Priorities for Research on Equity and Health: Towards an Equity-Focused Health Research Agenda

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Introduction


CSDH defined health equity as the absence of systematic differences in health, between and within countries, that are avoidable by reasonable action. Using health equity as the foundation of its approach, CSDH concluded [3] that “[s]ocial injustice is killing people on a grand scale” and made three overarching recommendations: improve people’s daily living conditions; tackle the inequitable distribution of power, money, and resources; and measure and understand the problem and assess the impact of action. CSDH emphasized that knowledge gaps must not be used as a reason for postponing action on the ample body of evidence already available, but also highlighted the need for ongoing research with a focus on social determinants of health and health equity.

Subsequently, WHO set up a task force to update the advice provided in 2005, incorporating evidence collected for the CSDH by Knowledge Networks and benefiting from research priorities on equity and health held at seven international meetings during 2007–2009. This article draws from the second task force’s longer report [4] completed in 2010, and responds to two questions:

1. In what areas of research could WHO and other development partners concentrate support in order to best advance health equity?

2. What aspects of research, including the development of concepts, methods, norms and standards, and synthesis approaches, could best benefit from global collaboration?

The second task force recommended three key additions: focus on identifying and evaluating policy options, propelled by the search for what works in practice to reduce health inequities; empower research managers, policy makers, and funders to generate national and regional research agendas and fund priorities that address equity and health; and support the strengthening of collaborations, capacities, and methods to do so. Our hope is to help WHO to further advance the health equity agenda, as recently re-articulated in 2010 in World Health Assembly resolution 63.21 on health research [5].

Advancing Health Equity: A Paradigm Shift in Health Research?

The first wave of contemporary health research focused on medicine and the life sciences, with clinical solutions as a primary endpoint. Although such research remains foundational, understanding the social origins of disease—the “upstream” influences on (ill) health and its distribution [6]—generally and almost unavoidably falls outside the biomedical frame of

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Abbreviations: CSDH, Commission on Social Determinants of Health; WHO, World Health Organization

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Summary Points

- Based on extensive review of global evidence, the recommendations of the WHO Commission on Social Determinants of Health highlight the need for strengthening research on health equity with a focus on social determinants of health.
- To do so requires a paradigm shift that explicitly addresses social, political, and economic processes that influence population health; this shift is under way and complements existing research in medicine, the life sciences, and public health.
- Reflecting further synthesis and stakeholder consultations, an agenda for future research on health equity is outlined in four distinct yet interrelated areas: (1) global factors and processes that affect health equity; (2) structures and processes that differentially affect people’s chances to be healthy within a given society; (3) health system factors that affect health equity; and (4) policies and interventions to reduce health inequity.
- Influencing regional and national research priorities on equity and health and their implementation requires joint efforts towards creating a critical mass of researchers, expanding collaborations and networks, and refining norms and standards, with WHO having an important role given recent mandates.

Research Priorities

Using this frame, we recommend an agenda for research on health equity organized around four distinct yet interrelated areas:

(1) Global Factors and Processes That Affect Health Equity

“Global health has come to occupy a new and different kind of political space that demands the study of population health in the context of power relations in a world system” [9]. Numerous global processes affect social determinants of health [10]. Global re-organization of production has involved the emergence of an increasingly feminized and formalized global labour market with adverse effects on women’s health and their social protection and increases in child labor. Trade liberalization has led to losses of livelihood, sometimes large revenue shortfalls for low- and middle-income countries, increasing privatization of public services such as water, and reduced access to essential medicines. The hyper-mobility of capital has also constrained social policy, as jurisdictions compete for investment, and exposed national economies to the destabilizing effects of disinvestment and financial crises.

It is necessary to improve the evidence base about globalization, not only negative effects, but also positive impacts: for example, expanded social and economic opportunities for women despite harsh working conditions [11]. Comparative cross-national research should be complemented by detailed national case studies that connect household-level impacts with national policies and global forces. Similarly, research on how to redesign institutions for global decision-making—often referred to as “global governance”—is needed so that these institutions address not only trade and economic crises, but other global issues, such as climate change, that have important social and health consequences. The financial crisis of 2008 only underscored this urgency [12].

