World Health Organization

PRIORITIES FOR RESEARCH TO TAKE FORWARD THE HEALTH EQUITY POLICY AGENDA

Report from the WHO Task Force on Health System Research Priorities for Equity in Health

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Coordinator

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Note to the reader
This report is the output of the Task Force on Health System Research Priorities for Equity in Health. It has been prepared in close cooperation with the **WHO Health Equity Team**. The report will feed into the *World Ministerial Summit on Health Research* that will take place on the 16-20th of November 2004 in Mexico City.

WHO Task Force on Health System Research Priorities for Equity in Health

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Foreword

The overall purpose of the Task Force was to assist the WHO Equity Team (EQH) in liaison activities with the Department of Research Policy and Cooperation (RPC), to include equity as a cross-cut issue in research priorities for health system development in low-income countries and to establish a priority research agenda to fill the critical gaps in the health systems equity knowledge base.

The work of the Task Force has been informed by the WHO consultation with Civil Society Organizations on Equity and Health Systems Research Priorities, at the Third International Conference of the International Society for Equity in Health (ISEqH), 12 June 2004, Durban, South Africa.

This report will feed into the *World Ministerial Summit on Health Research* that will take place on the 16-20th of November 2004 in Mexico City.

SUMMARY

Despite impressive improvements in aggregate indicators of health globally over the past few decades, health inequalities between and within countries have persisted, and in many regions and countries have begun to widen. Our recommendations regarding a priority agenda for research on health equity are based on an assessment of what is required to understand how to substantially reduce socially-produced inequities in health. We recommend that highest priority be given to research in five general areas: (1) important global factors and processes that affect health equity and/or constrain what countries can do to address health inequities within their own borders; (2) specific societal and political structures and relationships that differentially affect people's chances to be healthy within a given society; (3) inter-relationships between individual-level factors and social context that increase or decrease the likelihood of achieving and maintaining good health; (4) health-care system factors that influence health equity and (5) documenting, and widely disseminating effective policy interventions to reduce health inequity in the four above areas, as examples that can suggest potential options for others to consider.

Background

Equity has been a stated or implied goal of health policy in many countries and international health organizations for several decades. At the WHO conference in Alma Ata in 1978, a global health strategy was launched by the World Health Assembly with the goal of Health for All by the Year 2000 (HFA).[1] HFA implicitly makes equity in health a priority, which was taken forward actively in the World Health Organisation's HFA strategy for Europe.[2] The European HFA strategy for the 21st century identifies promoting equity and improving health as its guiding principles.[3,4] The World Health Organization in Geneva launched a global initiative on Equity in Health and Health Care from 1995-1998.[5,6] Equity concerns were also prominent in parts of the 2000 Millennium Declaration, which gave rise to the Millennium Development Goals.[7] Although impressive overall gains have been

achieved in life expectancy and child survival during the second half of the 20th century, inequities in health status and in the health systems between more and less privileged groups within and between countries have persisted, and in many regions and countries have begun to widen.[8,9]

Health equity has emerged as an important theme also in research and advocacy.[10,11,12,13]

Pursuing equity in health "reflects a concern to reduce unequal opportunities to be healthy associated with membership in less privileged social groups, such as poor people; disenfranchised racial, ethnic or religious groups; women; and rural residents. In operational terms, pursuing equity in health means eliminating health disparities that are systematically associated with underlying social disadvantage or marginalization".[14] The unequal distribution of the social and economic determinants of health, such as income, employment, education, housing, and healthy environments remains the primary policy problem for reducing health inequities.[15] Striving for equity in health *care* is one aspect of the wider concept of equity in health *status*, and implies that health care resources are allocated and received according to need, and contributions to financing the system are made according to ability to pay.[16,17] In order to make rapid progress in narrowing existing gaps, and in a context of limited resources, it is necessary to give preference to the needs of those who have the greatest health needs and the least resources to address these needs.

