Putting health equity at heart of universal coverage—the need for national programmes of action

Article *in* BMJ Clinical Research · October 2019

DOI: 10.1136/bmj.l5901

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BMJ 2019;367:l5901 doi: 10.1136/bmj.l5901 (Published 25 October 2019)

ANALYSIS

Putting health equity at heart of universal coverage—the need for national programmes of action

Better data on health disparities and commitment to interventions focused on the determinants of inequality are essential, argue **Eric Friedman and colleagues**

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Income inequality is growing,[1] fuelling both right wing populism[2] and demands for progressive, inclusive policies. Global disquiet over inequality prompted the United Nations to pledge in the sustainable development goals (SDGs) that "no one will be left behind."[3] Health inequities present a defining challenge of our time,[4] and governments need to adopt and rigorously implement national programmes of action to respond across multiple dimensions so that economic and social status no longer determine human health and wellbeing.

Most of the data collected on health has been at national and global levels. Such aggregated data may mask deep unfairness in the distribution of good health, much as a growing gross domestic product can mask highly unequal distribution of wealth. For example, a baby born in a largely white, wealthy suburb of St Louis in the US can expect to live 35 more years than one born in a mostly black, lower income suburb a few miles away; the average life expectancy in Saint Louis County is close to 79 years, but ranges from 56 to 91across neighbourhoods.[5 6] Globally, life expectancy is 72 years but people in the United Kingdom live an average of 81 years while those in Sierra Leone average only 54.[7]

There have been few actionable, inclusive national initiatives expressly designed to achieve health equity—a missed opportunity as countries create national development strategies and develop health plans that include precise national health targets. Despite some important work on health equity, international institutions have not brought equity to the centre through concrete, actionable strategies. The political declaration on universal health coverage agreed at the 2019 UN high level meeting on universal health coverage, for example, reiterated the pledge to leave no one behind. but set out neither specific targets on, nor specific strategies to achieve, health equity.[60] We examine the reasons and suggest how to put health inequalities at the centre of the agenda and fulfil the SDGs' central promise.

Uneven progress on health inequalities

The millennium development goals (MDGs), which set targets to be achieved by 2015, saw accelerated health progress in target areas, saving millions of lives.[8] The international community created innovative institutions such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and a goal that would have once seemed fanciful—treating 15 million people with HIV/AIDS by 2015—was achieved.[9]

The MDGs, however, failed to articulate and implement targets through an explicit equity lens (box 1). Consequently, evaluations have used measurements of overall progress, masking inequitable distribution.[13] Reductions in HIV prevalence, for example, were relatively rapid for the wealthiest 60%, while the poorest 40% made little gains.[14] In one study, the poorest 40% were doing worse on MDG health outcomes in about a quarter of 64 countries analysed later in the MDG period, based on national surveys conducted between 1990 and 2011.[14] Relative inequality grew in MDG health outcomes in nearly half these countries.[15]

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Box 1: Health inequities have persisted despite overall progress

- The life expectancy gap between high income and low income countries narrowed during the millennium development goal (MDG) era, but not by much. In 2000, people in wealthier countries had a life expectancy 44% higher than those in low income countries; in 2015 it was 28% higher
- California halved its maternal mortality rate from 2008 to 2013, but the rate remained 3-4 times higher for African-American women than for those in other racial or ethnic groups.[10]
- Childhood stunting improved overall globally, but the relative gap between children in the wealthiest and poorest households increased in over one third of countries[11]
- In Peru, mortality among indigenous children under 5 years is over three times that of non-indigenous children[12]
- In sub-Saharan Africa in 2014, <30% of women below the lowest wealth quintile had accessed skilled birth attendants, compared with >80% of women above the highest quintile[11]

We analysed data on key MDG targets relating to reproductive, maternal, newborn, and child health (table 1).[16] Although child and maternal mortality nearly halved under the MDGs, progress towards narrowing gaps between wealthier and poorer populations has remained far too slow. Without substantial reforms, many countries will not close core health equity gaps this century, much less achieve the commitment to leave no one behind by 2030.

One reason for this is the failure to focus on equity. The aggregate nature of MDG targets and indicators limits our understanding of health inequities. A second reason is the complexity of health inequities, requiring action across numerous social determinants.[17 18] Siloed, medically focused approaches to health have become common since an initial push for comprehensive primary healthcare was quickly seen as too expensive.[61 62] Intersectoral collaboration and action require a change in mindset. This is made harder by the deeply rooted, structural nature of the injustices underlying health inequities, from power and wealth imbalances to centuries of discrimination against populations who experience poorer health. In addition, income inequality, a major determinant of health, is growing in nearly all the world's regions.[19] Without taking explicit account of these structural factors, little progress will be made.

