EQUITY IN HEALTH POLICY ASSESSMENT: REGION OF THE AMERICAS

PAHO

Pan American Health Organization

World Health Organization

REGIONAL OFFICE FOR THE Americas

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ABBREVIATIONS

COVID-19	coronavirus disease of 2019
ISI	import substituting industrialization
LGBT	lesbian, gay, bisexual, transgender
PAHO	Pan American Health Organization
PASB	Pan American Sanitary Bureau
SDG	Sustainable Development Goal
SDH	social and environmental determinants of health
UHA	universal health access
UHC	universal health coverage
WHO	World Health Organization

SUMMARY FINDINGS

Employing a 10-category analytic rubric designed for the investigation, this study assessed the content of 32 national health plans currently in effect in Latin American and the Caribbean to report on whether and how countries are integrating the achievement of health equity into strategic lines of health sector action. Meant to provide a snapshot of the advance of the Region of the Americas as of 2019, the study found that much of the attention to health equity in the Region is focused on aspects like statements of commitment to health equity and monitoring and disaggregation of data to track inequalities, while elements of health equity like the identification of populations in situations of vulnerability, the design and operationalization of accountability mechanisms, and collaboration with and regulation of private sector health providers receive noticeably less attention. Significant subregional differences in the emphasis on community participation in policy design and monitoring and on private sector engagement were also noted. Finally, an analysis of municipal health plans in Panama and Uruguay demonstrated that subnational entities can indeed surpass national plans with regard to depth of attention to themes like the social determinants of health.

Although this report is primarily descriptive, study findings are discussed in light of factors that influence policy-making in the Americas, for example,decentralization, structural adjustment, and corruption, and recommendations are made for policymakers to accelerate strategic actions to achieve health equity. Among the recommendations are suggestions to generate further evidence and analysis on the processes by which vulnerabilities are created; promote the redirection of budgets toward evidence-based policies and programs and away from those that may result in negative consequences with regard to inequalities and access; and promote efforts to institutionalize and educate citizens, residents, and migrants on the existence and use of accountability mechanisms to address violations of the right to health.

INTRODUCTION

Health Inequalities in the Americas

The 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs) are premised on the overarching aim of "Leave No One Behind," and include developing equity-focused targets and indicators for economic, social, and political inclusion under SDG Goal 10; gender equity and equality under SDG Goal 5; and health under SDG Goal 3, with target 3.8 referencing the achievement of universal health coverage, including access to quality essential health care services and essential medicines and vaccines.[1] In no region of the world is this both more urgent or more promising for transformative change than in the Americas, which is consistently characterized as one of the most inequitable in many aspects of development and well-being, including with respect to health.

Accordingly, Member States of the Pan American Health Organization (PAHO) have agreed on health equity as a priority within the Sustainable Health Agenda for the Americas 2018–2030, running in alignment with the SDGs. The Agenda establishes 11 regional goals and 60 targets toward the achievement of the "highest attainable standard of health with equity and well-being" and requires the collaboration of signatory countries, the Pan American Sanitary Bureau (PASB), and other partners, as well as the development of subregional and national plans to facilitate the achievement of goals and targets by 2030.

Regional Concern with Health Equity

In response to regional and international mandates to address health inequities and inequalities and national processes of democratization and decentralization, countries of the Americas have increased efforts to reform health systems and to improve access for and provide targeted services to groups in situations of vulnerability. Annual reports on progress toward achievement of the SDGs show that, prior to the outbreak of the coronavirus infection of 2019 (COVID-19) pandemic, many countries of the region were reporting and demonstrating moderate improvements in health and well-being indicators, more stable improvements on measures of gender equality, and were lagging in addressing social and economic inequalities (*1*), with the bulk of region's countries scoring in the mid-range on the SDG Index (*2*).

As the COVID-19 pandemic broke in early 2020, many countries were immediate in their circulation of pro-health equity policies and initiatives meant to ensure that groups traditionally considered to face vulnerability due to race, ethnicity, sexuality and gender

1 The achievement of health equity is also implicated in SDG Goal 17 (target 17.18), which calls for strengthening the means of implementation and revitalizing the global partnership for sustainable development through increased international support for "national plans to implement all the sustainable development goals … enhance capacity-building support … to increase the … availability of high-quality, timely and reliable data disaggregated by income, gender (sex), age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts." (SDGs)

identity, disability, poverty, and/or geographic location (*3*) were targeted for screening campaigns or provided increased access to testing and services.

For example, once the World Health Organization (WHO) declared the pandemic in March of 2020, some countries focused their COVID-19 emergency policies almost exclusively on addressing issues of discrimination and exclusion. This response included providing for dedicated transportation to testing for suspected cases of COVID-19 and issuing guidelines on reducing barriers to access based on ethnicity, mental health, pregnancy and lactation status, incarcerated and otherwise institutionalized populations, the homeless, the elderly and people with disabilities, and migrants, for example. Others also approved laws to ensure specific attention for populations in situations of vulnerability (though these groups were generally unnamed).

Some emergency policies and laws more strongly emphasized the economic impacts of COVID-19 by legislating the provision of emergency subsidies to citizens and/or the funding of extraordinary measures to increase social protection to cushion the economic impact of the quarantine and possible illness on groups deemed vulnerable, including reinforcing social safety nets.

Finally, most countries also decreed the institution of telework and distance education until further notice. Some countries made arrangements to increase access to educational curricula by making these available not only online but also by radio and television to address Internet access barriers that differ between regions and between neighborhoods in larger cities. These decrees were carried out with the support and, in cases, the creation and government approval of separate and complementary COVID-19 policies or amendments issued by or under the responsibility of ministries of education, labor, and social development. Ministries of transportation and tourism were and continue to be central to the response.

Though the success of the implementation of these policies has been varied (*4*), pro-health equity policy actions seen during the COVID-19 pandemic demonstrate that many countries in the Americas take seriously their mandate to ensure "health for all." That said, it is clear that the COVID-19 pandemic and response will, in most cases, reverse gains made in several of the SDGs in the short term and probably longer. The *Sustainable Development Report 2020* concludes that the pandemic will have highly negative impacts on SDG 3, health and well-being, and SDG 10, reduced inequalities, due to the disproportionate health and economic impact of confinement and the disease itself on populations in situations of vulnerability (*2*). And, as evidenced by a 2020 joint report by the Economic Commission for Latin America and the Caribbean (ECLAC) and PAHO on the COVID-19 response, "in order to both control the pandemic and reopen the economy, States must demonstrate effective and dynamic leadership and stewardship through national plans that incorporate health, economic and social policies" (*5*).

Countries' Commitments to Health Equity

The commitments made in response to the outbreak of the coronavirus infection echo those detailed in the Sustainable Health Agenda for the Americas 2018–2030, These are operationalized in PAHO Member States' definition of equity as one of the programmatic foci to be mainstreamed into all the Organization's technical work, alongside other equity-related themes, including human rights, gender, and ethnicity—the Organization's "cross-cutting themes." These cross-cutting themes are a call for all work at PAHO to be predicated on the achievement of health equity, and on the understanding that the right to health and related human rights, as well as gender and ethnic equality, are essential to its achievement in the Region of the Americas. In fact, Member States have also concretized their commitments in their approval of health equity focused PAHO Strategic Plans for 2014 through 2019, and again from 2020 to 2025. The latter includes, for the first time, an impact indicator on reduction of in-country inequities in health.

However, understanding of the ways in which health equity is being operationalized in diverse and concrete ways by governments of the region to meet these commitments is limited, due partly to diverse definitions of what these initiatives should look like, as well as the frequent perception of health equity as a value and an aim, rather than a coherent approach. Only limited research has been undertaken to evidence how health equity as a discrete objective is being operationalized, compared to the attention to and research on the other equity-related cross-cutting themes of gender, ethnicity, and human rights. This therefore creates difficulties in comparing equity efforts between and among countries and regions, although there have been significant efforts to monitor the health equity related determinants and, to a certain degree, outcomes.

As part of these efforts, the PAHO Independent Commission on Equity and Health Inequalities in the Americas was set up in 2016 by the PAHO Director. Its report, Just Societies: Health Equity and Dignified Lives, looked to governance and policy as engines to progress on the social determinants of health and reduce structural inequalities, the "power relationships in society" (*6*) toward social and economic development, and encouraged multisectoral governance approaches involving health and nonhealth, public and private sectors, as well as civil society, community, and citizens (*6*). The Commission recommends the undertaking of assessments of all policies and supporting the development of action plans to address its recommendations.

Objectives and Premise of the Study

The objective of this document is to provide an overview and to describe the current policy environment of countries in the Americas with regard to the integration of health equity concerns and approaches.

This study is formulated on the premise that the public health sector (ministry, secretariat) is the entity responsible first and foremost for results in health equity and inequalities. It additionally is based upon the premise that the health sector, itself a complex of individuals, public and private health services, and health policies, also plays a significant role as a social institution affecting equity not only in health but also in social and economic equity more broadly.

Thus, public sector health plans are an ideal starting point for inquiry on health equity at the national and even subnational levels, as these documents are the culmination of a planning process that: defines national health problems, documents needs, and surveys the availability of resources to meet the needs identified; establishes priority goals that are realistic and feasible; and projects administrative action to accomplish the agreed purpose *(7)*.

This study employs content analysis to examine how countries have envisioned the strategic actions needed to implement their national health policies through the publication of national health plans. Similar content analysis and systematic reviews of national health plans in the Region have assessed: the gender sensitivity of national health plans (*8*); pandemic preparedness (*9*); and the incorporation of strategic planning standards (*10*). This is the first study to interrogate whether and with what depth health equity has been integrated into strategic lines of action as laid out in national health plans.

Just as health is impacted by where we live, work, learn, and grow, policies that influence the achievement of health equity are not confined to those emanating from the health sector. As noted by the PAHO Independent Commission on Equity and Health Inequalities in the Americas, many other sectors, including education, housing, labor, infrastructure, and the natural environment, drive health equity and can exacerbate or ameliorate the impacts of social and economic inequality. Although this analysis does include a focus on how national health policies and plans themselves grapple with this need for intersectoral action on the social determinants of health, it does not include an assessment of how health equity is incorporated into nonhealth sector plans. Future inquiries, however, could usefully explore how the full policy context operates together to produce a country's health equity status.

