Breaking down the barriers to health equity

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In 1985, the World Health Organization (WHO) European Region published the document 'Targets for Health for All', defining 38 targets which the 32 member states had unanimously determined to complete by the year 2000.[1] A major theme of this document was that 'health for all implies equity', and in its first target it recognized that reducing differences in health status between and within countries requires improving the health of disadvantaged populations. Margaret Whitehead's widely known publication commissioned by WHO, 'Concepts and Principles of Equity and Health', later described health inequities as measurable differences in health profiles, which are not only 'unnecessary and avoidable, but in addition are considered unfair and unjust'.[2] Another proposed definition of healthy inequity is the presence of systematic health disparities between groups holding different positions within a social hierarchy. Braveman and Gruskin[3] Health equity demands that all people in a society must have the ability to achieve good health, in the absence of obstacles constructed by artificially established social, economic, demographic, or geographic inequalities.

Importantly, health inequity is not synonymous with health inequality. Health inequality refers to differences or disparities in health in a mathematical or measured sense, while inequity incorporates a moral and political component.[4,5] Health inequalities may result from the presence of a natural, unavoidable, biologic condition, whereas inadequate access to health care services is avoidable and unfair and thus would be an example of a health inequity.[2,5] From a health care services standpoint, horizontal equity requires that no differences in services are present where health needs are equivalent, and vertical equity implies that greater health services are provided where health needs are greater.[6,7]

For decades, a growing number of organizations, governments, and other private and public institutions, similarly to the WHO, have described commitments to eliminating inequities in health care.[4] Yet, the COVID-19 pandemic exposed the existence of brutal health disparities and their associated structural components, both among groups in different countries and within individual regions and nations. These inequities are evident at every level, from testing interventions[8] and health data documentation[9] to disease outcomes[10,11] and vaccine availability.[12]

Moreover, policy interventions designed to mitigate COVID-19 transmission have themselves exacerbated inequities.[13] Glover *et al.* developed a conceptual framework which identified numerous consequences of COVID-19 policies in both high- and low-middle-income countries, such as school closures contributing to increased food insecurities[14] and quarantine of urban informal settlements leading to reduced sanitation, overcrowding, and violence.[13,15]

Inequities in health are not limited to COVID-19, but likewise complicate other infectious diseases, multi-morbidities, maternal and perinatal health, mental and emotional conditions, and any other conceivable health state. Contributors to health equity are boundless and extend into social, political, economic, and cultural domains. Access to health care facilities may be hindered by geographical distance, lack of transportation, employment requirements, or confinement due to incarceration, refugee status, or political factors. Health care knowledge and awareness may be obstructed by language barriers, literacy, cultural differences, or limited access to technology (the 'digital divide').[16] Chronic illness progression may be affected by insurance status, food insecurities, or environmental conditions such as air pollution, lack of green and blue space, housing conditions, and access to shelter.[17,18] More blatant assaults on human rights also represent health inequities, such as female genital mutilation,[19] forced sterilization,[20,21] and prohibiting

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access to immunization for vaccine-preventable disease.[22,23]

Breaking down the barriers to achieving health equity begins with identification and acknowledgement of the issues and inciting factors, not only by society in general, but also within medicine. Evidence suggests that medical school programmes do not routinely place high emphasis on education regarding health inequities, while students from programmes that do include this training in their curricula have self-reported greater knowledge of social determinants of health.[24] Although more medical schools are devoting resources to diversity, equity, and inclusion via student interest groups and committees, the medical community at large will not advance their understanding in the absence of true integration of health equity education and quality improvement into graduate medical education.[25,26]

In addition, a better research agenda must be set. This can be accomplished by accepting uniform terminology, taking advantage of previously developed conceptual frameworks, defining key variables, elucidating the effects of various forms of influence, recognizing elements unique to specific populations, and distinguishing individual and combined effects of multiple forms of stress and discrimination.[6,27] Until more recently, limited studies directly focused on the impact of structural drivers of health disparities.[26,28] Yet, the frequency of the phrase 'health equity' appearing in medical literature has increased considerably in the last several years, reflecting growing scientific interest in this area. Finally, beyond education and research isolated to medicine, developing partnerships with individuals within communities is crucial, such as through community-based participatory research (CBPR).[29–31]

In this special collection of *Therapeutic Advances in Infectious Diseases*, the health equity research agenda will be expanded by examining contributing factors, key measures and manifestations, and related interventions. The objective is to deliver a high-quality description of the current state of health inequities as well as the mechanisms required to eliminate them. As the last 40 years have shown, change does not happen organically or through stated commitments alone. Explicit action needs to be taken, and causal pathways between determinants and health must be delineated in order for successful interventions to occur. It is with these tools that we can begin to dismantle the structures bolstering inequity within our communities, governments, and health care systems, and ultimately achieve health for all.

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