

Crafting National Programmes of Action to Achieve Health Equity—A Bold Approach for the SDG Era

Health equity programmes of action based on empowering participation and systematic approaches could notably accelerate progress towards health equity and the right to health.

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Income inequality is growing within countries,¹ fuelling both right-wing populism² and demands for progressive, inclusive policies. Global disquiet over inequality led the UN Sustainable Development Goals (SDGs) to promise “no one will be left behind.”³ Of all inequalities, health inequalities remain, in the words of Martin Luther King, Jr., the “most shocking and inhuman.”⁴ A defining challenge of our time,⁵ governments should adopt and rigorously implement national programmes of action to respond to health inequalities across multiple dimensions. Economic and social status must no longer be allowed to determine human health and well-being.

Aggregate health improvements [**Authors: could you briefly explain what aggregate improvements are**]⁶—that is, overall health improvements both nationally and globally—mask deep unfairness in the distribution of good health, both within and among countries. A baby born in a largely white, wealthy suburb of St. Louis in the United States can expect to live 35 more years than one born in a mostly black, lower-income suburb a few miles away.⁶ While people in the United Kingdom live an average of 81 years, those in Sierra Leone average only 52.⁷

Yet the dominant approaches to health remain inadequate to ameliorate inequalities. We have seen few actionable, inclusive national initiatives expressly designed to achieve health equity. Nor have international health institutions acted robustly on health inequalities. We risk continuing systemic neglect of health inequalities, putting at risk the SDG’s central promise.

We offer three key elements of a proactive approach. First, careful evaluation of health inequalities requires recognizing that limited progress was made under the Millennium Development Goal (MDG) strategy, which focused on improving aggregate health. Too little attention was paid to equity outcomes, resulting in failure to mitigate unfair distribution of good health. Second, we must measure what we value—investing the time, political attention, and resources to assess health disparities and set specific, actionable goals. Yet the SDG health-related targets, together with national plans, are framed primarily in aggregate terms,³ suggesting that reducing health inequities within countries is, at best, a goal secondary to overall health improvements, and [**Authors: can you suggest why framing these in aggregate terms is problematic**]. Third and most significantly, to turn understanding into action, we propose national health equity programmes of action developed through participatory processes—focusing on the full range of social and structural determinants of health to reduce inequalities within and among populations.

Health Inequalities Under the MDGs: Uneven Progress

The Millennium Development Goal (MDG) era saw accelerated health progress in target areas, saving millions of lives.⁸ The international community created innovative institutions, like the Global Fund. A goal that would have once seemed fanciful, treating 15 million people living with HIV/AIDS by 2015, was achieved.⁹ The MDGs, however, failed to articulate and implement targets through an explicit equity lens (see box 1).

Consequently, MDG evaluations often have used measurements of overall progress, thereby masking inequitable distribution.¹⁰ Reductions in HIV prevalence, for example, were relatively

rapid for the wealthiest 60%, while the poorest 40% made little gains.¹¹ In one study, the poorest 40% were doing worse than before on MDG health outcomes in one-quarter of 64 countries surveyed.¹¹

To underscore this point, we analysed data on key MDG targets relating to reproductive, maternal, newborn, and child health (see table).¹² While the MDGs cut child and maternal mortality nearly in half, progress narrowing gaps between wealthier and poorer populations has remained far too slow. Without changing approaches, many countries will not close core health equity gaps this century, much less achieve the commitment to leave no one behind by 2030.

Why the lack of progress? One reason is the absence of focus on equity. The aggregate nature of MDG targets and indicators, with a paucity of disaggregated data, thwarts understanding health inequities. A second reason is the complexity of health inequities, requiring action across numerous social determinants.^{13,14} In a world where siloed approaches to health have become common, intersectoral collaboration and action require a change in mindset. Third is the deeply-rooted, structural nature of the injustices underlying health inequities, from power and wealth imbalances to centuries of discrimination against populations who experience health inequities. And fourth, income inequality, a major determinant of health, is growing in nearly all the world's regions.¹⁵ Without taking explicit account of these structural factors, little progress will be made.