The analysis is also not forwarded assuming that plan implementation has occurred in complete alignment with the documented strategic lines of action analyzed here. Though intentions are an important element to action, the next phase of investigation will require a more rigorous approach to analyzing and evaluating the implementation of such policies. Future work should include a deeper engagement with the amendments, omissions, successes, and failures of health policies and measure which approaches and components have more or less impact on health inequalities over time.

Methodology and Limitations

This report relates the results of a desk review of active national health plans during the period of study, August 2019 through December 2019. Some plans may have since expired or have been updated. The length and duration of the national health sector plans assessed in this exercise vary across the countries included in the analysis, with the earliest beginning in 2005 (Honduras) and the longest periods in force spanning a decade or more (maximum 15 years). That said, the vast majority of health plans assessed were approved in or after 2010 (93%) and of these almost half (46%) were approved in the three years prior to the study. Because it could be suspected that plans approved before 2014 particularly may demonstrate less inclusion of health equity—as Regional mandates on health equity date mainly from that year to the present—this report includes a brief assessment of the findings on the integration of health equity into national health plans by differences in plan age to address this particular limitation of the overall main study.

Additionally, to assure the generalizability of findings, the study analyzed only health plans and policies. Health sector laws and other related health sector legislation were not included due to the obvious differences between policies, plans, and laws with regard to enforcement and the consequences of noncompliance. By excluding health sector laws from the analysis, the study necessarily omits the experiences of Canada,[2] Cuba,[3] and the United States of America[4] from this regional analysis.

The decision to conduct the analysis without these three pivotal countries also took into consideration the age of their main national health laws, as all were passed more than a decade ago, with the laws of Canada and Cuba dating from the mid-1980s. The acts of both Canada and the United States are also very specific to the provision of health insurance rather than to setting strategic lines of action for the entire health sector—as do the plans included in the analysis—rendering a fair comparison of these difficult to make. The exclusion of these three regional leaders from the analysis may have important implications for the conclusions made about the state of equity in the Region of the Americas. A brief analysis and discussion of the inclusion of health equity in the health laws in Canada, Cuba, and the United States is included as part of the report's conclusions.

2 Government of Canada. 1985. Canada Health Act (R.S.C., 1985, c. C-6). Available online at: https://laws-lois.justice.gc.ca/eng/acts/c-6/page-1.html#h-151436 Last accessed: 7 June 2020.
3 Cuba. 1983. Ley No. 41-83 de la Salud Pública. Available online at: http://www.parlamentocubano.gob.cu/index.php/documento/ley-de-la-salud-publica/ Last accessed: 7 June 2020.
4 Senate of the United States. 2009. Patient Protection and Affordable Care Act. HR 3590 EAS/PP. Available online at: https://www.hhs.gov/sites/default/files/patient-protection.pdf Last accessed: 8 June 2020.

Due to the nature of the data, the evaluation of these plans is qualitative and thus subjective to a certain degree. The authors have attempted to describe in detail the process of decision-making used to evaluate the plans, but it is true that qualitative assessments can differ from one person to another. The goal of this exercise, therefore, is not to rank countries against one another, but rather to provide a regional and subregional overview of where we are, and to use this information to plan strategic next steps for research and policy-making into the future.

Report Structure

The report is divided into four chapters. The first chapter will synthesize the methodology and findings of the analysis of health equity integration across the 32 countries included in the analysis. Chapter 2 will include brief, additional analyses of health equity integration into the selected health plans by subregion, as well as by the age of the health plans assessed. Chapter 3 is a review of the policy-making context in the Americas, with particular attention to extraregional actors and influences on policy content and planning. Finally, Chapter 4 proposes conclusions and overall recommendations for moving forward on health equity based on the findings presented in the report.

CHAPTER 1. METHODOLOGY AND RESULTS

Methods

In 2019, PAHO collaborated with the O'Neill Institute for National and Global Health Law (O'Neill) to carry out an analysis of the health equity focus of existing national health plans in the Region of the Americas. The analysis also included subregional health plans from two countries—Panama and Uruguay—chosen for their representation of low and high social and economic inequalities and gross domestic product, GDP. As noted above, those countries not included in the analysis, including Canada, Cuba, and the United States, did not have one unified plan that would be comparable to the others assessed in this exercise. Health plans were collected through publicly available information and documents from ministry of health and municipal government websites in Panama and Uruguay, as well as through requests to ministries made by PAHO country offices. Thirty-two plans in total were collected and analyzed.

Definitions

Assessment of the chosen health plans required the creation of a set of criteria by which to compare health plans between and among countries. Through a process of consultation with experts at the Johns Hopkins University and review of literature and reports from both PAHO and O'Neill,[5,6] the team from the O'Neill Institute created an analytic rubric consisting of 10 categories. This rubric was validated by external experts and had the sole purpose of facilitating a systematic framework for this review, both reflecting existing knowledge about the full breadth of possible health equity components as well as components already reflected in policy documents.[7] Thirty-eight indicator questions (Table 1) were designed to incorporate all phases of the policy cycle, from consultation to monitoring and results evaluation. The subnational plans for Panama and Uruguay were assessed using a reduced rubric that included only the 10 categories without the 38 indicator questions, as it was postulated that subnational plans would reflect less detail than national plans. Because Panama and Uruguay are not federated countries, the subnational plans reflect central government implementation of their health plans in different regions.

The 10 categories or domains included in the assessment rubric were identified after a reiterative process of literature review, discussion and feedback with experts, and review of the current components of the different national health plans and policies and the ways in which they could be systematized in a relatively meaningful comparative manner.

5 PAHO. 2019. PASB and Health Equity: An Overview. PAHO's 2014–2018 Strategic Plan Mandates and Technical Cooperation. Office for Equity, Gender, and Cultural Diversity. Internal Document.

6 O'Neill Institute for National and Global Health Law, Health Equity Programs of Action: An Implementation Framework (January 2019). https://oneill.law.georgetown.edu/media/HEPA-Guide-1.pdf (accessed 21 November 2019).

7 As noted, this 10-item rubric was created for the sole purpose of carrying out this desk review. It should not, therefore, be understood as a formal normative assessment of countries' advances, given that any such future application would necessitate further development and approval by Member States.

Although future analysis may expand and shift these categories (as further analysis of health and nonhealth sectoral and national development plans reveal more nuance), those used for the current analysis are as follows:

1. Health equity as mission and vision

Health equity is "the absence of avoidable or remediable differences among groups of people, whether these groups are defined socially, economically, demographically or geographically" (*11*). The inclusion of equity as a mission emphasizes countries' aims to measure success by incremental achievement of increasingly more equitable health outcomes, at least at the national level, if not also locally. Equity as vision demonstrates that health equity serves to undergird the strategic lines of action defining the health sector's work over the period of the plan.

Equity has as its focus those at greatest social, economic, geographic, etc. disadvantage. According to the WHO, societies that have narrowed health inequities also have much higher overall levels of health: this suggests that further gains in average population health require that health equity is also improved ([*12*] in [*13*]). Thus, equity can act as an accountability mechanism for government efforts to improve health access and outcomes.

2. Social and environmental determinants of health

Explanations for observable health inequalities or disparities that reach beyond the biological mechanisms of disease transmission have, for the past decades, been encompassed under the rubric of the Social Determinants of Health (SDH). The WHO Commission on Social Determinants of Health, convened in 2008, summarized current directions in SDH research under three generalized theoretical frames:

1. *Psychosocial approaches* that emphasize the impact of "personal perceptions and experience of personal status in unequal societies" (*14*) as drivers of stress and poor health outcomes;
2. The *social production of disease/political economy of health approach* that includes inequalities but also emphasizes inquiry into the systematic economic and political policies that cause inequalities (*14*);
3. The *ecosocial approach* that is best summarized by Krieger's concept of embodiment by which "we literally incorporate biologically influences from the material and social world in which we live, from conception to death" (*14*).

Among the SDH used to measure health equity are: employment; poverty; language and literacy; safe water and clean air (environmental factors); and housing access and quality. Because addressing the SDH requires the coordination of many nonhealth sectors, a Health in All Policies (HiAP) approach to improving health "incorporate[s] health considerations into decision-making across sectors and policy areas" (*15, 16*).

3. Public–private partnerships

According to the PAHO High-Level Commission "Universal Health in the 21st Century: 40 Years of Alma Ata," to address the SDH, governments must increase oversight of the private sector to address challenges to universal access inherent in private sector profit motives (*17*).

4. Participatory processes

Historically, community participation for health equity has been limited mainly to discussions of health system administration and governance, but there is currently a move toward an expanded definition.

Community has been defined in various ways in the health development literature—as "a group of people living in the same defined area sharing the same basic values and organisation"(*18*); as "a group of people sharing the same basic interests" (18); and as "target populations or 'at risk' groups"(*18*). *Community participation* is currently defined as a "social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs"(*18*).

Not only has the definition shifted; the goals of community participation have also been defined in many ways over time. Past conceptions of participation relied on a model in which communities are homogeneous and "were able to agree upon health actions when professionals educated and supported their efforts" (*19*). In the 1990s and beyond, participation has been viewed under the banner of a series of participatory approaches, like Community Based Participatory Research (CBPR) and Participatory Learning and Action (PLA), that are meant to support beneficiary populations to "define, implement, monitor and evaluate programmes of their choice" (*19, 20*). Also at this time, participation became associated with and often times was proxied by the concept of empowerment (*19*) (and thus related closely to addressing structural inequalities).

There are few viable methods available to measure successful community participation. One proposal suggests defining "process indicators that show participation on a continuum of the major factors that influence participation—needs assessment; leadership; organization; resource mobilisation; and management" (*18*).

5. Equity toward universal health

Universal health indicates the co-dependence of the achievement of universal health coverage (UHC) and universal health access (UHA). The achievement of UHC indicates a health system's capacity to meet the needs of the population. UHC includes not only health personnel but also medicines and up-to-date technology as well as adequate financing: "… universal health coverage implies that the [health] organizational mechanisms and financing are sufficient to cover the entire population. Universal coverage is not in itself

sufficient to ensure health, well-being, and equity in health, but it lays the necessary groundwork" (*21*).

UHA is defined as "the absence of geographical, economic, sociocultural, organizational, or gender barriers. Universal access is achieved through the progressive elimination of barriers that prevent all people from having equitable use of comprehensive health services determined at the national level" (*21*). The expansion of UHA increases the need for States to prioritize access to health for groups in situations of vulnerability, ensuring that social conditions and health services are both physically accessible and socially and culturally acceptable for these populations. A focus on UHA includes actions to reduce legal and policy hurdles, physical barriers to access (e.g., distance for rural populations or provision of facilitated access for people with physical disabilities), and economic and social impediments raised by health personnel (e.g., racial/ethnic discrimination, homophobia). Universal health in the Americas differs from both that defined by the WHO and the SDGs in its focus on access to health as an integral element of health equity.

