

# Health Equity Programs of Action: Towards Health Justice

**BRIEFING PAPER**



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# Introduction

In countries around the world, the life expectancies of residents of different neighborhoods – perhaps only miles apart – may differ by 10 years, 20 years, even longer. Certain populations – people who are poor and people living with disabilities, religious and ethnic minorities, indigenous peoples, and many others – may see similar dramatic differences in their chances to live long and healthy lives. Feeding into these patterns of inequity, the rates of different diseases – diabetes, tuberculosis, and many others – may be three, four, five – or even hundreds of – times higher in some segments of the population.

These realities represent extreme violations of social justice and the right to the highest attainable standard of health. The severity of these injustices has mobilized global commitments. Under the Millennium Development Goals, considerable progress was made on overall health levels. But this aggregate progress masked continued – and in some cases worsening – inequalities. Many people are living longer and better lives, but in some countries, some groups made no progress, or even lost ground.

Recognizing this, world leaders made equality a key consideration when moving to the Sustainable Development Goals.<sup>1</sup> A focus on health equity stands to serve as the central organizing principle for achieving this aim and organizing national action across the SDGs' 17 goals – for all SDGs are linked to health, with most among the social determinants of health.<sup>2</sup>

The SDG commitment to leave no one behind itself builds on a decade of global declarations, reports, frameworks, and resolutions calling attention to health inequities and committing to action – for example, the report of the WHO Commission on Social Determinants of Health and the Rio Political Declaration on Social Determinants of Health – and in recent years, an emerging set of WHO frameworks and tools to tackle health inequities. Recognizing the imperative of health equity, following on their commitments, and drawing on these resources, many countries are taking action to reduce health inequities.

Addressing health inequities requires national mobilization – involving all sectors, engaging and attentive to the overlapping and diverse needs of all populations who experience health inequities, and enabling marginalized and disadvantaged populations to be at the center of the response. A disjointed, piecemeal approach will fail. Health equity requires inclusive, empowering, rights-based, and systematic approaches that address the deepest structural drivers of inequities and respond to the priorities of people experiencing health inequities. We offer here just such as an approach: health equity programs of action.

Health equity programs of action would stand out for their singular, systematic focus on reducing health inequities for each population experiencing them, bringing to the center of national policymaking the concerns and rights of all people who face discrimination or other remediable circumstances that preclude them from equal opportunities at good health. These programs of action would build on well-accepted principles and approaches, such as participation, the social determinants of health, and monitoring and evaluation, but would go beyond – for instance, with marginalized and disadvantaged populations among the leadership of those driving these programs of action, addressing deep structural drivers of health inequities, and including a comprehensive suite of accountability measures.

National health plans and strategies, national development strategies, SDG strategies, or social inclusion strategies developed in line with these principles could be vehicles for developing health equity programs of action. Such programs of action could – and should – also be developed at local levels.

## Key principles

Health equity programs of action would ascribe to seven principles that, collectively, could be transformative:

1. *A People's Plan: Empowering Participation and Inclusive Leadership:* Foundational to health equity programs of action is how they should be developed, with a leading role for people experiencing health inequities in every aspect of developing these programs of action, from establishing their priorities to monitoring and revising them. Such participation in health-related decision-making is their right.<sup>3</sup> The process must ensure an opportunity for marginalized and disadvantaged populations to be part of decision-making processes, participating as equals – and indeed, to have their perspectives and priorities privileged. They should be part of the leadership of all structures associated with the programs of action. This empowerment through the process of developing health equity programs of action would itself constitute a redistribution of power, chipping away at one of the deepest determinants of health, the inequitable distribution of power in society.<sup>4</sup>
2. *Maximizing Health Equity:* Health equity programs of action would aim to achieve the maximum possible progress towards full national health equity. Health inequities are typically a product of many years, perhaps centuries, of discrimination, so they cannot be speedily abolished in their entirety. It may take years, even decades, to achieve health justice, even with sincere national commitment.