The vision of WHO over the last few decades has been that health and health services would come to be recognised in their broad social, cultural and economic context. The WHO defines health systems as "all the activities whose primary purpose is to promote, restore, or maintain health".[18] Given the larger context in which health systems operate and the impact that factors external to the health system can have on health, health systems become not only "producers of health and health care", but also "purveyors of a wider set of societal norms and values".[19] The research agenda articulated in a recent Lancet article identified this role under the concept of stewardship, through providing "effective approaches for intersectoral engagement".[20]

Health systems in many countries, however, have been unable to adequately deliver on or sustain improvements in health equity. The obvious reason why — as a recent synthesis of research on "vulnerability" to HIV, tuberculosis and malaria infection notes — is that health systems, and the people who use them, exist within a social context that powerfully determines people's chances to be healthy.[21,22] Social values and political processes determine decisions over the allocation of resources (wealth, power, and opportunities to acquire them) for health. This makes it unlikely that equity values will be realized without confronting the entrenched interests and political/economic practices that produce inequalities in the distribution of health resources or access to health care. This dimension of equity is reflected in *inter alia* the extent to which public policy and authority are structured to secure public interests and justice; which embodies, in turn, the degree to which non-elite groups can influence political decision making over the allocation of resources for health.[9]

Research and interventions that focus only on technical dimensions of health interventions or on the ways in which health systems are funded and clinical services delivered generally lose sight of these structural (political/economic) and social dimensions. Promoting health equity therefore requires (1) integrated action to develop healthier social, economic, political and physical environments where the roots of individual suffering and illness often lie; (2) the improvement of accessibility to appropriate universal health systems; and (3) priority interventions and programs within health systems (e.g., scaling up antiretroviral therapy for HIV/AIDS in sub-Saharan Africa) where the burden of disease is greatest and resources to address it are least.

How can the research community produce the findings to support interventions and policies that aim to improve health equity at each of these three levels? Biomedical research produces important knowledge about the mechanisms of disease aetiology; the clinical aspects of how people cope with disease and disabilities as individuals; and the biological and psychological mechanisms by which specific risk factors or risk conditions generate different diseases. While biomedical research remains foundational to the curative mandate of health systems, understanding the social aetiology of disease, i.e. the meso- and macro-level processes behind causes of observed differences in health important to the preventive mandate, generally falls

outside its frame of reference. Even the current focus of most non-biomedical health research is predominantly on individual risk factors; the social context that frames the distribution and modifies the effect of these risk factors is often neglected.[23,24]

What is needed now is more research into the effects of social context and position on individual and population health outcomes. Such research would lead to a better understanding of the impact of different macroeconomic and social policies on life chances and ultimately on health status for different sub-groups of the population, defined by socio-economic position, gender, race/ethnicity, religion or geography.[23,25] This requires research that (1) goes beyond the behavioural and other individual determinants of illness; (2) examines the link between proximal and structural (distal) determinants of ill health (a link that is often poorly conceptualized and integrated into research); and (3) explores the institutions and processes that lead to the social allocation of resources for health. It can be argued that we already have a considerable base of research evidence that meets these criteria, which would be a fair observation. But since the social and environmental determinants of health invariably raise policy questions that are highly political, there is a need for continuous generation of such research in order to keep the policy/political discourse on these issues both current and novel. Addressing the root causes of population health usually requires actions from multiple sectors, not just from the health care sector[26]; thus, new forms of equity-focused multidisciplinary research are also needed to support a multisectoral policy approach.[27,28]

Research, whether it is biomedical or social, is invariably informed by a specific set of values and perspectives. The equity-oriented research we discuss in this article is foremost defined by the desire to reduce modifiable inequalities that are considered to be unfair. The way we characterize or understand 'unfairness' influences not simply the type of research, but also the research agenda, the research questions and the methods to address them. It also shapes the social and state action that uses the new knowledge from research towards achieving equity. As one example: A justice norm that emphasizes equality in opportunity will inevitably increase differences between social groups, since those with more resources can take greater advantage of such opportunities. A justice norm that emphasizes equality of outcome, in contrast, would give preferential opportunities to groups endowed with

fewer resources. While not mutually exclusive, the two norms lead to differences in policy emphasis. The first ensures 'the rule of law;' the second requires strong re-distributive programmes.[29]

Priorities for future health equity research should be set based on identification of the most important gaps in current knowledge, which leads us to recommend an agenda for research in the following five areas:

A growing evidence base, but a lack of policy-relevant synthesis

To support improvements in health equity, research is needed in five distinct but interrelated areas: (1) global factors and processes that affect health equity; (2) the specific societal and political structures and relationships that differentially affect people's chances to be healthy within a given society; (3) the inter-relationships between individual factors and social context that increase or decrease the likelihood of achieving and maintaining good health; (4) health care system factors that influence health equity; and (5) how to influence (1)-(4) effectively, i.e., identification of policy interventions with the potential to reduce inequities in the determinants of health and health care. In each of these areas, much remains to be understood.