Despite these problems some countries have made substantial progress. Costa Rica achieved near equality in skilled birth attendant coverage between women in the poorest and wealthiest quintiles. The government built an extensive primary care network and increased girls' access to education.[20-22] The participatory slum upgrading programme improved the lives of 22 million people living in slums across 35 countries, reducing their negative effects on health.[23 24] Bolivia significantly reduced income inequality thanks to targeted social welfare programmes paired with macroeconomic strategies that raised income in the informal economy through strong currency, cheap imports, and increased minimum wages.[25 26] These approaches indicate not only that progress is possible but also that health equity requires comprehensive approaches.

Measuring what we value

An effective strategy starts with making health inequalities more visible. If we measure what we value, and act on what we measure, then it seems that the international community does not value health equity very much. For example, although the SDG indicator for universal health coverage (UHC) encompasses interventions for both the general and most disadvantaged populations, the monitoring report omits data for disadvantaged groups.[27] A failure to collect more granular data prevents UHC being compared "across different dimensions of inequality."[28]

Data that breaks down health indicators by population group, collected across sectors and monitored over time, is foundational to understanding, targeting, and establishing accountability for advancing health equity. Does the rate of improvement in health for disadvantaged populations exceed the national rate of improvement? Which populations are furthest behind in health outcomes and why? As well as numerical data we need qualitative data to understand the causes of health inequality and why policies are succeeding or failing.

Disaggregated data can help target interventions—such as in Rwanda, which is focusing on the most disadvantaged 25% of the population[29]—and shift "success" measures within the health system to include improved equity. But current surveillance data already provide governments with enough information to begin to identify common markers of discrimination and disadvantage without waiting for new data systems.

A new approach to equity will require increasing the quantity and quality of disaggregated data, including expanding the dimensions of inequality that survey instruments cover to include, for example, disabilities, indigenous communities, and gender, ethnic, and racial identity. It is important to link demographic survey data to health indicators, using sampling methods to fill data gaps.[30] SDG 17 includes a target of enhancing capacity for "high quality, timely and reliable" disaggregated data, yet these data remain sorely lacking. There are multiple reasons for this, including insufficient funding, failure to include relevant dimensions in survey and health instruments, and lack of training for public health authorities.[31 32] Greater development assistance and domestic investment to build statistical skills could substantially improve measurements of health inequities.[33 34]

The continued lack of attention to granular data on health inequalities cannot be justified. Supporting countries should be a priority for WHO, the World Bank, and national assistance programmes. Beyond country specific data, global reporting on SDG goals and targets should be disaggregated to enable fuller insights into the distribution of inequalities.

Health equity programmes of action

Understanding the problem is a start, but it is not enough. The persistence of health inequalities, their gravity, and the injustices they reflect demand action. To dramatically reduce health equity gaps, governments must explicitly plan to do so—dedicating time, political attention, and resources to setting priorities and crafting solutions expressly aimed at ending health inequities.

Promising approaches and interventions to reduce inequity do exist. UHC may be central to achieving health equity, but only if it focuses explicitly on progressively eliminating geographical, economic, sociocultural, and gender barriers.[35] Numerous interventions in the health, education, and economic sectors have been identified for action on social determinants of health.[25] Pairing data with approaches based on human rights has been shown to facilitate effective deployment of resources to advance equity. For example, as part of its effort to increase vaccination coverage for indigenous children, Brazil's health ministry used factors such as low vaccination coverage, difficult to access geographical areas, and poor immunisation information systems to identify priority areas for health teams to visit during a "vaccination of indigenous peoples" month, resulting in a 30-40% increase in vaccination coverage.[36]

The SDGs have failed to highlight mechanisms to translate promising approaches into action and there is, so far, little indication that governments have shifted towards active, comprehensive health equity planning.[37] Voluntary national reviews, presented every few years, continue to focus on overall health goals and pay little attention to equity. A recent UN report contained only one example of planning towards leaving no one behind in health—Canada's plans to improve health services for indigenous peoples—which is not new and focuses on a single disadvantaged population. The UN also highlighted Bhutan's vulnerability baseline assessment,[38] which identified opportunities to reduce inequities (not specific to health) but had no plan for resolving them.[39] A handful of high income countries have health equity strategies, pre-dating the SDGs, that cut across sectors to improve equity, with some population specific measures (box 2). For example, Norway's 2007 strategy encompassed income, childhood development, work and the workplace environment, and services and behaviour, with some targeted focus on several specific groups (box 2).[46] However, even these neglect important determinants contributing to health inequities or cover only certain populations, and they largely lack specific actions.[40]

