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Quality and equity: a shared agenda for universal health coverage

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INTRODUCTION

'Health equity' or 'equity in health' implies that everyone should have a fair opportunity to attain their full health potential. The COVID-19 pandemic has reinforced how far we are from attaining health equity with subpopulations experiencing: differing COVID-19 exposure risks, vulnerability and access to prevention and treatment services; differing health outcomes; and differing socioeconomic impacts of both (a) pandemic control measures and (b) illness and convalescence. For health equity to exist there should be an absence of unjust, avoidable and remediable differences in health across populations.[1] Endeavouring towards health equity, Target 3.8 of the Sustainable Development Goals (SDGs) focuses on achieving universal health coverage (UHC)—meaning everyone can access necessary health services of sufficient quality to be effective without experiencing financial hardship.[2] The 2030 Agenda for Sustainable Development and its SDGs has as a cross-cutting principle the concept of 'leaving no one behind'.[3] This commitment is reaffirmed in: the United Nations UHC political declaration; the World Health Assembly Resolution 69.11, which calls for 'health system strengthening for UHC, with a special emphasis on the poor, vulnerable and marginalized segments of the population'; and the zero draft of the WHO CA+, an international instrument on pandemic, preparedness and response that has equity as a guiding principle.[4–6] Global commitments have brought a welcome focus on equitable service access and effective coverage, based on a primary healthcare (PHC) approach but for this to be achieved attention must also be given to equity in the quality of services being used, particularly by the most disadvantaged subpopulations. Quality of care is 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge'.[7] Equity has been consistently highlighted as a key quality dimension alongside safety, effectiveness, people-centredness, efficiency, timeliness and integration.[7] Attention to equity as a key dimension of quality is critical for successful resilience and recovery, as well as for ongoing preparedness and response to health threats. In this commentary, we examine the interplay between equity and quality and explore actions that can be taken to address and strengthen their shared contribution to the goal of health for all.

SUMMARY BOX

- ⇒ An intentional focus on addressing quality of care through an equity lens could trigger a transformational change in the way health services are delivered, leading to better universal health coverage and a reduction in health inequities.
- ⇒ Equitable health services provide care that does not vary in quality on account of age, sex, gender, race as a social construct, ethnicity or indigeneity, geographical location, religion, socioeconomic status, migrant status, disability, language, sexual orientation, political affiliation or other factors.
- ⇒ Delivery of equitable quality care necessitates an understanding of the complex interplay of factors influencing a person's health and their experience of healthcare services.
- ⇒ Primary healthcare-oriented health systems are organised and operated to guarantee the right to the highest attainable level of health as the main goal, while maximising equity and solidarity.
- ⇒ Equity-oriented health information systems and barrier assessments can identify factors that influence suboptimal quality of care, which is disproportionately experienced by disadvantaged subpopulations, and inform the development of health policies and services that address inequities.
- ⇒ A national strategic direction on quality of care as part of reorientation of health systems towards a primary care approach provides a key entry point for provision of equitable services.

THE INTERPLAY BETWEEN EQUITY AND QUALITY

Equitable health services should provide care that does not vary in quality on account of age, sex, gender, race as a social construct, ethnicity or indigeneity, geographical location, religion, socioeconomic status, migrant status, disability, language, sexual orientation, political affiliation or other factors. They should respond to the varying health needs, both expressed and unexpressed, of all subpopulations, as well as their differing social circumstances. Thus, equity as a quality dimension goes beyond access and financing. Equal access to healthcare does not equate to equal treatment outcomes if the quality of care received is inequitable, failing to take account of the diverse needs across populations. Delivery of equitable care necessitates an understanding of the complex interplay of factors influencing a person's health and experience of healthcare services. This in turn requires appreciation of health inequities generated by health system deficiencies and supply-side bottlenecks, as well as those which arise from the wider determinants of health—the conditions in which people are born, grow, live, work and age and which are controlled by other sectoral domains.[1] The impact of structural discrimination must not be overlooked. Structural discrimination is in itself a social determinant of health; discrimination modulates other determinants by activating exclusionary dynamics across political, economic, cultural and social domains.[8] Social determinants influence risks for ill health, health-seeking behaviours, access to healthcare and positive treatment outcomes, as well as trust in and acceptance of healthcare systems, providers and treatments. The differing needs of subpopulations must be considered when designing and delivering health services as the quality of healthcare experienced is determined by how well an individual's needs are met. A perspective that takes intersectionality into account is necessary as the compounded discriminatory and oppressive impact of overlapping pathways generating inequities must be recognised if it is to be addressed. Illustrative equity orientated actions that encompass quality of care domains and impact health outcomes are given in table 1. While far from an exhaustive list, the case examples demonstrate how a focus on the nexus between health service quality and equity can achieve improvements in population health.