6. Targeted approach to health for populations traditionally considered to be at risk or vulnerable

The WHO *Conceptual Framework for Action on the Social Determinants of Health* (*22*) model gives "causal priority…[to] the structural factors" that include both the socioeconomic and political context and socioeconomic position, comprising social class, gender, and ethnicity (racism) that impact on health equity and well-being through a set of intermediate determinants or social determinants of health. These determinants encompass material circumstances like housing and neighborhood quality and consumption potential, psychosocial circumstances like stressors, and behavioral and biological factors like nutrition and tobacco consumption (*22*).

The institutional drivers of inequity are often grouped as "structural inequalities" (or, in health, structural determinants of health inequities) and their roots are to be found in discrimination and inequalities in power relations. For example, gendered race- and ethnicity-based bias against Afro-descendant and indigenous women and men in the Americas can be traced to the conquest and colonization of the region, which established social and economic structures, stratification systems, and mores exhibited in the post-colonial period through the socioeconomic hierarchy and social class relationships within the society (*6*). For example, despite increases in educational attainment over the past decade, employed Afro-descendant and indigenous women continue to be overrepresented in low wage and low prestige positions (*23*). That said, in fact, Afro-descendant women have the highest jobless rates among all groups in the region, followed for the most part by Afro-descendant men as compared with all other men across the region (*23*). Similarly, neocolonial relations between countries of the North and the South in which the economic system and political policy of sovereign nations—particularly countries of the South—is directed from the outside, may also be based or justified based on biases driven by racial or ethnic assumptions.

Structural inequalities influence health access and outcomes and are recreated and reinforced through institutions like the state, schools, policing and the criminal justice system, medical services and hospitals, the labor market, and religious traditions. According to the WHO, structural determinants are "the mechanisms [that] configure the health opportunities of social groups based on their placement within hierarchies of power, prestige and access to resources … operate through intermediate determinants of health [or social determinants] … to shape health outcomes …" (*22*). The WHO goes on to detail that the "most important structural stratifiers" (*22*) are income and educational inequalities, occupational segregation and wage gaps, classism, sexism, and racism/xenophobia. In addition to these, political systems, policy and macroeconomic environments, and culture and social values also act as structural determinants of health inequities.

7. Disaggregated data and targets

The literature provides strong evidence that health equity cannot be measured because equity is not easily compared between and among countries due to differences in how justice is viewed in different cultures and societies (*18*). Differences in health access and outcomes and determinants of health associated with lower social position are the usual proxy measures of equity. When measured quantitatively, inequalities in health are demonstrated through the analysis of both health data and social stratifiers, also called subgroup categories, that include, but are not limited to income, gender, age, race, ethnicity, migratory status, disability, geographic location, and other characteristics relevant in national contexts (*24*). Differences in these social stratifiers can be measured in many ways, both simple and complex, using either absolute or relative differences both between and within countries (*15, 25*) and at the national and subnational levels. No matter the measurement method used, reliable data, disaggregated by these common social stratifiers, are needed to form a clear picture of existing health inequalities and thus understand the magnitude of health inequity in a country.

8. Monitoring

Monitoring is the continual process of observation with the goal of detecting changes over time. Monitoring health allows for information on whether health is improving, worsening, or unchanged (26). Monitoring of health inequalities is the method by which health inequities are measured. The existence of health data (population-level, household, administrative, or other) stratified by indicators of equity like economic status, sex, geographic region, ethnicity and race is a prerequisite for monitoring health inequalities.

The PAHO Commission on Equity and Health Inequalities in the Americas recognizes routine monitoring of equity stratifiers and social determinants as a mechanism by which to measure the effectiveness of health systems and the consequences of policy implementation to hold governments accountable. These disaggregated data are also crucial to contrast effects across groups that may react differently to policies and social

change. The Commission concludes that "the most promising way forward appears to be to align these indicators with some of those recommended for monitoring progress on key SDGs, selected on the basis of their relevance to health equity."[8]

9. Accountability

State accountability for achieving stated health sector commitments is related closely with human rights and the right to health, as these commitments are not only spelled out in the constitution and national law and policy, but are also "enshrined in the international and regional human rights treaties [a State] ratifies"(*27*). Mechanisms for ensuring this accountability include State engagement with multiple actors, including civil society, professional organizations, and the private sector. When mechanisms or process for holding the State accountable are weak or absent, progress toward achieving is slowed, halted, and sometimes reversed.

10. Health system responses to health inequities

The health system, and its delivery of equitable health services, plays a central role with regard to the achievement of equitable outcomes through the delivery of health services that remove barriers to health and that respond to the right to health.

The right to health is a recognition of the rights of all to enjoy the "highest attainable standard of health" *(28)*. Health services that reflect the concept of right to health should include the following elements, defined by the circumstances of each country: (a) available; (b) accessible; (c) acceptable; and (d) must be of quality. The concept of the right to health is an essential component of health equity and includes equity of "distribution of healthcare resources" *(29)* (access) and equity of "outcome, quality of care and, chiefly, health status" *(29)*. Wide variations in differences in both access and outcomes are indicators of health inequities and violations of the right to health.

Research in this area supports the formulation of evidence based pro-equity policy and should both seek to evaluate whether the elements of the right to health—availability, accessibility, acceptability, and quality—are present in all health services across income and geography and proposes interventions to redress patterns of violations of this right (e.g., by ethnicity, gender, income, or geography). Studies should also include data collection and analysis not only of trends in access to health services but also in outcomes of treatment and health status differences by ethnicity, gender, income, geography, and other indicators of social and economic inequality.

8 The Report names 11 SDGs with specific target indicators whose disaggregation could be useful for monitoring equity: SDG 1, no poverty; SDG 2, zero hunger; SDG 3, good health and well-being; SDG 4, quality education; SDG 5, gender equality; SDG 6, clean water and sanitation; SDG 8, decent work and economic growth; SDG 10, reduced inequalities; SDG 11, sustainable cities and communities; SDG 16, peace, justice, and strong institutions; and SDG 17, partnerships for the goals.

Table 1. Health Plan Assessment Rubric

Health equity plan classification categories	Timeless questions	Indicators
1. Health equity as mission and vision	Is health equity included as part of the health plan's mission or vision?	
2. Social and environmental determinants of health	Does the national health plan address social and environmental determinants of health?	Does the health plan incorporate measures to improve underlying determinants of health (e.g., increasing access to nutritious food, safe water, improved sanitation, healthier environments)?
		Does the plan include financing models to incentivize health sector action on the social determinants of health?
		Does the plan include actions that the health sector is taking to respond to climate change?
3. Public–private partnerships	Does the health plan include any measures to address health equity in the private sector?	

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Table 1. Health Plan Assessment Rubric *(continues)*

Health equity plan classification categories	Timeless questions	Indicators
4. Participatory processes	Were any participatory processes/ mechanisms used to develop the national health plan?	Does the health plan refer to or describe a process in developing the plan that included public engagement, civil society engagement, or both?
		If yes, does the plan refer to specific outreach to or inclusion of diverse populations including populations in situations of vulnerability?
		If yes, did the process refer to the participation of nonhealth sectors in developing the plan?
	Does the national health plan include any participatory processes/ mechanisms for developing and implementing health policies and programs?	Does the health plan refer to the importance of public participation in developing and implementing and refer to specific mechanisms for public (or civil society) participation? If yes, does the health plan include any actions to support the functioning of these mechanisms (e.g., funding, training, outreach to marginalized populations)?

Health equity plan classification categories	Timeless questions	Indicators
5. Equity toward universal health	Does the national health plan include actions toward achieving equity within the health sector?	*Nondiscrimination* 1. Does the health plan incorporate or refer to a strategy to address discrimination in the health sector?
		Physical access 1. Does the health plan include at least one action (other than health workforce related) to increase accessibility to quality primary health services in remote, rural, or otherwise underserved geographic areas or communities (e.g., constructing facilities in these areas, mobile health clinics, telemedicine)? 2. Does the health plan include at least one action to ensure the accessibility of health facilities for people with disabilities?
		Health work force 1. Does the health plan include actions to increase the number of health workers in underserved communities to the health work force? 2. Does the health plan include any actions regarding recruiting people from underrepresented communities into the health work force, including management or other positions of authority?

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Table 1. Health Plan Assessment Rubric *(continues)*

Health equity plan classification categories	Timeless questions	Indicators
5. Equity toward universal health		*Health financing* 1. Does the health plan include interventions to increase health service affordability for disadvantaged populations (e.g., delinking health service use from costs for these populations, subsidies)? 2. Does the health plan include strategies to increase the equitable distribution of health funding (e.g., more funding to communities with worse health outcomes, more disadvantaged populations)?
		Health information 1. Does the health plan include any actions to increase health literacy of marginalized populations? 2. Does the health plan address language barriers to health services (e.g., interpretation services, health workforce recruitment from linguistic minorities)?
	Does the health plan include a goal of universal health coverage?	
6. Inclusion of populations in situations of vulnerability	Does the health plan consider specific populations in situations of vulnerability?	Does the health plan identify specific populations in situations of vulnerability who face extra obstacles to equal health? 1. Are Afro-descendants among the populations identified? 2. Are indigenous peoples among the populations identified? 3. Are Roma peoples among the populations identified? 4. Are people with disabilities among the populations identified? 5. Are members of the LGBT community among the populations identified? 6. Are migrants among the populations identified? 7. Are people living in situations of poverty among the populations identified? 8. Are other populations living in situations of vulnerability according to the national context among the populations identified?
		Does the health plan include specific actions to reduce barriers to good health for identified populations in situations of vulnerability?