(1) Global factors and processes that affect health equity

The diffusion of new knowledge and technology through trade and investment should in theory improve disease surveillance, treatment, and prevention. Economic growth, necessary for sustaining public goods such as health care, should both improve the supply of, and access to, essential health promoting services, while also reducing poverty, both of which would lead to better health.[30,31] These outcomes, however, have failed largely to materialize. Considerable evidence now suggests that the current policy approaches to

globalisation, which emphasise trade and investment liberalisation, privatisation of state assets and global market integration, have not reduced social and economic inequalities or inequities in health.[32,33,34] Instead, they have contributed to the rapid spread of infectious diseases and increased adoption of high risk lifestyles[35,36], systematically undermined the public provision of essential services and food self-sufficiency, and reduced the authorities and capacities of states to protect public health.[37]

"Although much remains to be understood about how globalization phenomena can be harnessed to improve global health outcomes, we have now lived through two decades of increased market integration and a decade of enforceable trade rules. With respect to trends in two fundamental health-determining pathways (poverty or inequality and environment sustainability), the impacts have been largely negative".[38]

Other problematic consequences of contemporary globalisation include trade in health damaging products, such as military weapons and tobacco, migration of people displaced by conflict and/or poverty, new environmental threats including resource depletion and climate change, and increased commercialisation and privatisation of essential services associated with segmentation of health systems and diminished access to services in poor communities.

Notwithstanding ongoing debates about the extent to which globalisation is reducing or exacerbating global poverty rates, its current form, with its emphasis on commercial trade and capital interests, with inadequate commitment to or measures for public health and welfare, is generating serious problems for health and health care, and increasing negative environmental and social outcomes.[39] Research aimed at maximising or protecting health and access to health care of necessity must confront these features of globalisation.

Such research cannot be confined to national and sub-national levels. The economic and political drivers of harm to health include policies and trends that transcend national borders and are at least in part beyond the policy 'reach' of national governments acting in isolation.[40,41,42,43,44] Hence while research

strategies need to assess the health impacts of stratification by class, gender, ethnicity/religion/national origin, as well as the domestic policy dynamics underlying regional disparities within countries, they need also to understand the transnational nature of both the drivers of these disparities and of the response to them.

PANEL 1. **Examples of high-priority research questions for understanding global factors and processes that affect health equity:**

- What impacts do debt payments, and the harsh conditions laid down for debt relief, have on public revenue and spending on the health and social sector? How do these impacts affect global health equity and within-country health equity?
- What are the impacts on health equity of capital flight (related to capital market liberalization, currency crises, *causes* of currency crises and policy alternatives, existence of tax havens) and tax avoidance/tax competition through, *inter alia,* their effect on public revenues for social spending?
- What are the impacts on health equity of conditions laid down to meet macroeconomic goals (generally: liberalization, privatization of state assets, decreased general social spending)? These conditions were once associated with structural adjustment programmes, but are still present in Poverty Reduction Strategy Programmes, IMF/Bank loans, WTO agreements and increasingly in development assistance (e.g. USA Millennium Challenge Account)?
- How are GATS, TRIPS and other WTO policies, as well as bilateral 'free trade' negotiations, impacting on health and health services? How have these mechanisms been used by multinational pharmaceutical and other companies to influence domestic policies related to health?
- How do the levels, conditions and effectiveness of Overseas Development Aid influence health equity?
- What are the impacts on health equity of changes in fossil fuel consumption and natural resource depletion/throughputs?

All of the issues/questions listed in *Panel 1* require not simply comparative cross-national studies, but detailed national case studies that go from household levels to national policy sectors, in turn assessing carefully the impacts of specific globalisation 'drivers' on the national policy capacity (related to revenue generating capacity) and space (related to trade agreement restrictions on new

national policy-making). Related, and overarching questions of all such research would be: What *a priori* global, international and national economic, governance and policy conditions produce economic growth in poverty-reducing, disparity-reducing, health-promoting ways?

Finally, and importantly, there is a need for policy research on possible conflicts between (and remedies for) multilateral environmental agreements (which have health impacts), human rights (notably right to health) and trade/finance liberalization agreements and various aid, debt relief and Bank/IMF loan conditions.