Globalization is implicated, as well, in many health risks associated with environmental hazards [13]. Potential natural limitations of support for the human species have been widely discussed in recent environmental health fora: our current global trajectories of unsustainable development are important areas for future research.

Rapid urbanization in the developing world is closely connected to globalization: a turning point was reached early in this century, when for the first time a majority of the world’s population lived in cities. It is estimated that 1.4 billion people will live in slums in 2020 in the absence of rapid and effective policy interventions [14], creating formidable challenges for reducing health inequities in low- and middle-income countries [15]. Pertinent questions include how global-scale processes lead to social changes that are beyond the reach of local or metropolitan government policies and interventions. Conversely, the emergence of metropolitan areas as global-scale economic actors in their own right potentially offers a new frame of reference for initiatives to reduce health inequities.

Research on globalization and health clearly covers many topics. Building on existing international frameworks and efforts at global health diplomacy, we suggest asking, for example, how the international human rights law framework and recent changes in donor policy, as contained within the Paris Declaration, can shape development assistance and better advance health equity.

(2) Structures and Processes That Differentially Affect People’s Chances to Be Healthy

The social environment in which we live generates unequal distributions of power, wealth, exposures and vulnerabilities to illness. What are the interactions between the axes of social differentiation and how do these contribute to the patterning of inequity at population level [16]? What is the full range of public policies that affect determinants of health like employment relationships and conditions [17] or the operation of gender norms [18]? More specifically, how do economic status, ethnicity, and gender intersect to shape health risks and outcomes? For example, the determinants and consequences of limited to no access to health services often vary by both the gender and class location of sick individuals and their households: research only analyzing class markers can be misleading, as differences across classes can be misinterpreted without gender analysis [19]. How are these intersections affected by the interaction of economic and social policies? Such interactions and their effects...
Box 1. Characteristics of Third Wave Health Research Strategies and Methodologies

- Go beyond the behavioral and other individual determinants of illness.
- Examine the intersections among different social hierarchies, such as class and gender, and their cumulative impacts on health status and health inequities.
- Examine the levels, pathways, and power connections across the “upstream” determinants or root causes of health inequities—that were central to the CSDH’s conceptual framework [3]—and the more traditionally investigated determinants of health inequities, such as risk factors or access to care.
- Treat patterns of health inequity as a social reality in their own terms, requiring social (economic, sociological, political, and cultural) explanation that adds on to the aggregation and interpretation of individual biomedical processes and outcomes.
- Consider the dynamic (rather than static) nature of equity in different country contexts, introducing a temporal dimension when investigating social structures, public policies, and impacts over the life course.
- Describe the social institutions and processes that influence the generation and allocation of resources related to health and its social determinants.
- Focus on how the global context affects choices about resource allocation at national and sub-national levels.
- Build on active collaboration among researchers and other knowledge producers from different disciplines.
- Recognize that certain kinds of evidence, such as results from randomized controlled trials, cannot be generated with respect to many interventions that address social determinants of health; therefore, a need exists to embrace diverse methodologies—fit for purpose—including a wide range of study designs, generating qualitative and quantitative data, that provide critical insight on the questions being examined.
- Involve affected populations, which is often essential to appropriate research designs and their execution.

frequently begin in early childhood and continue across the life course [20,21].

Against this background, coordinated and urgent efforts are needed to shift research from single risk factor analysis to more comprehensive perspectives. The single risk factor approach fails to uncover multi-causal mechanisms and root causes behind health disparities, and is likely to overlook the accumulation of influences on health over the life course or across generations. The life-course perspective, in turn, requires fundamental rethinking of both research priorities and policy and practice to reflect what is already known about, for example, how material deprivation and stresses associated with subordinate or marginalized social status “cluster cross-sectionally and accumulate longitudinally” [22] and about the underlying biological mechanisms [20,23]. Nevertheless, it is essential not to lose sight of the importance of acting on what is already known [24,25]. For example, the links between health and opportunities for productive and fulfilling social activities require integrating occupational health with a broader social analysis.