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CHAPTER 1. METHODOLOGY AND RESULTS

Table 1. Health Plan Assessment Rubric *(continues)*

Health equity plan classification categories	Timeless questions	Indicators
6. Inclusion of populations in situations of vulnerability		Does the health plan refer to any actions to ensure that programs and services are differentiated to meet distinct gender responsive needs of women, girls, men, and boys?
7. Disaggregated data and targets	Does the health plan include collection of disaggregated data and use these data to set targets?	Does the plan include baseline data on health inequities across multiple dimensions (e.g., income, gender, age, race, ethnicity, indigenous status, migratory status, disability, geographic location)?
		If disaggregated data are included, does the health plan include data disaggregated by the dimensions included in target 17.18 of the SDGs (income, gender [sex], age, race, ethnicity, migratory status, disability, geographic location, and other characteristics relevant in national contexts)?
		Does the health plan include time-bound targets on reducing absolute or relative health inequalities in health service access (coverage) or in health outcomes?
8. Monitoring	Does the health plan include processes for monitoring progress in its implementation?	Does the health plan include any process for regularly monitoring and evaluating its objectives and targets?
		Has the health plan been made readily accessible to the public? 1. Is the health plan available online? 2. Does the health plan include any strategies for communicating the plan's contents to the public including members of marginalized communities
		Does the health plan include a role for the public/civil society in monitoring and evaluating the health plan's implementation?
9. Accountability	Does the health plan include mechanisms to redress violations of people's right to health?	Does the health plan include mechanisms for educating people on their right to health?
		Does the health plan include mechanisms for reporting right-to-health violations?
		Does the health plan include mechanisms for enforcing people's right to health?
		Does the plan include mechanisms for investigating and reducing fraud and corruption?

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Table 1. Health Plan Assessment Rubric *(continues)*

Health equity plan classification categories	Timeless questions	Indicators
10. Response to health inequities	Does the health plan include any actions on research to better understand and address health inequities?	

Scoring

The rubric was applied to each of the national and subnational health plans. Due to the potential of biases related to subjective assessments, PAHO and O'Neill performed some interrater reliability tests in which plan assessments were made by three reviewers, then results compared and discussed. This exercise was carried out on five national rubrics and three subnational rubrics using cases for which responses to the rubric timeless questions and indicators were equivocal (i.e., inclusion of health equity indicators was unclear), to arrive at a final coding of plans. After applying the rubrics using "yes/no" responses to each indicator or timeless question (in the case of subnational plans), scores were assigned for each element of the plan or strategy. Each question received a 1 for a "yes" answer and 0 for a "no" answer. Subquestions in the Indicators column (see Table 1) received fractional scores so that the total for any given indicator question would be 1.

In the detail of results, percentages reported represent both the number of indicators to which national health plans (and subnational entities) responded as a fraction of all categories and a fraction of the maximum score for each category obtained by the country, region, or subregion. For example, should the maximum score possible for category X be 96, a subregion whose scores summed to 32 on this category would have obtained 33% of the maximum score. At the same time, 78% of countries or subnational entities may have responded to category X with a range of scores, from 1 to the maximum score. Because three of the categories' maximum scores are 1—health equity as mission and vision; multisectoral action; and capacity to address violations of right to health—both percentages for the country and the category are equivalent, so for these three categories only the percentage of response will be reported.

It should be noted here that the term "score" here is not designed to indicate any qualitative or quantitative judgement of commitment to health equity, or efficiency of approach, but is only aimed at providing a mechanism to assess what particular components each country has included in its own context from the range of possible health equity approaches that have been identified. Without a further analysis of each context, it would not be possible to state whether the particular components included or emphasized in each case are likely to be appropriate to achieve health equity aims.

Results

Figure 1 demonstrates the results of the analysis of the 32 national health plans. The Region of the Americas achieved an average of 13.1 of a maximum health equity integration of 31 points using the rubric created for this analysis. El Salvador led the region due to its strategic plans to improve universal health, with a clearly stated goal to achieve UHC and include strategic actions to ensure nondiscrimination in access to health services. Additionally, the health plan of El Salvador highlighted actions to increase physical accessibility of health facilities and the numbers and distribution of health workers, and to dedicate funds to the provision of health care at the regional and local levels and to the acquisition of medicines and medical technology.

On the whole, the Region highly prioritized the explicit inclusion of achieving health equity in health plans, as more than 90% included this category in their plans. Assessed plans achieved greater than 50% of the maximum scores for the inclusion of monitoring plan progress objectives and targets and for making results available to the public (56%), whereas almost all countries (97%) included some provision.

Only one-third of health plans name Afro-descendants as a population that experiences barriers to health (31%), fewer than half name indigenous peoples (47%), one country mentions Roma, and 22% mention LGBT people. More than half (54%) of the maximum score was achieved for adopting measures to reduce barriers to health for people in situations of vulnerability (whether or not these groups are named) and 90% of countries included some aspect of this category topic in their plans (Figure 2).

People with disabilities and the poor are the most often named among vulnerable populations (in 66% of plans), but only 34% of plans include actions to reduce barriers to health for people with disabilities. Chile's National Health Strategy 2011–2020 is one of the few plans that do refer to outreach to or inclusion of identified vulnerable populations, including indigenous peoples, people with disabilities, people living in poverty, women, those with less education, the geographically isolated, and the homeless.

Countries have, on the whole, included attention to certain populations in situations of vulnerability in their health plans, though with a few notable exceptions, only about a quarter of plans identified Afro-descendants, fewer than half identified indigenous people, including some countries with large indigenous populations, and only four countries in the Region included attention to migrants. Fewer than a third of plans (28%) refer to any expectation that programs and services developed would be gender responsive, considering women's and men's specific needs.

The Region was less consistent in including mechanisms to ensure government accountability for the commitments made as part of the health planning process, with 38% of countries making mention of this need, and in ensuring government readiness to address violations of the right to health. Twenty-two percent of responses included some reference to addressing violations of the right to health. Only two countries' health plans discuss mechanisms for reporting right-to-health violations and three mention mechanisms for investigating and reducing fraud and corruption. El Salvador again led the Region in the inclusion of plans to educate citizens on their right to health and in reporting and investigation of violations of that right.

The other five categories assessed also appear to be well represented in the plans of the Region of the Americas. Notably, although fewer than half of plans included all elements related to addressing the social determinants of health (48%), 94% of countries made mention of the SDH in their strategic lines of action. No country included financing models that incentivize addressing the SDH in its plan.

> Under the framework of the National Policy on Social Participation, each health establishment, in coordination with the National Health Forum (FNS, Spanish abbreviation), will include in its annual operating plan mechanisms for social participation that guarantee deepening of citizens' oversight, decision-making and humanized treatment, including the necessary mechanisms to lodge complaints and make reparations for victims of violations of the right to health.
>
> - El Salvador, National Strategic Plan for Health, 2016-2025

Forty-two percent also included participatory processes, and nearly all plans (91%) consider participatory processes to be somewhat essential to the policy formulation, execution, and monitoring process. Close to 70% of these plans describe a development process that includes public engagement, civil society engagement, or both.

Plans achieved only a bit more than a third of the maximum scores for disaggregated data and targets (39%), with 66% of countries having included disaggregated data as a priority of some magnitude; equity for universal health (38% of maximum score), 97% inclusion; and work with multisectoral actors in the private sector (31% of maximum score).

Plans were also varied in their addressing of health and health care overall, including measures that are key to health equity. Most plans (*22*) included a goal to provide UHC, though the path toward this goal was less detailed. The most common areas addressed were medicines—with just under half of plans including interventions to increase access of marginalized populations to medicines (e.g., addressing affordability, reducing stock-outs in remote areas)—and physical accessibility, with just over half including at least one action to increase accessibility to quality primary health services in remote, rural, or otherwise underserved geographic areas or communities. Ten of 32 countries included actions to increase the number of health workers in underserved communities, though only Jamaica explicitly included strategic plans to recruit people from underrepresented communities into the health work force (*30*).

Less than half of countries, 40%, included time-bound targets on reducing absolute or relative health inequalities. On the whole, those setting such targets also have fairly equity-robust plans across the board. There are, however, notable exceptions that do set clear targets for health equity but include very few of the health equity indicators in the health plan. In addition, a few of the countries with the most robust plans have not yet set time-bound equity targets (*30*).

CHAPTER 2. ADDITIONAL RESULTS

Analysis by Date of Plan Approval

Figure 3 shows an analysis of the results of this assessment of health equity in national health plans by health equity rubric category and the date of health plan approval. The chart demonstrates that there is no noticeable trend in responses to categories based on the age of the health plans. In fact, with only universal health and accountability are any likely trends seen, as there has been a decline in the inclusion of universal health in health plans over time and an increase in the inclusion of accountability mechanisms over this same period. This analysis, though brief, is important to establish the validity of the observations made about the current state of health equity in policies and plans in the countries assessed.

Subregional Analyses

An analysis of study results by subregion of the Americas reveals important differences among the emphases placed on certain aspects of health equity in the plans assessed. Although health equity as mission and the establishment of monitoring mechanisms were the most likely to receive a majority of high scores across subregions, each subregion demonstrates important strengths that are worthwhile highlighting.

The Caribbean stands out among subregions in its prioritization of multisector collaboration with the private sector, with plans achieving 57% of the highest score in this category, while the numbers for the Southern Cone, Andean subregion, and Mexico and Central America are 20%, 0%, and 25%, respectively (Figure 2).

Andean Countries

The Andean countries lead all subregions in the inclusion of a variety of health equity indicators in the subregion members' national health plans. With an average score of 14.4 on the assessment rubric, Andean countries easily surpassed the regional average of 13.1 (Figure 1).

It is therefore no surprise that the Andean subregion's strengths are many. In addition to a shared prioritization of the inclusion of health equity as mission and vision and understanding of the importance of monitoring health inequalities seen across the Americas, Andean countries received high scores for:

- The inclusion of populations in situations of vulnerability, for which plans received 67% of the maximum score. All five countries included some method to increase the inclusion of populations in situations of vulnerability in their respective health plans;
- Data disaggregation and targeting (60% of maximum score);
- Participatory processes (56% of maximum score); and
- Actions to improve universal health (53% of maximum score).

Colombia leads this subregion due to its commitment to employing participatory processes for policy-making and planning. It is also one of the only countries assessed in any subregion that included among its definition of vulnerability a large swathe of populations, including: Afro-descendants; indigenous peoples; Roma peoples; people with disabilities; LGBT people; victims of the armed conflict; and the elderly.

Close behind these categories is the Andean subregion's attention to the social and environmental determinants of health, for which plans scored just under 50% of the maximum score.

Weaknesses among the Andean health plans include the almost complete omission of government accountability mechanisms; the absence of mention of private sector collaboration or oversight; and low commitment to improving the capacity to respond to violations of the right to health.

The Ministry undertook a process of consultation on the Decennial National Plan for Public Health 2012-2021 (PDSP, Spanish abbreviation) between March and October of 2012. The process convened various community and institutional actors using five strategies.

