Authors: Lindholm L, Rosen M
Title: On the measurement of the nation's equity adjusted health
Publisher: Sweden Health Econ 7(7): 621-8
Year: 1998
Country: Sweden
Keywords: Health services, Health status indicators
Location: Department of Epidemiology and Public Health, University of Ume.ANG.a
Pages: 8pp
Abstract: The aim of this article is to show a method for measuring the nation's equity-adjusted health. In order to estimate what the 'nation's health function' looks like, data from a survey sent to a sample of Swedish politicians were used. The results from the survey can be interpreted as a measure of inequity aversion, and this was applied to data on healthy years (HY) for males in different social groups for the period 1975-1990. The mean of healthy years increased during the period 1986-1990 by 1.09% while equity adjusted healthy years (HY(EDE)) dropped by -1.78%. The nation's health has decreased in spite of the fact that the individual's health has increased.

Author: Berlinguer G
Title: Equity in health, between ethics and economy
Publisher: Rev Med Suisse Romande 118 (12): 989-93
Year: 1998
Country: Rome
Keywords: Medical ethics, health policy, health economics
Location: Universita La Sapienza
Pages: 5pp
Abstract: None

Author: Bloom G, McIntyre D
Title: Towards equity in health in an unequal society
Year: 1998
Country: United Kingdom
Keywords: Health Care Reform; Health economics
Location: Institute of Development Studies, University of Sussex, Brighton, U.K.
South Africa is one of the world's most unequal societies and its health sector mirrors these inequalities. Since the first democratic elections in 1994 the government has been under enormous pressure to diminish disparities between population groups in access to health services. This paper documents the structural inequalities in the health sector and discusses the strategic options that are being considered for reducing them. The overall level of health expenditure is high, amounting to 8.5% of GDP. However, less than 40% of expenditure is on public health services and three quarters of that is on acute care hospitals. A more detailed analysis of public health expenditure reveals large differences between census districts. The districts where household incomes are low tend to have fewer public health services. Public health expenditure per capita was lower than the estimated cost of providing basic primary health care in a fifth of districts. The most urgent need is to improve the services likely to reduce excess mortality and morbidity. This will involve additional funding of primary health service services, particularly in underserved localities. Government cannot increase public health rapidly and it will have to re-allocate funding from hospitals. The paper discusses options for achieving this, including the introduction of social health insurance. It argues that restructuring the health sector is complex and there is a risk of failure. Governments should base their strategies on a good understanding of the health sector and of the likely impact of different reform options.

Author: Banerji D
Title: Ethics, equity and health for all letter
Publisher: World Health Forum 19(3): 298-9
Year: 1998
Country: Switzerland
Keywords: Primary health care, Health services
Location: IDRC library
Pages: 2pp.
Abstract:

Author: Yach D, Skov Jensen M, Norris A, Evans T
Title: Promoting equity in health
Publisher: Promoting Education 5(2): 7-13, 43, June
Year: 1998
Country: Geneva, Switzerland
Keywords: Health promotion, health rights
Location: World Health Organisation
Pages: 8pp.
Abstract: There is evidence that widening income gaps are a global phenomenon; that in many advanced industrialised countries unemployment rates
are rising; that globalisation of the world economy has led to several countries becoming marginalised with a concomitant increase in poverty; and that the absolute number of poor has steadily increased over the last decade. All of these phenomena emphasise the need to focus on equity as a global concern.

Authors: Poland B, Coburn D, Robertson A, Eakin J
Title: Wealth, equity and health care: a critique of a "population health" perspective on the determinants of health
Publisher: Social Science and Medicine 46(7):785-98
Year: 1998
Country: Canada
Keywords: Health services, health policy
Location: Critical Social Science Group Department of Behavioural Science, University of Toronto Ontario Canada.
Pages: 11pp.
Abstract: In this paper we examine the recent ascendancy of a "population health" perspective on the "determinants of health" in health policy circles as conceptualized by health economists and social epidemiologists such as Evans and Stoddart [Evans and Stoddart (1990) Producing health, consuming health care. Social Science & Medicine 31(12), 1347-1363]. Their view, that the financing of health care systems may actually be deleterious for the health status of populations by drawing attention away from the (economic) determinants of health, has arguably become the "core" of the discourse of "population health". While applauding the efforts of these and other members of the Canadian Institute for Advanced Research for "pushing the envelope", we nevertheless have misgivings about their conceptualization of both the "problem" and its "solutions", as well as about the implications of their perspective for policy. From our critique, we build an alternative point of view based on a political economy perspective. We point out that Evans and Stoddart's evidence is open to alternative interpretations--and, in fact, that their conclusions regarding the importance of wealth creation do not directly reflect the evidence presented, and are indicative of an oversimplified link between wealth and health. Their view, that the financing of health care systems may actually be deleterious for the health status of populations by drawing attention away from the (economic)determinants of health, has arguably become the "core" of the discourse of "population health". While applauding the efforts of these and other members of the Canadian Institute for Advanced Research for "pushing the envelope", we nevertheless have misgivings about their conceptualization of both the "problem" and its "solutions", as well as about the implications of their perspective for policy. From our critique, we build an alternative point of view based on a political economy perspective. We point out that Evans and Stoddart's evidence is open to alternative interpretations--and, in fact, that their conclusions regarding the importance of...
wealth creation do not directly reflect the evidence presented, and are indicative of an oversimplified link between wealth and health. Their view also lacks an explicit substantive theory of society and of social change, and provides convenient cover for those who wish to dismantle the welfare state in the name of deficit reduction. Our alternative to the "provider dominance" theory of Evans and Stoddart and colleagues stresses that the factors or forces producing health status, which Evans and Stoddart describe, are contained within a larger whole (advanced industrial capitalism) which gives the parts their character and shapes their interrelationships. We contend that this alternative view better explains both how we arrived at a situation in which health care systems are as costly or extensive as they are, and suggests different policy avenues to those enunciated by Evans, Stoddart and their confreres.

Authors: Castiel D, Jourdain A
Title: Equity and health planning: critical analysis of the SROS and implications for a model of resource allocation
Publisher: Cah Sociology Demographic and Medicine 37(3-4): 205-35
Year: 1997
Country: France
Keywords: Health planning; health services
Location: IDRC library
Pages: 11pp.
Abstract: Not available

Authors: Diczfalusy E
Title: In search of human dignity: gender equity, reproductive health and healthy aging
Publisher: International Journal of Gynaecology and Obstetrics 59(3):195-206
Year:1997
Country: Sweden
Keywords: Health rights
Location: Karolinska Institutet, Stockholm
Pages: 7pp.
Abstract: This paper analyzes the nine pillars of human dignity (sufficient food, potable water, shelter, sanitation, health services, healthy environment, education, employment and personal security), which humankind tries to establish by following nine approaches to reality (scientific, cultural, religious, ethical, economical, ecological, socio-critical, philosophical and political) in a world drastically changed by nine revolutions (demographic, scientific, technological, communication, global identity, environmental, contraceptive, reproductive health and gender equity). The author's generation participated in these revolutions and
contributed to the global intellectual process by which gender equity and reproductive health assumed a central role in world affairs. A rapidly aging world population constitutes another major challenge. Its likely impact on the very fundamentals of our future social, economical, health and even political infrastructures is—as yet—incompletely comprehended by the international community. The International Federation of Gynecology and Obstetrics (FIGO) has and will continue to have an indispensable role in assisting humankind to reach its ultimate goal: human dignity.