Systems, institutions, and financing mechanisms for social protection vary widely in their comprehensiveness and in the stages of the life course involved, for example, support for reducing child poverty, unemployment or old-age pensions. Research has been concentrated on high-income countries where the proportion of the working population in the formal labor market is relatively high and coverage of social protection widespread [26,27,28]. Even in such countries, much remains to be learnt about how variations in systems of social provision, for example eligibility based on contributions versus universal approaches, operate to influence health. Another important dimension to investigate is the distribution of benefits from public services and their financing sources. In simplest terms, do public expenditures primarily benefit the poor or marginalized, or is their distribution regressive, with the poor disproportionately paying out more than they receive? Understanding the cumulative effects of social protection systems over the life course in a variety of contexts remains important, particularly low- and middle-income countries where systems of social protection are highly diverse and approaches to generate funds remain limited. All countries should monitor and evaluate the gendered health impacts of privatization of social security and pension reform.

(3) Health Services and Health System Factors That Influence Health Equity

In the past three decades “health sector reform” (HSR) around the world involved increased emphasis on market-based and privately financed solutions. This direction was actively promoted by international financial institutions [29] and exacerbated by domestic austerity programmes during the era of structural adjustment. Available research on HSR suggests that many of the reforms have increased barriers to access to essential preventive services and medical treatments. Crucially, out-of-pocket expenditures for public and private health services continue to drive many families into poverty in low- and middle-income countries [30,31]. With increased attention to universal health coverage [32,33], a major area for investigation is how to increase access to health services without catastrophic financial burden. Mechanisms that health systems can use to progress towards universal coverage and increase health equity should be evaluated within countries, with evidence synthesized and shared across countries [34]. An important question is why some jurisdictions do far better in providing health services, to a wider range of people in need, than others where public expenditure per capita is comparable. Recognizing the limitations of relying only on supply-side approaches, research needs to generate increased understanding of the value of “demand-side” interventions and approaches to enhance the accountability of health service providers to users [35]. Related, new, or updated methodologies (for example, benefit-incidence analysis, micro-simulation, long-range scenario planning, etc.) could contribute to research on health systems and equity.

Health inequities often cannot be addressed adequately if health systems must be financed only from domestic resources. With much work on identifying resource needs already available, research should identify sustainable and innovative mechanisms for longer-term and predictable forms of global financing of health systems in low-income countries. Rapid investigations on how the current financial crisis is affecting public financing for health systems would be timely and practical as inputs to government policy making on health systems and development aid [36]. How are countries or decentralized administrative units coping with increased budgetary
pressures and their potential effect on equity? Under what policy and implement-
tion models does decentralization lead to improved local decision-making, net
health equity gains, and community empow-
ernment? The recent rise of “medical
tourism” also warrants further study of
such questions as whether public funds are
subsidizing the creation of private, often
state-of-the-art hospitals to attract foreign
patients and foreign currencies to the
detriment of residents’ access to health
services [37].

Health systems deliver better and more
equitably distributed health outcomes
when organized around primary health
care (PHC) that combines prevention and
health promotion with treatment and
rehabilitation [32,34]. Thus, another area
for research is how different funding,
delivery, and management models of
PHC support comprehensiveness of ser-
vices and equity in access. As PHC
principles also include intersectoral ap-
proaches, research on how health systems
can champion and contribute to actions
on social and environmental determinants
of health would be particularly useful.
Relatedly, major importance are re-
search and policy that focus on human
resources for health. The quality, com-
mitment, and dedication of health workers
are critical to the functioning of health systems
[38]. The role of women in both formal
and informal health services provision is
drangically neglected and under-reported,
and the gendered nature of human
resources for health has not figured largely
in health research or policy [39]. Recent
assessments indicate that the “brain drain”
of providers from low-income countries,
especially from those in southern Africa,
threatens to precipitate a complete col-
lapse of health systems already stretched to
the breaking point by financial constraints
and the impacts of HIV and AIDS [30].
Key questions include identifying the most
important policy actors and entry points to
reduce the health inequities arising from
health worker migration patterns.

(4) From “Problem Space” to
“Solution Space”: Effective Policy
Interventions to Reduce Health
Inequity

Research oriented towards reducing
health inequity has until recently focused
on what might be called the “problem
space.” Building on the foundation of
research evidence about causal processes,
it is also important to design research that
specifically addresses what might be called
the “solution space” [40]: the strategic
drivers of reductions in health disparities,
the differential health effects of public
policies, and the comparative effectiveness
of options for enhancing equity.