Box 2: Principles for health equity programmes of action—and how they can work

Principle 1: Empowering participation and inclusive leadership

The Global Fund's multistakeholder country coordinating mechanisms (CCM), responsible for developing funding applications, are required to include civil society and affected populations (such as people living with HIV) as at least 40% of their membership, chosen through transparent processes by their own constituencies.[42] In a few cases members of affected communities have chaired their country's CCM,[43] but in others the CCMs fail to conform to requirements and not all affected communities are represented.[44]

Principle 2: Maximising health equity

In 2008, Australia's government set the goal of "equality in health status and life expectancy between Aboriginal and Torres Strait Islander people and non-indigenous Australians by the year 2031." In partnership with Aboriginal and Torres Strait Islander people, it developed a health plan for 2013-23 to work towards this goal. The plan recognises the racism and discrimination these peoples face and includes implementing the national anti-racism strategy among its key strategies.[45]

Principle 3: Health systems and beyond

Several countries have developed national strategies to reduce health equities that include the health system and other social determinants of health.[45 46] For example, along with healthcare, Norway's strategy to reduce social inequalities in health encompasses areas such as income, education, child welfare, work and the work environment, diet, physical activity, and housing.[47] California's plan to promote health equity, primarily a comprehensive analysis of health inequity in the state, encompasses income security, food security and nutrition, housing, environmental quality, the built environment, healthcare access and quality, clinical and community prevention strategies, experiences of discrimination and health, neighbourhood safety and collective efficacy, cultural and linguistic competence, and mental health services[48]

Principle 4: Every population counts

California's plan encompasses people of various racial and ethnic groups, including American Indians, lesbian, gay, bisexual, and trans communities, immigrants, people with disabilities, and people with limited English proficiency.[48] Norway's strategy addresses, at various points, specific needs of populations, including people who are homeless, immigrants, the indigenous Sami people, people with substance use disorders, people in and recently released from prison, and children.[47] But even these health equity plans do not include a comprehensive analysis of all populations experiencing health inequities.

Principle 5: Actions, targets, and timelines

Australia's National Aboriginal and Torres Strait Islander health plan incorporates targets set in the country's 2008 Closing the Gap framework. These include halving disparities in under 5 mortality between indigenous and non-indigenous children, halving the employment gap between indigenous and non-indigenous Australians within 10 years, and halving the gap in reading, writing, and numeracy between indigenous and non-indigenous students within 10 years.[45] In its Health 2015 programme (adopted in 2001) Finland sought to reduce mortality inequalities among people of different education levels and different vocations by 20% by 2015.[49] National health plans also often include time bound targets.

Principle 6: Comprehensive accountability

Launched in 2003 and with findings reported to UNAIDS, the National Commitments and Policy Instrument (NCPI) is used to monitor HIV related laws, policies, and programmes and their implementation. It involves several notable features that contribute to its value in monitoring and evaluation, one key element of accountability. These include the centrality of civil society (government and non-governmental organisations fill different but partially overlapping parts of the instrument to enable comparison); transparency (findings are publicly available); comprehensiveness (its scope has grown over the years); and identification of challenges (although it lacks recommendations on how to overcome them).[50 51]

At a more local level, health promoters in Peru accompany women during antenatal care and delivery to ensure respect for their rights and their proper care.[52] A citizen monitoring programme, also in parts of Peru, involved capacity building for women leaders in their communities. The women then evaluated local health facilities through direct observations and talking with health service users, informing them of their rights in the process. The citizen monitors reported on their findings, entered into dialogue with health authorities and providers to secure commitments to improvements, and monitored the commitments.[53]

Principle 7: Sustained high level political commitment

When the right to healthcare becomes part of the national fabric, governments of various political stripes and philosophies have remained committed. The UK's National Health Service, introduced more than 70 years ago by a Labour government, has retained political commitment from all subsequent governments. Despite concerns about the fate of Thailand's famed 30-baht universal health coverage scheme after the country's 2014 military coup, the scheme has remained in place. Though reforms are being considered as health costs continue to grow, the government continues to voice its commitment.[54]

Governments need to develop and implement health equity programmes of action to ensure progress on effective strategies.[41] Programmes of action could be standalone or, better still, integrated within health and development planning both nationally and regionally as required. Action programmes should establish explicit targets, a costed set of actions, and a timebound accountability framework for improving health equity, moving beyond the outdated assumption that improving health overall will improve equity. To be effective, they must begin with a clear understanding of the complexity of health inequities, identify systemic approaches designed to be effective for specific populations, and include both biomedical and social determinants.