Author: Kennedy KM, Wofford DA
Title: Physician equity in health care delivery systems: three alternative models
Publisher: Journal of Health Care Finance 24(2): 36-47
Year: 1998
Country: USA
Keywords: Health services, health economics
Location: IDRC Library
Pages: 12pp.
Abstract: The 1990s have seen many health care organizations attempting to merge, acquire, or affiliate with physician groups. Many have failed to provide physicians a stake in the success of the newly formed enterprise, frequently resulting in declining physician productivity, poor morale, and large operating losses. These problems warrant a reexamination of the traditional acquisition model of growth in favor of structures that retain a physician ownership component. This article examines three models of health care organization in which physicians share in the success of the enterprise and compares them in terms of ownership structure, governance, and funds flow.

Author: Gerdtham U G
Title: Equity in health care utilization: further tests based on hurdle models and Swedish micro data
Publisher: Health Economist 6(3): 303-19
Year: 1997
Country: Sweden
Keywords: Health status indicators; health services
Location: Centre for Health Economics, Stockholm School of Economics
Pages: 16pp.
Abstract: This paper tests the null hypothesis of no horizontal inequity in delivery of health care by use of count data hurdle models and Swedish micro data. It differs from most earlier work in three principal ways: First, the tests are carried out separately for physician and hospital care; second, the tests are carried out separately for the probability of seeking care and the amount of care received (given any use);
and third, the tests are based on a model that includes several socioeconomic variables, e.g. income, education and size of community of residence. The paper rejects the hypothesis of no inequity because socioeconomic factors also have significant effects on utilization, e.g. income and size of community of residence. Size of community of residence has a positive significant effect on the frequency of physician visits but not on the probability of visiting a physician.

Author: Calman K C
Title: Equity, poverty and health for all
Publisher: British Medical Journal 314 (7088): 1187-91
Year: 1997
Country: London
Keywords: Health policy, health rights
Location: Department of Health
Pages: 4pp.
Abstract: Not available

Author: Morris TA, Guard JR, Marine SA, Schick L, Haag D, Tsipis G, Kaya B, Shoemaker S
Title: Approaching equity in consumer health information delivery
Publisher: Journal of American Medical Information Association 4(1): 6-13
Year: 1997
Country: USA
Keywords: Health information
Location: NetWellness University of Cincinnati Medical Center Libraries
Pages: 7pp.
Abstract: The growing public interest in health and wellness information stems from many sources, including social changes related to consumers' rights and women's health movements, and economic changes brought about by the managed health care revolution. Public, hospital, and medical center libraries have been ill-equipped to meet the increasing need for consumer-oriented materials, even though a few notable programs have been established. The "Information Superhighway" could be an effective tool for sharing health information if access to telecomputing equipment and training were available to those with an information need. The University of Cincinnati Medical Center, with its libraries in the leading role, is delivering NetWellness, an electronic consumer health library service, to residents of 29 counties in three midwestern states. Users connect directly through the Internet, through regional Free-Nets, and by visiting one of 43 public access sites where networked workstations have been installed. The continued success of the project depends on developing partnerships, providing quality content and maintaining fair access.
Author: Krasnik A  
Title: The concept of equity in health services research  
Publisher: Scandinavian Journal of Social Medicine 24(1): 2-7  
Year: 1996  
Country: Sweden  
Keywords: Health services; forecasting health trends  
Location: Department of Social Medicine, University of Copenhagen  
Pages: 6pp.  
Abstract: A population approach and the general right to health and medical care have been important issues in the development of health policy over many centuries. However, equity is still a crucial issue in the planning and evaluation of health care. Many definitions and criteria related to equity have been formulated on the basis of conflicting theories and models. Three dimensions of fair and just resource allocation are essential when needs-based models are used: equity in access, utilization, and quality of care relative to needs. Health services research should concentrate on such outcome measures regarding equity and the effect of organizational and processual characteristics of health care systems. Prominent examples of such research efforts are presented, but, unfortunately, there are few reliable and systematic data from this kind of study. Health care researchers have a special responsibility towards the population at large to undertake qualified research on equity and to communicate the results to the general public.

Author: Jan S, Wiseman V  
Title: Equity in health care: some conceptual and practical issues  
Year: 1996  
Country: Australia  
Keywords: Health services, health rights; participation in health  
Location: Department of Public Health and Community Medicine, Westmead Hospital, NSW. Australia  
Pages: 3pp.  
Abstract: Not available

Author: Bollini P, Siem H  
Title: No real progress towards equity: health of migrants and ethnic minorities on the eve of the year 2000  
Publisher: Social Science and Medicine 41(6):819-828  
Year: 1995  
Country: Geneva  
Keywords: Health status indicators
The paper reviews the available evidence on access to health care and two health outcomes, perinatal mortality and accident/disability, for migrant and ethnic minorities in selected receiving industrialized countries. The health of these communities is analyzed using the entitlement approach, which considers health as the product of both the individual's private endowments and the social environment he or she faces. Migrants, especially first and second generations, and ethnic minorities often have reduced entitlements in receiving societies. Not only are they exposed to poor working and living conditions, which are per se determinants of poor health, but they also have reduced access to health care for a number of political, administrative and cultural reasons which are not necessarily present for the native population. The paper argues that the higher rates of perinatal mortality and accidents/disability observed in many migrant groups compared to the native population are linked to their lower entitlements in the receiving societies. Policies aimed at reducing such health gaps need to be accompanied by a more general effort to reduce inequalities and to promote full participation of these groups in the mainstream of society.

Author: Lairson DR, Hindson P, Hauquitz A  
Title: Equity of health care in Australia  
Publisher: Social Science and Medicine Aug 1995, 41(4): 475-82  
Year: 1995  
Country: England  
Keywords: Health services; health economics  
Location: School of Public Health, University of Texas, Houston Health Science Center USA.  
Pages: 8pp  
Abstract: This paper examines the equity characteristics of health care financing and delivery in Australia and compares its performance with recent findings on systems in Europe and the United States. Vertical equity of finance is evaluated with income and payment concentration indices derived from published survey data on taxes and expenditure by income decile. Horizontal equity of health care delivery is assessed with standardized expenditure concentration coefficients for three measures of health status and four types of health services, derived from household survey data on health care utilization, health status, income and demographics. Health cover is available to the entire population. Results show the financing system is slightly progressive despite the fact that 30% of payment comes from private sources, which are regressive. The equity index compares favorably to many European countries and is much better than the U.S. which has a regressive financing system. The Australian system fares less well in terms of equity of health care delivery. Several features favor privately insured higher income persons in use of health care and this is reflected, for some health
status measures and types of service, in inequity favoring the better off. This contrasts with inequity favoring the less well off in many European countries and the U.S. This analysis provides a benchmark for monitoring the equity of the Australian system and provides information on the equity of a mixed private and public financing system that covers the entire population. This is relevant to the U.S. which is moving in this direction by extending private cover to the uninsured and to European countries that are increasing private sector involvement in health care financing.

