Editor's Briefing

EQUITY AND HEALTH

This month's Journal includes a remarkable series of articles dealing with aspects of primary care in many countries of the world. In an illuminating editorial Mathers and Huang explore the complex issues involved in developing a primary care service in China — a task of enormous complexity and challenge, given the dizzying demographics of that huge country. In another article on primary care in Asia, Chan and colleagues make a strong case for mandatory vocational training as the basis for effective primary care systems, which at present do not exist in some of Asia's most developed economies. There are also contributions about general practice in Palestine, the work of the RCGP Junior International Committee, and an article and an editorial about the practical and ethical questions associated with short-term international medical volunteer placements in resource-poor settings. Mant and colleagues' study of migrant health workers in sub-Saharan Africa reveals another example of the inverse care law: where health care is most needed, it is often most poorly provided.

The juxtaposition of these articles, about countries struggling to train for and deliver primary care, with the appeal from the Chair of the RCGP for more resources for general practice is interesting. General practice in the UK — the jewel in the crown of the NHS — has long been regarded as the gold standard, the model to which others should aspire, yet we too are struggling. The reasons for this are difficult to fully understand, given the widespread recognition, including awareness among healthy economists, that a strong primary care sector within a health system is associated with lower overall costs and better health outcomes.[1] Recent research has sounded a slight warning note on this, however, because the costs of building up primary care when secondary care is dominant may, at least in the short to medium term, increase total health system costs.[2] However, important as these health and economic imperatives may be, it seems to me that they are trumped by the potential, still largely unrealised, of primary health care to contribute to health equity.

The determinants and consequences of health equity are complex. In an extraordinary Lancet study,[3] Jon Rohde and colleagues looked, 30 years after the declaration of Alma-Ata, at whether primary health care has worked. They assessed progress in terms of changes in life expectancy, corrected for national income and HIV prevalence, to identify overachieving and underachieving low-income and middle-income countries with the highest average yearly reduction in mortality among children under the age of 5 years. The 14 countries that had progressed to comprehensive primary health care, which includes high coverage of skilled attendance at birth and of childhood immunisations, were characterised by political stability and a strong, consistent government commitment to health. Those that failed were often marked by a lack of healthcare leadership, political corruption, and civil unrest.

In his paper *Why health equity?*[4] the great welfare economist and philosopher Amartya Sen comments that '*... an adequate engagement with health equity also requires that the considerations of health be integrated with broader issues of social justice and overall equity.*' The relationships between socioeconomic inequality, health equity, civic society, and government are complex, but there can be little doubt about the potentially transformative power of equitable and effective primary care. At a time when the gap between the richest and poorest within and between nations is getting wider and wider, and when oppression, conflict, and civic strife seem to be everywhere, this, at least, is something worth fighting for.

Roger Jones
Editor

REFERENCES

1. Starfield B. Is primary care essential? *Lancet* 1994; **344(8930):**1129–1133.
2. Kringos DS, Boerma W, Van der Zee J, *et al.* Europe's strong primary care systems are linked to better population health, but also to higher health spending. *Health Aff (Millwood)* 2013; **32(4):** 686–694.
3. Rohde J, Cousens S, Chopra M, *et al.* 30 years after Alma-Ata: has primary health care worked in countries? *Lancet* 2008; **372(9642):** 950–961.
4. Sen A. Why health equity? *Health Econ* 2002;**11(8):** 659–666.

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