Over the short term, more emphasis is
needed on evaluation methodologies that
capture contextual and other critical
influences, to understand not only how
interventions work, but also why they
work [41]. Because policies that affect
health are often made by finance minis-
tries and not by health ministries, health
impact assessments (HIAs) that specifically
incorporate equity analysis and apply to
policies outside the health system offer a
useful basis for integrating the distribution
of health outcomes into governmental
decision-making [42]. To evaluate impact,
a key question is: How will we know in 20
years which initiatives, by whom, have worked to
reduce health inequities within and across
countries? Answering this question requires
improved baseline data on health out-
ces and social conditions, linked data-
bases, and study designs that enable
understanding of complex causality, cou-
pled with research on how policies that do
not explicitly target health outcomes affect
social determinants of health. Such re-
search, in turn, must rely on a plurality of
evaluation methodologies and a broader
range of knowledge producers.

Knowledge translation to policy
makers. Finally, more attention must
be paid to making research accessible and
useful to policy makers and other potential
users, such as civil society organizations.
In the context of what is already known about
social determinants of health and working
within broader development agendas,
research useful implies norms for
data collection and disaggregation [43] and
more attention to synthesis of relevant
evidence generated outside of disciplines
familiar to some mainstream health
researchers, for example, in development
economics, international political economy,
and sociology.

Next Steps to Advance an
Equity-Focused Health
Research Agenda

(a) Building a critical mass of
researchers with backgrounds in
social sciences and non-medical
disciplines, with experience in a plural-
ity of methods, complementing existing
biomedical and biostatistical competencies
and in engaging policy makers to further
refine research questions. Notably, this will
enhance the quality of technical support
and policy advice to WHO Member States
and enable WHO to function as a more
effective advocate.

(b) Building networks for re-
search support and advocacy and
pursuing new research partners-
ships focused on social determinants of
health and health equity with academic
research units, civil society organizations,
and other multilateral entities with rele-
vant expertise. Building research partners-
ships with other UN and development
agencies, and with researchers and orga-
nizations in low- and middle-income
countries, is especially important.

(c) Establishing and expanding a
budget dedicated to supporting research
and research policies related to social
determinants of health and health equity.
For WHO, this implies mobilizing the
resources necessary to support consider-
able increases in the budget allocation for
its strategic objective 7 addressing “the
underlying social and economic determi-
nants of health through policies and
programs that enhance health equity and
integrate pro-poor, gender-responsive, and
human rights-based approaches”, as noted
in WHO’s 2008-2015 medium-term stra-
tegic plan [44]. Appropriate resources will
further enable intensive efforts across
WHO to integrate reduction of health
inequities into national and regional
research agendas and enable the WHO
secretariat to facilitate Member States’
requests related to resolution 62.14 [1].

(d) Ensuring that norms and stan-
dards for the monitoring and as-
essment of health inequalities on
multiple dimensions including
class, gender, age, and ethnicity
are updated and used in the course of
data gathering, statistical analysis, and
dissemination to support countries in their
efforts and wider global monitoring.

Conclusion

The report of the CSDH has placed
health equity on the agenda of the
international community in an unprece-
dented way, leading to numerous respons-
es. The WHO Region for Europe recently
commissioned a European Review of
Social Determinants and the Health
Divide, to highlight the relevance of the
findings of the CSDH and enhance
 capacities both within and outside the
health sector to address health inequities
within the region’s 53 countries [45].
During the Spanish presidency of the
European Union, the government of
Spain led the preparation of an expert
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Author Contributions

Wrote the first draft of the manuscript: PO TS RS JB LG CH MPK TK RL OL CM JP GS ZV. Contributed to the writing of the manuscript: PO TS RS JB LG CH MPK TK RL OL CM JP GS ZV. RMJE, criteria for authorship and met: PO TS RS JB LG CH MPK TK RL OL CM JP GS ZV. Agree with manuscript results and conclusions: PO TS RS JB LG CH MPK TK RL OL CM JP GS ZV.