Author: McLachlan H V
Title: Smokers, virgins, equity and health care costs
Publisher: Journal of Medical Ethics 21(4): 209-13
Year: 1995
Country: Scotland
Keywords: Health economics; health policy
Location: Department of Social Sciences, Glasgow Caledonian University
Pages: 14pp.
Abstract: Not available

Author: Newbold KB, Eyles J, Birch S
Title: Equity in health care: methodological contributions to the analysis of hospital utilization within Canada
Publisher: Social Science and Medicine 40(9): 1181-92
Year: 1995
Country: Canada
Keywords: Health services
Location: Department of Geography, McMaster University, Hamilton, Ontario, Canada
Pages: 11pp.
Abstract: Electronic dissemination and publication); two reports on health reform outcomes in the Southern Cone and the Andean Region; two international seminars and a regional Andean Workshop database on health reform outcomes; strengthened cooperation between research centres in the Southern Cone and Andean Region; and publication of a book, newsletter, abstracts, working papers and at least eight articles in scientific journals. Special attention will be given to the dissemination of the results among policymakers, managers, public officials and professionals. By contributing to the debate on health reform policies, it is expected that the project will improve community access to health care services in the medium and long term.

3.1 CONCEPTUALISING EQUITY IN HEALTH

Author: Gilson L
Author: Mooney G  
Title: Equity in future South African Health care: a tale of minimally decent Samaritans or good South Africans?  
Publisher: Department of Public Health and Community Medicine  
Year: 1998  
Country: Australia  
Keywords: Health values, health planning, health policy  
Location: TARSC  
Pages: 22pp.  
Abstract: This paper discusses how best to represent health care planning at the individual consumer level where the prime concern is with treatment for that individual, and at the community level, where the concern is with the health care system as a social institution. The greater emphasis in the literature to date has been at the individual level and very little at the community level. That imbalance perhaps needs to be redressed and in the redressing it seems that certain doors open which may allow different ways of analyzing health care policy. This is particularly the case in respect of health care systems and their valuation. This has repercussions however for various facets of these systems including equity, both in delivery and financing. One of the difficulties for economists in this context is the obsession with preference maximisation, irrespective of how the preferences are formulated nor with regard to the issue of what the preferences are for. The paper proposes ways of linking community values health systems.

Author: Gwatkin D R  
Title: Poverty, equity and health in the developing World: an overview  
Publisher: World Health Organisation
Abstract: After a decade or more of neglect, a concern for the health of the poorest and for equity in health has begun to make a comeback. However, a review of current thinking and recent experience suggests that those concerned with equity and poverty in health are currently in a poor position to design and implement activities that can accomplish their objectives. There are three reasons for this:

* First, lack of consensus about the nature and relative importance of equity and poverty, and thus about objectives. While the differences that exist about this issue have been of limited practical significance in the past, they promise to become increasingly important as development and the demographic-epidemiological transition proceed.

* Second, deficiency of basic information about health conditions that prevail among the poor, either in absolute terms or relative to other socio-economic groups. Health has thus far lacked a tradition of collecting data by socio-economic status comparable to that which has produced information about income distribution and poverty levels for use by equity and poverty-oriented economic planners.

* Third, absence of an overall strategic vision for addressing poverty and equity through the health sector. There is at present nothing comparable to the concepts of "primary health care" and the "child survival revolution" that, whatever their subsequently-revealed limitations, proved so effective in shaping health policy and mobilising support when poverty and equity were last in favour. Numerous techniques exist that can and should be much more frequently applied in order to make health programs more relevant for those in greatest need. But it is difficult to see how these techniques alone can suffice to accomplish the degree of reorientation necessary in health systems that are much better suited to serve the needs of the rich than of the poor. The international health community will need to move quickly in dealing with these three issues and in finding a way forward if it is to take advantage of the opportunity currently before it.

3.2 EQUITY IN HEALTH RIGHTS AND POLICIES

Authors: Yach D, Zwarenstein M, Chetty K
Title: Application of Health for All concepts in South Africa - focus on equity
Publisher: CME-VMO 7(11):1309-1317
Year: 1989
Country: South Africa
Keywords: Health policy, health care
Abstract: This article describes international strategies to achieve 'Health for All' (HFA), examines South Africa's response to these strategies and highlights health status and how health care is distributed in South Africa.

Author: Sekeramai S T
Title: Planning for Equity in Health
Publisher: Ministry of Health
Year: 1984
Country: Zimbabwe
Keywords: Health policy
Location: Ministry of Health
Pages: 74pp
Abstract: This White Paper outlines Zimbabwe's post independence health policy consistent with the in 'Growth with Equity', policy seeks to establish a socialist, egalitarian and democratic society in Zimbabwe. It asserts that national development which can be measured by a nation's state of health. The liberation struggle rid Zimbabwe of inequalities in political and social status, wealth and income as well as in health status and access to health care. The rich enjoyed better health, were urban based and had privileged access to the most sophisticated health care. On the other hand the poor who were in the majority were rural based with minimal health and other social facilities. This group was plagued by malnutrition, infection and ill health, and yet the minimal health facilities were provided for them.

Planning for "Equity in Health" seeks to redress this imbalance and demands that the rural population be cared for first. It advocates the adoption of the Primary Health Care (PHC) approach whose key components are appropriateness, accessibility, affordability and acceptability of the care provided. This approach advocates for a conscious acceptance by a community of the responsibility for its own health. The Government's role becomes one of guidance and support with the health care sector adopting the role of lead agent in a multi-sectoral drive to provide health for all. Far from being a strictly medical problem health is correctly identified as a developmental problem. Like under-development, ill-health becomes the concern of all sectors, which demands clear political commitment, a marshalling of adequate resources and a clearly defined strategy with set goals and target.

Authors: Connor S S, Herman L, Puelma F
Title: A comparative constitutional Study: Health rights
Publisher: Scientific Publication No. 509
Year: Not available
Abstract: This paper explores the meaning of the term right to health, as it relates to the State's role in assuring an individual right to health and the health of the nation. It analyzes the modern concept of health, the distinction between public health and individual health care services, and the various elements of a 'right to health'; the constitutional texts purporting to frame a 'right to health' and cursorily the national legislative policies towards public health and the provision of health care. As of the end of the 1980s, forty years after the initiation of the modern international human rights movement, the right to health is still expressed as a programmatic or progressive right, directed primarily towards legislatures, for the highest attainable standard of health with few definable standards. Health has the same standing in these international documents on social and economic rights as to food, education, work, protection of the family etc., although it has been elevated above a mere element indication of an adequate standard of living, its treatment in the Universal Declaration.