(2) The specific societal and political structures and relationships that differentially affect people's chances to be healthy

The social environment, or social context, in which we live generates unequal distributions of power, wealth and risks to health. The way our society and communities are organized has a major impact on determinants of population health and health inequalities[45]. Dimensions of concern include policies on the labour market and income maintenance,[46] gender norms,[28] land use planning (e.g. in ways that influence rural production and household food security or that influence urban demand for automotive transportation and the associated air pollution and stress in concrete), access to social services, health care,[47] and education system, housing, environmental protection, water and sanitation, transport and security. Many of these policy areas, and their direct and indirect health impacts, are beyond the reach of health systems and the key decision-makers within those systems. Several studies have revealed that a given social arrangement, e.g. introduction of user fees for health services, differently affect people's chances to remain healthy.[47]

Indicators and methods must be developed urgently for systematic health equity impact assessments that assess not only a policy's impact at an aggregate level, but on different population groups, including the marginalized and vulnerable; such an assessment must be applicable not only to health systems policy, but also to policy in other sectors.[48,49] Devising the indicators and

methods for health equity impact assessments is not just a technical exercise. It should incorporate an understanding of the social values and political choices that strengthen fair process and outcomes in policy decision-making *(Panel 2)*.

PANEL 2. **Examples of high-priority research questions for understanding how and why specific societal and political structures and relationships differentially affect people's chances to be healthy:**

- What are the health equity impacts of tax policies, structural changes in welfare systems, labour market policies, housing policies, policies influencing access to credit etc?
- What methodologies facilitate and strengthen such research? What new methods need to be developed?
- How are socio-economic determinants of environmental changes associated with health outcomes, e.g. air quality, water quality/consumption, toxic emissions and/or waste management, energy consumption, biodiversity, etc.
- What is the relationship between good governance and health equity? (For example, how do social and economic entitlements for citizens, fair processes in decision-making, access of the poor to policy processes and improved accountability of decision-makers affect the health equity impacts of policy decision-making?)
- How do specific policies (health sector reforms, privatisation) transform the relationships between citizen and state in health interventions, and with what impacts on service provision, access and health equity outcomes?
- How can research processes themselves strengthen the organisation and use of community knowledge and experience? What is the relationship between different research approaches and socially emancipating actions for health?
- How can states foster or undermine individuals' and communities' ability to engage in effective action in the pursuit of their own and their communities' health?

(3) The inter-relationships between individual factors and social context

Numerous studies directed to understanding inequalities in health have focused on exploring the individual attributes that differentiate health risk, such as smoking, alcohol consumption, eating patterns, and blood pressure. The burgeoning literature on the social determinants of health emphasizes that

many of these risk factors are corollaries of, or strongly influenced by, an individual's social position: income level and accumulated wealth as well as economic (in)security, place of residence, gender, ethnicity, educational attainment, work environment, etc. The limitations of a focus on individualized risk factors have been critiqued with special force, as "public health behaviourism"[50] in the literature on HIV/AIDS. It is not enough to study the impact of a specific, proximate risk factor, purportedly separated from confounding influences of other risk factors, on health and social inequities in health. Such a 'risk factor' approach fails to uncover multi-causal mechanisms and root causes behind social inequities in health and ignores the fact that influences on health accumulate over the life course.[51] More generally, social context and social position may play an important role in predisposing some population groups to heavy social consequences from disease or injury, or in buffering them against such consequences.[23] Despite the large body of contributions from low and high income countries to knowledge about the social determinants of health and health equity, the evidence base in this regard exhibits major gaps.[8,52,53,54] There is much still to be learned about the specific pathways by which disadvantaged social positions translate into ill health *(Panel 3)*.

PANEL 3. **Examples of high-priority research questions for understanding the inter-relationships between individual factors and social context**

- How do socio-economic factors interact with other risk factors in contributing to health inequities in middle and low-income, countries?
- What changes in local-level contextual factors can best mitigate negative health effects of compositional factors, and vice versa?
- What are the interrelationships between compositional factors (e.g. the social and economic characteristics of populations who live in a given area) and contextual factors (e.g. place characteristics, physical environment qualities, social relationship dynamics, availability of services) on health inequities?
- What poverty dynamics are related to ill health in low- and middle-income countries? In particular, how do socio-economic factors contribute to ill health at the household-level, and what strategies best mitigate these in both a coping (short-term) and socially transformative (long-term) way?