The programmes will need to be adequately and sustainably funded, buttressed by high level political support from national governments as well as a supportive global environment. This should include funding from higher income countries, WHO, and other multilateral institutions to promote this approach and facilitate knowledge sharing. If national governments are unwilling or unable to take the initiative, or simply unaccountable to their populations, localities could still develop local or regional programmes of action; a health minister could take the lead if a broader governmental initiative is not forthcoming or civil society could develop its own programme of action as a basis for advocacy.

We propose seven key principles to underpin the programmes of action (box 2).[55] In developing these plans it is vital for governments to fully engage diverse communities experiencing disadvantage and ensure that marginalised populations have a central role in decision making—including holding leadership positions. Actions should build capacities for meaningful participation and be based in the realities of populations living in situations of vulnerability.[56]

The programmes of action should have the express goal of maximising health equity and include times for achieving targets towards this goal. This will require actions on structural determinants, including discrimination, political exclusion, and skewed distribution of and control over resources.[18 57] To be effective, the programmes of action must also be systematic. They should encompass the full range of social, environmental, economic, commercial, and political determinants of health, with genuine collaboration across sectors.[58] They need to identify all populations experiencing health inequities, analyse underlying factors, and propose policies to narrow inequities, with additional research as needed. Actions would address causes shared across populations (eg, unaffordable or inaccessible healthcare) and those specific to particular populations (eg, migrants' exclusion from equal rights to health

services, education, and other benefits and challenges of providing services to remote rural communities).

To ensure that the programmes of action are implemented they need to contain specific targets and timelines that are integrated into each sector's strategies. They should include measures to ensure accountability. Official and independent reporting on progress, fully transparent and bolstered by joint external evaluations, should be supported by disaggregated data. Accountability mechanisms could be as diverse as village health committees, parliamentary hearings, access to courts, and health impact assessments. Finally, programmes of action need sustained high level political commitment to succeed. A supra-ministerial committee could oversee intersectoral action, with leadership from heads of government.

Call to action

Progress in health equity can serve as an organising principle, a bellwether of global action and a powerful response to today's most pronounced political currents. This requires moving health equity to the centre of health and development agendas. But several years into the SDG era, transformational health equity action planning remains absent.

Health equity programmes of action could be a powerful tool for organising and planning a strong path forward. These require empowering participation, precision, and accountability, with robust political and financial backing. International coordination is necessary because trans-national factors (eg, climate change, migration, and trade) contribute to inequities. Programmes of action could drive multisectoral action for better health for the many people who are yet to benefit from improved overall health outcomes. Governments should make firm commitments, backed where needed by wealthier nations and international financing and action, while the UN builds reporting on these commitments into SDG processes.[59]

Inequities are at the root of millions of preventable deaths every year. It would be a grave injustice to see 2030 approaching, and yet again, find the world has failed to turn lofty promises into tangible action.

Key messages

- Progress towards national health equity has been limited with vast inequities persisting at the end of the millennium development goal era
- Sustained progress towards health equity requires deliberate planning and inclusive approaches backed by political will and financing
- Enhanced investments are required in developing disaggregated data and continuing to increase monitoring and evaluation of health inequities.
- Health equity programmes of action hold considerable promise creating an immediately implementable systematic and systemic set of actions for governments and other bodies

Contributors and sources: All authors contributed equally to this manuscript and are guarantors. LOG is director of the World Health Organization Collaborating Center on National and Global Health Law. MR, including when a director of PAHO, has focused on health equity, including empowering communities, inclusive policies, and reducing social exclusion. MM led the Commission on Social Determinants of Health and has focused on the social determinants and health equity in England and globally. AC leads PAHO's work on health equity, gender, and cultural diversity, and previously worked at UN Women and elsewhere on gender equity and women's empowerment. AB focused on the health of poor populations as Rwanda's health minister, is vice chancellor of the first university on health equity, and researches inequities in health service access. JM has devoted her career to the right to health as chief medical officer of Partners In Health and through initiatives at the Brigham and Women's Hospital and Harvard Medical School. MC is the vice chair of BRAC, the world's largest development NGO, founding director of its research and evaluation division, and founding dean of its school of public health. TR recently chaired the Inter-American Commission on Human Rights and serves on PAHO's commission on equity and health inequalities in the region of the Americas. VGV works to improve HIV services in Brazil, particularly among those most at risk, and led Brazil's ART universal access programme in the 1990s. CW has taught health law at Tsinghua University, and is deputy chair of the China Association of Health Law. MW has focused on community health services as a form of empowerment and better health for disadvantaged populations, including when chair of AMREF. LOG is public and global health scholar, with a career of extensive scholarship and participation in numerous WHO, Institute of Medicine, and other high level committees. MK's research and advocacy focuses on the health of marginalised populations globally, with an emphasis on HIV. EAF led the O'Neill Institute work on health equity programmes of action and is focused on the right to health.