Author: Bell N K
Title: Responsibilities and rights in the promotion of health: differing positions of the individual and the state
Publisher: Social Science and Medicine 43(5): 775-782
Year: 1996
Country: USA
Keywords: Health promotion, individuals
Location: College of Arts and Sciences University of North Texas - USA
Pages: 7pp.
Abstract: Medicine is the practice of humanitarianism. Many of the demands being voiced for a more responsive and humane system of health care grow out of the public's concern that individuals, especially those who are weak or vulnerable, are no longer a central focus of health care delivery. Critics of health care fault changing social values the failure of individuals to take responsibility for their own health, the greed of providers and or payers, the technological imperative, and various other factors as causes of medicine's loss of its patient-centred ethos. Yet bioethicists, care givers, health care providers, and theologians cannot agree on the appropriate role of the individual in health care contexts. This essay develops a framework within which to examine questions involving rights and responsibilities in medical and health care decision making.

Author: ZCTU
Title: Structural adjustment programmes and workers Health: Case
studies in Africa
Publisher: ZCTU
Year: 1992
Country: Zimbabwe
Keywords: Economic policy and health
Location: ZCTU Information Centre
Pages: 4pp.
Abstract: This paper outlines a programme of work developed with worker organisations/trade unions in four participating countries on the impact of structural adjustment on workers health.

Author: Ekpo A H
Title: Structural Adjustment Programme in Nigeria: impact on Health and equity in the cross river state
Publisher: Economic Policy and Health Network
Year: 1995
Country: Nigeria
Keywords: Macro-economic policy and health
Location: TARSC
Pages: 34pp
Abstract: The study examines the impact of the Structural Adjustment Programme on the health pattern in selected areas of Cross River State. Using survey data, the results show that the SAP had some adverse effect on the health care behaviour and pattern in the area. Most of the households maintained that the SAP was either partially or wholly responsible for the hard times which invariably reduced their ability to cater for their health requirements. It is suggested that the State should enhance both the quantity and quality of health care; use of fiscal incentives to encourage the importation of essential drugs. Moreover, households should be educated on the dangers of self-medication or patronising quack health practitioners.

Author: Dag Hammarskjold Foundation
Title: Equity in Health Policies for Survival in Southern Africa: An Agenda for Action
Publisher: Dag Hammarskjold Foundation
Year: 1997
Country: Sweden
Keywords: Health policy
Location: TARSC
Pages: 12pp.
Abstract: The seminar on equity in health - Policies for Survival in Southern Africa was jointly organised by the National Institute of Development Research and Documentation of the University of Botswana and the Dag Hammarskjold Foundation, Uppsala, Sweden form the 13 to 16 March 1997 at Kasane
in Northern Botswana. The seminar brought together 34 participants from eight Southern African countries, drawn from various disciplines and organisations. It included a range of people, such as politicians, policy makers, health and development practitioners, academics and NGO activists. The report outlines the discussion in the seminar on critical issues of Equity in Health in Southern Africa, and the solutions and actions proposed.

Author: Nyakunu T
Title: Who is kidding who?
Publisher: SAPEM December/January
Year: 1994
Country: Zimbabwe
Keywords: WHO
Location: TARSC
Pages: 3pp.
Abstract: This is the second in a series of articles analyzing the role of the World Health Organisation. It notes that WHO devotes more money and time pleasing its sponsors, mainly governments of the First World, than on the poorest, and unhealthiest nations of the world. The paper reports on a study conducted in the USA to present normative arguments about public goods and external costs that envision government as acting to provide those services that people would be willing to pay for but which they could not secure through ordinary market processes.

Authors: Laurell A C, Arellano O L
Title: Market commodities and poor relief: the World Bank proposal for health
Publisher: International Journal of Health Services 26(1):1-18
Year: 1996
Country: Mexico
Keywords: Health policy
Location: TARSC
Pages: 19pp
Abstract: Investing in health is the World Bank's blueprint for a new health policy within the context of structural adjustment. While this document includes a broad range of arguments, its implicit premises are neoliberal as can be deduced from its `agenda for action'. Health is defined as a private responsibility and health care as a private good. This leads to a health policy based on two complementary principles: the reduction of state intervention and public responsibility, and the promotion of diversity and competition (i.e. privatization). Thus, public institutions should provide only a limited number of public goods and narrowly defined, cost-efficient forms of relief for the poor. All other health-related activities are considered private utilities, to be resolved by the market, NGOs or families. The World Bank policy provides a
pragmatic contribution to efforts to achieve fiscal balance. However, it also pushes to recommodify health care and to turn health into a terrain for capital accumulation through the selective privatization of health-related financial and `discretionary' services. The proposal implies large-scale experimentation and dismantling of public institutions which are the only alternative now accessible to the majority. It rejects health as a human need and a social right, and violates basic values by claiming that life and death decisions can be justly made by the market or through a cost-effectiveness formula.

Authors: Zwi A B, Mills A
Title: Health policy in less developed countries: past trends and future directions
Publisher: Journal of International Development 7(3):299-328
Year: 1995
Country: Developing countries
Keywords: Health Policy
Location: LSHTM UK / TARSC
Pages: 29pp
Abstract: Health policies worldwide have changed dramatically in the last few decades. We reflect upon these changes, highlight current trends and identify key issues and challenges as the year 2000 approaches. The article comprises five sections: (i) comments on concepts of health and of policy; (ii) historical developments which have influenced policy; (iii) discussion of the context within which health policies in low income countries are formulated and implemented, including macro-political and macroeconomic developments, health needs and determinants, financing, approaches to health planning and priority setting, and the key international health policy actors; (iv) an overview of the content of current health proposals in less developed countries which considers the financing, organisation and management of health systems and (v) a concluding section which identifies key issues for the coming years. The recent World Bank Development report, Investing in Health (1993) and other health sector reform efforts, form the backdrop for this discussion.

Author: Cassels A
Title: Health sector reform: key issues in less developed countries
Publisher: Journal of International Development 7(3):329-347
Year: 1995
Country: Developing countries
Keywords: Health sector reform
Location: TARSC
Pages: 18pp.
Abstract: This paper explores the meaning, and some of the practical implications, of health sector reform in less developed countries. It reviews the problems that reforms have to address, and the policy objectives they are
designed to achieve. It argues that the process of reform is not concerned only with defining priorities and refining policies, but also with reforming and restructuring the institutions through which health policies are implemented. Even though some organisational principles are likely to be common to all reform programmes, a prescriptive approach to institutional reform is inappropriate. The choice of reform options can be influenced by technical advice and analysis, but the decision to proceed, and the subsequent success of implementation, will be dependent on political support. The latter part of the paper presents examples of institutional reform from several less developed countries and includes a consideration of the role and influence of donor agencies.

Author: The World Bank
Title: Investing in Health - World Bank Development Report
Publisher: Oxford University Press
Year: 1993
Country: USA
Keywords: Health policy, financing health
Location: World Bank New York
Pages: 2pp.
Abstract: The report proposes a three-pronged approach to government policies for improving health.
1. Fostering an environment that enables households to improve health
2. Improving government spending health
3. Promoting diversity and competition in the health sector
The report observes that increased scientific knowledge has accounted for much of the dramatic improvement in health that has occurred in this century -by providing information that forms the basis of household and government action and by under-pinning the development of preventive, curative, and diagnostic technologies. Investment in continued scientific advance will amplify the effectiveness of each element of the three-pronged approaches proposed.