ADDRESSING INEQUITY IN RECEIPT OF QUALITY HEALTH SERVICES

The authors advocate using the entry point of quality of care as a mechanism to help ground equity in everyday healthcare services planning and delivery. A nationally led multi-level whole system commitment is essential, requiring country level contributions by all actors, including government, public and private health service providers, communities, civil society, research institutes and multilateral partners. Development of a National Quality Policy and Strategy (NQPS) is a pragmatic framework for countries to start taking action on equitable health service provision (figure 1). The WHO has developed a *NQPS Handbook* and offers technical assistance to support strategic direction-setting for quality at country level.[9 10]

Ultimately, health systems have the power to be at the forefront of efforts to address health inequities. PHC orientated health system strengthening can serve to enhance both service quality and address structural discrimination, as effective PHC tackles the root causes of poor health, embodies social justice, engages in intersectional and multisectoral approaches, and empowers communities.[11] Indeed, PHC-oriented health systems are health systems organised and operated so as to make the right to the highest attainable level of health the main goal, while maximising equity and solidarity. The strategic and operational levers identified in the WHO-UNICEF Operational Framework for Primary Health Care offer concrete entry points for actions to address discrimination, promote intercultural care and enable delivery of equitable high-quality healthcare.[12]

In implementing UHC, the adoption of progressive universalism is required in the roll-out and expansion of services to ensure they benefit disadvantaged populations at least as much as they benefit better-off populations. Effective delivery of both PHC-oriented health systems strengthening and progressive universalism requires health system actors and policy makers to be aware of and understand the inequities in access to quality healthcare that exist. Collection of data disaggregated by socioeconomic, spatial and demographic factors known to differentially affect health outcomes and linkages across data sets is necessary. Equity-oriented health information systems can enable monitoring of health inequalities in terms of service coverage, morbidity and mortality, and detect inequities in inputs (eg, health personnel, medicines, devices, basic amenities) and responsiveness. In addition, barrier assessments can facilitate identification of factors that influence suboptimal quality to which subpopulations experiencing disadvantage may be disproportionately exposed and can inform the development of health interventions and policies that address health inequities.[13] Mixed-method approaches can be employed to explore barriers in relation to the following, for example:

- Availability—for example, lack of availability of appropriately skilled health workforce, necessary equipment, health products; lack of same sex provider for certain services
- Accessibility—for example, financially inaccessible services, geographically inaccessible services, service information provided in formats inappropriate for the heterogeneity of the local population; inaccessible service opening times and systems to schedule appointments.
- Acceptability—for example, service design does not account for cultural beliefs about health and illness; limited connectivity/integration of health services with indigenous/traditional health systems; lack of

Table 1 Illustrative actions to support equitable provision of quality health services

