



GLOBAL HEALTH EQUITY



Health for some is not good enough. An equitable opportunity to be as healthy as possible is necessary for all.

THE ISSUE

Global health equity means everyone having the opportunity to be as healthy as possible. It rests on every last person having access to essential health services across the entire spectrum of care, with optimum quality, when and where they need it, without financial difficulty, **and regardless of their socio-economic status, where they live, and any other personal characteristics (e.g., disability, age).** Global health equity is paramount to making Universal Health Coverage a reality.

Yet, systemic barriers — both visible and invisible — affect the health outcomes of the poorest and most marginalized populations, increasing their risk of suffering from diseases, health conditions, and mental health issues:

- At least 15,000 people in low- and middle-income countries (LMICs) die each day due to their lack of access to healthcare.¹
- The difference in life expectancy between high- and low-income countries is 19 years.²
- 94% of all maternal deaths occur in LMICs.³
- In the United States, Black mothers have a 2.5x greater mortality rate than White mothers.⁴

Up to 70% of individual health outcomes are due to social determinants of health⁵ such as education and literacy level, access to decent housing, the ability to afford enough and nutritious foods, and the ability to earn an income. **Health inequalities are driven by colonialist, patriarchal, biased, and discriminatory systems and structures** that drive inequitable policies, budgets, infrastructures and services, and a chronic lack of disaggregated data.

In times of crises, health inequalities are magnified. This has been made exceedingly clear during the COVID-19 pandemic. The impact of the COVID-19 varies depending on intersecting factors of vulnerability to the infection and access to vaccines.

- 10% of people in low-income countries have received at least one dose of a COVID-19 vaccine v. 80% in high-income countries (HICs).⁶
- Women, ethnic minorities, and LMICs have been the hardest hit by growing inequalities during the pandemic.⁷
- The wealth of the 10 richest men in the world has doubled, while the incomes of 99% of humanity are worse off because of COVID-19.⁸
- Even before COVID-19, the life expectancy of Black Americans was far less than their White counterparts. 3.4 million Black Americans would be alive today if their life expectancy was the same as White people's, rising from an already alarming 2.1 million prior to the pandemic.⁹

WHAT'S AT STAKE

Health systems are weak and have been overwhelmed by COVID-19.

The pandemic has been a brutal reminder of lack of adequate investment in health systems across the globe. However, with under-funded and under-prioritized healthcare systems and insufficient investment in human resources the most devastating impacts of COVID-19 have been in LMICs. This has exacerbated challenges faced by the poorest and most marginalized populations in accessing health services. Movement restrictions, transportation costs, distance to access services, language barriers, lack of health insurance, lack of access to digital technologies, and discrimination have proven to be key barriers to accessing both essential health services as well as COVID-19 tests and treatment.

There is a chronic lack of investment in social protection programs.

The economic aftershocks of COVID-19 have highlighted the inadequacy of social protection programs, such as cash transfers, for those who need it the most but who are often invisible to governments or systematically excluded, including informal workers and undocumented migrants. Around 55% of the world's population have no, or inadequate social protection, especially in Africa where 80% of people are not covered.¹⁰

The social protection response to the pandemic has also been very uneven. Africa provided the lowest levels of coverage at 2% for cash and 5% for cash and in-kind measures combined. The health needs of the poorest and most marginalized increased — due to bad nutrition and lack of access to water and decent housing, among other reasons — but they were not able to access health services for financial reasons or other barriers.

Civil society and communities remain excluded from decision making.

Civil society organizations (CSOs), including community-based organizations, are often the lifeline of the most marginalized and excluded groups who are being left out of governments' systems and donors' strategies. They contribute to a range of health system functions, from service delivery to monitoring quality of care and responsiveness.¹¹ Their role in supporting communities in the pandemic has been vitally important. Yet, CSOs serving the most impacted groups have largely been excluded from national and global pandemic responses and recovery, including in the Access to COVID-19 Tools (ACT) Accelerator (ACT-A) and the Pandemic Treaty negotiations. Even more blatant is the exclusion of vulnerable and marginalized communities in decisions that directly affect them, both at the country and international levels. As a result, there is a critical lack of data on the most at risk groups, which further compounds their invisibility in health funding and programming and social protection packages.