Author: Sterky G
Title: Towards another development in health
Publisher: Dag Hammarskjold Foundation
Year: 1975
Country: Sweden
Keywords: Health policy
Location: TARSC
Pages: 5pp.
Abstract: The 1977 Dag Hammarskjold Seminar on 'Another Development in Health' that brought together 17 social scientists, medical doctors and policy-makers, most of them officials of governments and international organisations. The objective of the Seminar was to promote a general and open
debate on how the basic health needs can be satisfied and health given political priority and political visibility, particularly in the Third World. But the intention was also to underline the need for a thorough-going reorientation of health thinking and health policies in the industrialised countries, where preventive and promotive measures should be given greater importance than the present, increasingly costly, high technology care, whose benefits are becoming more and more marginal.

Author: Klugman B
Title: The Role of NGOs as an agent for Change
Publisher: Women's Health Project
Year: 1997
Country: South Africa
Keywords: NGOs, health policy
Location: Women's Health Project, South Africa
Pages: 23pp.
Abstract: This paper outlines ways in which NGOs can influence policy in the direction of equity; the skills required by NGOs in order to play this role; and the strategies required in order to influence the policy process. It reflects on related philosophical questions such as the legitimacy of NGOs as role-players in the policy process. Having developed a framework for analyzing the role of NGOs in facilitating policy change, and used a number of case studies for illustration, the paper draws conclusions about the challenges facing all those concerned with health and equity, regarding the role of NGOs in Southern Africa. The paper sets a context in which people have access to those conditions which are essential in order for people to be healthy, and to express themselves as human beings on the one hand facilities such as clean water, health services, education, safe housing, and communications services; on the other hand, social conditions such as the right to free association, to freedom of expression, and to freedom from fear, whether in the home, or in public life which can be characterised as a human rights culture. This goal is home, or in public life which can be characterised as a human rights culture. This goal is centrally concerned with the achievement of equity in a global context in which economic growth is understood as the means to reduce poverty, yet is associated with increased inequity. The promotion of citizenship in its fullest sense encompasses the goal of equity.

Author: Mooney G
Title: Equity in future South African Health care: a tale of minimally decent Samaritans or good South Africans?
Publisher: Department of Public Health and Community Medicine
Year: 1998
Country: Australia
Keywords: Health values, health planning, health policy
Abstract: This paper discusses how best to represent health care planning at the individual consumer level where the prime concern is with treatment for that individual, and at the community level, where the concern is with the health care system as a social institution. The greater emphasis in the literature to date has been at the individual level and very little at the community level. That imbalance perhaps needs to be redressed and in the redressing it seems that certain doors open which may allow different ways of analyzing health care policy. This is particularly the case in respect of health care systems and their valuation. This has repercussions however for various facets of these systems including equity, both in delivery and financing. One of the difficulties for economists in this context is the obsession with preference maximisation, irrespective of how the preferences are formulated nor with regard to the issue of what the preferences are for. The paper proposes ways of linking community values health systems.

Author: Mills A
Title: Reforming Health sectors: fashions, passions and common sense
Publisher: LSHTM
Year: 1998
Country: UK
Keywords: Health reforms
Location: LSHTM (UK)/TARSC
Pages: 25pp
Abstract: Within this complex field of action and research, the aim of this paper is to:
- map the terrain of health sector reform
- identify common themes where they exist, and
- separate out rhetoric from reality.
In doing so, it draws on the writings of some of the key theorists and researches in health sector reform. It presents a broad analysis of overall themes in health sector reforms and issues of the similarity and differences in reform themes and strategies across the world. In the attempt to cover reforms across the world, it uses a diversity of different country groupings. Since the level of complexity of the health system and particularly of the formal private sector is strongly affected by income level countries are categorised by the groupings of low, middle and high income and formerly socialist.

Author: Gilson L
Title: Re-addressing equity: the search for the Holy Grail: the importance of ethical processes
Publisher: Centre for Health Policy - University of Witwatersrand
Abstract: Equity is again receiving attention in international health policy debates. Within the space of two weeks in November 1997 there were at least four meetings in different parts of the world focusing on issues of equity, and bringing together public health professionals from different countries and different disciplinary backgrounds. Given the growth of interest in equity, what concepts and experiences can inform future equity-oriented health policy? This paper seeks to address this question firstly by reviewing some key issues relating to the equity impact of current health care reforms. It then puts forward the understanding that ethical processes are critical in promoting equity, before identifying some practical areas of action through which this perspective can influence policy development. Within the paper primary attention is given to experience in low and middle income countries. However, high income country ideas and experience are also used to provide insight on the issues raised - and the conclusions are relevant across countries.

3.3 EQUITY IN HEALTH CARE AND HEALTH CARE

Authors: Zwarenstein M F, Price M R
Title: The 1983 distribution of hospitals and hospital beds in the RSA by area, race, ownership and type
Publisher: South Africa Medical Journal 77(5): 448-452
Year: 1990
Country: South Africa
Keywords: Health services, health planning
Location: Centre for Epidemiological Research in Southern Africa
Pages: 5pp.
Abstract: This study used published data to analyze the 1983 distribution of hospitals and hospital beds in South Africa by `race', geographical area, type of hospital (academic, specialist, general or other) and the nature of ownership (e.g state, for-profit). Hospitals and hospital beds were found to be inequitably distributed. Overall bed ratios were 150 whites per bed compared with 260 blacks/Asians/coloured per bed. The distribution of beds by geographical area was 130 people per bed for urban whites, 260 for rural whites, and 150, 460 and 300 for urban, rural non-`homeland', and `homeland' blacks/Asians/coloured respectively. These differentials are inefficient and unjust, and should be regularly documented to spur their decline. The continued collection of population group information from health service users is required to monitor changes in `race' disparities. The analysis of distribution by ownership and type suggested that only the public sector is able to provide a
hospital service with the appropriate balance of all levels of care for the entire population; but within this sector the dominant position of tertiary care needs to be re-examined. The study highlighted the absence of adequate information on health care resource allocation and utilisation. Appropriate studies in these areas are required and consideration should be given to unifying the planning and management of all hospital resources.

Authors: Broomberg J, de Beer C, Price M R
Title: The private health sector in South Africa - current trends and future developments
Publisher: SAMJ 78(4): 139-142
Year: 1990
Country: South Africa
Keywords: Health services
Location: Centre for Health Policy, South Africa
Pages: 4pp.
Abstract: The private health sector is experiencing a crisis of spiralling costs, with average annual cost increases of between 13% and 32% over the decade 1978-1988. This trend is partly combination of the `fee-for-service' system and the `third-party' payment structure of the sector. Medical schemes have responded by promoting the idea of `flexible packages', and have won the right to `risk-rate' prospective members. It is argued that these measures will undermine the principle of equity in health care, and will not solve the problems of the private sector. Instead, a more significant restructuring of the sector is likely to emerge. This may take the form of `managed care' structures, along the lines of the health maintenance organisation model from the USA. The principles, advantages and problems of managed care structures are described. These are shown to be potentially more rational and efficient than the current structure of the private sector. Although some resistance to managed care structures can be expected the convergence of interests of large employers and trade unions in containing health care costs suggests that their emergencies is a likely development.