Yet true health equity is what social justice and human rights require. Towards this end, health equity programs of action would address a comprehensive set of health issues – health inequities in areas as diverse as death and injury from violence, pollution, maternal mortality, and infectious diseases. They also need to address deep structural determinants of health inequities, such as systemic discrimination, political exclusion, and lack of control over resources. And since ending health inequities will require the greatest possible understanding of these inequities, programs of action would be based on evidence and should include a robust agenda for gaining further understanding, including enhancing data disaggregation, building monitoring and evaluation into programs intended to reduce these inequities, and targeted research.

3. *Health Systems and Beyond: All Social Determinants of Health:* Health equity programs of action would contain actions to respond to the full range of factors leading to health inequities, both inequities related to health care, such as a lack of health workers to serve marginalized and disadvantaged communities and reduced access to health facilities in remote communities, and those beyond the health sector. Addressing the full range of determinants of health – social (including cultural), environmental, economic (including commercial), and political – adds greatly to the potential impact of health equity programs of action. Commitment from within and outside the government, with coordination and collaboration across sectors and stakeholders, will

be necessary too. The agenda will be ambitious – prioritization will be needed – but the comprehensive scope is required to achieve health equity and meet countries’ human rights commitments.

Resources and energy could be focused on determinants where the most rapid and significant progress towards health equity is possible, yet without neglecting structural determinants that may take longer to remedy. To help ensure sustained action, health equity could be incorporated into the mandates of each sector, relevant indicators established, and health equity impact assessments regularly conducted.

4. *Every Population Counts:* A defining feature of health equity programs of action is that they would identify and encompass all populations who are impacted by health inequities. They would include but go beyond addressing common metrics of inequity and marginalization, such as low income and little education, and populations who receive particular attention for other reasons, perhaps historical (e.g., indigenous populations) or based on specific international norms (e.g., people with disabilities, following the Convention on the Rights of Persons with Disabilities). They would include these populations, but also any other population experiencing health inequities. The programs of action would be attentive to shared obstacles to health equity, such as social and political exclusion and low income, and to those particular to specific populations. Including groups that might otherwise be overlooked in planning processes is one of the motivating ideas behind health equity programs of action, which would seek to ensure that truly no one is left behind – and that everyone can advance towards long and healthy lives together. Responding to the needs of each marginalized and disadvantaged population to achieve health equity is central to the core human rights principle of non-discrimination, encompassing all forms of discrimination, whether intentional or the result of history, direct or an unintended result of apparently neutral policies, and in the public or the private sphere.<sup>5</sup>
5. *Actions, Targets, and Timelines:* Health equity programs of action would provide for specific actions to be taken, accompanied by timelines for these actions, and timebound, measurable targets. The programs of action should also be costed, and integrated into budgets for each sector. And they should identify the parties responsible for each action. The programs of action should also incorporate the priorities that marginalized and disadvantaged populations themselves have expressed.
6. *Comprehensive Accountability:* Accountability for health equity programs of action must be robust. Monitoring and evaluation would include reports from both the government and independent entities. These reports should draw on many sources of information, including input from civil society and marginalized and disadvantaged populations, and should include analyses of shortcomings and recommendations for improvements where benchmarks and targets are not being met. National health equity dialogues could enable members of the public to directly engage policymakers.

Further, programs of action should include a comprehensive suite of measures to strengthen health accountability at all levels of government. These could include, for instance, operational village health committees, complaint mechanisms, community scorecards, mobile phone technology, health rights education for the public, improved access to courts, ensuring the right to information, and legislative hearings. Measures should also include capacity building and support for civil society, and for individuals

and communities experiencing health inequities, to enable them to hold governments and other responsible actors accountable, both through advocacy and by their being full participants in, and having leadership roles in, health accountability mechanisms. Actions and indicators included in the health equity programs of action should be integrated into each sector as relevant, with those responsible for carrying out these actions made clear.