The first of these strategies is a territorial strategy with in-person meetings directed to the population at large and developed by an external third party (***Unión Temporal UNIDECENAL***). The territorial consultation was operated in 166 zones with the participation of 934 municipalities, four districts, 32 departmental and six regional meetings with a total of 20,018 citizens, local actors from the health sector and other participating sectors.

- Colombia, Ministry of Health, ***Plan Decenal de Salud Pública***, 2012-2021

Southern Cone

The Southern Cone subregion revealed similar tendencies, incorporating slightly fewer of the health equity elements than Andean countries with an average of 13.7 (Figure 1). In addition to the shared regional strength in the Americas with regard to the inclusion of health equity as part of plan mission and vision, Southern Cone countries demonstrate strong leadership in the inclusion of provisions to reduce barriers to access for populations in situations of vulnerability, as well as participatory processes and the inclusion of goals to achieve universal health (Figure 2). Uruguay leads the Southern Cone due to its particular commitment to the achievement of universal health and accessibility for people with disabilities.

Attention to both the social and environmental determinants of health and the collection of disaggregated data and targets is solid in this subregion (Figure 2).

In addition to the shortcomings common to all subregions (i.e., the creation of accountability mechanisms and building capacity to respond to health inequities), the main weakness among countries of the Southern Cone is the existence of very shallow collaboration with or oversight of the private sector. .

> Area of intervention: Access for all to health services, taking the life course into consideration and inclusion of disability as a dimension in all health policies.
>
> Lines of Action: Develop an operational manual that details a health service accessibility plan at all levels of attention for people living with disabilities.
>
> - Uruguay, Ministry of Public Health, ***Objetivos Sanitarios*** 2020

Mexico and Central America

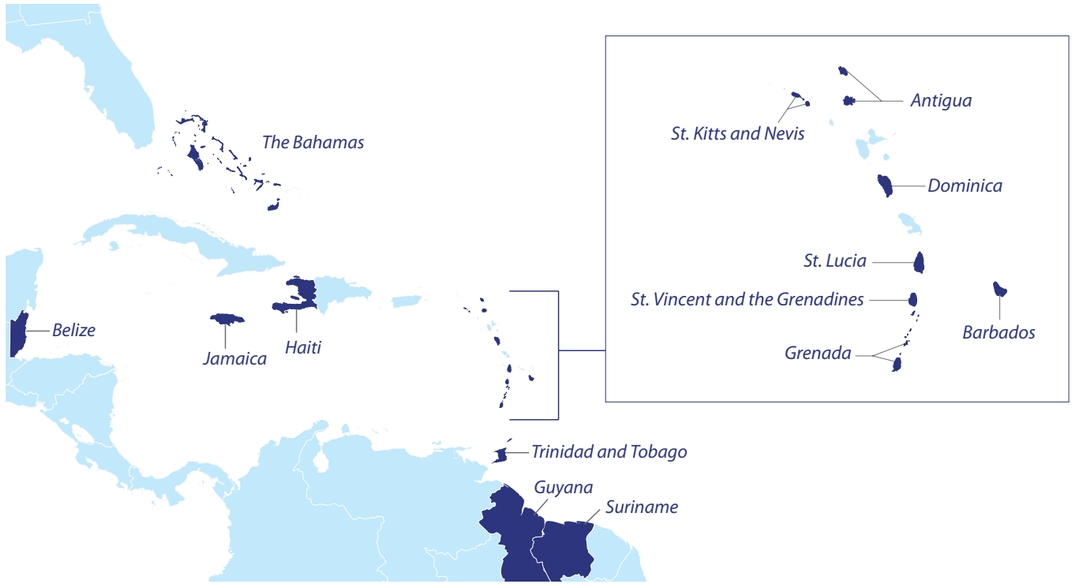
Although the plans of Mexico and Central America include less of the different health equity components, with a subregional average of 13.0 (Figure 1), the subregion shares strengths with other subregions, including health equity as mission and vision, as well as in incorporating monitoring mechanisms into national plans.

This subregion excels in its inclusion of populations in situations of vulnerability, with all countries indicating having identified and incorporated some mechanisms for the improvement of access for several groups. The Mexico and Central America subregion achieved almost three-fourths (71%) of the maximum score for this category (Figure 2). The health plans of both El Salvador and Honduras lead the subregion, with their emphases on participatory processes and the achievement of universal health.

Uniquely, collaboration with or oversight of private sector health providers is less commonly expressed in health plans in Mexico and Central America.

In addition, this subregion included comparatively less mention of the use of participatory mechanisms in plan design and monitoring (75% of countries only including 28% of the maximum number of identified relevant aspects in their plans).

Caribbean



The Caribbean subregion was well represented in this exercise, with assessed health plans including 12.54 of all identified health equity components (Figure 1). The subregion remains on par with others in its consideration of health equity as mission and vision and in the employment of mechanisms to monitor results, and stands out for its commitment to private sector collaboration and oversight (57% of countries), led mainly by Belize, Suriname, and Trinidad and Tobago.

The Caribbean subregion health plans also demonstrated a relatively solid inclusion of most all other health equity categories assessed. With regard to the inclusion of strategic actions to address the SDH, the Caribbean received 50% of the highest score for this category, and 93% of countries included actions related to addressing the SDH in their plans.

Additional satisfactory results are reported for the inclusion of populations in situations of vulnerability, participatory processes, data disaggregation and targets, capacity to respond to violations of the right to health, and universal health.

Guyana leads among countries in this subregion in overall health equity integration, and across categories for its actions to strengthen universal health.

The health plans for the Caribbean subregion were less rigorous in inclusion of strategic planning toward the adoption of accountability mechanisms for government.

Subnational Health Plan Analysis

Panama and Uruguay were chosen for subnational analysis due to their similar population sizes (Panama 4.3 million and Uruguay 3.4 million) and their representation of extremes of social and economic inequalities. In 2018, Panama was one of the countries with the highest levels of economic and social inequality in the Region as measured by the Gini coefficient (0.498), while Uruguay had the lowest Gini indicator in the Region at 0.391 in 2018 (*31*).

Convenience also played a role as these two countries also have a great deal of subnational government information available online. As mentioned above, the analysis of the subnational health plans for Panama[9] and Uruguay[10] differed from that of the national plans. The rubric used to analyze the subnational plans in these countries included only the timeless questions (Table 1). For this reason, the maximum overall integration score of health equity elements for the subnational plans was 12. When grouped, the subnational plans of both countries included 50% of the maximum health equity integration, higher than the result for the national plans.

Viewed separately, there was important variation in the inclusion of health equity in health plans between the countries and among departments and provinces.

Comparisons by Percent Response per Category

In comparing the subnational plans to the national plan (Figure 5), fewer of the subnational plans explicitly named health equity as their mission or objective, though significantly more subnational plans:

- Include provisions to address the social and environmental determinants of health, with all subnational plans making mention of strategic actions;
- Plan collaboration with or oversight of the private sector, 50% versus 34% of national plans; and
- Employ participatory processes for plan design. This category is led by Uruguay, where all departments reported participatory efforts and consultations.

Subnational health plans were less likely than national plans to: have established government accountability mechanisms, 13% of subnational plans and 38% of national; have created mechanisms to monitor outcomes, 57% of subnational plans versus 97% of national; and emphasize the need for disaggregated data for decision-making, 13% subnational and 66% national (Figure 5).

9 The analysis for Panama did not include the three provincial-level indigenous comarcas (territories) of Emberá, Guna Yala, and Ngōbe Buglé as these are autonomously governed.

10 Included among Uruguay departments are the plans for all capital city—Montevideo—municipalities, as there is no single unified city health plan.v

Comparisons by Percentage of Maximum Score in Category

Analysis by percentage of maximum category score brings to light additional strengths in addressing health equity at the subnational level (Figure 6). The subnational plans assessed were more likely than national plans to:

- Have responded to more of the social and environmental determinants of health indicators, with 100% of subnational plans incorporating all components for this category;
- Have responded to more items related to the goal of providing universal health. Panama provinces including three-quarters (75%) of all categories in this regard;
- Have responded positively to more items related to identifying and targeting health care for populations in situations of vulnerability, again led by 88% of Panama provinces (and 81% of Uruguay departments); and
- Have incorporated accountability into strategic plans for the health sector, with 13% of departments and provinces attaining the maximum score.

CHAPTER 3. INTERPRETATION OF FINDINGS: THE CONTEXT OF POLICY-MAKING

As stated above, this exercise is not intended to indicate any qualitative or quantitative judgement of commitment to health equity, nor can it measure the relative efficiency of the approach to achieving health equity taken by any one country or subregion; rather, it is a tool to assess which elements of a set of indicators of health equity a country has included in its national health plan. A different set of indicators might produce a different assessment. The context, therefore, is key to understanding how any analysis of policy or plan content currently in force in the Region can be interpreted. More importantly, contextualizing offers a road map to supporting the future design of pro-health equity policies and plans. Any further interpretation of results—in particular the reasons why some aspects are included and some not—would need to be undertaken with reference to national challenges and the realities of health equity in terms of wider socioeconomic development challenges as well as health system configurations, strengths, and weaknesses.

The interpretation of study results also relies on an understanding of the context in which health policy[11] planning and implementation is undertaken in the Americas. Though central and local government leads decision-making around national and local health aims, many other sectors and factors influence the content, focus, and implementation of policy. Of particular importance in the context of the Americas are political-economic circumstances and supranational actors that have taken center stage in policy considerations in this Region. Encouragingly, much of the Region is engaged in planning that considers many of the essential elements of pro-health equity policy. In this chapter we will explore the likely influence of decentralization, structural adjustment programs, and corruption in defining the content and scope of health policies and plans. Later, we will refer to their possible incidence on study findings.

Decentralization

Decentralization in Latin America has been linked closely with the market opening and re-democratization of the region that began the 1980s, after a period of military dictatorship and import substituting industrialization (ISI) that sought to transform Latin America from a dependent, "third world" provider of raw materials to a self-sufficient, industrialized society capable both of producing raw materials and adding the value to these products, which would improve the region's economic position and ensure economic growth *(33)*. ISI and the military dictatorships that fostered it as a development strategy ended mainly as a result of a series of economic shocks and crashes, a gradual regional slowing of

11 The WHO defines health policy as "a general statement of understanding [to] guide decision making that results from an agreement or consensus among relevant partners on the issues to be addressed and on the approaches or strategies to deal with them" (*32*).

economic growth, and increased influence of the Washington Consensus.[12] The objectives of decentralization are not only to increase community participation and social inclusion but also to enhance the competitiveness of local governments and enable them to develop fruitful partnerships with the private sector, though the latter has been less sought as a result of decentralization in the Latin American and Caribbean context (*34*).

