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Introduction to the Special Issue, Part 1: Advancing Health and Equity: Best Practices in an International Perspective

Special Issue Part 1 Editor

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Introduction

Health equity is about ensuring that populations across the globe can attain the highest level of health and wellbeing irrespective of need. Inevitably there are differences in health performance across and within countries and regions. Some of these health differences are unavoidable, depending on genetic differences at birth and varying health performance over time. The elderly can hardly expect to enjoy the same good health as younger populations (Braveman 2014).

However, health inequities are cause for concern. Health inequities or disparities may arise according to a specific economic, social, or environmental disadvantage (US Department of Health and Human Services 2008). Such differences may occur when an individual or a group of individuals face obstacles to attain good health owing to their racial or ethnic group, socioeconomic status, gender, age, and so forth. Obstacles might also arise because of diminished mental health, cognitive or physical disabilities, geographical location, or historical disadvantages. Health inequalities are often driven by differences in environment; income or housing; differences in health behaviors, such as smoking, drinking, diet, physical activity; and psycho-social factors, such as social networks and self-esteem. Finally, unequal access or negative experience of health services can also generate inequity in health performance (US Department of Health and Human Services 2008).

But discrimination and exclusion can also prevent individuals from attaining a good level of health and wellbeing. In the USA, and many other developed nations, it has been found that racial and ethnic minorities still suffer from poorer health status and health outcomes for many diseases and illnesses than the average. These include chronic diseases such as diabetes, cardiovascular disease, but also cancer and end-stage renal disease (Williams, Walker, and Egede 2016).

A study conducted by the Institute of Medicine (IOM) examined variation in health performance according to race and difference in relation to access to healthcare services. While these differences tended to decrease when socio-economic differences were taken into consideration, they still existed. When looking at clinical encounters, it found that stereotyping,

bias, and uncertainty led to disparities in the provision of health care. It thus reported that awareness of these disparities and effective solutions to deal with these inequities were essential. Subsequent research has worked on identifying disparities, understanding the determinants, and intervening to reduce those disparities (Institute of Medicine 2003).

Central to the aim of achieving a high standard of health for all is equal supply of health care. However, depending on the country or region of supply, this might imply ensuring equal use of health services for equal need, equal use of health services according to willingness to pay for that use, equal health outcomes for equal merit, or equal health care payment by people according to ability to pay. So, in some ways, the interpretation is normative and thus based on individual or collective value judgements. This ambiguity or the normative framework relating to achieving health equity may lead to resources not being employed for the intended purposes (Morris et al. 2012).

Beyond healthcare provision, equity in health should address economic and social disadvantage. Individuals may have a low level of material resources or opportunities and so they may not be able to acquire the resources (goods or services) to ensure good health. Residing in a poor neighborhood can put individuals at a disadvantage in terms of pollution, other environmental harms, lack of economic opportunities, and so forth. Such social, economic, and environmental disadvantages will inevitably have an impact on health and wellbeing.

So, attempts to reduce inequities or disparities in health performance must take a holistic approach to health looking at the wider disadvantages. Resources to ensure that everybody can enjoy good health, therefore, go beyond the domain of medical care and should be employed to help promote healthy living and working conditions.

The legal framework within each country can also help ensure equity in health. Most countries have ratified human rights legislation and treaties that set forth principles to eradicate health disparities. These treaties set forth common and fundamental rights to health for all populations irrespective of the status of the individual living in those countries. Specifically, they underline the importance of equality: that everyone has the right to the "enjoyment of the highest attainable standard of physical and mental health" (UN 2002). Human rights principles in international law also call for the removal of obstacles to good health, beyond the provision of health care, including in education, transportation, and other areas that can impact healthy living. Human rights legislation also upholds the principle of non-discrimination. States should oppose any policies or practices that discriminate against certain social groups (Williams, Walker, and Egede 2016).

However, in practice, limited resources and unintentional policies, processes, or structures may well lead to discrimination or uneven access to healthy living or health care. Sometimes, it may be difficult to identify and measure health equity, and to distinguish between inequity (unfair differences in health performance) and inequality (inevitable differences).

At a micro-level, Mate and Wyatt (2017) make five key recommendations for addressing health inequity in communities. First, they recommend that health equity be addressed by leaders of health and social care provision. The strategy of reducing health inequity should

be driven from the top. Second, sufficient structures and processes need to be developed to support equity. This should include the necessary financial and information resources but also a clear governance structure. Third, specific action needs to be taken to address the social determinants of health. The root cause of health disparities needs to be identified in communities and tackled through concrete actions to close the gap. These actions may be employment initiatives, healthy choices opportunities, etc. Fourth, institutional racism within organizations needs to be monitored and dealt with because, as we have previously identified, this is often a driver of poor health, intentional or unintentional discriminatory care practices, and implicit bias on the part of patients or staff. Finally, partnering with community organizations is a key factor in ensuring more equal health among the population. If health care and community organizations work together to address health equity in the local population, it can lead to a massive reduction in health inequalities.

Williams, Walker, and Egede (2016) also suggest a number of solutions to reduce the gap in health performance, which include 1) developing standardized race measurements within and across health systems; 2) implementation of more effective population-based health interventions; 3) aiming at more diversity in the workforce; 4) supporting technological advances that further equity in supply of health and social care; and 5) developing initiatives such as personalized medicine to ensure greater health equity.

Despite a number of initiatives to reduce inequities in health and disparities in the United States and across Europe, these gaps continue. Access to universal health but also a solid welfare system, which is lacking in many developed countries but notably the US, is essential in addressing these disparities beyond the local initiatives. In the US, out-of-pocket expenses and health insurance status play an important role in the widening of health inequalities. This has partly been addressed by the Affordable Care Act of 2010 and globally via the UN General Assembly resolution for high-level political commitment. But universal access to health care needs to go further.

Finally, health inequalities have also been reported to have widened since the outbreak of the COVID-19 pandemic. Exploring the theme of equity and health care seems all the more appropriate given that long-standing systemic health and social inequities have put many racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19. Some health systems can provide more equity in health provision than others. Therefore, at the heart of our analysis in Part 1 of this Special Issue is the exploration of social justice in terms of ensuring good health and delivering health care across both more and less advantaged socioeconomic groups.

The articles in Part 1 this Special Issue thus present some of the most advanced practices that aim at achieving equity in health and wellbeing. In Russo and Williams' Participatory Action Research Study, the authors underline how integrative medicine, which tackles the primary causes of most chronic disease is intended to treat patients regardless of their ability to pay, via non-profit federally qualified health centers. These centers also promote health equitably across communities by combining integrative medicine practices with community

health center-sponsored group interventions. Strange's paper describes how transdisciplinary approaches across the academic and professional fields during the pandemic have helped advance health and equity in health and social care delivery. Finally, Martin and Sibbald's contribution looks at how patient engagement can improve the provision of equitable care for patients who suffer from Chronic Obstructive Pulmonary Disease. The authors present a review to determine how patient engagement can help patients self-manage the disease, how such engagement can ensure equitable care and identify best practices. Finally, Strange's paper describes how transdisciplinary approaches across the academic and professional fields during the pandemic have helped advance health and equity in health and social care delivery.

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