(4) Health care system factors that influence health equity

Although the antecedents of health inequities often need to be tackled within the broader social and economic arena, the role of health care in reducing ill health and suffering, redressing inequities, and preventing future inequities remains critical.[55, 56] In the short term, the health sector may be one of the promising points of entry for policies and interventions to tackle health disparities,[8] to prevent impoverishment due to health care expenses,[11] and to prevent the decline in social position of those with chronic diseases.[57]

In the past two decades powerful trends in health sector reforms were observed around the world. The main element of these reforms is an orientation towards market-based solutions, and has been actively promoted by international financial institutions. Some of these are structural measures that have fundamentally reorganised the values and principles driving health systems to include privatisation, commercialisation and segmented financing. Others are more process or management related, e.g., health sector administrative reforms (such as performance-based funding or private sector management contracts), formal mechanisms for priority setting and an expanded range of health care financing options, including increased forms of private financing.[58] While the options adopted vary from country to country and region to region,[59] these health system reforms can have fundamental consequences for many people's day-to-day lives and well-being. The main motivation for reform appears to be economic efficiency rather than health equity[60].

Research on health sector reforms suggests that many of the reforms have raised barriers to access to essential care for the less well off. Despite rhetorical acknowledgement that public expenditure cuts and the imposition of user fees has impeded access to health care, little has been done to remove these harmful effects or to protect the most vulnerable segments of the population.[61] Direct effects include decreased access to health services and delays in health-seeking behaviour leading to worse health outcomes.[62] This may affect women disproportionately as they have less access to household resources, their risk of poverty is higher and they require more preventive reproductive health

services.[63,64] Some have assumed that the introduction of user fees would offer health care providers increased budgetary allocations for improvement of quality services.[65] However, user fees in public health systems have neither realised the presumed benefit nor enhanced equity in access.[66] Out-of pocket expenditures for public and private health care services drive many families into poverty, especially in developing countries[67,68,69,70,71] – the "medical poverty trap".[47]

These negative consequences of health sector reforms are seldom recognized for purposes of policy and implementation. Research should not only assess the social and health costs, benefits and trade offs of policy shifts, but also examine the value systems and assumptions that are incorporated with these policy shifts. Research on the effects of introducing a competitive health systems market on equity in provision of and access to health care should provide clear information for planning on short and long term costs and benefits, particularly on the quantity, relevance, distribution and quality of health services. Such research should also promote increased understanding of existing demand-side constraints that need to be overcome and address the social and demand-side consequences of differing policy options[72] *(Panel 4).*

Research and policy need finally to focus on the human component of health-systems development. The quality, commitment and dedication of health care providers are critical to health, equitable health systems and development. Numerous recent assessments indicate that the 'brain drain' of providers from developing countries, especially from those in southern Africa, threatens to precipitate at complete collapse of health systems already stretched to the breaking point by financial constraints and the impacts of HIV and AIDS.[73]

PANEL 4. **Examples of high-priority research questions for understanding health-care system factors that influence health equity**

- What factors and interests are driving the commercialisation of health services at local to global levels, and what are their impact on health equity outcomes and the policy measures for confronting them?
- What appropriate strategies for addressing inequities in the public-private mix in health systems (in terms of the resources located in each sector relative to the population each serves)? What appropriate regulatory frameworks would ensure that private sector activities contribute to overall health sector goals in an equitable way? What financing mechanisms would allow system-wide changes that promote equity (i.e., by improving cross-subsidies in health care financing across entire populations)?
- How can crucial components of cross subsidy and risk pooling in environments of market reforms be better secured?
- What are the key factors that influence health worker migration in different contexts? What strategies could promote positive health worker attitudes and morale and limit inequitable migration patterns (rural to urban, public to private sector and low- and middle-income to high-income countries), as a result of *inter alia* under-funded systems, lack of safety or proper management and active recruitment?
- What are the most important 'demand-side' aspects of promoting equitable health service access (e.g. information constraints relating to understanding of ill-health and what health services have to offer, perceptions relating to health service quality, cultural access barriers, etc.)?
- How can health systems contribute to actions on social and environmental health determinants through, amongst others, empowerment approaches to health service planning and delivery, community development, partnership development, policy advocacy, strengthening civil society responses, etc?