As countries decentralize, budgets and decision-making power are transferred to subnational levels (e.g., states and municipalities) through a series of policy changes and adaptations meant to transform the role of the central government from sole provider to co-administrator. Decentralization in the region has contributed to fiscal and administrative strengthening of local government, improved communication and dialog between central and local government, and has been especially implemented in the areas of health and education (*34*).

Structural Adjustment

Structural adjustment policy reforms implemented as conditions to the receipt of International Monetary Fund (IMF) bailouts and related policy-focused loans financed by the International Bank for Reconstruction and Development (the World Bank) and the Inter-American Development Bank were meant to shore up balance of payments, reduce hyperinflation, and stabilize exchange rates in economies facing severe debt crises in the 1980s and 1990s, including those experiencing the results of failed ISI and authoritarianism in Latin America and the Caribbean. Cash-strapped economies were advised strongly by these international financial institutions to impose restrictions on government spending in health, education, employment and wages, and social safety net spending, while increasing productive income-generating pursuits that would facilitate timely loan repayment and attract foreign investment. The structural adjustment prescription formula of stabilization, liberalization, deregulation, and privatization was applied almost uniformly across the Region. Each, in its way, contributed to increasing inequalities (*35*), reducing the role of government in the provision of social services, and widening regional inequities, as newly "empowered" local governments were ill equipped to manage the funds and responsibilities being transferred to them under mandated decentralization. Following protests against the social and environmental impacts of structural adjustment in the early 2000s, the international financial institutions undertook reforms that shifted focus toward the active role of government in increasing competitiveness and globalizing markets (*36*).

12 The Washington Consensus is the common name for 10 policy reforms proposed by economist John Williamson in 1989 to renew growth in Latin America. The 10 reforms were: fiscal discipline; reordering public expenditure priorities to pro-growth and pro-poor; tax reform; liberalizing interest rates; competitive exchange rate; trade liberalization; liberalization of inward forward direct investment; privatization; and deregulation.

Corruption

The PAHO Commission on Equity and Health Inequalities in the Americas identifies corruption as an essential threat to health equity, impacting on citizens' trust in the health system. The presence of high levels of corruption is an indicator of low social cohesion and increasing inequalities, because it reduces access to services (*6*)"properties":{"form attedCitation":"(6. Similarly, the High-Level Commission on "Universal Health in the 21st Century: 40 Years of Alma-Ata" identifies corruption as a structural problem that should be combated by increasing transparency in the provision of information and the creation of accountability mechanisms (*17*), actions that also improve indices of health inequality and thus accelerate health equity.

Corruption or "abuse of public roles or resources, or use of illegitimate forms of political influence by public or private parties" (*37*) is often entrenched in health systems, particularly in "societies [formerly colonized by countries of the North and former Soviet states] with less adherence to the rule of law, less transparency, and less accountability mechanisms" (38) ensured through citizen involvement in public decisions and limits on the discretion of government officials (*37*). As such, corruption is a factor in both policy planning and implementation. The content of health policies, plans, and budgets may consciously or unconsciously be adjusted to account for corruption. For example, "within the health sector, investments may … tend to favor construction of hospitals and purchase of expensive, high-tech equipment over primary health-care" (*37*), where corrupt practices are most often seen. At the same time, costs of health sector corruption exert an outsize impact on the effectiveness of health policy to transform the health sector by providing universal health access and coverage, and on programming to provide universal health care and reduce health inequalities. Impacts even extend beyond the health sector, affecting "the possibility of a country's graduation from aid or mother support" (*38*).

The manifestations of corruption can range from the petty to more organized national and multinational operations. The most common types of corruption include: absenteeism; informal payments from patients; embezzlement and theft of money, supplies, and medications; provision of treatments not driven by medical considerations alone; favoritism; and manipulation of data (*38*). Corruption in the health sector has been linked to increases in long-run infant mortality (*39*) and maternal and infant birth outcomes (*40, 41*).

Canada, Cuba and the United States

Canada, Cuba, and the United States have all passed important public health laws aimed at increasing access to health services. The United States Code, "the codification by subject matter of the general and permanent laws of the United States" (*42*), includes a chapter on Public Health and Welfare in the 2017 version that issues instructions for the management of the public health sector. In addition, the Code of Federal Regulations, "the codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government" *(43*) also contains several chapters that include health equity issues like environmental health and food and drug regulation and public welfare under descriptions of the administrative regulations and special programs run by three arms of the Department of Health and Human Services—Public Health Service; Centers for Medicare and Medicaid Services; and Office of the Inspector General-Health Care. Finally, the Patient Protection and Affordable Care Act of 2010 is focused primarily on increasing access to health insurance and reducing the costs of health care (*44*). Though each of these legal provisions does reflect important aspects of health equity as assessed by the rubric, none incorporates enough of the categories to be fairly comparable with comprehensive national health plans. These documents are much longer and more complex than the health plans assessed for this exercise and do not represent the current planned strategic actions of the United States to address health overall.

Similar to the Patient Protection and Affordable Care Act, the Canada Health Act (R.S.C., 1985, c. C-6) has a generally narrow scope of focus on criteria for insured health services. The Act has as its primary aim "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (*45*). Again, despite its clear intent to improve indices of health inequalities caused by lack of access to health services, the Act would not fare well on the rubric used for the present study.

Cuba's Health Sector Law (Ley 41/83 *Ley de la Salud Pública*), though currently in the process of update, was passed in 1983 *(46)*. When the study rubric was applied to the Law, most responses were negative because the Law consists mainly of generic language that assigns responsibility for certain health-related functions to ministries, rather than laying out a set of strategic lines of action. Considering the robust nature of Cuba's equity focus under its UHA and UHC mandate *(47)*, an analysis of the Health Sector Law would have given a false view of how the country has incorporated health equity into its health planning apparatus.

Future work on health equity in policy in the Americas should look to increase comparability among countries of the Region. Though perhaps not possible through the comparison of policies, plans, and laws, this may be done through the creation of robust databases that share important health equity-related indicators. Such data would allow for a more accurate regional statement and monitoring of the regional trajectory toward or away from equity in health.

CHAPTER 4. CONCLUSIONS AND RECOMMENDATIONS

This study was undertaken to provide an overview of the state of the inclusion of specific health equity indicators in national and select subnational health plans in the Americas. The rubric used to evaluate health equity integration was designed specifically for the study, so no cross-regional comparisons are available that would allow for a better understanding of how the Region of the Americas is addressing health equity compared to others. That said, it is notable that the Region tends to focus its attention on certain aspects of health equity rather than others. **Regional strengths were seen in the definition of health equity as a goal of policy planning and implementation, and planning for the monitoring and disaggregation of data to track inequalities.**

Areas that are less represented, as identified by the results of this exercise, include:

- The identification of populations in situations of vulnerability who experience barriers to health and the creation of interventions to reduce barriers for these groups;
- The design and operationalization of accountability mechanisms whereby government commits to improving education on the right to health and creates mechanisms to enforce rights and report and investigate violations;
- Increasing community participation in the design, monitoring, and evaluation of health policy and plans; and
- Collaboration with and regulation of private sector health providers.

No differences in results were seen by health plan age, but subregional differences demonstrated that **the Andean and Southern Cone subregions lead the Region in overall incorporation of the various categories of health equity approaches into their health plans.** Both subregions' national health plans were weighted toward community participatory methods for policy and plan design and monitoring, gave weight to the need for monitoring and disaggregated data, made concerted efforts to identify a variety of groups at risk of facing barriers to health, and included several actions to improve universal health. Though the **Mexico and Central America subregion and the Caribbean subregion both fared well in terms of inclusion of comparatively more categories, they demonstrated unique strengths, particularly in their collaboration with and oversight of private sector health actors.** Future subregional work on health equity should be tailored both to take advantage of prior subregional advances in planning for equity and support increased work in areas where there is currently less attention.

The results also revealed that **subnational health plans**, though evaluated more simply, **surpassed national health plans in their engagement with the private sector and in their employ of participatory methods for plan design and monitoring.** Additionally, **unlike the national plans assessed where attention was satisfactory, subnational health plans placed heavy emphasis on actions to address the SDH.** There are two

important considerations to be made in interpreting the meaning of these subnational results for Panama and Uruguay. First, because "both countries are centralized states, rather than federations … the provincial health plans … were in a sense more implementation plans, following overall directions from the national health plans, rather than plans entirely within the discretion of the provinces" (*30*). And second, limiting rubric evaluation merely to the timeless questions may have led to inflated assessments that belie the same variations and oversights seen in the national plans.

Future analysis of subnational health plans across the Region of the Americas may reveal important differences between and among centralized and decentralized states, because, however positive decentralization has been for increasing the effectiveness of government programming for local level development, its impact on health equity has depended on political priorities at the local and national levels. Over 30 years, decentralization has advanced and receded across the Latin American region several times, providing important empirical data on the impacts of decentralization and recentralization on inequalities. The general consensus now is that decentralization may exacerbate inequalities under certain circumstances and that "balancing equity and efficiency goals" in decentralization efforts is the key to achieving equity (*48*).

In addition, the ability of subnational entities within centralized states to surpass the depth of attention but not extend the focus of national plans demonstrates increased local government capacity, as would be expected after almost four decades. As states engage in the dance of recentralization and decentralization over time, maintenance of local capacity will be key to maintaining and increasing an equity focus in health on the ground.

Similarly, the new face of structural adjustment may be exerting its own negative impacts, particularly on health equity. Under the revamped structural adjustment model, the World Bank and the Inter-American Development Bank turned to "targeting" health and social services to the poor as a strategy to correct the fallout of previous government and international financial institution market interventions, rather than supporting universal access and coverage (*35*).

There is also some evidence that conditions mandating labor market deregulation—e.g., cuts to or limits on wages and wage increases and workforce reductions, particularly in the public sector—are having the greatest impacts on health equity, as these directly influence health system access through lowered wages and unemployment (*35*). For some countries, this process has led to an erosion of public sector capacity to implement programs, handing this role over to nongovernmental actors, who over time have participated heavily in national health planning and goal setting (*49*). Structural adjustment has therefore both increased the number of extragovernmental actors involved in planning for health and dictated the extent to which, and areas in which, governments can plan to implement actions to address health inequities. This may explain the findings of overall high levels of commitment to universal health seen in the plans that were coupled with shallow lines of action.