Yet we also learn from this era that substantial progress is possible. With its extensive primary health care network using a team-based approach to primary health care enabling wide coverage, along with women's increased access to education, Costa Rica has virtually no gap in skilled birth attendant coverage between women in the poorest and wealthiest quintiles [**Authors: can you briefly state how they did this? Did they take an approach similar to that you are suggesting?**].^{16,17,18} The Participatory Slum Upgrading Programme improved the lives of 22 million people living in slums across 35 countries; slums have multiple negative effects on health.^{19,20} Bolivia significantly reduced income inequality thanks largely to significant income growth among workers in the informal economy driven by a strong currency, cheap imports, and large minimum wage increases (applying to the formal sector but affecting informal sector wages), along with targeted social welfare programs [**Authors: can you briefly state what approach they used to do this?**].^{21,22}

Measuring What We Value

An impactful strategy starts with making oft-ignored health inequalities visible. If we measure what we value, and act on what we measure, then it would appear that the international community does not value health equity very much. While the SDG indicator for universal health coverage (UHC) encompasses interventions for both the general and most disadvantaged populations, the monitoring report omits data for the latter.²³ “Data limitations”—countries not collecting disaggregated data—preclude comparing the coverage “across different dimensions of inequality.”²⁴ [**Authors: what are these limitations? Are they real?**]

Disaggregated data [**Authors: could you provide a simple definition of disaggregated data?**] across sectors, monitored over time, are 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? Such data collection should not be limited to numerical metrics. Qualitative data are needed too to gain further insight into health inequality dimensions and causes, along with reasons why extant policies are succeeding or failing.

Disaggregated data can help target interventions—such as in Rwanda, with a focus on the most disadvantaged 25% of the population²⁵—and shift “success” measures within the health system to include improved equity. Existing surveillance capacities can enable governments to begin now 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 (e.g., disabilities, indigenous communities, and gender/ethnic/racial identity). It is important to link demographic survey data to health indicators, using sampling methods to fill data gaps.²⁶ SDG 17 includes a target of enhancing capacity for “high-quality, timely and reliable” disaggregated data, yet these data remain sorely lacking for reasons include the added cost coupled with insufficient funding, failure to include all relevant dimensions in survey instruments, and lack of training to identify sources of, analyse, and use of disaggregated data [**Authors: why is this the case?**].^{27,28} Development assistance for statistical capacity-building needs to at least double.^{29,30} [**Authors: do you anticipate that this would solve the problem?**]

There is no justification for the continued lack of attention to granular data on health inequalities. 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.

Health Equity Programmes of Action

Understanding the problem is not enough. The persistence of health inequalities, their gravity, and the injustices they reflect demand mobilization. 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.

We do not lack promising approaches and interventions to ameliorate inequity. UHC is central to achieving health equity, but only if it focuses explicitly on progressively eliminating geographic, economic, sociocultural, and gender barriers.³¹ Numerous interventions in the health, education, and economic sectors have been identified for action on social determinants of health.²⁰ Pairing data with human rights-based approaches has been shown to facilitate effective deploy resources to advance equity.³²

Yet the SDGs have not created mechanisms to translate promising approaches into action and there is, so far, little indication that governments have shifted towards active, comprehensive health equity planning.³³ Voluntary national reviews, presented every few years, have demonstrated a continued focus on aggregate health goals, with little attention on 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.³⁴ Yet while the assessment identified opportunities to reduce inequities (not specific to health), it did not plan for resolving them.³⁵ 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. However, even these neglect important determinants contributing to health inequities or all populations, and largely lack specificity regarding actions.³⁶

We therefore propose governments develop and implement *health equity programmes of action* to plan concretely on rigorous implementation of effective strategies.³⁷ Programmes of action could be stand-alone or, better still, integrated within health and development planning. We use the term “programmes of action” to emphasize the importance of concrete steps, and to show the possibilities of integrating actions into existing strategies or plans, nationally but also sub-nationally.