Authors: Chimhowu A O, Tevera D S
Title: Intra-provincial inequalities in the provision of health care in the Midlands Province of Zimbabwe
Publisher: Geographical Journal of Zimbabwe 22
Year: 1991
Country: Zimbabwe
Keywords: Inequalities in health care
Location: University of Zimbabwe
Pages: 12pp.
Abstract: The paper outlines a study of the provision of health care facilities and personnel in the Midlands Province highlights that ten years after independence, there still exists a maldistribution of health resources in
Zimbabwe both at the national level (between rural and urban areas) and at the provincial level (both between rural and urban areas and also between districts within the same province). Despite the considerable strides in health care planning and provision since 1980, striking spatial inequalities in opportunity levels for access to health care facilities still exist in the Midlands province of Zimbabwe. Although district and provincial boundaries are quite porous and allow inter-provincial and inter-district flows of patients, the people living in rural districts with less than a fair share of doctors or health institutions invariably travel longer distances to the nearest health facility than their counterparts in the better served areas. In Zimbabwe transport networks do not always exist throughout the provincial areas and even if they do, public bus transport may be infrequent and unreliable. Furthermore, most of the rural people cannot afford the high travel costs to distant urban areas where comprehensive health facilities are available. Unequal access to basic facilities such as hospitals and schools partly accounts for the increasing marginalisation of the rural people. The spatial variations in access to health facilities in the province that were revealed in this study have important implications for planning. They indicate that there is need for government to allocate more financial and human resources to the rural sector if its objective to provide `health for all' by the year 2000 is to be realised. Social well-being in the rural districts would be enhanced by increased governmental expenditure on both preventive and curative medicine.

Author: Ministry of Health - Zambia
Title: Health reforms implementation provincial capacity building proposal 1995-1999
Publisher: The Provincial Capacity Building Working Group
Year: 1995
Country: Zambia
Keywords: Health sector reform, human resources
Location: Ministry of Health - Zambia / TARSC
Pages: 4pp
Abstract: This report outlines the outcome of `the consultative workshop for provincial health management teams, Lusaka August 1994' where the future role, structure, and functions of the Regional Health Office within the Health Reforms was discussed.
Current needs identified for the provincial level include:
* Restructuring the Regional Health Office to redefine authority, responsibilities, and tasks in support of a decentralised health system
* Developing attitudes, skills, and tools for monitoring, evaluation and the use of health information
* Capabilities to provide technical advisory support to districts and hospital management boards
* Developing skills and tools for quality assurance on clinical, preventive, and promotive health care
Developing knowledge and skills on research methodology
Developing capacity to coach districts and hospital management boards on resource management
Basic material resources to improve efficiency in work performance (e.g., computers, printers, photocopiers etc)

A brief situation analysis is provided of the provinces and the offices of the Provincial Medical Officers, using the existing information and results of a questionnaire regarding the available human resources and present tasks, is presented in chapter two. Major weaknesses including the unclear relationship between the Regional Health Office and the General Hospitals are identified. In chapter three the role, structure, and functions of the Regional Health Office is described. The Regional Health Office will have a similar relation to the hospital management boards as with the districts, i.e. monitoring and support without a command authority. A tasks analysis of the Regional Health Office within the Health Reforms reviews the following areas of support with respect with respect to the districts and hospital management board.

Authors: Banda E N, Walt G
Title: The private health sector in Malawi: opening Pandora's box
Publisher: Journal of International Development 7(3):403 - 421
Year: 1995
Country: Malawi
Keywords: Private health sector
Location: University of Malawi, Chancellor College/TARSC
Pages: 17pp.

Abstract: In 19887 the Malawi government liberalized its Medical Practitioners and Dentists Act, allowing doctors in the public sector to undertake part-time private practice, and permitting paramedical and allied health professionals to enter into private practice. Using a policy analysis approach, the authors trace the context within which policy change occurred, the actors involved, and how the process was initiated and implemented. A rapid survey was undertaken of about half the paramedical and one fifth of the doctors practising privately. This showed that growth of private practice has been greatest among paramedical, that a typical private clinic has a single practitioner, is located in a township, trading centre or peri-urban area, and that although charges per patient visit are relatively low, incomes in the private sector are considerably higher than in the public sector. Growth in the private health sector raise a number of policy questions around control and quality of care for the majority of Malawians.

Author: Marmot M G
Title: Improvement of social environment to improve health
Publisher: The Lancet 351: 57-60
During the 19th century, advances in the health of the population mostly came from improvements in nutrition and the environments in which people lived and worked. In the 20th century, the focus shifted from the environment to the behaviour of individuals. According to this view, the great achievement of epidemiology was to nail down smoking and, to a lesser extent, cholesterol. Having done that, the epidemiologists’ job was largely complete. In the future, advances in human health will come from the revolution in molecular biology and genetic approaches to combating disease, and the role of epidemiology will, in its evidence-based, clinical form, be to support the assessment of individual risk, diagnosis, and treatment. Concern with individuals and parts of individuals has been the dominant trend in epidemiology. Ecological analysis, the correlation between the characteristics groups, has been seen as a second-rate way to approach individual risks. Although poor sanitation and malnutrition have been solved in developed countries, the circumstances in which people live and work are still crucial determinants of disease rates and, therefore, potentially provide the place for effective interventions to improve the public’s health. As Rose states, “The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social”. If the environment is important, the appropriate analysis should be at the environmental level. Thus ecological analyses are not second rate but are the most useful way to examine the effect of social environment on health.
sector, which led to the emphasis on reform are outlined, and a descriptive over-view of the nature of the reforms presented. The difficulties both in implementation and evaluation of the reforms are discussed. It is noted that reform is as an inherently normative and political process but that reforms were introduced in a piecemeal fashion, lacking a cohesive overall policy framework, without considering the `side-effects' on equity of access or long-term implications for the structure of the health system. In the midst of reforms, the goal of Health for All and concepts of Primary Health Care were often overlooked, but the evidence to date points to the importance of maintaining a vision and overall direction for health systems development. The cost effectiveness of equitable provision of primary health care, the effectiveness of empowering primary providers both in terms of patient choice and cost containment, and the importance of public participation in decision-making, setting of priorities and sustainability of reforms are some of the lessons learnt from the reform process. There is a need to assess outcomes of health reforms not only by the traditional economist's indicators of efficiency and equity, but to encompass health status measures, quality of care and sustainability of systems. It is clear also that incremental rather than radical change is not only more feasible, but more desirable in most countries, and that international `recipes' for reform are unlikely to be successful without local ownership, adaptation and contextual `fit'. In developing future strategies for health systems, the knowledge base that the reforms process has given us and the needs of countries as they face the demands of the future must be assessed realistically. Critical issues are likely to be the evolving role and leadership required by Ministries of Health; the impact of globalisation, both on the macroeconomic environment and on the health sector specifically, and the search for more equitable financing of health systems, particularly in the poorest nations, but also within nations. It is time for a reform in thinking, that establishes health as an essential component of human development, reframing the debate about systems and services in this context.