The pivotal importance of community health workers in LMICs is overlooked.

Community health systems play a unique role in enabling hard-to-reach and marginalized groups' access to healthcare, including in times of crisis. Community health workers (CHWs), in particular, have contributed to reducing inequities relating to geography, gender, disability, and discrimination. During the pandemic, they played a key role in maintaining the delivery of essential services and delivered COVID-19 prevention and treatment.

However, community health systems remain under-funded and under-prioritized in health financing and the centrality of CHWs in health systems is overlooked. For example, CHWs are not integrated within health care systems; they are not remunerated, supervised, or provided with ongoing training. Donors are also reluctant to invest in community health system delivery. For example, the ACT-A's Health Systems and Response Connector pillar does not acknowledge community systems strengthening and community-led responses to COVID-19 as an integral element of the health systems.¹²

Women are not at the table.

Women and girls have been disproportionately affected by COVID-19, as they are in any crisis – whether it be war, a natural disaster, or a health emergency. Women make up most of the global health workforce (70%) and dominate CHWs' numbers. As a result, they have unique knowledge and experiences of the lived realities of marginalized groups. At the same time, they are at higher risks of contracting infections, such as COVID-19. Yet, global health governance continues to be led by men, with women holding only 25% of leadership roles in health.¹³ As a result, women are largely excluded from national COVID-19 taskforces. Ultimately, responses to the pandemic have been gender-blind and inadequate given the disproportionate impacts of COVID-19 on women.



“The pursuit of health equity is widely held to be global health's *raison d'être*; and yet, the deep inequities laid bare by the current pandemic underscore that the field must do more and we must do better.” ¹⁴



RECOMMENDATIONS

Achieving equity in global health requires a collective approach that reaches across sectors, communities and countries, with health and social justice at its core. The pandemic has underscored the need for equity to be at the center of the global health agenda to ensure that the most marginalized and excluded have access to essential health services. It has also highlighted the need to re-think the global health equity agenda to focus on the foundational causes of health inequalities.

The U.S. Government and other donors must:



SCALE UP financing for health systems strengthening, especially at the community level. We must ensure that hard-to reach populations and those whose health outcomes are influenced by financial and socio-economic obstacles are able to access the healthcare they need. Ensuring all people have access to quality health services, when and where they need it, without suffering financial hardship, must be the overarching objective that drives global health assistance.



ENSURE THE MEANINGFUL PARTICIPATION OF CIVIL SOCIETY AND AFFECTED COMMUNITIES in global health governance to better understand marginalized and excluded populations' needs and identify gaps in current health systems. This is paramount to creating equitable health budgets, policies, and programs that address the intersecting and multi-layered levels of health disparities. In order to achieve health equity, we must break down the obstacles — such as poverty, discrimination, and stigma — that continue to adversely affect those who are marginalized and unable to access care.



INVEST IN CHWs, which should be provided proper accreditation for their work and remunerated. As funding and policy decisions are made, key affected populations must play a leading role in developing the solutions that will work best in their unique community contexts. Therefore, they should be at the heart of healthcare program planning because they have the field experience to make the most effective and community oriented programmatic decisions.



INCLUDE WOMEN as key representatives in global and national health decision making processes, including in pandemic response and recovery teams. Women's voices must be heard, respected, and prioritized to properly respond to the health, social, and economic welfare of the poorest and most marginalized populations.



IMPLEMENT A MULTI-SECTORAL AND INTEGRATED APPROACH TO GLOBAL HEALTH that addresses the gender and socio-economic drivers of health inequalities and focus on equitable outcomes for health, including through pro-equity social protection measures.

Join us in working to achieve equity in global health.
To learn how, visit: www.globalhealth.org



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