Competing interests: We have read and understood BMJ policy on declaration of interests and have no relevant interests to declare. The Stop TB Partnership supported the O'Neill Institute's work on developing the framework for, and an implementation guide on, health equity programmes of action but did not participate in this article.

Patient and public involvement: Although no patients or the public were included in the development of this article, we did involve members of the public in developing the health equity programme of action framework. This included holding meetings with members of civil society from several countries as well as a consultation with civil society from numerous countries, developing an advisory committee that included several people who had had tuberculosis, and opening a draft of the framework for public comment through the O'Neill Institute website.

Provenance and peer review: Not commissioned; externally peer reviewed.

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Table

Table 1| Achievement of targets relating to reproductive, maternal, newborn, and child health for poorest and richest fifth of population in low and middle income countries[16]

Country (year of most recent survey)	Intervention coverage for poorest fifth (%)	Intervention coverage for wealthiest fifth (%)	Annual absolute average reduction in inequality (%)*	No of years to close gap between richest and poorest
Nigeria (2013)	13	68.4	-0.8	Never
Ethiopia (2011)	22.3	61.4	-1	Never
Guinea (2012)	27.2	62.4	-0.4	Never
Republic of Congo (2011)	45.7	70.3	-0.2	Never
Dominican Republic (2014)	74.3	82.2	-0.4	Never
Mozambique (2011)	40.6	72.1	0.2	157.5
Tanzania (2015)	50.3	73.1	0.2	114
Benin (2011)	39	61	0.2	110
Mali (2012)	30.1	64.3	0.4	85.5
Senegal (2015)	43.8	68.2	0.4	61
Burkina Faso (2010)	41.9	68.5	0.5	53.2
Cote d'Ivoire (2011)	29.9	60.2	0.7	43.4
Bangladesh (2014)	56.8	75.9	0.4	42.7
Kenya (2014)	56.5	80.1	0.6	39.3
Haiti (2012)	43.5	64.2	0.6	34.5
Nepal (2014)	58.5	78.6	0.6	33.5
Niger (2012)	38	65.4	0.9	30.4
Chad (2014)	22.1	45.9	0.8	29.75
Zambia (2013)	61.4	81.8	0.7	29.1
Indonesia (2012)	63	78.5	0.6	25.8
Togo (2013)	46	65.7	0.8	24.6
Jordan (2012)	73.5	75.6	0.1	21
Gabon (2012)	47.5	61.7	0.7	20.2
Philippines (2013)	58.8	76.4	1.1	17.6
Uganda (2011)	51.4	68.9	1	17.5
Zimbabwe (2015)	66.5	81.8	0.9	17
Vietnam (2013)	68.8	81.7	0.9	14.3
Armenia (2010)	66.4	73.1	0.5	13.4
Namibia (2013)	70.3	81.4	1	11.1
Rwanda (2014)	63.9	72	0.8	10.1
Peru (2012)	63.3	78.3	1.6	9.3
Egypt (2014)	73.9	80.2	1	6.3
Lesotho (2014)	70.5	79.8	1.6	5.8
Ghana (2014)	60.7	70.2	2.1	4.5
Cambodia (2014)	64.1	71.2	1.8	3.9
Malawi (2015)	75.2	78.7	1.5	2.3

The data are based on the demographic and health surveys, multiple indicator cluster surveys, and reproductive health surveys, all nationally representative surveys involving face-to-face interviews with women. The data cover eight RMNCH interventions: demand for family planning satisfied (modern methods); antenatal care coverage (at least four visits); births attended by skilled health workers); BCG immunisation coverage among 1 year olds; measles immunisation coverage among 1 year olds; DTP3 immunisation coverage among 1 year olds; children aged <5 years with diarrhoea receiving oral rehydration therapy and continued feeding; and children aged <5 years with pneumonia symptoms taken to a health facility.

* Calculated from year of latest survey to date earlier in the MDG era, varying by country and as early as 2000.