3.4 EQUITY IN RESOURCE ALLOCATIONS FOR HEALTH

Author: Segall M
Title: Planning and Politics of resource allocation for primary health care: promotion of meaningful national policy
Publisher: Social Science and Medicine 17(24):1947-1960
Year: 1983
Country: England
Keywords: Resource allocation, primary health care
Location: IDS at the University of Sussex
Pages: 14pp.
Abstract: Securing resources for primary health care (PHC) involves consideration of the entire health sector: the higher levels of the health service as well as the primary level, and the private and/or social security
sub-sector as well as the government service. Reshaping resource distribution is less a redistribution of existing resources than the allocation of new resources in accordance with PHC priorities. In this the planning of future current costs is a crucial element and requires a budgetary system that identifies expenditures by geographical area and level of care. Resources should be allocated geographically to reduce health care inequalities through the provision of an appropriate mix of different levels of care. Central resource planning and local health care programming (with `dialogue' between the two) should be the basic planning division of labour, which largely resolves the so-called top-down/bottom-up dichotomy. The private medical sub-sector exerts economic, ideological and political influences on the public health service. Compulsory health insurance schemes can have some similar effects. Success of a PHC policy requires that governments adopt a holistic approach to the health sector. The allocation of health care resources on the basis of need and equity, as opposed to demand, is a political decision. The establishment of a national PHC policy backed up by adequate resources involves a specific politico-technical exercise with four components: research, planning, policy formulation, and government policy decision making. The resource planning method, based on social epidemiology, is contrasted with conventional health planning methods, based on epidemiology. The articulation of these two approaches is discussed in terms of WHO's Managerial Process for National Health Development.

Authors: Laurell A C, Arellano O L
Title: Market commodities and poor relief: the World Bank proposal for health
Publisher: International Journal of Health Services 26(1):1-18
Year: 1996
Country: Mexico
Keywords: Health policy
Location: TARSC
Pages: 19pp
Abstract: Investing in health is the World Bank's blueprint for a new health policy within the context of structural adjustment. While this document includes a broad range of arguments, its implicit premises are neoliberal as can be deduced from its `agenda for action'. Health is defined as a private responsibility and health care as a private good. This leads to a health policy based on two complementary principles: the reduction of state intervention and public responsibility, and the promotion of diversity and competition (i.e. privatization). Thus, public institutions should provide only a limited number of public goods and narrowly defined, cost-efficient forms of relief for the poor. All other health-related activities are considered private utilities, to be resolved by the market, NGOs or families. The World Bank policy provides a pragmatic contribution to efforts to achieve fiscal balance. However, it also pushes to recommodify health care and to turn health into a terrain for capital accumulation through the selective privatization of health-related
financial and ‘discretionary’ services. The proposal implies large-scale experimentation and dismantling of public institutions which are the only alternative now accessible to the majority. It rejects health as a human need and a social right, and violates basic values by claiming that life and death decisions can be justly made by the market or through a cost-effectiveness formula.

Author: Davies R, Loewenson R
Title: Macro-economic trends in the health sector
Publisher: University of Zimbabwe
Year: 1997
Country: Zimbabwe
Keywords: Health, economics
Location: University of Zimbabwe Dept of Economics / TARSC
Pages: 12pp.
Abstract: This paper describes the overall trends in health financing in Zimbabwe. It does not review specific details but rather the general picture, is mainly concerned with the 1990s, but provides some data for the 1980s as a way of comparison. The paper outlines trends in four major areas.

i. Economic performance or activity of the health sector
ii. Trends in health sector earnings
iii. Trends in government spending on health
iv. Trends in costs of health care

Author: Gilson L, Russell S, Buse K
Title: The political economy of user fees with targeting: developing equitable health financing policy
Publisher: Journal of International Development 7(3):369-401
Year: 1995
Country: General
Keywords: User fees, health financing
Location: LSHTM/TARSC
Pages: 32pp
Abstract: Since the 1980s user fees for government services have become an accepted financing option for the health and social sectors in developing countries. Even countries which had a tradition of providing health services free of charge have now introduced fees and the focus of debate has shifted from whether or not to introduce them, to when and how they should be introduced. Proponents of used fees stress that equity and efficiency gains can be achieved through the implementation of a cost-recovery policy package. Within this package user fees are complemented by decentralisation and combined with two targeting mechanisms favouring low income groups: exemptions and the use of fee revenue to improve the services offered to them. The extension and improvement of primary health care, for example, will disproportionately benefit low income
groups by addressing their health needs in a cost-effective way. However, targeting mechanisms, and exemptions in particular, have received little attention in theoretical debates within the health sector and current practices have rarely been reviewed. Relatively little is known about their effectiveness or about the conditions required to ensure and enhance it. This paper seeks to contribute to health financing policy debates by reviewing targeting options and assessing the available evidence concerning these issues. Success in protecting the poor appears to be limited and there are considerable informational, administrative, resource and socio-political constraints undermining the development of effective targeting mechanisms. The paper, therefore, urges caution in developing health care financing policy and identifies a relevant research agenda.

Authors: Buse K, Walt G
Title: An unruly melange? coordinating external resources to the health: A Review
Publisher: Social Science and Medicine 45(3): 449-463
Year: 1997
Country: Europe
Keywords: health policy, international assistance
Location: LSHTM/TARSC
Pages: 14pp.
Abstract: The past two decades have witnessed an upsurge in the number of external agencies involved in the health sectors of developing countries. Concomitantly, there has been an increase in the volume of resources transferred through multilateral, bilateral and non-governmental organisation to these health systems. Notwithstanding the beneficial impact of increased resources, recipients and donors are increasingly concerned about the effects of this trend. This is particularly pertinent where the effort lacks adequate coordination. Recipients despair of an unruly melange of external ideas and initiatives, that too often results in project proliferation and duplication, unrealistic demands, and ultimately a loss of control over the health development process. Donors on the contrary, are concerned about aid efficiency and effectiveness, two areas it is assumed will gain from increased attention to coordination. Both recipients and donors are looking for ways of better managing the aid relationship. Although there has been considerable experience with coordination strategies, most writing has considered external assistance in general, rather than the health sector in particular. The literature is striking in its bias towards the needs and perspectives of the donor community. There has been little analysis of the manner in which recipient ministries of health manage donors and the influx of resources. This review begins to fill this gap. Its focus is country-level, where most direct gains from co-ordination are to be reaped. The paper begins with an enumeration of the many and diverse trends which have raised the salience of aid coordination. A definition of coordination, a term used ambiguously in the existing literature,
is then developed and the principles of aid coordination outlined. Finally, attention is directed to the initiatives of recipients and donors to improve the coordination of health sector aid.