7. *Sustained High-Level Political Commitment:* The health equity programs of action should have high-level political commitment and leadership, from local to national levels. Only with such commitment will they successfully guide policymaking and resource allocation throughout the government. Political commitment could be based on factors as diverse as the promises of the SDGs and obligations of human rights, economic returns of health investments, and the fact that people’s marginalization and disadvantage may increase their risk of contracting infectious diseases, which pose a health risk for the entire population. This level of political commitment will require key government actors and entities to be full participants in the process of driving and developing health equity programs of action.

### Health Equity Programs of Action: Through National Health Plans, Development Strategies, and More

Health equity programs of actions could be developed through and incorporated into national health plans, particularly where these plans extend beyond the health sector, or into national development or social inclusion strategies. These would provide space for the fullest implementation of the health equity program of action principles, though countries could choose to focus on health systems and certain other determinants of health that are judged to be priorities, rather than on all social determinants. Provinces (states) and municipalities often have considerable authority and scope for action in health and its determinants, and are well-positioned to develop their own health equity programs of action. In addition, these principles could – and should – be incorporated into other health plans, such as those that are disease-specific. While those plans would not incorporate every element of these principles – such as covering all health issues – they could incorporate most elements.

## An Implementation Framework

The O’Neill Institute for National and Global Health Law has developed a guide, *Health Equity Programs of Action: An Implementation Framework*, that expands on these seven principles and on how countries or local jurisdictions could implement them, including the processes of and complexities in crafting these programs of action. With this focus on locally- and nationally-owned processes, and an emphasis on inclusive participatory processes that prioritize the perspectives of populations experiencing health inequities, the guide is not directive as to specific strategies that countries should take to improve health equity. When countries or other jurisdictions develop

health equity programs of action, though, local, national, regional, and global evidence on specific approaches to improving health equity – successes and failures, overall and for specific segments of the population – will be vital to consider.

Since these programs of action may typically be created through existing processes, such as those used to develop a national health plan or development strategy, the guide is organized around these seven principles, which could be incorporated into the relevant steps in developing such a plan or strategy. These include, among a number of others ways in which these principles would be incorporated, how members of populations experiencing health inequities could participate in the entities developing health plans, including their leadership; ways in which health inequities would factor into situational assessments conducted as part of developing health plans, including systematic assessments of each social determinant of health and each population experiencing health inequities; how the perspectives and experiences of marginalized and disadvantaged populations would be taken into account in determining plans' priorities and actions, with the guide offering possible processes, and; how the plans might be monitored as part of ensuring robust accountability and the centrality of populations experiencing health inequities.

The guide is available through: <http://oneill.law.georgetown.edu/projects/tuberculosis-law-and-human-rights-project/health-equity-programs-of-action/>

## Intended audiences and uses

The following are among the main intended audiences of the implementation guide.

*Policy makers (including political leaders, ministry officials, legislators, governors, and mayors):* Health equity programs of action would help governments carry out their highest obligations, providing for the health and welfare of all of their people. By focusing on the needs of marginalized and disadvantaged populations, governments can help bring about more inclusive – and hence more stable and prosperous – societies, benefitting all. Health investments frequently have very high economic returns, including through increased productivity and greater economic growth.<sup>6</sup> This should be especially true for marginalized and disadvantaged populations, for whom the potential gains for health and productivity are the greatest. By identifying priorities through an intersectoral, multi-stakeholder, evidence-based approach, these programs of action should help governments direct their resources in ways that have the greatest impact on the health and well-being of their populations. They would help governments live up to their SDG promise to leave no one behind – as well as their commitment to universal health coverage – and bring coherence to the array of goals and targets in the SDGs. The programs of action would also contribute to other government priorities, whether in health, education, employment, or other areas, that require addressing marginalization and the people who are being left out.

Along with national action, we also encourage municipal, district, and provincial (state) policymakers to develop health equity programs of action for their jurisdictions to advance health equity locally. Furthermore, policy innovations often take place at these lower levels of government, and could serve as models for elsewhere.

*Communities experiencing health inequities:* The most direct benefits of health equity programs of action would flow to the people experiencing health inequities. They can also be the most important advocates for developing them.