Whatever the exact form, action programmes would establish explicit targets, a costed set of actions, and a time-bound accountability framework for improving health equity, moving beyond the 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 to address both biomedical and social determinants. Action programmes must be adequately and sustainably funded, buttressed by high-level political support. To align with human rights norms, programmes of action should be developed through highly participatory approaches, work towards substantive equality, and establish accountability, with clear targets and timeframes for progress.³⁸

We propose seven key principles (see box 2 for illustrations).³⁹ First, and absolutely central, the programmes of action should be developed through inclusive processes that empower marginalized populations and include them in leadership positions in the mechanisms that develop them. In planning to reduce health inequities, it is vital for governments to fully engage diverse communities experiencing disadvantage and ensure marginalized populations a central role in decision-making, including leadership positions. Actions should build capacities for meaningful participation, and be based in the realities of populations living in situations of vulnerability.⁴⁰

Second, the programmes of action should aim to maximize health equity. Setting the express goal of maximizing health equity, programs of action would include time-bound benchmarks on the path towards full equity. This requires actions on structural determinants including discrimination, political exclusion, and skewed distribution of and control over resources.^{13,41}

The next two principles relate to the systematic nature of the programmes of action. They should encompass both the health sector and other sectors, encompassing the full range of social, environmental, economic, commercial and political determinants of health, with genuine collaboration across sectors,⁴² the third principle. And the fourth principle is that they should comprehensively identify all populations experiencing health inequities, analysing underlying factors, and proposing policies to narrow inequities, with additional research as needed. Actions

would address causes shared across populations (e.g., unaffordable or inaccessible health care) and those specific to particular populations (e.g., migrants' exclusion from equal rights to health services, education, and other benefits, challenges of providing services to remote rural communities).

The final three principles relate to what is required to ensure that the programmes of action are indeed implemented. They should be action-oriented, with specific policies and programmes to be developed and fully implemented, accompanied by targets and timelines, all integrated into each sector's strategies – the fifth principle. Sixth, they should include a comprehensive suite of measures to ensure accountability, Official and independent reporting on progress, fully transparent and bolstered by joint external evaluations, would be supported by disaggregated data, a vital aspect of judging success. Public health equity dialogues could provide opportunities for policymakers to answer directly to the public. Accountability mechanisms could be as diverse as village health committees, parliamentary hearings, access to courts, and health impact assessments. Seventh and finally, programmes of action need sustained high-level political commitment to succeed. Political commitment is required for successful intersectoral action, coordination, and implementation. A supra-ministerial committee could oversee intersectoral action, with leadership from heads of government.

A Call to Action

Progress in health equity can serve as an organizing principle, a bellwether of global action and a powerful response to today's most pronounced political currents. That requires moving health equity to where it belongs—at the centre of health and development agendas. Inequities that remained through the MDG era underscore the importance of the SDG promise to leave no one behind. The coming years can be, and must be, different. But several years already into the SDG era, transformational health equity action planning remains absent. Concerted action of this kind, however, is what the extent, complexity, persistence, and injustice of health inequities require. This begins with the basics: gathering data to make today's inequities visible, and setting specific targets on all the dimensions of health inequities.

Health equity programmes of action could be a powerful tool for organizing and planning a strong path forward. These require empowering participation, precision, and accountability, with robust political and financial backing. International coordination is necessary because transnational factors (e.g., climate change, migration, trade) contribute to inequities. Programmes of action could drive multi-sectoral action for better health for so many 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.⁴³

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

- Overall, progress towards national health equity was limited during the MDG era, with vast inequities continuing.
- Significant and 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 programs of action hold considerable promise as a powerful vehicle towards health equity, creating an immediately implementable systematic and systemic set of actions for governments and other actors to undertake.

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