(5) Documenting and widely disseminating effective policy interventions to reduce health inequity

The research agenda must also place great emphasis on the identification and analysis of effective models of policy approaches and cost-effective interventions.[8,13,74] In some cases the evidence is that typical interventions, if applied in the traditional (non-equity-focused) way, could actually increase inequalities, since high-income groups are generally better able to access and utilize services or knowledge from public health interventions.[75] There is a paucity

of information on interventions that have successfully addressed social determinants of health inequities, and little concrete guidance is available to policymakers. The research in the health equity field has, until recently, been devoted mostly to describing the inequalities and much less to explaining them and proposing interventions to address the inequities. The time is now ripe for increasing our investments in research on evaluating the health effects of policies and interventions among different segments of the population, but also on framing the health consequences of alternative options for enhancing equity, to guide affirmative policy making. Research must be oriented toward policy solutions that can effectively link priority targeted health programmes; strengthening of the broader health system; and action on the social determinants of health. The health sector should play an advocacy role in catalyzing and guiding multisectoral action to address the social determinants of health. A key task for equity-oriented health systems research is to identify strategies and "pressure points" for this process *(Panel 5)*. Research must provide evidence that will enable us to tackle the root causes of health inequalities, not just the symptoms or the most immediate precursors of observed damage. This can be done at various levels. For example, evaluation of the improvement of the condition of and heating in older houses in colder climates can be done to make them warmer, particularly as older houses are disproportionally lived in by people on low incomes.[76] At a wider level, for example, research can demonstrate and measure systems wide gains and costs of different approaches to the expansion of ART, particularly to inform health systems strengthening choices.

How we define evidence on successful interventions, what constitutes such evidence and how we value evidence provided by different stakeholders, i.e. international and national scientific groups, communities and NGOs, are in themselves also important issues for research. The process of implementation or successful interventions may be just as important as the outcomes. Policy changes provide opportunities for natural experiments to further the understanding of the relationship between policies and health outcomes. We need also to bear in mind that there is no universal blueprint: solutions have to be devised that suit the context specific to each country.[59] An equally important issue is the accessibility of the results of evaluation studies. Developing an international

reporting system to collect information on ongoing and completed evaluation studies in order to increase the accessibility for policy-makers to relevant information needs to be encouraged.

PANEL 5. **Examples of high-priority research questions for understanding effective policy interventions to reduce health inequity**

- Which are the potential entry points for equity-oriented healthy public policies?
- What policies and policy interests undermine health equity? What are the mechanisms through which policies that promote or impede health equity are advanced?
- Which political forces must be dealt with, and what strategies are most likely to succeed at global and national levels, to achieve greater equity in health?
- Which specific policy interventions have been successful in promoting health and health system equity? How are these policies designed, and what process were involved in developing and implementing them? What are those contextual factors that may have influenced their success, in order to determine the possible broader relevance of such 'success stories'?
- How can the effectiveness of policies and interventions to reduce inequities in health best be evaluated? What data from existing evaluation studies examining average impacts on population health can be re-analysed to identify which interventions have differential health impacts across the social spectrum?
- What natural policy experiments* can be used to assess the impact on health equity of major social and health policies?

***** The term 'natural policy experiment' refers to the situation where the introduction of a specific policy within one country or its adoption in several countries provides the opportunity for an experimental design or a comparative analysis that can be used to identify the policy's impacts on different social groups.

Conclusion

This paper argues that unfair inequalities in health arise at a number of levels, in the economic, social and environmental determinants of health, in the policies that influence the distribution of these determinants and in the political and economic interests that shape these policies. It argues further that these conditions are being powerfully transformed by a process of globalisation in which the interests of transnational capital dominate public health and national authority. Any research process that seeks to explain and understand the sources and drivers of this inequality would need to take account of these determinants, and the policies, interests and imperatives that influence them. More importantly, a research process driven by values of equity, and goals of justice, would need to generate knowledge that confronts these trends and promotes public, population health interests in a way that preferentially benefits the most disadvantaged in society.

This has implications for both the type of research questions we ask, and the way we seek to address them. In this paper we propose some research priorities. We also pose the need for such questions to be addressed in ways that strengthen social action for health equity and that reinforce policy actors promoting health equity.

The global community has set itself targets such as the achievement of the Millennium Development Goals. We may see in the coming year a great deal of research that describes the gap between these targets and the current lives of many in the world. This is necessary but not sufficient in the face of a growing unmet demand for health equity and justice. We need to do more with our research. We need to choose the questions and generate the knowledge and analysis that explains the drivers of unacceptable gaps between our social aspiration and our social practice. More importantly, we need to generate the knowledge and analysis that informs public policy-making and the social processes that influence it.

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