Illustrative actions to support equitable provision of quality health services	Quality domains implicated	Case examples
Health services should address the disproportionate risk of physical and mental ill health experienced by marginalised subpopulations through responsive reconfiguring of service delivery models for successful prevention and management of disease	Effective People-centred Timely Integrated	**Outreach screening for marginalised populations:** Systematic household-based and mobile outreach tuberculosis (TB) screening can address the geographic and financial barriers to access, reduce stigma and increase patient awareness. Earlier diagnosis can improve health outcomes and lessen the socioeconomic impacts of TB, for example, decreased work absence and reduced earning loss.[16] For example, one Nigerian state has integrated outreach TB screening with COVID-19 screening and vaccination; done in non-stigmatising ways, this has been successful in overcoming healthcare access barriers but also in building trust within communities for increased service uptake[17]
Language and literacy needs should be accounted for to enable effective communication for accurate diagnosis and dissemination of treatment advice	Safe Effective People-centred Timely Efficient	**Use of interpreters and translators:** Evidence shows that use of medical translators improves patient safety, quality of care and health outcomes for people who do not speak the same language as their health and care worker and at limited additional cost.[18 19] In the UK, the National Health Service (NHS) Act 2006 states that NHS England, 'in the exercise of its functions, must have regard to the need to reduce inequalities between patients with respect to: their ability to access health services; and the outcomes achieved for them by the provision of health services'.[20] Guidance is available to support local commissioners of primary care services when commissioning translation or interpreting services[21]
Health workers should be aware of how physical and mental health problems may present, manifest and respond to treatment differently due to biological and social factors and be able to manage patients accordingly	Safe Effective People-centred Timely Integrated	**Sex-specific clinical education, guidelines and research:** Among females, myocardial infarction accounts for one-third of all deaths globally and has worse outcomes and higher mortality than in males.[22] Reasons for this disparity include male-biased clinical research and insufficient awareness by health professionals of sex-specific symptoms and presentation of cardiovascular disease (CVD). The Lancet Commission to reduce global burden of cardiovascular disease in women by 2030 recommends the development of educational programmes on CVD in women for healthcare professionals.[22] Sex-specific clinical recommendations for primary prevention of CVD in women have been produced by the American College of Cardiology.[23] The European Union is committed to addressing sex and gender inequalities in research and innovation and provides methodological tools for sex, gender and intersectional analysis and case studies on how these can be applied in the field of health[24]
Intercultural care and integration of public and private (including non-governmental organisations, voluntary, community and social enterprise organisations and traditional medicine) health sectors should be used to help people navigate the patient pathway to access quality care	Safe People-centred Timely Efficient Integrated	**Integration of traditional medicine and intercultural care into national and local health systems:** The WHO established a Global Centre for Traditional Medicine, responsible for creating an evidence base for policies and standards on traditional medicine practices and products and supporting countries to integrate it as appropriate into their health systems and regulate its quality and safety for optimal and sustainable impact.[25] There are examples of intercultural care interventions to improve quality of maternity services and address health inequities including: The Australian Queensland government's 'Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy 2019–2025' which prioritises creation of an ethnically representative maternity workforce with culture competence delivering services codesigned with communities; and the Pan-American Health Organisation's culturally safe childbirth tool and manual to guarantee the safety of childbirth for indigenous women[26 27]
The health system should account for and be responsive to life circumstances and adverse living and working which influence service use and pose barriers to accessing health and care services. Patients should receive the required social support to facilitate effective access to health services, across the full continuum of care	Effective People-centred Efficient Integrated	**Integrated health and social care:** People experiencing homelessness face a range of barriers to effective service access and also tend to have greater health needs, largely influenced by social determinants of health. In recognition of this, the Neunerhaus non-governmental organisation in Austria worked to address the needs of people experiencing homelessness through integrated social and healthcare.[28] By providing health and dental care, housing and counselling in the neighbourhood of homeless shelters, Neunerhaus focused on addressing exclusion and achieving sustainable improvement in social conditions that influence health
Attention should be given to preventing the negative impact of corruption on equitable access to health services (eg, informal payments, stockouts of public sector medicines due to drugs being sold on the black market, etc)	Safe Effective Timely Efficient	**Minimising corruption risks in COVID-19 vaccine roll-out:** Corruption risks in some settings threaten to impede whole population access to safe and effective COVID-19 vaccines necessary for pandemic control. Corruption threats include substandard and falsified vaccines, vaccine theft, leakages in emergency funding designated for the development and distribution of vaccines, nepotism, favouritism and corrupted procurement systems.[29] There is an evidenced nexus between corruption and governmental and health sector performance.[30] The WHO supports countries to focus on anticorruption, transparency and accountability in national health policies, strategies and plans[31]

Continued

Table 1 Continued

Illustrative actions to support equitable provision of quality health services	Quality domains implicated	Case examples
At the point of delivery, healthcare must be devoid of discrimination and stigmatisation, including in relation to racism, classism and sexism, known to detrimentally affect provider behaviour and decision making	Safe Effective People-centred Timely	**Decolonisation of medical education and diversification of the workforce**: Decolonisation, diversity and inclusion, antiracist and human-rights based approaches offer potential entry points to addressing discrimination at the point of healthcare delivery.[32] The Joint United Nations Statement on ending discrimination in healthcare settings highlights areas for targeted action.[33] An example of action at health workforce level is decolonisation of medical education by the Northern Ontario School of Medicine. The school reserves places for indigenous applicants, delivers core modules on indigenous health, provides a 1-month residency programme whereby students live and work in indigenous communities, and promotes activities associated with advocacy and public health of indigenous communities[11]
Social participation platforms should be in place for codesign, decisions on coimplementation, and comonitoring and evaluation of health services and action on social determinants with communities	Safe Effective People-centred Efficient Timely Integrated	**Participatory processes for health decision making and service delivery:** WHO has published a handbook and toolkit on social participation to support stakeholders to meaningfully engage with the population, communities and civil society.[14 34] Thailand's National Health Assembly's 'People Sector' has reportedly motivated, enabled and empowered communities to engage with the health policy-making process.[14] Health mediation programmes are one example of implementation of social participation tools. In Romania, The Roma Health Mediation Programme appointed Roma specialists to develop its training. The role of mediators included facilitating communication between patients and clinical staff; advising on bureaucratic processes with the Roma population to ensure their medical assistance; and conducting community work with Roma to encourage prevention in healthcare and to improve access to the healthcare system[34]