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Authors: Jan S, Mooney G  
Title: Resource allocation in Australian Aboriginal Health Care: staking a claim for claims  
Publisher: Department of Public Health and Community Medicine  
Year: 1998  
Country: Australia  
Keywords: Health financing  
Location: University of Sydney/TARSC  
Pages: 15pp  
Abstract: The health of the Australian Aboriginal and Torres Strait Islander population - the indigenous people of Australia - is well below that of the rest of Australians. This disadvantage is also reflected in other social indicators. The aim of this paper is to build a framework for the equitable allocation of health service resources for Aboriginal and Torres Strait Islander people. For reasons elaborated upon in the paper, three important features of such a framework are: 1) defence to procedural rather than distributive justice; 2) an accounting for vertical equity; and 3) the use of the equity criterion of `equal access for equal need'. These are tied together under what we have termed a `claims' approach and illustrated by a comparison with the commonly arguments. From this discussion, certain principles are established for the allocation of resources at three levels: 1) within indigenous communities; 2) across indigenous communities; 3) between Aboriginal and Torres Strait Islander people and other Australians. The paper has relevance beyond Australia to any country in which there are marked differences groups in the society and/or different ethnic or cultural groupings.

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Authors: Supachutikul A, Gilson L, Tangcharoensathien V  
Title: Targeting the poor: experience from Thailand  
Publisher: Health Systems Research Institute  
Country: Thailand  
Year: 1998  
Keywords: User fees, health financing  
Location: LSHTM - UK/TARSC  
Pages: 15pp.  
Abstract: User fees have always been charged at government health facilities in Thailand and doctors would charge a lower fee or grant exemptions to low income groups. A formal nation-wide exemption policy for the poor started in 1975. The community screening procedures and identification card or `Low Income Card' (LIC) was introduced in 1981. There has been gradual changes to improve the effectiveness of the scheme through information campaigns, a
more proactive role for the village head, and an easier interview process. The coverage rate for the eligible poor was improved from 33% in 1987 to 61% in 1990. Problems of under-coverage and leakage have been recognised. The factors involved are weak implementation policy, difficulty or applying eligibility criteria, local politics and socio-cultural problems. Health care utilisation of LIC holders was influenced by perceived severity, perceived quality of care, accessibility and cost of services. The low income spend greater percentage of their income on health care than the wealthier. There is a need to improve policy implementation for the existing scheme and to ensure accessibility for the borderline poor.

3.5 MONITORING EQUITY IN HEALTH

Authors: Zwarenstein M, Krige D, Wolff B
Title: The use of a geographical information system for hospital catchment area research in Natal/KwaZulu
Publisher: South Africa Medical Journal 80(6): 497-500
Year: 1991
Country: South Africa
Keywords: Health services, inequalities in health care, health indicators
Location: Centre for Social and Development Studies University of Natal
Pages: 4pp.
Abstract: We use a computerised geographical information system (GIS) to study the population per bed ratios and the implications of open access to the private and the formerly white hospital services in Natal. The advantages of the GIS method over the more usual administrative boundary-based beds per capita ratios are discussed. While the latter method would suggest that hospital bed resources in the province are racially unequal but nevertheless adequate (264 people per general and referral bed for the whole population, 195 for whites and 275 for blacks) the GIS analysis reveals widespread inadequacy, worse for blacks. Of the estimated hospital catchment areas half have more than 275 black people per general and referral bed, and half of these have more than 550 black people per bed. One-third of the catchment areas estimated for whites have ratios above 275 people per bed, and one half of these are also above 550 people per bed. The GIS analysis shows that open access to beds previously reserved for whites will make no difference to rural blacks, and almost none to urban blacks, because there were relatively few such beds, and they were concentrated in the cities. For the same reasons, the opening of private hospital beds to all patients would not significantly alleviate the apparent bed shortages in priority areas. By contrast, people in these priority areas would gain significantly improved access to general hospital care if selected chronic disease and industrial hospitals were upgraded to provide general hospital services. We find the technology to be useful for health planners and recommend that it be implemented as a routine in the national planning office of the Department of National Health and Population Development, with communication of
Accounting for, and being accountable to, the public's health requires carefully documenting and analyzing social inequalities in health. Controversies abound over which measures of socio-economic position to use, at which points in time, and at what level e.g. individual, household, and neighbourhood. Important debates also concern how to analyze these data and relate them to inequalities involving race/ethnicity and gender. Addressing these complex issues is particularly timely in the light of persistent and even widening social inequalities in health. To improve tools for evaluating socio-economic gradients in health in 1994 the US Public Health Service and National Institutes of Health sponsored a conference on Measuring Social Inequalities in Health. This introduction to the Section on social inequalities in Health introduces five articles presented by participants at the conference. Topics include: a historical review of efforts to measure socio-economic inequalities in health in the US between 1900 and 1950; income dynamics and health; measuring inequalities in health among non-employed persons; and analyzing links between racial/ethnic and socio-economic disparities in health; and using neighbourhood-based socio-economic data in public health research. Together, these five articles point to a new emphasis on refining methodologies to assess relationships between social position and health and their expression in population patterns of social inequalities in health.
United States generally disaggregate health data by age, sex and race. Many public health data sets, whether Federal, state or local do not contain socio-economic variable at all, severely limiting our understanding of how and why differentials in health outcomes occur. In an era when cost-effective and targeted health planning is more important than ever, these deficiencies in the availability and reporting of data are no longer acceptable. The paper reports a meeting of the Public Health Service under National Institutes of Health leadership in September 1994 in Annapolis, MD, to address these data gaps and related issues in the measurement of social inequalities in health and to make recommendations for improvements in the collections and reporting of socio-economic data.

Author: Braveman P
Title: Monitoring equity in health: An approach for low-and middle income countries First Draft for Review/Comments
Publisher: WHO/ARA
Year: 1998
Country: Europe
Keywords: Monitoring health, health indicators
Location: WHO Geneva/TARSC
Pages: 105pp.
Abstract: This document addresses the challenges faced by decision-makers and researchers seeking information to guide policies to reduce inequities in health in their countries. Inequities affecting health are large and widespread throughout the world, both between countries and within countries of all income levels. While both concerns are crucial and highly inter-related, the primary focus of this document is on ways to assess equity within rather than between countries. This is because until now, differences between countries have often received more attention, yet distinct challenges arise in trying to obtain information on differences within countries. In addition, prior technical work by WHO on equity has focused primarily on Europe, but people in most low and middle income countries who want to assess equity within their own national borders face particular challenges, given the greater constraints they face both with existing information and the resources to obtain new information. Therefore, while it is hoped that this material will be relevant to all countries, the first priority has been to respond to the needs of people in low and middle income countries who want information to help them develop more equitable national and local policies. In focusing on information, however, it should be emphasised that information is necessary but not sufficient for informed action. Without political will, even the best information will not lead to greater equity. This document is about obtaining information to guide policies for greater equity in health. But information, while necessary, is not sufficient for informed action, particularly where the goals is to achieve more equity. Without political will, even the best information will not lead to greater equity.