The programs of action would move their health and well-being nearer the center of the policymaking agenda, and help lead to the tools, mechanisms, and information that should help keep it there, such as new or strengthened structures for accountability, health equity impact assessments, and disaggregated data. These communities would have, perhaps for the first time, a central role in the policymaking process. Their realities, their perspectives, and their priorities would be the foundation of policies. They would have the proverbial seat at the table – and indeed, in partnership with government, at the head of the table.

*Civil society:* Civil society organizations that are committed to the rights and well-being of marginalized and disadvantaged populations would see their missions advanced through these programs of action – particularly in light of the range of marginalized and disadvantaged communities that health equity programs of action would address, along with their multisector nature. The programs of action could lead to more resources and a more enabling environment for organizations working directly with these communities, and should also lead to clear commitments and targets that facilitate accountability, empowering civil society efforts in this area. Ensuring accountability for these programs of action would make use of civil society organizations' many capacities, as they contribute their expertise, help hold governments accountable, and join in health equity programs of action development and follow-up accountability mechanisms. As with populations experiencing health inequities, civil society organizations can advocate with their governments to develop these programs of action.

*Service providers:* Health equity programs of action should contribute to the efforts of people who directly serve communities experiencing health inequities – as health workers, teachers, social workers, lawyers, and so forth. The programs of action are likely to provide them greater resources and create an enabling policy environment in which they can better serve the people with whom they work. Service providers may, as certain elements of these programs of action are implemented, gain additional skills that enable them to more fully live up to the creeds of their professions, particularly regarding service to all. Further, service providers do not always have a voice in policymaking despite their skills and firsthand experiences; health equity programs of action would provide space for their participation.

*Development partners:* Development partners would likely participate in developing, and may support implementing, health equity programs of action. These partners would have many of their own goals and commitments advanced through these programs of action, for health and for other sectors. The comprehensiveness of health equity programs of action could help enable them to more effectively prioritize their activities, including so that they are more fully based on the priorities of marginalized and disadvantaged populations. The specific actions, targets, and timelines of these programs of action would contribute to mutual accountability. And development partners may be able to use lessons from these programs of action to advance their missions.

Development partners could catalyze health equity programs of action by providing funding to lower-income countries to develop them, and offer financial support for their implementation. They could also encourage countries to develop these programs of action through their program and funding guidelines.

# Endnotes

- 1 United Nations General Assembly, “Transforming Our World: The 2030 Agenda for Sustainable Development,” UN G.A Res. 70/1, September 25, 2015. [http://www.un.org/en/ga/search/view\\_doc.asp?symbol=A/RES/70/1](http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/1).
- 2 WHO Secretariat, “Contributing to Social and Economic Development: Sustainable Action Across Sectors to Improve Health and Health Equity (Follow-up of the 8th Global Conference on Health Promotion): Report of the Secretariat,” WHA 68/17, May 18, 2015. [http://apps.who.int/gb/ebwha/pdf\\_files/WHA68/A68\\_17-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_17-en.pdf).
- 3 Committee on Economic, Social and Cultural Rights, “General Comment 14, The Right to the Highest Attainable Standard of Health,” U.N. Doc. E/C.12/2000/4 (2000), at para. 11. <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm> (accessed August 23, 2017).
- 4 WHO, Innov8 Approach for Reviewing National Health Programmes to Leave No One Behind: Technical Handbook (Geneva, WHO: 2016). <http://apps.who.int/iris/bitstream/handle/10665/250442/9789241511391-eng.pdf> (accessed August 17, 2018).
- 5 Committee on Economic, Social and Cultural Rights, “General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights (Art. 2, Para. 2),” U.N. Doc. E/C.12/GC/20 (2009), at paras. 8, 10, 11. <http://hrlibrary.umn.edu/gencomm/escgencom20.html> (accessed July 19, 2017).
- 6 Dean T. Jamison, Lawrence H. Summers, George Alleyne, Kenneth J. Arrow, Seth Berkley, Agnes Binagwaho, et al., “Global Health 2035: The World Converging Within a Generation,” *Lancet* (2013) 382(9908): 1898-1955. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)62105-4/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62105-4/fulltext).