age-appropriate and gender-transformative service delivery; discriminatory treatment by providers; lack of confidentiality.

- Effective coverage—for example, inadequate treatment adherence as a consequence of: unclear instructions, poor patient–provider relationship, mismatch between treatment prescribed and patient compliance ability; lack of service provider support to ensure patient follow through with timely referral.

To ensure equitable access to quality healthcare across all subpopulations healthcare services and their providers must be responsive to their needs, as outlined in table 1. Meaningful social participation of subpopulation groups in the development, implementation and evaluation of health services, including leadership in quality improvement activities can be a progressive step to achieving this ambition.[14] Integration of compassion throughout the healthcare system and at all interfaces can also play a facilitative role. There is evidence that compassionate leadership enables a culture of improvement and innovation and ultimately improves quality of patient care.[15] Introduction of indicators of compassion into performance-based finance schemes and supportive supervision checklists may also increase healthcare quality and address health inequities.

CONCLUSION

To successfully achieve ambitions to deliver quality or equitable healthcare, attention must be given to both.

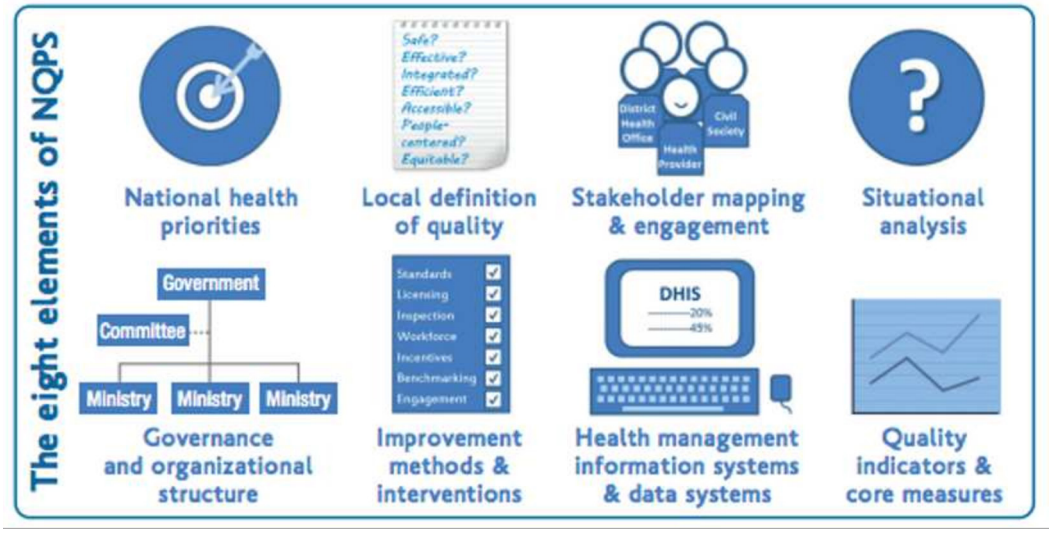

Figure 1 The eight elements of NQPS. Source: WHO NQPS Handbook, 2018.[9] NQPS, National Quality Policy and Strategy.

Table 1 demonstrates how equity orientated approaches help deliver on the dimensions of quality and highlights that actions are required at facility, community, regional and national levels. A collaborative effort from all stakeholders across the system (including decision makers, data analysts, healthcare providers, community groups and patients) with an intentional focus on addressing quality through an equity lens could trigger a transformational change in the way healthcare services are delivered, leading to better UHC, improvements in population health and a reduction in health inequities. Tools and approaches exist for integrating equity into national strategic direction on quality of care (figure 1) and this also provides a key entry point for national and subnational dialogue on provision of equitable services based on a PHC approach. By aspiring to quality and equity, stakeholders across the healthcare system can overcome key barriers to the global ambition of UHC.

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