnecessary, avoidable, and unfair. While many health inequalities meet these three criteria, not all of them do. This comes through with particular clarity in the discussions of gender in the pieces by

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Gómez and by Sen. Women's almost-universal advantage in greater longevity is not necessarily inequitable, given the possibility that this difference is attributable to biological factors and is thus not preventable by policy interventions. As shown by Gómez, Latin American women have a higher rate of health service utilization than men do. Nevertheless, this constitutes an inequality that is fair since it tends to compensate for the higher frequency of illness from which women suffer. On the other hand, in almost every country in the Region of the Americas, women must bear a higher proportion of out-of-pocket expenses for health services and products than men do. This is clearly an inequitable situation that can and should be addressed by specific policy measures. Such examples demonstrate the need for careful thought before concluding that an inequality constitutes an inequity.

- *Different population groups view their health differently.* This comes through in the papers by Gómez and by Dachs. Gómez reports that women in the countries surveyed typically report a greater frequency of illness than men do. The issue figures even more prominently in the Dachs paper, which looks at self-reported health status (SRHS) across socioeconomic class and finds that the rich often consider themselves as ill as the poor do. This finding, which is in line with others based on self-assessment of health status, is distinctly at odds with the much higher levels of mortality and morbidity found among the poor, as shown through studies of mortality records and through objective determination of health status by physical and laboratory examination. This suggests that the rich and the poor have different standards. That is, what a better-off person considers a set of debilitating symptoms is merely a condition to be shrugged off as a normal, everyday experience by a poor person. It is tempting to take this disparity as proof of the danger of relying on SRHS. But SRHS is important, if only for its implications for resource allocation. The rich consider themselves sick and demand and receive a large proportion of the health services that, if allocated according to externally established epidemiological criteria, should go primarily to the disadvantaged. If the rich weren't overly sensitive to their health condition, and the poor realized how sick they really are, it would be easier to achieve health equity.
- *The determinants of health inequity need to be addressed by comprehensive cross-sectoral policies and by appropriate health interventions that reduce discrimination and unfair disparities.* The overriding cause of health inequities continues to be the persistent marked differences in the distribution of essential goods and services. These patterns of unequal access to the means for fulfilling basic needs and for exercising control over one's life are defined by gender and age relations within the family, and in the larger society by income distribution, socioeconomic status, ethnicity, educational level, and geographic location. The health sector can do much to reverse the most evident health consequences of wider social and economic disparities. In the long run, however, broader-based social and economic policy interventions that improve the lot of the most disadvantaged will have a much larger impact. The linkages among economic growth, poverty, and income distribution in Latin America and the Caribbean are analyzed by Casas. The health impact assessment approach described by Barnes and Scott-Samuel is one means by which the health sector can actively engage other development partners at the local and national levels in dealing with the formulation and implementation of public policies aimed at promoting equity. Another approach to this objective is the implementation of policy tools for achieving more equitable health financing and access to services, as presented in the papers by Suárez and by Gwatkin.

The themes listed above obviously do not simplify the challenges facing persons who want to achieve greater health equity. But an awareness of these themes is necessary to protect against adopting oversimplified and counterproductive approaches. The authors of the pieces appearing in this issue of the *Revista Panamericana de Salud Pública/Pan American Journal of Public Health* are to be thanked for sharing their wisdom and for helping us to make the best possible choices in this difficult area.