Additionally, many of the plans assessed overlook issues of health workforce coverage and retention and eschew plans for private sector engagement on health—two areas often impacted by required cuts to wages and positions on the one hand, and facilitated entry into the health market on the other under structural adjustment (*50*). Research on the extent to which structural adjustment conditionalities do impact on health planning across the Region—and thus the Region's ability to accelerate action on health equity—could usefully therefore be a central topic of study for equity-focused health economists.

Finally, the ubiquity of corruption often means that much government attention is paid to actions to increase transparency and community participation in an effort to rein it in; but perhaps these government actions occur, at times, at the expense of other pro-equity actions (*51*). Again, the results here demonstrate that subregions whose citizens report a greater percentage of experiences with corruption in public clinics and health centers and who viewed the government itself as highly corrupt (*52*), like Andean countries and Mexico and Central America, are those whose plans were stronger than others in their employ of community participation in the policy design and in strategic plans for plan monitoring.

However, one of the main tools to combat corruption—accountability—is also missing from most of the health plans evaluated (*38*). Whether this lack of attention to accountability indicates the countries made no consideration of possible barriers to implementation placed by corrupt practices is unclear. In future, research should look specifically at anticorruption policies meant to address the public and private health sectors.

Recommendations

The following are recommendations for the Region of the Americas with regard to accelerating the incorporation of equity into health planning.

1. Given inconsistencies in the identification of groups considered to face barriers to health in policies, and in the actions to tackle these barriers:
    - Develop consistent and standardized methods for identifying groups in situations of vulnerability;
    - Generate further evidence and analysis on the processes by which vulnerabilities are created; and
    - Pair identification of these groups and processes with evidence-based actions to reduce barriers to health and satisfy unmet needs and guarantee rights in relation to health.

2. Given that the goals of incorporating health equity into planning are to: (1) implement actions that will reduce health inequalities and increase health access for all; and (2) estimate the financial costs of implementation and execute programming efficiently and effectively; and given the disparate nature of the inclusion of health equity considerations and approaches in policies and plans assessed in this exercise in ways that may perhaps not represent the most efficient use of funding:

    - Encourage and finance further research to explore which specific policies and actions work to reduce inequities in health access and outcomes from the health sector, as well as in multisectoral action in relation to the specific national contexts of policy-making, the groups in situations of vulnerability in each context, and the processes by which vulnerability is created; and

    - Promote the redirection of budgets toward evidence-based policies and programs and away from those that may result in negative consequences with regard to inequalities and access.

3. Given the varied results in terms of the current inclusion of different elements of health equity and, therefore, the lack of comparability between and among countries for tracking progress in the implementation of potentially effective actions across the Region:

    - Facilitate agreement on a regional framework that incorporates the variety of actions already being taken toward health (as demonstrated in the implementation of this preliminary rubric) as well as best evidence, and emerging research results, with respect to their relative impacts;

    - Revise and further evolve the regional rubric proposed here, and develop and agree on related indicators to evaluate health equity in policy, plans, and implementation for the health sector and beyond.

4. Given the significance of planning for accountability as a means to increase trust in health institutions and improve financial efficiency and the sound efforts made by countries toward community participation:

    - Promote further efforts to institutionalize and educate citizens, residents, and migrants on the existence and use of accountability mechanisms to address violations of the right to health at the level of health service access and at the national and subnational levels to address inequities in health outcomes.

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APPENDICES

Figure 1. Average tendencies for health equity integration

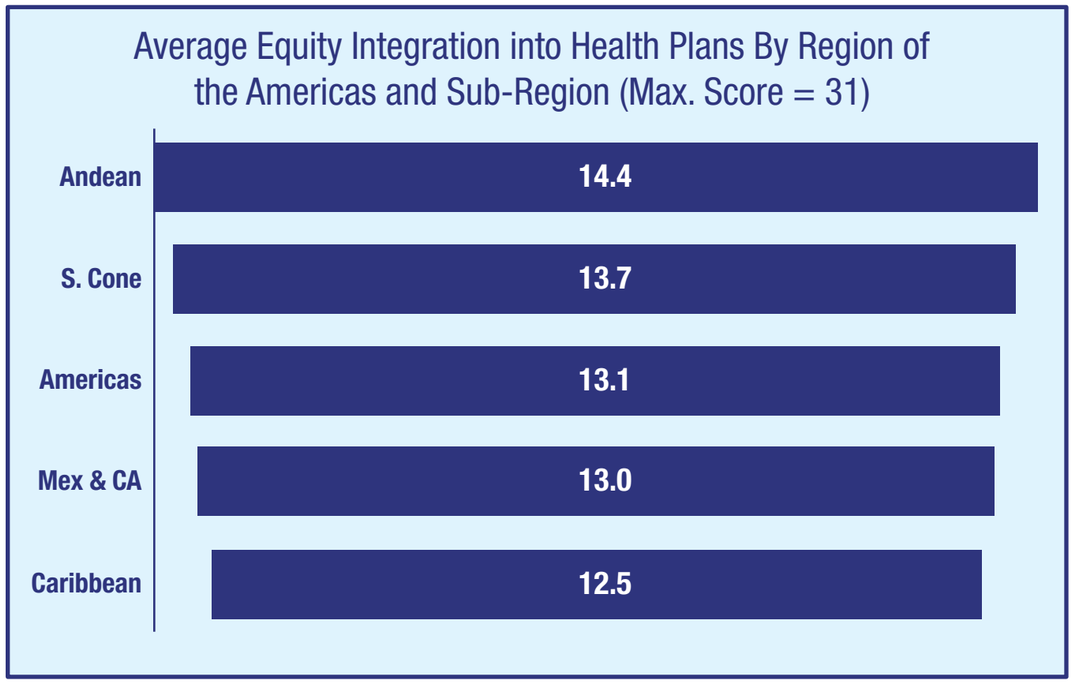


Figure 2. Health equity integration as percentage of maximum category score by Region of the Americas and subregions

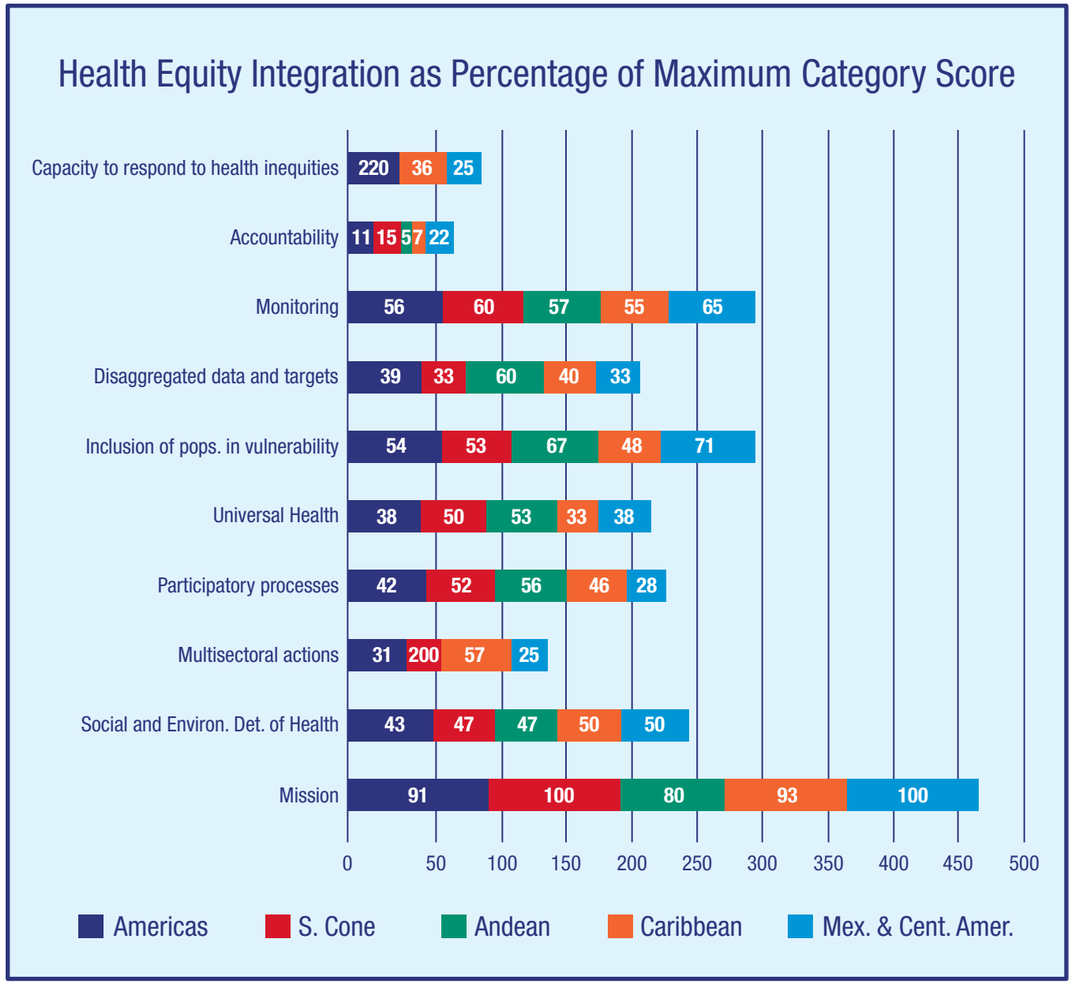


Figure 3. Health equity integration by category and plan approval date

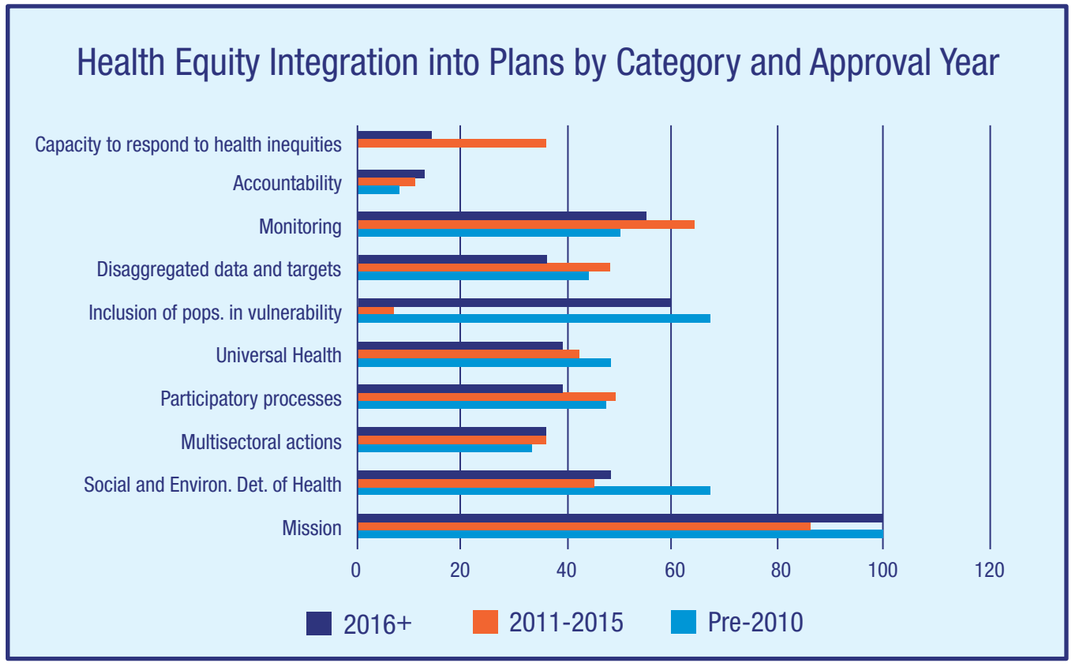


Figure 4. Average tendencies for subnational health equity integration

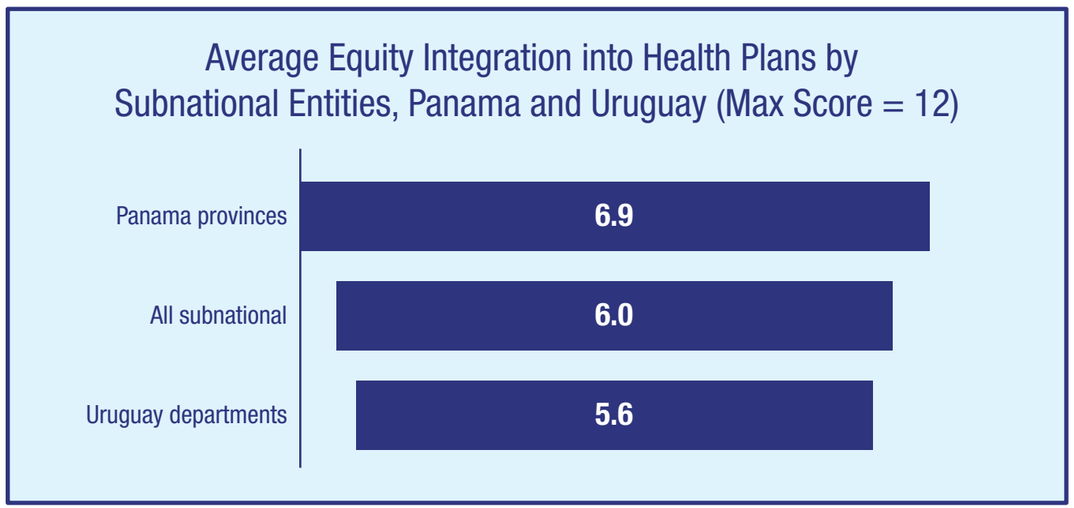


Figure 5. Percentage of responses, Region of the Americas and subnational entities (Panama and Uruguay)

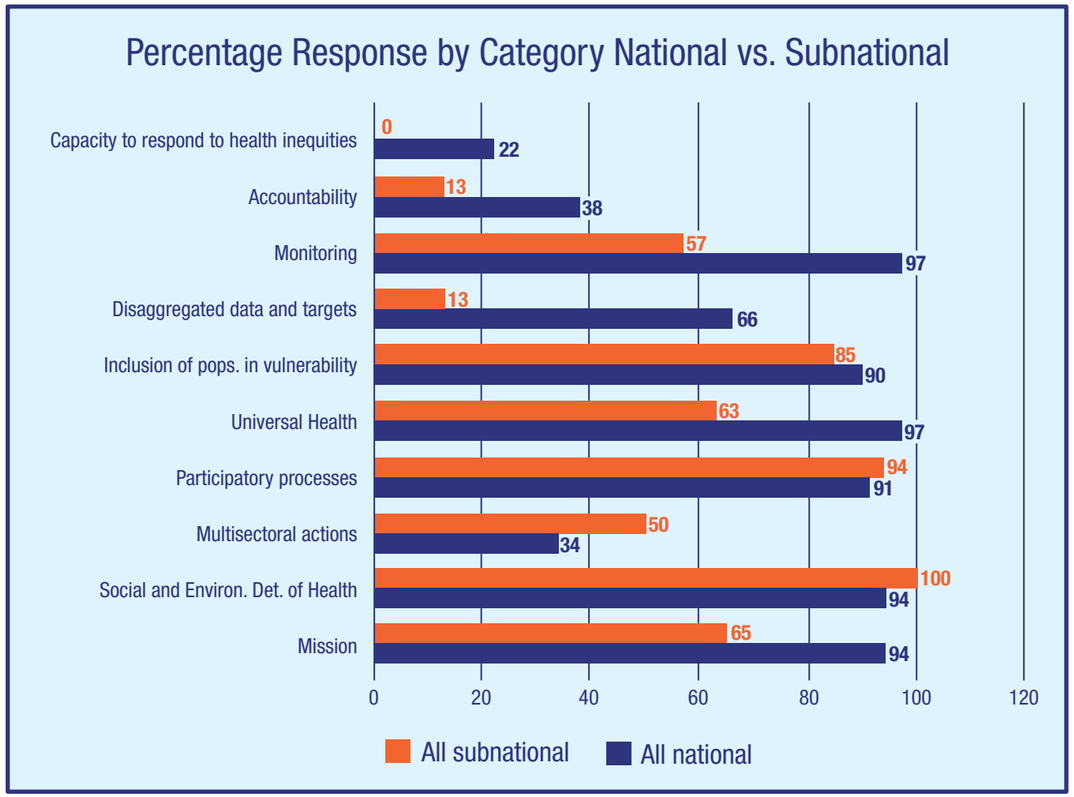
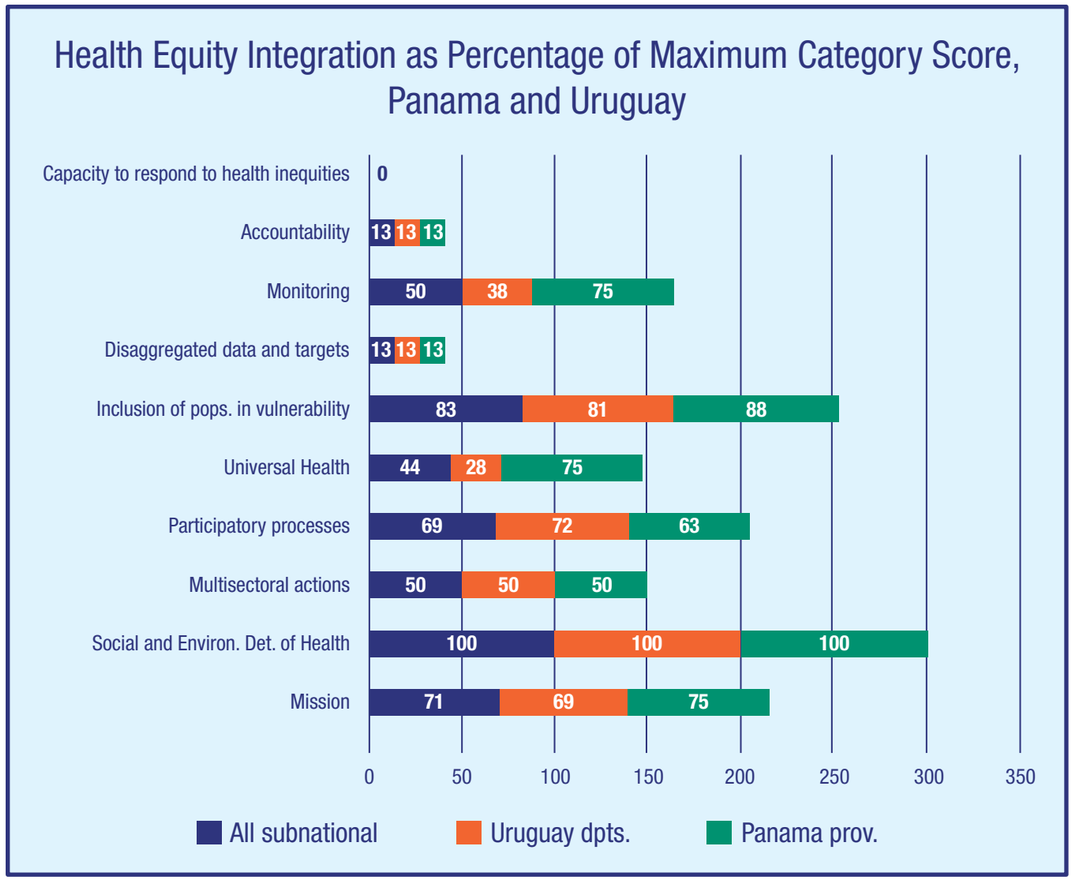


Figure 6. Health equity integration as percentage of maximum subnational category, Panama and Uruguay



The Region of the Americas has prioritized the achievement of health equity—"the absence of avoidable or remediable differences among groups of people, whether these groups are defined socially, economically, demographically or geographically" (WHO)—both through regional agreements, such as the Sustainable Health Agenda for the Americas (2017), and by reporting progress toward the 2030 Agenda for Sustainable Development (the Sustainable Development Goals) (2015). Public sector policy is the principal initial lever through which both national and local governments institute and finance actions toward accelerating the achievement of equity in health. This study assessed 32 national health plans to report on whether and how countries in the Region are integrating the achievement of health equity into strategic lines of action in the health sector. It provides a snapshot of approaches and advances, allowing for knowledge sharing among countries on options for attention to equity in health policy. It will also facilitate future monitoring of trends in the integration of health equity aims and approaches in policies.

The study found that stated overall commitments to health equity are common, as are commitments toward the disaggregation of data and monitoring of inequalities, while other elements of health equity like, for example, the identification of populations in situations of vulnerability, receive less attention. While further study is needed on the implementation and impacts of approaches in specific programmatic actions, the study provides useful insights to inform efforts for a stronger framework for health equity action toward the Region's goals for 2030.

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